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PRIOR VICTIMIZATION: A RISK FACTOR FOR CHILD SEXUAL ABUSE AND FOR PTSD-RELATED SYMPTOMATOLOGY AMONG SEXUALLY ABUSED YOUTH

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Abstract—The experience of prior victimization (sexual and nonsexual) was found to increase children's risk for experiencing later child sexual abuse (CSA) in a national random sample of 2,000 American children aged 10–16 years. Prior victimization predicted subsequent CSA even when background variables (child's gender, race, age, geographic location, quality of relationship with parents, and relative level of violence in the home community) were controlled for. In addition, the prior victimization of a family member also predicted later CSA. Among children who experienced CSA, prior victimization increased the level of post-traumatic stress symptomatology, even after demographic factors and characteristics of the CSA episode (e.g., severity of the assault, severity of injury, fear of death or serious injury) were included in the model. These results suggest that prior victimization is a factor that needs to be addressed by educators who design CSA prevention interventions and by mental health professionals who counsel child victims of sexual abuse.

Key Words—Sexual abuse, PTSD, Risk, Children.

ONE OF THE most provocative findings in the literature on sexual assault is that people seem more at risk for sexual assault if they have experienced a *previous* sexual victimization. Several studies have found that survivors of child sexual abuse (CSA) are more likely than other women to experience rape as an adult as well (Frieze, 1983; Fromuth, 1986; Herman, 1981; Russell, 1986). However, several issues relevant to this very important finding need to be addressed.

First, is the relationship between prior and subsequent sexual victimization found *within* childhood as well as between childhood and adulthood? Most research has examined prior childhood sexual abuse as a risk factor for *adult* sexual victimization. But it seems plausible that one sexual abuse would create vulnerability for another sexual abuse even during childhood. Unfortunately, studies of risk factors for sexual abuse in childhood have not included prior CSA as a variable (e.g., Finkelhor, 1980; Gruber & Jones, 1983).

Second, could other kinds of prior victimization besides sexual abuse also increase vulnerability for later sexual abuse? Many of the dynamics that link prior and subsequent sexual abuse might also apply to prior *nonsexual* victimizations, like physical assaults, gang assaults, attempted kidnappings or assaults by siblings, making them risk factors for CSA. Moeller, Bachmann, and Moeller (1993) found that, among adult women, the number of *different types*

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of childhood victimization, not childhood sexual assault alone, predicted sexual assault as an adult. In the only study to address the temporal relationship between CSA and other forms of child abuse with child subjects, Paradise, Rose, Sleeper, and Nathanson (1994) found an association between CSA and *prior* physical abuse or neglect as documented in children's hospital records. Twelve percent of 154 sexually abused children, but only 4% of the 53 nonabused control children, had records of prior physical abuse and neglect. Although this association was not statistically significant, the first author of this research indicated that she was "clinically impressed" with the difference in prior, nonsexual victimization between the groups (J. Paradise, personal communication, April, 1994). Although such research suggests that prior nonsexual victimization may serve as a risk factor for subsequent CSA, more evidence is needed to address this question.

A third question that needs to be addressed is whether the victimization of another family member, what has been termed *indirect victimization*, could also be a risk factor for child sexual abuse. Indirect victimizations can have a large impact on children (Kilpatrick & Resnick, 1993), and it seems plausible that they might affect children's vulnerability in similar ways to direct assault.

Fourth, can the relationship between prior and subsequent victimization be demonstrated independent of other prior risk factors? Some of the other risk factors that should be considered are suggested by current theory in the field of criminal victimology (Miethe & Meier, 1994). This theory draws attention to risk factors for victimization like proximity to high crime areas, exposure to crime via risky behavior, absence of adequate guardianship against victimization, and defenselessness, which would make a person a more attractive target for an offender. One plausible explanation of the connection between prior and subsequent assault is through "proximity to crime," that people who live in dangerous communities are exposed to more predatory individuals and thus suffer more victimizations. Another is that children who are less well supervised by parents because of impaired relationships have less "guardianship" and are therefore more vulnerable to multiple victimizations. A thorough analysis of the relationship between prior and subsequent victimization needs to control for the potentially confounding influence of such factors.

The present paper will try to expand the findings on prior victimization in each of these areas: the extent to which prior victimization represents a risk factor for sexual victimization *during childhood*, the extent to which forms of *nonsexual victimization* and *indirect victimization* are also risk factors, and the extent to which these such relationships exist even controlling for dangerous environments and low-quality parent-child relationships.

The Effects of Prior Victimization on Response to Subsequent CSA

This research also seeks to expand the study of prior victimization into one additional area: effect of prior victimization on the *response* to child sexual abuse. If prior abuse serves as a risk factor for experiencing later abuse, it might also exert an influence on reactions to that abuse. For example, previous assault might result in symptoms of post-traumatic stress that are then aggravated by a later experience. This hypothesis finds support in current theory about traumatic reactions.

Foa and her colleagues suggest that traumas get represented in memory by "fear structures"—networks containing information about a fear-invoking situation, about responses that may be made to this situation, and subjective information about the meaning of the situation and responses (Foa & Kozak, 1986; Foa, Steketee, & Rothbaum, 1989). Stimuli associated with a fear-invoking situation (like victimization) come to signal fear in and of themselves, and may therefore trigger fear-related responses such as anxiety, numbing, or avoidance. We hypothesize that, in the case of multiple victimizations, the survivor may generate multiple

fear structures in memory, with a concomitant increase in the number of different stimuli that could potentially trigger a PTSD-related response. For example, a child who is physically assaulted by peers on the school yard may come to develop a fear response to the school yard, the school, and to activities that remind him or her of the school yard environment (swings, a basketball hoop, etc.). If that child is also sexually assaulted in another setting, a second fear structure arises, containing an entirely new set of cues. This child might have a much more diverse and more easily triggered fear structure, and therefore be more prone to trauma symptomatology, than a child who has only been victimized in one situation. In support of this hypothesis, the research literature has shown that Vietnam veterans were more likely to develop PTSD after similar levels of stress exposure, if they had been previously abused in childhood (Bremner, Southwick, Brett, Fontana, Rosenheck, & Charney, 1992). It seems plausible that such trauma reactions may be more likely among sexually assaulted children if they, too, had been previously victimized or abused.

Thus, the present study will test the hypothesis that child victims of CSA who have been previously victimized will show increased trauma-related symptomatology. Consistent with some of the other previous hypotheses, we will also examine whether such effects can be associated with a variety of both sexual and *nonsexual prior victimizations*, including *indirect victimization*. This latter prediction is based upon research showing that concrete and vivid information is more likely to impact people's judgments and mental processes than abstract "facts" (Kahneman & Tversky, 1973; Nisbett & Ross, 1980) and that concepts that are presented repeatedly are likely to be readily accessible in memory (Higgins, 1989). A child whose sibling was mugged on the way home from school might develop fear structures for the home-to-school route as a result of their exposure to the concrete and possibly vivid description of their sibling's victimization, resulting, over time, in the development of post-traumatic-like symptomatology. Research on the effects of indirect victimization support this hypothesis, and suggest the presence of post-traumatic stress symptomatology among the family members of people who are physically assaulted (Kilpatrick & Resnick, 1993) or sexually assaulted (Resnick, Veronen, & Saunders, 1988).

