CenterinG
Newsletter of THE CENTER: Posttraumatic Disorders Program
VOLUME1, NO. 2, FALL 1996

Preventing Revictimization

Mary Ann Dutton, Ph. D.

Victimization not only leads to posttraumatic and other distressing psychological reactions, it can increase vulnerability to revictimization, such as domestic violence from an intimate partner, sexual assault by an acquaintance or stranger, or sexual harassment by a coworker or employer. Revictimization may also be in the form of continued violence and abuse from the initial perpetrator, such as in the case when a parent/caretaker or sibling continues sexual abuse from childhood into adulthood or when domestic violence is chronic. This article briefly discusses pathways from traumatization by violence and abuse to later revictimization. It also describes prevention efforts for reducing revictimization among individuals who have been chronically and severely traumatized by childhood physical, sexual, and psychological abuse. The term "victim" will be used to acknowledge the trauma done, although the term "survivor" would also be appropriate.

Impact of Traumatic Experience

Traumatic experiences such as physical, sexual, and psychological abuse are associated with various types of traumatic reactions, including flashbacks and intrusive nightmares, dissociation, depression and suicidality, substance abuse, somatic complaints, difficulty with regulation of affect, disruption of trust, difficulty with interpersonal boundaries, and changes in beliefs about self, others, and the world (Herman, 1992; van der Kolk, 1996). Traumatic experiences and others' response to them also help to socialize victims about "normative" behavior, for example, concerning the level of violence tolerated within the family, gender-role expectations, and culturally-sanctioned strategies for responding to violence.

Pathways to Revictimization

Both traumatic reactions and socialized behaviors and beliefs increase the victim's vulnerability to revictimization.

- *Numbing of responsiveness* to the environment increases vulnerability to revictimization by decreasing the victim's ability both to identify cues of threat and to respond effectively to actual danger.
- *The reduced energy level* associate with depression increases vulnerability to revictimization by decreasing one's personal resources available to take action to protect oneself from danger. Further, *suicidal and self-harming behaviors* may increase the likelihood that intimate partners and family members are brought into the treatment process. Without adequate screening and identification, the risks for revictimization that these individuals pose may go unrecognized.
- The downward social mobility often associated with chronic and disabling emotional and psychological distress increases vulnerability to revictimization. Employment instability reduces economic resources, thus increasing the victim's dependency on others. With fewer options for living independently, the vulnerability to revictimization from those who can provide such resources (e.g., shelter, transportation, clothing, childcare, access to mental health treatment) increases.
- *Anger and hostility*, normal reactions to abusive experiences, may lead to aggressive and violent behavior which in turn increases vulnerability to revictimization. Angry feelings may turn to aggressive behavior, for example, when the victim experiences the intrusion of memories of prior traumatic events.
- *Damage to self perception* increases vulnerability to revictimization through shame and low self-esteem. Believing that one is undeserving or unworthy may decrease the likelihood that one will take protective action, even when such danger is perceived.
- *Disruptions in the ability to develop healthy emotional attachments* can increase vulnerability to revictimization. Subsequent unhealthy attachments may be associated with minimizing the damaging impact of violent or abusive experiences and, instead, idealizing the perpetrator as someone who is "wiser" than is the victim or is someone whom the victim cannot live without.
- Victimization can socialize a victim to believe that *violence and abuse is normal, inevitable, or at least not unusual* within intimate and family relationships, by men against women, or by those with authority over those in subordinate roles.
- *Stereotypic gender-role socialization* often underscored by abusive experiences, especially during childhood, increases vulnerability to revictimization, especially among women and girls. In such cases, women may perceive self-protective behavior and boundary-setting with males and those in authority as "out-of-role" and, thus, not "nice" or appropriate.
- The victim's *actual experience of no one being available, willing, or able to protect* increases the risk of revictimization. These socialized beliefs make efforts to seek help and support from others less likely, even when the victim's appraisal of risk is clear.

Prevention of Revictimization

Risk assessment and safety planning are

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essential to the prevention of revictimization. Universal violence screening has been recommended by major health care organizations (e.g., AMA, APA) as routine practice for health care professionals in all settings. The emphasis here is on its role as a means of secondary prevention, that is, identification and assessment of current risk for those with a prior history of victimization (Dutton, et al., 1996). Several protocols for risk identification and assessment are available (cf. AMA, 1995; Campbell, 1995). Important considerations are to conduct the inquiry in private, to ask questions directly, to use behaviorally descriptive language (e.g., hitting, touching sexually) rather than labels (e.g., abuse), and to inquire in a supportive and empathic manner.

When risk assessment identifies current risk, safety planning becomes a necessary next step. Safety planning can be developed (1) when the victim has chosen to remain in a situation where the perpetrator has physical access to the victim (e.g., living together, employment situation), (2) when the victim is in a transition period deciding about the status of a relationship with a perpetrator, and (3) when the victim has terminated the relationship with a perpetrator or one who poses such risks. Mandatory reporting does not typically apply to the victimization of adults (with some exceptions). Extreme caution should be taken when concerns about revictimization are disclosed to anyone other than the victim since doing so may actually increase the risk of danger and may be a violation of confidentiality. Safety planning is a process, not merely a product. The goals are to empower victims to identify cues to danger, consider alternative responses to it, evaluate those alternatives in terms of their risks and benefits, and take action when it is appropriate to do so. Safety planning is a dynamic, not static, process in which the former victim can acquire the skills necessary to engage in ongoing safety planning, revising the plan as changes in the situation demand.

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