Universität Bielefeld

Fakultät für Psychologie und Sportwissenschaft

Abteilung klinische Psychologie und Psychotherapie

Ist einmal Opfer-Sein nicht genug?-

Eine differenzierte Untersuchung des Reviktimisierungsphänomen

Dissertation

zur Erlangung des akademischen Grades

eines Doktors der Naturwissenschaften (Dr. rer. nat.)

vorlegelegt von

Lioba Langer (M. Sc. Psych.)

Bielefeld, Mai 2021

Erstgutachter:

Prof. Dr. Frank Neuner

Zweitgutachter:

Prof. Dr. Tobias Hecker

Hiermit versichere ich, dass ich die vorliegende Synopse selbstständig, sowie die für den Kumulus vorliegenden Schriften als Erstautor verfasst habe. Damit trage ich die inhaltliche und methodische Verantwortung für die angeführten Schriften. Die Arbeit hat in der gegenwärtigen oder in einer anderen Fassung keiner anderen Fakultät oder Universität vorgelegen.

Bielefeld, den 22.05.2021

Lioba Langer

Danksagung

Folgenden Personen möchte ich meinen aufrichtigen Dank ausrichten…

…Prof. Dr. Frank Neuner, der sich bereit erklärte, meine Arbeit zu betreuen und mir somit die Möglichkeit gab, mich in dieses sehr interessante Thema zu vertiefen. Ich möchte mich besonders für die unzähligen Ratschläge und die stetige fachlich hoch kompetente Unterstützung bedanken.

…Justin Preston, der die Manuskripte in kurzer Zeit und mit sehr wertvollen Kommentaren Korrektur gelesen hat.

…den Teilnehmern der Studie, die sich die Zeit für meine Studie genommen haben und den Mut hatten auch deutlich belastende Erfahrungen zu berichten.

…der (ehemaligen) LNK Dr. Spernau, welche mir die Möglichkeit gegeben hat, die Datenerhebung flexibel und autonom durchzuführen und in den therapeutischen Prozess zu integrieren.

…Giovanni Ronge, der mich bei jedem Schritt mit seinen Ideen und seiner Geduld unterstützt hat.

…meiner Familie, die mich ebenfalls auf so vielen Ebenen bei dem Promotionsverfahren unterstützt hat, insbesondere meinem Bruder **Laurenz Langer** auch durch seinen fachlichen Rat.

Inhaltsverzeichnis

Liste von Tabellen

Liste von Figuren

1. Zusammenfassung

Die vorliegende Arbeit untersucht das Phänomen, dass Opfer von interpersonellen Gewalterfahrungen in der Kindheit zu einem späteren Zeitpunkt ein erhöhtes Risiko aufweisen, erneut Opfer von Gewalterfahrungen zu werden. Dieses sogenannte Reviktimisierungsphänomen hat zwar ein hohes soziales Ausmaß und gravierende Folgen für die Betroffenen, ist aber bislang ein einem sehr einseitigen Blickwinkel untersucht worden und wurde in seinen Wirkmechanismen noch kaum verstanden. Die vorliegende Arbeit beschäftigt sich mit den Forschungslücken, die insbesondere folgenden Fragen betreffen: Haben die unterschiedlichen Arten von Gewalterfahrungen in der Kindheit und im Erwachsenenalter (sexuelle, physische und emotionale) spezifische Zusammenhänge untereinander? Zeigen sich diese Zusammenhänge im Sinne eines Reviktimisierungsphänomens auch bei Männern oder stehen Gewalterfahrungen bei Männern im Sinne eines Opfer-Täter Zyklus in Zusammenhang zueinander? Welche Variablen vermitteln die Zusammenhänge von Gewalterfahrrungen in der Kindheit und erneuten Gewalterfahrungen im Erwachsenenalter?