Whether direct or indirect, the contribution of prior victimization to symptomatology must be considered in the context of other factors that have been shown, over wide variety of studies, to contribute to trauma (Browne & Finkelhor, 1986). It is possible that prior victimization might be associated with trauma-related symptomatology not because it predisposes children to be more fearful during subsequent episodes, but because it interacts with other episode-related characteristics. The present study will therefore assess the extent to which prior victimization explains PTSD-related symptomatology over and above the contribution made by characteristics of the subsequent CSA episode (e.g., severity of abuse, extent of injury, identity of perpetrator, etc.), demographic characteristics, and the quality of the parent-child relationship.

METHOD

Survey Sample

Contacting respondents. Study staff interviewed by telephone a nationally-representative sample of 2,000 young people between the ages of 10 and 16 and their adult caretakers. A national sample of households was contacted and screened for the presence of appropriately-aged young people through random digit dialing. Telephone interviewing is a cost-effective methodology (Weeks, Kulka, Lessler, & Whitmore, 1983), demonstrated to be comparable in reliability and validity to in-person interviews, even for sensitive subjects (Bajos, Spira, Ducot, & Messiah, 1992; Bermack,

1989; Czaja, 1987; Marin & Marin, 1989) and assessment of psychological symptomatology (Potts, Daniels, Burnam, & Wells, 1990; Wells, Burnam, Leake, & Robbins, 1988).

Interviewers spoke with the primary caretaker in each household, explained the objectives of the study, and obtained a variety of information about the household and about their perceptions of children's vulnerability to crime. After obtaining parental permission, interviewers talked to a randomly selected child, described the study to the child, obtained their consent, and proceeded with an interview that lasted between 30 minutes and an hour. The participation rate was 88% of adults approached and 82% of the eligible children in the households of cooperating adults. Parents were slightly more likely to bar younger children (ages 10 and 11) from participating than older children [ages 12–16; 18% vs. 13%; $\chi^2(1) = 10.87, p < .001$]. Parents who were willing to let their children participate reported that they perceived violence to be more of a problem in their community ($M = 2.07, SD = .84$; scale range 1 = "not a problem" to 4 "a great problem") than did parents who denied permission [$M = 1.94, SD = .84; t(2,419) = 2.74, p < .005$]. There were no other significant differences between eligible households that did and did not participate in the study.

Final sample. The final sample of 1,042 boys and 958 girls was fairly well-matched to U.S. Census statistics for a population of this age: about 10% Black, 7% Hispanic, and 3% from other races including American Indian and Asian. Fourteen percent came from families with annual incomes of under \$20,000, and 41% came from families in which the highest level of education attained by the household head was high school or less. Fifteen percent were living with a single parent at the time of the survey, another 13% with a parent and a step-parent, and 3% with a nonparental caretaker. Because the majority of children lived with a parent or parents, the term *parents* will be used in this paper to refer to children's caretakers. A summary of the demographic characteristics of the children in the whole sample ($N = 2,000$) is presented in Table 1.

Survey Measures

Assessment of victimization. Adolescents in this sample were asked a total of 12 screener questions about victimizations they might have experienced, including six screener questions concerning sexual victimization and six concerning nonsexual forms of victimization. Of the nonsexual screeners, two dealt with physical assault committed by nonfamily members, two with physical assault by family members (not including spanking), one with attempted or completed kidnapping, and one with violent assault to the genitals (a primarily violent, not sexual, assault). In addition, children were asked to indicate whether a family member had ever been "attacked, robbed, mugged, or sexually abused." The screener questions assessed whether or not a child had experienced each form of victimization and when the *most recent* episode of that victimization occurred. (Additional information about these items may be found in Appendix A.)

Assessment of sexual victimization. Classification of sexually abused children was based on a two-stage process. Children initially responded to the six screener questions that described various forms of sexual victimization they might have experienced. Up to two of these victimization screeners were "followed up" immediately after the screener section with more extensive questions to elicit details about the CSA episode. Children who indicated that they had been sexually abused in response to a screener question and who provided details about the episode in the follow-up period were classified as having been sexually abused. Prior research with this sample has suggested that even apparently "mild" forms of child sexual victimization (e.g., being propositioned by an older person, being shown pornography, etc.) may be associated

Table 1. Sample Demographics

	<i>n</i>	% Sample
Children's Age		
10 years	268	13%
11 years	326	16%
12 years	315	16%
13 years	288	15%
14 years	279	14%
15 years	281	15%
16 years	226	11%
Parent's Education		
Less than high school	159	8%
High school grad.	654	33%
Some college	564	28%
College graduate	319	16%
Graduate	298	15%
Geographic Location		
Large city	273	14%
Large city suburb	399	20%
Large town	327	16%
Small town	553	28%
Rural	428	22%
Caretaker(s) Child Lives With		
Both natural parents	1,311	70%
1 natural parent	296	15%
1 natural/1 step	258	13%
Other	52	3%
Child's Race		
Black	194	10%
White	1,604	80%
Hispanic	138	7%
Other	57	3%

N = 2,000.

with increases in symptomatology (e.g., depression, PTSD-related symptoms, school-related difficulties; Boney-McCoy & Finkelhor, 1994). We therefore included children with "minor" CSA experiences like these, as well as children who reported sexual abuse involving the genital contact or penetration in our classification of child sexual abuse.

Trauma symptoms related to post-traumatic stress disorder. Because of the extremely low incidence of clinically diagnosable post-traumatic stress disorder (PTSD) in the general child population (cf. McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988), no attempt was made to render a formal DSM-IV diagnosis of this disorder. Instead, children were asked to indicate how often in the past week they had experienced each of 10 symptoms that have been associated with post-traumatic stress. These symptoms were not specific to any particular event and could thus be assessed for children who had not been victimized as well as for those who had. The symptoms were taken from a modified version of the Symptom Checklist-90&-Revised (SCL-90-R; Derogatis, 1977; modified by Saunders, Arata, & Kilpatrick, 1990), such as "thoughts and images that are frightening," "trouble falling asleep," and "temper outbursts you could not control." Responses included "not at all" (coded 1), "only a little bit" (coded 2), and "quite a bit" (coded 3) to create a scale that could range from 10 to 30 ($A = .75$). A version of this scale has performed adequately ($\eta = .70$) in comparison with structured clinical interviews of adult women. Women with higher scores on these items were more likely to be diagnosed with PTSD (B. Saunders, personal communication, November, 1993). This scale has been used in other research on trauma in young people (J. R. Freedy, personal communica-

tion, April, 1994). Although they cannot be used to yield a clinical diagnosis of PTSD, higher scores on this scale reflect higher levels of symptomatology *related to* PTSD, in that these items include PTSD symptoms specified in the DSM-IV (American Psychiatric Association, 1994) and appear to discriminate between persons with a formal clinical diagnosis of PTSD and those without it. (A complete copy of this scale is given in Appendix B.)