In einer Online-Umfrage wurden bei 135 Frauen sexuelle, körperliche und emotionale Gewalterfahrungen getrennt nach ihrem Auftreten in der Kindheit und im Erwachsenenalter, erfasst. Darüber hinaus wurde ein Set von Variablen abgefragt: Emotionsregulationsdefizite, bindungsbezogene dysfunktionale Einstellungen, Selbstwirksamkeit, Selbstbehauptung, sexuelle Selbstbehauptung, Präferenz für dominante Partner und missbrauchsbezogene Schuld- und Schamgefühle. Dieseleben Konstrukte ergänzt durch die Ausübung unterschiedlicher Arten von Gewalt im Erwachsenenalter wurden in einer Stichprobe von 47 Männern untersucht. Die Stichprobe wurde teilweise online und teilweise in einer psychiatrischen Klinik rekrutiert.

Mittels Regressionsanalysen wurden die spezifischen Zusammenhänge von sexueller, physischer und emotionaler Gewalt in der Kindheit und im Erwachsenenalter (Opfer- und Täterperspektive) untersucht. Bei den gefundenen Zusammenhängen wurden in einem nächsten Schritt Mediationsanalysen durchgeführt und die acht potenziell vermittelnden Variablen untersucht.

Die Ergebnisse liefern Hinweise auf eine Bedeutsamkeit der unterschiedlichen Arten von Gewalt. Insbesondere zeigt sich auch eine wichtige Rolle der, bislang in Untersuchungen ausgesparten, emotionalen Gewalt. Ebenso zeigten sie, dass bei Männern sowohl Reviktimisierungsprozesse als auch den Opfer Täter Zyklen nach Gewalterfahrungen in der Kindheit einsetzen. Bemerkenswert ist bei den Ergebnissen v.a. die Rolle von missbrauchsbezogenen Schuld- und Schamgefühlen. Diese erwiesen sich über alle untersuchten Variablen hinaus als konsistenter Mediator bei den Reviktimisierungsprozessen der Frauen und teilweise auch bei denen der Männer.

Diese Ergebnisse dieser Arbeit werden insbesondere mit ihrer Auswirkung für die Entwicklung speziell zugeschnittener Behandlungs- und Präventionsmöglichkeiten und für die psychotherapeutische Praxis diskutiert.

1.1 Überblick über die eingereichten Manuskripte

Revictimization and the Specificity Hypothesis-

Do Different Subtypes of Interpersonal Violence Predict Each Other?

Autoren: Lioba Langer & Prof. Dr. Frank Neuner

Eingereicht bei BMC Psychiatry

The Mediating Processes of Revictimization after Child Abuse in a Sample of Adult Women

Autoren: Lioba Langer & Prof. Dr. Frank Neuner

Veröffentlicht 2021 beim Journal of Family Trauma, Child Custody & Child Development (1-22)

The cycle of violence reconsidered, in a sample of male survivors of child abuse

Autoren: Lioba Langer, Dr. Christian Konkol & Prof. Dr. Frank Neuner

Eingereicht bei BMC Psychiatry

1.1.1 Beiträge der Autoren zu den Manuskripten

Die Studie wurde von mir konzeptualisiert. Ich habe die Datenerhebung durchgeführt. In der Psychiatrischen Klinik erfolgte die Datenerhebung unter der Leitung des damaligen Chefarztes Dr. Christian Konkol. Ich habe die Datenauswertung und Interpretation übernommen. Weiterhin habe ich die drei Manuskripte verfasst. Prof. Neuner hat alle Schritte supervidierend begleitet. Er hat alle Manuskripte gelesen und supervidiert.