Episode characteristics. We assessed the contribution of nine CSA episode characteristics to post-CSA symptomatology. The first was a three-level index of *abuse severity* based on extent of contact (1 = "attempted" sexual abuse, e.g., being propositioned by an older, unrelated individual; 2 = "serious, noncontact" sexual abuse, e.g., being propositioned by a parent or witnessing an exhibitionist; 3 = "contact" sexual abuse, e.g. ranging from fondling above clothes to genital penetration). The second characteristic included was *extent of injury received* (a 0 to 4 scale reflecting the number of the following consequences reported by the child: cuts and bruises; bleeding; hurting the next day; seeing a doctor or going to the hospital). Additional episode characteristics included: whether or not the perpetrator threatened to hurt the child; whether or not the child feared serious injury or death during the episode; the closeness of the relationship between the child and the perpetrator (range from 1 = stranger to 5 = parent); whether or not the perpetrator was using alcohol or drugs during the episode; the number of times the child had been sexually abused; whether or not this episode was one of a series of sexual abuses by the same perpetrator; and the child's age at the time of the CSA. For children who provided us with episode characteristics on more than one CSA incident, we chose the episode characteristics from the most serious incident. This choice seemed to maximize the potential contribution of episode characteristics to PTSD-related symptomatology, and hence to provide a more stringent test of the unique contribution of prior victimization in multivariate analyses.

Demographic measures. Respondents' parents were asked to identify their geographic location (a 5-point scale ranging from "rural area" to "large city," their own level of education as a measure of SES (a 5-point scale ranging from "less than high school" to "post-graduate work"), their race (coded as two dummy variables: Black or not; White or not), and their child's gender and current age. Children indicated whether or not they lived with both biological parents at the time of the interview. Finally, an index was constructed to reflect parents' perceptions of the safety of their community. Parents were asked five questions, including: "How much of a problem is violence in your (son's/daughter's school)?" "How concerned are you about your [child's] safety: At school? On the way to school? In your neighborhood?" and "How much of a problem is violence in your community?" Parental responses to these questions were made on 4-point scales, on which higher scores reflected more concern or more perceived community violence. Parents' responses were summed to form an index reflecting their perception of the level of violence or danger from violence in their community ($A = .73$). Although an independent index of community violence would have been preferable to this measure (which could be influenced by parental reaction to their own children's victimization experiences), parental perceptions of community danger provide an indication of the general safety level of the communities in which the children reside. Such a measure is desirable in these analyses, to assess the extent to which overall community violence level, and not prior victimization, might be responsible for any effects seen on the dependent variables.

Quality of parent-child relationship. Children in our sample also responded to seven items assessing the quality of their relationship with their parents or adult caretakers (e.g., "Does [the parent who knows most about your activities] know who you are with when you are not at home?"; see Appendix C) that were summed to form an index of the quality of the parent-

child relationship ($A = .67$). Scores on this scale ranged from 7 to 35, with higher scores indicating higher-quality relationships.

RESULTS

Prior Victimization as a Risk Factor for CSA

Analyses were conducted to assess whether victimization that occurred prior to the past year would predict CSA occurring *within* the past year. This time frame was chosen because we had clear indicators from the screener questions of whether or not children's sexual abuse and other victimizations fell within or prior to this time, and because there were a sufficient number of children with CSA during the past year to make statistical analyses meaningful.

Classification of children. Children were classified as having experienced a sexual abuse in the past year ($n = 132$) or not ($n = 1,746$). Some cases (25 sexually-abused children and 57 nonsexually-abused children) were excluded from analyses due to missing information on at least one of the 27 variables used. Chi-square tests revealed that the sexually-abused children who were included in the sample did not differ from those who were excluded on any of the demographic factors considered, on quality of parent-child relationship, or on any dimension of prior victimization (all $ps > .14$). Among nonsexually-abused children, those included in the sample differed from those excluded due to missing data on only two measures. Children who were excluded due to missing data were more likely than included children to live in communities described as violent or dangerous by their parents (63% vs. 46% of included children, $p < .01$), and tended to be younger in age than included children (37% over age 12 vs. 53% of the included children over age 12). Of the sexually-assaulted children, 37 (28%) were male and 95 (72%) were female. Fifty-one percent of these sexual abuses were classified as "attempted" ($n = 67$), 19% were classified as "serious noncontact" ($n = 25$), and 30% fell into the category of "contact" sexual abuse ($n = 40$). Prior national surveys of reported child abuse and neglect have estimated the yearly incidence of child sexual abuse to be around .2% (2 per 1,000 children; National Center on Child Abuse and Neglect, 1993; Sedlak, 1991). The incidence estimate derived from the present sample for the category of contact sexual abuse, the category that most closely approximates the forms of sexual abuse typically included in these national reports, is about 2% (20 per 1,000 children). The discrepancy in these figures may be due largely to the *source* of the data for the prior national reports, which included only those cases of victimization that were reported to either state agencies, mental health service providers, or other officials. The estimate from the present study was derived from directly interviewing children themselves, only a small percentage of whom (20% of the 40 children reporting contact sexual abuse,) had disclosed their sexual abuse to an authority (school officials, police, child protection services, or other authority).

Prior victimization. For these analyses, incidence of prior victimization was based upon children's responses to the 12 victimization screener items. We wanted to identify victimizations that had taken place *prior to the past year* in order to assess the extent to which they might serve as risk factors for sexual abuse that had occurred *during the past year*. Because the 12 screener items asked children to indicate the *most recent* occurrence of each type of victimization, we were able to assess whether or not the children in our sample had experienced various forms of victimization *prior to* the past year. Five dummy-coded terms were constructed to reflect whether or not children had experienced the following forms of victimization at some point prior to (but not during) the past 12 months: (a) physical assault by a family member (not

including spanking); (b) physical assault by a nonfamily member; (c) attempted kidnapping; (d) a violent assault to the genitals (an assault that was primarily violent rather than sexual); or (e) sexual abuse. A sixth dummy-coded term indicated whether or not a family member of the child had been victimized prior to the past year (indirect victimization). In addition to these dummy-coded terms, a variable indicating the number of *different types* of prior victimization children had experienced, including indirect victimization, was constructed (range 0 to 6). Table 2 provides an indication of the amount of time that had elapsed since the prior victimizations in each category.

Analyses. The 132 children who had been sexually abused in the past year were first compared to all other children in the sample in chi-square tests of association to assess the bivariate relationships between demographic factors and each of the forms of prior victimization, and the likelihood of sexual abuse in the past year. Next, logit analysis assessed the unique contribution of each of the six (dummy-coded) forms of prior victimization. Also included in this simultaneous, forced-entry logit analysis were demographic characteristics and the parent-child relationship index.

A third analysis was conducted based on Moeller and colleagues (1993) finding that the number of different *types* of abuse in childhood predicted subsequent (adult) sexual abuse. Chi-square analyses assessed the association between the number of different types of prior victimization and sexual abuse in the past year.