2. Einleitung

„Meine Kindheit kann ich nur so beschreiben, dass meine Mutter mich kaum geliebt hat. Häufig schickte sie mich weg, beachtete mich gar nicht oder sagte ich sei hässlich und nervig. Wenn ich nicht gehorcht habe, wurde ich verhauen. Mein Vater war selten da. Wenn er da war, ist er nachts zu mir ins Bett gekommen. Er hat mich berührt. (…) Ich habe mich irgendwann getraut meiner Mutter das zu sagen. Sie hat mir nicht geglaubt. Sie hat gesagt, wenn so etwas passiert wäre, dann bestimmt mit meiner Absicht, da ich ihn verführen würde. (…) Als ich 17 war, wurde ich nach einer Party von einem Bekannten von mir vergewaltigt. (…) In meiner aktuellen Beziehung fühle ich mich nicht wohl. Sie fing sehr schön an. Jetzt erniedrigt er mich ständig. Er hat mich mehrfach geschlagen. Danach entschuldigt er sich und sagt er liebt mich. Einerseits möchte ich ihn verlassen, andererseits habe ich große Angst alleine zu sein. (…) Mich belasten immer wieder auftauchende Gedanken an all diese Erfahrungen. Ich bekomme sie einfach nicht aus dem Kopf. Außerdem verstehe ich mich selbst nicht. Warum gerate ich immer wieder an Leute, die mich misshandeln? Wieso habe ich nach all dem Schlimmen, was mir passiert ist, kein Warnsystem? Vielleicht verdiene ich auch einfach eine solche Behandlung. Ich weiß vom Kopf her, dass es nicht so ist, aber mein Gefühl sagt häufig etwas ganz anderes. Können Sie mir helfen? (aus Datenschutzgründen leicht abgeänderter Auszug aus einem psychotherapeutischen Gespräch von mir als Psychotherapeutin mit Frau X).

Leider kann man auf die Frage von Frau X „Können Sie mir helfen?“ nur antworten, „nicht so umfassend, wie sie sich das wünschen“. Fälle wie der von Frau X sind in der psychotherapeutischen Praxis leider keine Seltenheit. Natürlich kommen traumafokussierte Behandlungselemente zum Einsatz. Bei dem Wunsch von Frau X, gegen ihr Muster anzugehen, immer wieder an gewaltbereite Personen zu geraten, sehen die Möglichkeiten

jedoch schon geringer aus. Eventuell erarbeitet man Strategien zur Abgrenzung vom aktuell gewalttätigen Partner. Auch der Satz „ich verdiene eine solche Behandlung“ muss bearbeitet werden. Möglicherweise kommt es zu einer Stabilisierung und einer Trennung vom Partner. Ein Jahr später ist Frau X dann jedoch wieder in Behandlung. Sie hat sich auf eine neue Beziehung eingelassen und auch hier kommt es wieder zu Gewalterfahrungen. Die besprochenen Strategien waren nicht langfristig wirksam. Frust zeigt sich auf Seiten der Patientin. Jedoch kommt auch mit der Zeit und mehreren Therapien Frust auf Seite der Behandler auf, denn der Fall von Frau X ist nicht nur bzgl. der Biographie, sonders auf bzgl. des weiteren Verlaufs nach therapeutischer Arbeit kein Einzelfall. Leider gibt es bislang kaum erprobte Behandlungsstrategien, die darauf ausgerichtet sind, erneute Opfererfahrungen abzuwenden.

Der exemplarische Fall von Frau X ist dazu geeignet ein paradoxes Phänomen aufzuzeigen, das s.g. „Reviktimisierungsphänomen“: Opfer von Gewalterfahrungen in der Kindheit haben ein erhöhtes Risiko im Jugend- und Erwachsenenalter erneut Opfer von Gewalt zu werden (Bockers & Knaevelsrud, 2011). Ein erhöhtes Risiko bedeutet etwas konkreter: Zwei von drei Individuen, die Missbrauchserfahrungen in der Kindheit gemacht haben, werden in einem späteren Lebensabschnitt erneut Opfer von sexuellen Misshandlungserfahrungen (Classen, Palesh, & Aggarwal, 2005). Frauen mit physischen oder sexuellen Missbrauchserfahrungen in der Kindheit haben 3,5-mal höhere Wahrscheinlichkeiten Opfer von häuslicher Gewalt zu werden als Frauen ohne Gewalterfahrungen in der Kindheit (Coid et al., 2001).