Bivariate relationships. Table 3 shows the contribution of demographic and background factors to the risk for CSA in this sample. For the purposes of chi-square and logit analyses, continuous variables were recoded into two categories, 0 and 1, with the higher category always reflecting the presumably more "risky" value. The variable indicating quality of parent-child relations was recoded so that children who scored more than one standard deviation below the mean on this measure (coded "1") were contrasted with all other children in the sample. The variable indicating geographic location was recoded so that children who lived in "rural" areas (exact wording) were contrasted with all other children in the sample (urban = "1"). Child's current age was split at its median value, 12 years (older = "1"), as was parental rating of violence in the community (more violent = "1"). Parent's education was split between values of "high school graduate or less" (coded "1") and "some college or more." At the bivariate level, only parental education and geographic location failed to show an association with CSA. It should be noted that two demographic variables, the quality of the parent-child relationship, and parental perceptions of community violence, might be consequences as well as precursors

Table 2. Percent of Victimization Occurring at Various Intervals Prior to the Past Year

Type of Prior Victimization	Most Recent Occurrence of Each Victimization Type			
	Prior to 1 Year Ago	Prior to 2 Years Ago	Prior to 3 Years Ago	4 Years Ago or More
Physical Assault by a Non-Family Member	15%	9%	4%	4%
Physical Assault by a Family Member	9%	9%	5%	6%
Attempted Kidnapping	14%	16%	11%	25%
Genital Violence	13%	13%	5%	14%
Sexual Abuse	13%	10%	3%	18%
Indirect Victimization ^a	10%	11%	8%	41%

^a Victimization of a family member.

Table 3. Bivariate Association Between Background Characteristics and Sexual Abuse Within the Past Year

Background Characteristic	Children Sexually Abused in Past Year (n = 132)	Children Not Sexually Abused in Past Year (n = 1,746)	Risk Ratio and 95% Confidence Interval
Child is Female	72%****	46%	3.0 (2.0–4.5)
Poor Relations with Parents ^a	30%****	14%	2.6 (1.7–3.9)
Child Lives with Only One Parent	47%****	29%	2.2 (1.5–3.1)
Child is More Than 12 Years Old	77%****	54%	2.8 (1.9–4.2)
Child is Black	18%***	9%	2.3 (1.4–3.6)
Child is White	72%**	81%	.6 (.4–.9)
Relatively Dangerous Community ^b	56%*	47%	1.5 (1.0–2.1)
Urban Location	85%	78%	—
Parental Education of High School or Less	44%	40%	—

* = $p < .05$; ** = $p < .01$; *** = $p < .001$; **** = $p < .0001$.

^a Child scored more than one standard deviation below the mean on this measure.

^b Median split on parental rating of violence in their community.

of CSA. However, because of the magnitude of their association with CSA, and because of theoretical concerns surrounding the link between these variables (cf. Briere, 1992; Briere & Elliott, 1993) we retained them in multivariate analyses.

As can be seen from Table 4, almost all forms of prior victimization were associated with increased likelihood of CSA in the past year. The exception was prior genital violence, which showed a marginal association with subsequent CSA ($p < .10$). Prior sexual assault was most strongly connected to subsequent CSA, with a risk ratio of 11.7, but prior physical assault by a family member was also strongly predictive of CSA, with a risk ratio of 3.4. Indirect victimization through the assault of a family member also appeared to constitute a risk factor for CSA; children with a previously assaulted family member were over three times more likely than other children to report experiencing CSA in the past year.

Table 4. Prevalence of Sexual Abuse in the Past Year Among Children With and Without Prior Victimitizations

Type of Prior Victimitization	Children With Each Prior Victimitization		Children Without Each Prior Victimitization		Risk Ratio & 95% Confidence Interval
	n	% past year CSA	n	% past year CSA	
Prior Sexual Abuse	109	39%****	1769	5%	11.7 (7.5–18.2)
Prior Physical Assault by a Family Member	102	19%****	1776	6%	3.4 (2.0–5.7)
Prior Physical Assault by a Non-Family Member	247	10%*	1631	7%	1.6 (1.0–2.5)
Prior Attempted Kidnapping ^a	73	14%*	1805	7%	2.2 (1.1–4.4)
Prior Genital Violence ^b	88	11%	1790	7%	
Prior Victimitization of a Family Member ^c	149	17%****	1729	6%	3.2 (2.0–5.2)
Any Prior Victimitization ^d (including indirect)	558	15%****	1320	4%	4.7 (3.2–6.8)

* $p < .05$; ** $p < .01$; *** $p < .001$; **** $p < .0001$.

^a The majority of kidnappings reported in this sample (98%) were attempted.

^b Primarily violent (rather than sexual) genital assault.

^c Indirect victimization.

^d 0 = no prior victimization; 1 = one or more forms of prior victimization.

Logit analyses predicting CSA in the past year. Those forms of prior victimization and demographic/background measures that were significantly associated with CSA at the bivariate level were forcibly entered (simultaneously) into a logit analysis to determine their independent contributions to CSA in the past year (see Table 5).

Three forms of prior victimization emerged from the logit analysis as independent predictors of CSA ($ps < .05$). Prior sexual abuse, prior physical assault by a family member, and prior victimization of a family member were all associated with increased risk for CSA. In addition, girls, children over the age of 12 and children with poor parent-child relationships reported experiencing CSA in the past year more than other children. Parental perception of community violence, child's race, whether the child lived with both parents, prior kidnapping (attempted or completed), and prior assault by a nonfamily member were not uniquely associated with CSA (all $ps > .10$). We recognized that the prediction of CSA by prior victimization would be considerably enhanced if children suffered repeated victimizations at the hands of the same perpetrator. Although such experiences would qualify as revictimization, they might differ on important dimensions from multiple, unrelated assaults by different perpetrators. In internal analyses, we dropped the 48 subjects who had been sexually abused in the past year who indicated in follow-up questioning that their sexual abuse "represented a series of incidents where the same person(s) was (were) involved" (36% of the sexually-assaulted sample). Then we re-ran the bivariate and logit analyses to assess the impact of dropping these children. Only two substantial changes from the analyses reported in the text were observed. First, the bivariate relationship between prior kidnapping and subsequent CSA dropped below significance ($p > .05$). Second, both physical assault by a family member and physical assault of a family member dropped below significance in the logit equation, although they remained significantly related to subsequent CSA at the bivariate level. These analyses suggest that the apparent link between prior and subsequent victimization is not entirely due to repeated victimization by the same perpetrator.

Community violence. Given that community violence was predicted by the crime victimization model (Miethe & Meier, 1994) to make an independent contribution to CSA, analyses were undertaken to understand why this was not observed. Correlational analyses revealed significant associations between parental perception of community violence and significant contributors to the logit model, including prior sexual assault of the child respondent ($\Phi = .06, p < .01$), prior family assault of the child respondent ($\Phi = .05, p < .05$), prior assault of a family

**Table 5. Significant Risk Factors for Sexual Abuse in the Past Year:
Logit Model^a**

Predictor Variable	Relative Risk Ratio
Prior Sexual Abuse	7.45****
Prior Physical Assault by a Family Member	1.92*
Prior Victimization of a Family Member ^b	1.97*
Child is Female	2.64****
Poor Relations with Parents ^c	2.44****
Child is More than 12 Years Old	2.09***

* = $p < .05$; *** = $p < .001$; **** = $p < .0001$.

$N = 1,878$ (other cases were missing values on some variables).

^a Only those variables that were unique predictors ($p < .05$) in the complete logit model are shown here. Other variables from Tables 1 and 2 were significant independent predictors.

^b Children who scored more than one standard deviation not below the mean on this measure.

^c Indirect victimization.

member ($\Phi = .05, p < .05$), quality of parent-child relationship ($\Phi = .06, p < .05$), and child's gender ($\Phi = .10, p < .001$). These analyses demonstrate substantial multicollinearity between parental perception of community violence and other components of the model, which may partly explain the failure of this term to exhibit a significant independent relationship with CSA.

Multiple types of prior victimization and CSA. Chi-square analyses examined the relationship between the number of different types of prior victimization (range 0 to 6, including indirect victimization) and CSA in the past year. As can be seen from Table 6, only a small percentage of children who were not previously victimized experienced CSA in the past year (4%). This proportion increased steadily as children accumulated different types of prior assault [$\chi^2(5) = 96.7, p < .0001$].

Additional analyses revealed that children with two or more types of prior victimization were much more likely to have experienced CSA in the past year (23%) than were children with no prior victimization or only one type of prior victimization [6%; $\chi^2(1) = 68.9, p < .0001$].

Summary. Prior sexual abuse, prior physical assault by family and nonfamily members, prior attempted or completed kidnapping, and prior indirect victimization through the assault of a family member were significant bivariate predictors of children's CSA in the past year. Only prior sexual abuse, physical assault by a family member, and indirect victimization emerged as independent predictors of CSA in logit analyses that also included demographic/background characteristics. Female gender, current age of more than 12 years, and poor parent-child relationship also emerged as significant independent predictors of CSA. Finally, the more different types of prior victimization a child experienced, the more likely they were to have experienced CSA in the past year.

The Influence of Prior Victimization on PTSD Symptomatology

We tested the general hypothesis that experiencing one or more forms of prior victimization would be associated with elevated PTSD-related symptomatology among children with CSA. Prior analyses of this data set revealed that, among the sample as a whole ($N = 2,000$), sexual abuse was associated with elevated levels of PTSD-related symptomatology (Boney-McCoy & Finkelhor, 1994). We wanted to determine whether, among sexually-abused children, the presence of prior victimization was associated with even further increases in the level of PTSD-related symptomatology. We also examined each of the forms of prior victimization individually to ascertain the strength of their associations with PTSD-related symptomatology. Finally, we investigated the extent to which prior victimization was able to explain unique variance in PTSD-related symptomatology among sexually-abused children after characteristics related to their sexual abuse episode were taken into account. To test these effects, we considered as "sexually abused" the 132 children who were represented in the previous set of

Table 6. Number of Types of Prior Victimization and Risk for Child Sexual Abuse in the Past Year

Number of Types of Prior Victimization ^a (N)	0 (1320)	1 (401)	2 (113)	3 (36)	4 (7)	5 (1)
Percent Reporting Sexual Abuse in the Past Year	4%	13%	20%	22%	43%	0%

$\chi^2(5) = 96.7, p < .0001$.

^a Range 0-6 (prior physical assault by a non-family member; physical assault by a family member; sexual abuse; attempted kidnapping; genital violence; victimization of a family member).

analyses (those who were sexually abused during the previous year), and, to maximize the n , we included 16 more children who were sexually abused sometime *before* the past year and who had complete data on all of the variables used in these analyses. Of these children, 44 (30%) were male and 104 (70%) were female, and the average age was 14.0 years. A similar distribution among the categories of sexual abuse severity was seen among this sample as was seen among the previous, slightly smaller sample (“attempted” = 46%; “serious, noncontact” = 21%; “contact” = 33%).

Prior victimization. For these analyses, six dummy-coded variables indicated whether children who had experienced CSA ($n = 148$) had experienced each of the five forms of victimization or indirect victimization *prior to their sexual abuse experience* (not just prior to the past year). The change in reference for prior victimizations (from “prior to the past year” to “prior to the CSA episode”) was necessary to allow for the inclusion of “prior” victimizations that occurred during the past year (but before the CSA incident). In addition, a summary variable was created that indicated whether sexually-abused children had ever experienced *any* of these types of victimization prior to their CSA (0 = no; 1 = yes). For children who provided us with detailed follow-up information on more than one episode CSA ($n = 46$), prior victimizations were those occurring before the child’s *most serious* CSA episode (based on the extent of contact and penetration experienced). In half of these cases ($n = 23$), both CSA incidents were of equal severity, and the most recent experience was selected as the “target” CSA episode. Of the remaining 23 cases, in nine, the most serious was also the most recent; in 14, the most serious was not the most recent, and the most serious episode was selected.

Analyses. Pearson correlations were conducted to ascertain which of the demographic/background variables had significant bivariate associations with PTSD-related symptomatology among children who had suffered CSA. Then, partial correlations assessed the relationship between episode characteristics and symptomatology and between prior victimization and symptomatology, controlling only for the significant demographic/background variables.

In order to determine whether prior victimization would account for additional variance in PTSD-related symptomatology once significant episode characteristics had been entered into the model, a three-stage hierarchical regression analysis was performed. In the first stage of this regression, significant background/demographic variables were entered in a block. In the second stage, episode characteristics that were significantly correlated with PTSD were entered in a block. The dichotomous term indicating whether or not children had experienced any form of prior victimization was entered last.

PTSD-related symptomatology and demographic/background measures. Three of the demographic/background measures were significantly correlated with PTSD-related symptomatology. The strongest association occurred between symptomatology and the quality of parent-child relationship index; lower quality relationships were associated with higher levels of symptomatology [$r(148) = -.34, p < .001$]. PTSD-related symptoms also tended to be more numerous as a function of female gender [$r(148) = .16, p < .06$], and nonrural geographic locations [$r(148) = .14, p < .10$]. These three measures were included in subsequent analyses (partial correlations and multiple regression) as significant background/demographic influences. Parental education, White race (child’s), the child’s current age, and whether the child lives with both parents were not significantly correlated with PTSD-related symptomatology (all $ps > .12$). Most notably, the correlation between parental rating of community violence and children’s PTSD-related symptomatology was only $r(148) = .05 (p > .50)$.

Partial correlations between predictor variables and PTSD-related symptomatology. As can be seen from the partial correlations reported in Table 7, prior experience with sexual abuse, prior physical assault by a family member, and prior attempted kidnap were all associated with higher levels of PTSD-related symptomatology (all $ps < .05$). In addition, the dichotomous term representing the presence or absence of *any* form of prior victimization (coded 0 = no prior victimization, 1 = one or more forms of prior victimization) was significantly associated with the extent of PTSD-related symptomatology ($p < .01$). Prior indirect victimization (assault of a family member) was marginally associated with PTSD-related symptomatology ($p < .10$), but prior genital violence and prior victimization by a nonfamily member did not show even marginally significant associations with this outcome variable ($ps > .15$).