In Deutschland und weltweit gibt es immer noch eine Prävalenz von sexuellen, physischen und emotionalen Missbrauch in der Kindheit von 8-35,5 % (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Briere & Elliott, 2003; Häuser, Schmutzer, Brähler, & Glaesmer, 2011).

Die Zahlen legen nahe, dass min. 2/3 dieser Betroffenen erneut Opfer interpersoneller Gewalterfahrungen werden wird. Aufgrund dieses erheblichen Ausmaßes ist das Reviktimisierungsphänomen mittlerweile als ein sozial relevantes Phänomen anerkannt (Bockers, Roepke, Michael, Renneberg & Knaevelsrud, 2014). Trotz dieses erheblichen Ausmaßes ist das Reviktimisierungsphänomen bislang nicht ausreichend untersucht. Es existieren verschiedene Forschungslücken. Dem folgend sind Präventionsprogramme gegen eine Reviktimisierung sehr sporadisch vorhanden und werden als wenig effektiv eingeschätzt (Messman-Moore, Coates, Gaffey & Johnson, 2008).

Ziel dieses Promotionsvorhaben ist es dem entgegenzuwirken. Insbesondere möchte ich herauszufinden, welche Rolle bestimmte Variablen beim Reviktimisierungsphänomen spielen. Erst durch eine differenzierte Untersuchung der verschiedenen Gewalterfahrungen und möglicher vermittelnder Variablen sind Rückschlüsse auf intrapsychische Prozesse möglich, die bei den betroffenen Individuen vorliegen und sie anfälliger für eine mögliche erneute Viktimisierung machen. Dies bietet eine erste Grundlage dafür effektive Präventionsmethoden zu entwickeln.

2.1 Hintergrund/Forschungsstand

Die bisherigen Forschungsarbeiten zum Reviktimisierungsphänomen wurden fast ausschließlich bei Frauen durchgeführt (Cloitre & Rosenberg, 2006). Dabei konzentrierten sie sich hauptsächlich auf sexuellen Missbrauch in der Kindheit und auf sexuelle Reviktimisierung im Erwachsenenalter (Widom, Czaja, & Dutton, 2008). Vermittelnde Variablen sind daher jeweils isoliert betrachtet beim sexuellen Reviktimisierungsprozess untersucht worden. Es ergeben sich hieraus viele Forschungslücken, bzgl. der anderen Arten von Gewalterfahrung,

möglicher vermittelnder Variablen und auch bzgl. Viktimisierungserfahrungen bei Männern. Auf diese unterschiedlichen Lücken werde ich in Folge näher eingehen:

2.1.1 Unterschiedliche Arten von Gewalterfahrungen

Bislang wurde die Bedeutung unterschiedlicher Arten von Gewalterfahrungen eher vernachlässigt. Wenn unterschiedliche Arten von Gewalt in der Kindheit gemeinsam erfasst wurden, dann wurde meistens nur der kumulative Effekt betrachtet. Hierbei zeigte sich, dass das gemeinsame Vorliegen mehrerer Arten von Gewalt in der Kindheit (sexuell und physisch) die Wahrscheinlichkeit einer späteren sexuellen Reviktimisierung erhöhte (Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Messman-Moore, Walsh, & DiLillo, 2010). Forschungsarbeiten zu den Auswirkungen der unterschiedlichen Gewalterfahrungen in der Kindheit legen jedoch nahe, dass nicht nur der kumulative Effekt, sondern auch ein spezifischer Effekt betrachtet werden sollte.