Of the episode characteristics, fear of serious injury or death during the episode, severity of the sexual abuse (e.g., degree of contact, penetration, etc.), severity of injuries sustained, reporting that the perpetrator appeared to be using alcohol or drugs at the time of the episode, and being threatened by the perpetrator were all associated with elevated levels of PTSD-related symptomatology (all $ps < .05$; see Table 8). Other episode characteristics, including the number of sexual abuse episodes the child reported, whether the child experienced multiple sexual abuses by the same perpetrator, closeness of relationship to the perpetrator (stranger, acquaintance, nonparent family member, or parent), and age at time of the CSA were not significantly associated with PTSD-related symptomatology (all $ps > .20$).

Regression of PTSD-related symptomatology on prior victimization and episode characteristics. We wanted to assess the extent to which *any* prior victimization was related to PTSD-related symptomatology, over and above the contribution of abuse episode characteristics. For that reason, a single variable coded 0 = no prior victimization and 1 = one or more forms of prior victimization was entered in the third stage of a hierarchical regression, after demographic/background measures and CSA episode characteristics that showed significant partial correlations with PTSD-related symptomatology were entered in the first two stages.

Table 9 shows the results of these regressions. The demographic variables and the parent-child relationship index accounted for 18% of the variance in PTSD-related symptomatology among these sexually-assaulted children ($p < .001$). An additional 9% of the variance was

Table 7. Partial Correlation Between PTSD-Related Symptomatology and Prior Victimization Among Sexually Abused Respondents^a

Prior Victimization	PTSD-Related Symptomatology ^b
Prior Sexual Abuse	.22**
Prior Physical Assault by a Family Member	.20*
Prior Physical Assault by a Non-Family Member	.12
Prior Attempted Kidnapping	.28***
Prior Violence to Genitals ^d	.12
Prior Victimization of a Family Member ^c	.14
Any Prior Victimization ^f	.24**

* = $p < .05$; ** = $p < .01$; *** $p < .001$.

$N = 148$.

^a Partialling: child's gender, quality of parent-child relationship, and child's geographic location.

^b Range 10–30.

^c Prior to the child's most serious episode of CSA (vis degree of contact/penetration).

^d Primarily violent (not sexual) assault to the genitals.

^e Indirect victimization.

^f 0 = no prior victimization; 1 = one or more types of prior victimization.

Table 8. Partial Correlation Between PTSD-Related Symptomatology and CSA Episode Characteristics Among Sexually Abused Respondents^a

CSA Episode Characteristics ^b	PTSD-Related Symptomatology ^c
Child Feared Death or Serious Injury	.22**
Severity of Sexual Abuse ^d	.19*
Severity of Injuries ^e	.19*
Perpetrator Using Alcohol or Drugs	.19*
Child Threatened by Perpetrator	.18*
Number of Sexual Abuses	.10
First Time vs. One of a Series of CSAs by <i>This</i> Perpetrator	.07
Closeness of Relationship to Perpetrator ^f	.05
Age at Time of CSA	.01

* = $p < .05$; ** = $p < .01$.

$N = 148$.

^a Partialling the effects of: child's gender, quality of the parent-child relationship, and child's geographic location.

^b Associated with the child's most serious CSA.

^c Range 10–30. episode (vis degree of contact/penetration).

^d 1 = attempted CSA; 2 = serious, non-contact CSA; 3 = contact CSA.

^e Range 0–4.

^f Range 1 = stranger to 4 = parent.

accounted for by the episode characteristics ($p < .01$). Finally, the single indicator variable representing the presence of prior victimization added 3% more explained variance to the equation in the third stage ($p < .05$). In the final equation, only prior victimization, female gender, quality of parent-child relationship, and the child's perception that the CSA perpetrator was using alcohol or drugs at the time of the abuse, were significant as independent predictors, although geographic (urban) location was marginally significant ($p < .10$).

Table 9. Hierarchical Regression of PTSD-Related Symptomatology Among Sexually-Assaulted Children on Demographic/Background Characteristics, Prior Victimization, and CSA Episode Characteristics

	R^2 Change for Block	Standardized Beta From Final Equation
Step 1: Demographic/Background Characteristics ^a	.18***	
Child's gender		.19*
Quality of parent-child relationship		-.33***
Geographic location		.13+
Step 2: CSA Episode Characteristics ^b	.09**	
Perpetrator using alcohol/drugs		-.15*
Perpetrator threatened child		.07
Severity of injuries		-.02
Child feared serious injury/death		.15
Severity of sexual abuse		.11
Step 3: Prior Victimization ^c	.03*	
Presence of one or more forms of prior victimization		.18*
Final Model $R^2 = .27$ $F(9,138) = 6.10$, $p < .0001$.		

* = $p < .05$; ** = $p < .01$; *** = $p < .001$.

$N = 148$.

^a Demographic/background characteristics that were significantly correlated with PTSD-related symptomatology.

^b Associated with the child's most serious CSA (vis degree of contact/penetration).

^c Prior to the child's most serious CSA.

Summary. Several of the prior victimization variables significantly predicted PTSD-related symptomatology in partial correlations controlling for background/demographic factors, as did a variable representing the presence or absence of any prior victimization. The variable indicating the presence of any form of prior victimization accounted for a significant amount of variance in PTSD-related symptomatology in a multiple regression after background/demographic factors and episode characteristics were entered into the model, suggesting that prior victimization experiences do not influence PTSD solely through effects on the dynamics of subsequent episodes.

DISCUSSION

The present study shows that a prior victimization acts as a risk factor for later child sexual abuse, and in addition exacerbates the symptoms associated with post-traumatic stress in the wake of such an experience. This relationship holds true not just for earlier victimizations of a sexual nature, but for earlier nonsexual victimizations, like physical assaults, as well. Even an "indirect victimization," the victimization of a child's family member, is associated with an increase in risk for CSA, although it does not have the same effect on post-CSA symptomatology.

In the framework of crime victimization theory (Miethe & Meier, 1994), prior victimization may actually increase the risk for victimization through increased exposure, decreased guardianship, or increased target attractiveness. Thus, to the extent that sexualization following sexual abuse (Browne & Finkelhor, 1986) may prompt risky behavior, it could put a child at increased risk. Family assault might create alienation from family members who could serve as guardians against extrafamilial sexual abuse. Fearfulness engendered by exposure to a victimized family member might result in overt characteristics that would make a child a more attractive target.

These findings extend earlier research on prior victimization in a number of important directions. Although child victimization had been demonstrated previously to increase the likelihood of a sexual abuse in adulthood, the current research suggests that a prior victimization can increase the risk for *childhood* sexual abuse. The fact that one victimization may lead to another in shorter succession than the interval suggested by the adult studies highlights that the time frame for intervention to break the connection may be relatively short.

The present study also extends the previous literature in finding that multiple kinds of victimization, not just sexual abuse, may be a risk factor for later CSA. Sexual abuse itself is, of course, associated with the largest risk, but physical assault by a family member is also associated with a substantial risk. Even nonfamily physical assaults, like peer and gang violence, are associated with an increased risk at the bivariate level. However, this increased risk from prior victimization is affected when other risk factors for sexual abuse are taken into account. Being older than 12, Black, or female, living in a single parent household, or having a poor relationship with one's parents also contribute to the risk for CSA. Notably, however, prior sexual abuse, physical assault by a family member, and the prior victimization of a family member each continue to be independent risk factors (although at somewhat reduced risk ratios), even controlling for these other sources of vulnerability.