Bereits die Forschungsarbeit von Briere und Runtz (1990) zeigte, dass unterschiedliche Arten von Gewalterfahrungen in der Kindheit mit unterschiedlichen psychosozialen Dysfunktionen im Erwachsenenalter in Zusammenhang stehen. Sexueller Missbrauch in der Kindheit ist verbunden mit maladaptiven sexuellen Verhalten im Jugend- und Erwachsenenalter, physischer Missbrauch ist assoziiert mit Gewalt gegenüber anderen Personen und emotionale Misshandlung sagt insbesondere einen niedrigen Selbstwert voraus. Diese Dysfunktionen stellen bei Frauen Prädiktoren für bestimmte Arten der Gewalterfahrung im Erwachsenenalter dar.

Maladaptives sexuelles Verhalten beinhaltet risikoreiches Sexualverhalten wie häufig wechselnde Geschlechtspartner, Geschlechtsverkehr außerhalb romantischer Beziehungen und kein Schutz beim Geschlechtsverkehr. Dieses risikoreiche Sexualverhalten ist der konsistenteste Prädiktor für sexuelle Reviktimisierung (Messmann-Moore & Long, 2003).

Ein niedriger Selbstwert in der Kombination mit physischen Gewalterfahrungen führt zu einer hohen bindungsbezogenen Angst. Dies bedeutet ein starkes Bedürfnis nach Nähe bei gleichzeitig hoher Angst verlassen zu werden. Hohe bindungsbezogene Angst ist ein Prädiktor für physische Gewalterfahrungen in späteren Beziehungen (Bockers & Knaevelsrud, 2014). Durch emotionale Misshandlung kommt es nicht nur zu einem geringen Selbstwert, sondern soziale Fähigkeiten werden ebenfalls nicht erlernt (Clausen & Crittenden, 1991). Fehlende soziale Fähigkeiten stellen sowohl bei Männern als auch bei Frauen ein Prädiktor für spätere emotionale Opfererfahrungen wie z.B. Mobbing dar (Ma, 2001).

Somit gibt es Hinweise darauf, dass die spezifischen Arten von Gewalterfahrungen in der Kindheit auch in einem spezifischen Zusammenhang mit den Arten von Gewalterfahrungen im Erwachsenenalter stehen. Konkrete Überprüfungen eines solchen spezifischen Zusammenhangs sind bislang jedoch nur vereinzelt vorhanden, bestätigen jedoch die Idee des spezifischen Zusammenhangs der Gewalterfahrungen untereinander (Blom, Högberg, Olofsson & Danielsson, 2014).

In meiner inzwischen veröffentlichten Masterarbeit (Langer & Catani, 2016) zeigte sich, dass insbesondere sexuelle Gewalterfahrungen in der Kindheit sexuelle Gewalterfahrungen im Erwachsenenalter vorhersagen. Besonders physische Gewalterfahrungen in der Kindheit sagen physische Gewalterfahrungen im Erwachsenenalter voraus. Leider wurde in dieser Studie emotionale Gewalt im Erwachsenenalter nicht zusätzlich untersucht. Insgesamt ist bei der Reviktimisierungsforschung der Rolle der emotionalen Gewalt sowohl in der Kindheit als auch im Erwachsenenalter bislang wenig Aufmerksamkeit geschenkt worden (Langer & Catani, 2016).

Weitere Überprüfungen möglicher spezifischer Zusammenhänge von Gewalterfahrungen unter Einbeziehung emotionaler Gewalterfahrungen, wären somit

dringend benötigt. Eine differenzierte Erfassung aller drei Arten von Gewalterfahrungen bietet nämlich die Grundlage dafür, das Reviktimisierungsphänomen besser zu begreifen. Weiter oben in den Schilderungen deutet sich bereits an, dass nach der ersten Gewalterfahrung im Kindesalter bestimmte Verhalten- und Erlebensmuster entstehen. Diese unterscheiden sich je nach Art der primär erlebten Gewalt und stellen somit Risikofaktoren für unterschiedliche Gewalterfahrungen im Erwachsenenalter dar. Für eine mögliche Prävention von Reviktimisierung ist unerlässlich ebendiese Verhaltens- und Erlebensmuster möglichst genau zu kennen, da nur diese Ziel von Behandlungsansätzen sein können.