These findings suggest that the relationship between prior victimization (at least of certain sorts) and sexual abuse is not a spurious result of simply being in a dangerous environment or having a poor relationship with parents. Logically, and consistent with previous literature, the two most risky prior victimizations appear to be prior sexual abuse and assault by a family member. It has been observed that sexual abuse creates specific traumatic effects, like traumatic sexualization (Finkelhor & Browne, 1985) and a view of oneself as "spoiled goods," that might in particular create vulnerability for later sexual abuse. For its part, family assault may

create impaired attachments, which have been shown to be risk factors for later victimizations (Perry, Kusel, & Perry, 1988).

Although this and other research appears to confirm the existence of effects related to prior victimization, little has been done to analyze and test all the possible mechanisms that may underlie these effects. However, it seems likely that these factors may fall into at least three categories: (a) characteristics of the child that were present prior to, and were also risk factors for, the first victimization experience, such as low self-esteem, small physical stature, or fearfulness (personal antecedent characteristics); (b) environmental conditions that were present prior to the first victimization, such as living in a dangerous neighborhood or living with only one parent (external antecedent conditions); or (c) characteristics of the child that in some way result from the initial victimization experience (personal post-victimization characteristics). Into this last category fall characteristics such as depression or an image of the self as a victim. It is critical when discussing the first and third categories to remember that victims do not "cause" their victimizations; responsibility for perpetration lies entirely with the instigators of assaults on both children and adults. But responsibility for perpetration must not be confused with potential for avoidance. If research reveals that certain personal characteristics put children at increased risk for victimization, it would be irresponsible for researchers to demur from discussing these findings in the name of not "blaming the victim," particularly if these characteristics also exacerbate subsequent victimization-related symptomatology. It is beyond the scope of these data to elucidate the factors underlying this association, but subsequent research should strive to identify factors in all three categories that might contribute to such a link.

One of the findings from this study deserving of some special note is that prior *indirect* victimization, that of a family member, increases children's risk for CSA. This finding is important because indirect victimization is rarely considered as a risk factor. It is generally discussed only in very specific contexts, such as the notion that sexually abused mothers may somehow pass their vulnerability on to their children. This study suggests that other kinds of family victimization may also increase vulnerability. In trying to understand why, many of the same factors that operate with prior victimization may explain the apparent effects of indirect victimization as well. One plausible hypothesis is that indirect victimization may have a corrosive psychological impact on the child and her ability to protect herself. For example, since people tend to view their own vulnerability as similar to that of those close to them (Perloff & Fetzer, 1986), exposure to a victimized family member might increase a child's feeling of vulnerability and weaken their assumption that the world is a safe, controllable place (Janoff-Bulman & Frieze, 1983). Because feeling vulnerable or powerless has been suggested as a risk factor for CSA (Russell, 1986), victimization of a family member might, in this way, put children at higher risk for CSA. More research is needed on the impact of indirect victimization on perceptions of vulnerability and on other factors that might link this experience with subsequent CSA.

This study also breaks new ground in the link found between prior victimization and symptomatology, the first such finding in studies of children. The contribution of prior victimization to symptomatology has been researched previously in regard to adult sexual abuse with somewhat mixed results (Resick, 1993; see Sorenson, Siegel, Golding, & Stein, 1991, for a review). In some of these studies survivors of multiple assault show more negative symptomatology, suggesting an additive effect (Burgess & Holmstrom, 1979; Ruch & Leon, 1983). But other studies have suggested the presence of an "innoculation effect," in which the coping skills learned from a first assault seem to make subsequent assaults less impactful in certain ways (Marhoefer-Dvorak, Resick, Hutter, & Girelli, 1988). Other studies find no difference (Frank, Turner, & Stewart, 1980; Mandoki & Burkhart, 1989). Although the present study clearly supports the additive model, it is certainly possible that prior victimizations may exacerbate some effects but not others. For example, while it might increase fearfulness, a prior victim

may not experience any additional social stigma from a subsequent assault. Future research on the contribution of prior victimization should assess a wider spectrum of post-assault functioning, and also explore possible differences between children and adults. Although PTSD-related symptoms have been frequently examined in studies of sexual abuse (Kilpatrick, Veronen, Saunders, Best, Amick-McMullin, & Paduhovich, 1987; Kiser, Ackerman, Brown, Edwards, McColgan, Pugh, & Pruitt, 1988; Lindberg & Distad, 1985; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Wolfe, Gentile, & Wolfe, 1989), there is a widespread agreement among researchers and clinicians that it represents only a small segment of the symptomatology that is often observed (Kendall-Tackett, Williams, & Finkelhor, 1993).

Unfortunately, this is one of only very few studies that have examined prior victimization in the copious literature on the impact of sexual abuse in childhood. This literature has tended to focus on the contribution of abuse characteristics, family support, and aspects of disclosure and intervention. But for large numbers of abused children in these studies, the incidents reported may not represent their first victimization—a possibility that should be taken into account in future research.

The findings from this study are, of course, subject to some important caveats, based on some the limitations of the design. Despite the modest strength of most of the associations reported in this paper, it is possible that the relationship found here between prior victimizations and subsequent sexual abuse and its trauma symptomatology may be spurious or overstated because of factors we have not been able to measure. We did not have objective measure of the level of violence in the communities in which our respondents lived, and a substantial degree of multicollinearity existed between parent's assessment of community violence and other elements in the logit model; this overlap may have been responsible for the failure of community violence to make a significant independent contribution to the prediction of CSA and limits conclusions that can be drawn about the role of this factor. We did not include measures of the previctimization personalities or temperamental qualities of the children that may explain multiple victimization or subsequent reactions. In addition, we did not measure victimizations at different points in time, so that some of the relationships observed might be due to correlated measurements or interview factors. Finally, although the response rate for this survey was high (only 12% of adults approached refused to participate), it is certainly possible that children who have suffered multiple, serious victimizations at the hands of their parents, especially sexual abuse, were underrepresented due to the need for parental permission to participate. As a result, the findings in this paper may actually underestimate the links between prior *family* victimization and subsequent sexual assault.

Although these findings leave much to be understood about prior victimization, they do have important implications for both educators and clinicians. Much effort is currently being devoted to designing educational programs to help prevent sexual abuse (Finkelhor & Strapko, 1992; Wurtele & Miller-Perrin, 1992). Although these programs are usually targeted for children in general, it is especially important that they reach and address the needs of high-risk children. This study clearly suggests that previously victimized children are one of the high-risk groups who deserve special attention in the planning of prevention educators.

These findings have implications for clinicians, too. Since this study suggests that the extent of impact and symptoms may be related to prior victimizations, clinicians who work with sexually abused children may need to be more systematic in eliciting reports of these additional episodes. Although clinicians are often thorough in obtaining information about the event that forms the basis of a referral, it is not certain that a child, referred because of one victimization, will necessarily be screened for other forms as well. Clinicians may need that knowledge in order to plan therapy and interventions that address all the child's sources of trauma.

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Résumé—Il a été observé que le fait d'avoir été précédemment victime d'abus (sexuel ou non) augmentait le risque pour un enfant de subir plus tard un abus sexuel dans un échantillon national randomisé de 2,000 enfants américains âgés de 10 à 16 ans. Cette prédiction d'être une future victime subsistait après avoir contrôlé l'échantillon pour les autres variables (le sexe de l'enfant, sa race, son âge, son lieu géographique de résidence, la qualité de sa relation avec ses parents et le niveau relatif de violence dans la communauté de résidence). De plus, le fait qu'un membre de la famille qui a été victime d'abus était aussi prédictif d'un futur abus sexuel. Parmi les enfants ayant subi un abus sexuel, ceux ayant déjà un antécédent de victime exprimaient des symptômes de stress post-traumatique à un niveau accru, même après inclusion dans le modèle mathématique des facteurs démographiques et des caractéristiques de l'épisode d'abus sexuel (par exemple sévérité des symptômes, sévérité de lésions, risque de décès ou de lésions graves). Les résultats suggèrent que l'antécédent de victime est un facteur qu'il est nécessaire de prendre en compte tant par les éducateurs qui développent une prévention aux abus sexuels que par les professionnels de la santé mentale qui consultent les enfants victimes d'abus sexuels.

Resumen—En una muestra nacional aleatoria de 2,000 niños americanos de edades comprendidas entre 10 y 16 años, se observó que la experiencia de una previa victimización (sexual o no sexual) aumentaba el riesgo del niño para experimentar un posterior abuso sexual infantil. La victimización previa predijo el abuso sexual posterior incluso cuando fueron controladas las variables de la historia del sujeto (sexo del niño, etnia, edad, situación geográfica, calidad de las relaciones con los padres, y nivel relativo de violencia en la comunidad de residencia). Además, la victimización previa de un miembro de la familia también predijo el posterior abuso sexual infantil. Entre los niños

que experimentaron abuso sexual infantil, la victimización previa aumentó la cantidad de sintomatología de un trastorno por estrés posttraumático, incluso después de que fueran incluidos en el modelo los factores sociodemográficos y las características del episodio de abuso sexual infantil (p.e., severidad de la agresión, severidad del daño, miedo a morir o sufrir un daño severo). Estos resultados sugieren que la victimización previa es un factor que necesita ser estudiado por los educadores que diseñan intervenciones preventivas del abuso sexual infantil y por los profesionales de la salud mental que tratan a los niños víctimas de abuso sexual.

APPENDIX A: VICTIMIZATION SCREENER QUESTIONS

NON-FAMILY ASSAULT

1. "Sometimes kids get hassled by other kids or older kids, who are being bullies or picking on them for some reason. Has anyone—in school, after school, at parties, or somewhere else—picked a fight with you or tried to beat you up?"
2. "Has anyone ever ganged up on you, you know, when a group of kids tries to hurt you or take something from you?"

FAMILY ASSAULT

1. "Sometimes kids get pushed around, hit, or beaten up by members of their own family, like an older brother or sister or parent. Has anyone in your family ever pushed you around, hit you or tried to beat you up?"
2. "Has anyone in your family gotten so mad or out of control you thought they were really going to hurt you badly?"
3. "Have your parents or other adults you live with ever hit or slapped you so hard that you bled or had to go see a doctor?"

KIDNAPPING

1. "We've heard about some kids getting hassled by adults or older kids in cars. Has anybody ever tried to kidnap you, or tried to get you to get into their car when you thought you might be taken somewhere and hurt?"

SEXUAL ABUSE/ASSAULT

Note: The introduction to this set of screeners read as follows:

"Now another thing some kids report these days is adults or older kids who try to trick them or force them into doing something sexual. This includes an older person who tries to touch your private parts, or tries to make you touch or look at their private parts. Kids report that these types of things sometimes happen to them, even with people they know well and trust, like teachers and relatives."

1. "Has there ever been a time when an older person, like an adult, an older teenager, a babysitter, or someone like that deliberately touched or tried to touch your private parts (*for females*: including your breasts)?"
2. "Has there ever been a time when an older person, like an adult, an older teenager, a babysitter, or someone like that tried to make you touch or look at their private parts?"
3. "Has there ever been a time when an older person tried to feel you, grab you, or kiss you in a sexual way that made you feel afraid or bad?"
4. "Has there ever been a time when someone your own age—a boy, a girl, or a group of them—tried to threaten, force, or trick you into doing something sexual that you didn't want to do?"
5. "Has there ever been a time when anyone—an older person or someone your own age—did something sexual to you that you didn't want?"
6. "Sometimes they won't actually threaten or hurt you, but adults and older teenagers may act in ways that are strange or suspicious or that make you wonder what they're up to. Has there ever been a time when an older person began to act in a strange or suspicious way around you that made you wonder if they were trying to get sexual with you? This would include acting in a way that seemed too friendly, or hanging around you when they weren't wanted, or touching you in ways you didn't like, or trying to get you to do things that were weird or strange. Has this ever happened to you?"

VIOLENCE TO GENITALS

1. "Has there ever been a time when anyone intentionally tried to hurt your private parts by hitting you, kicking you there, or trying to hit them with an object?"

INDIRECT VICTIMIZATION

1. "Has a member of your family, with whom you have lived, ever been attacked, robbed, mugged, or sexually assaulted?"

APPENDIX B: ITEMS COMPRISING THE PTSD-RELATED SYMPTOMATOLOGY INDEX

How much, if at all, have you been bothered in the past week by [READ ITEM]? Quite a bit, only a little bit, or not at all?

1. Trouble falling asleep.
2. Sleep that is restless or disturbed.
3. Thoughts and images that are frightening.
4. Temper outbursts that you could not control.
5. Feelings of guilt.
6. Heart pounding or racing.
7. Feeling easily annoyed or irritated.
8. Feeling hopeless about the future.
9. Feeling afraid in open spaces or on the street.
10. Feeling critical of others.

APPENDIX C: ITEMS COMPRISING THE QUALITY OF PARENT-CHILD RELATIONSHIP INDEX

A preliminary question was asked to ascertain which adult in the child's household "knows most about [their] activities." This adult's title (mother, father, etc.) was inserted in the questions wherever the word [ADULT] is listed.

1. Does [ADULT] know where you are when you are not at home? (4 = always; 1 = almost never)
2. Does [ADULT] know who you are with when you are not at home? (4 = always; 1 = almost never)
3. Do you feel that [ADULT] trusts you? (4 = always; 1 = almost never)
4. If you were in trouble or you were sad, would you discuss it with [ADULT]? (4 = always; 1 = almost never)
5. Do you and your parent(s) [the adult(s) you live with] have fun together? (1 = all the time; 5 = never)
6. How often do/does the adult(s) you live with nag you? (1 = all the time; 5 = never).
7. How often do/does the adult(s) you live with take away your privileges? (1 = all the time; 5 = never).