2.1.2 Vermittelnde Variablen

Bisher wurden in der Literatur vermittelnde Variablen überwiegend in Hinblick auf den sexuellen Reviktimisierungsprozess oder auf physische Gewalt in Partnerschaften bei Frauen untersucht. Die untersuchten Variablen und die daraus abgeleiteten Theorien, warum diese einen Reviktimisierungsprozess vermitteln oder daran beteiligt sein könnten, werden im Folgenden dargestellt:

In der bisherigen Forschung zeigte sich, dass eine beeinträchtigte *Emotionsregulation* einen vermittelnden Effekt von der Erfahrung von sexueller Gewalt in der Kindheit auf sexuelle Gewalt im Erwachsenenalter bei Frauen hat (Messman-Moore et al., 2010), insbesondere dann, wenn sexuelles Verhalten zur Regulation von negativen Affekten wie Einsamkeit oder Trauer genutzt wird. Denn ein solches Verhalten kann als Einverständnis zu sexuellen Kontakten missinterpretiert werden (Noll et al., 2000).

Weiterhin scheint eine *mangelnde Selbstbehauptung* in sexuell risikoreichen Situationen einen vermittelnden Effekt beim sexuellen Reviktimisierungsprozess darzustellen (Livingston, Testa & VanZile-Tamsen, 2007). Begründet wird dies über die Vermutung, dass

Frauen in risikoreichen sexuellen Situationen ihre Verweigerung nicht vehement genug darstellen können. So kann es ebenfalls zur Missinterpretation das Einverständnis kommen, oder die Täter sehen wenig durchsetzungsfähig Frauen als „leichte Opfer“ an (Livingston et al., 2007).

In diesem Zusammenhang wurde auch die Bedeutung von *missbrauchsbezogenen Schuld- und Schamgefühlen* diskutiert. Denn es wurde gezeigt, dass selbstbeschuldigende Attributionen bzgl. der primären Gewalterfahrung indirekt über eine geringe sexuelle Selbstbehauptung eine spätere sexuelle Reviktimisierung voraussagten (Katz, May, Sörensen & DelTosta, 2010).

Eine *hohe bindungsbezogene Angst* wurde als ein unterliegender Faktor bei Gewalterfahrungen in der Kindheit und der Erfahrung von *physischer* Gewalt in Beziehungen diskutiert. Theoretische Überlegungen hierzu besagen einerseits, dass die betroffenen Frauen aufgrund der hohen Angst vor Einsamkeit besondere Schwierigkeiten haben die gewaltausübende Person zu verlassen (Smith & Stover, 2015). Andererseits könnten Individuen mit hoher bindungsbezogener Angst Verhaltenstendenzen zeigen, die zu Beziehungsunzufriedenheit und interpersonellen Konflikten beitragen (Sandberg, Valdez, Engle & Menghrajani, 2016).

Bei weiteren Variablen wurden korrelative Zusammenhänge zum physischen Reviktimisierungsprozess dargestellt und diskutiert: Die *Selbstwirksamkeitserwartung* einer Person beschreibt das Vertrauen ein bestimmtes Verhalten erfolgreich ausführen zu können. Durch die Unkontrollierbarkeit des Missbrauchs in der Kindheit kommt es zu einer Wahrnehmung der eigenen Person als hilflos, schwach und einflusslos (Renner & Slack, 2006). In interpersonellen risikoreichen Situationen im Erwachsenenalter wird diese Selbstwahrnehmung aktiviert. Die betroffenen Personen haben somit eine sehr geringe Selbstwirksamkeitserwartung in Bezug darauf, dass sie durch ihr Verhalten die Situation in

irgendeiner Form abwenden könnten. Diese Selbstwahrnehmung könnte mit einem Unvermögen einhergehen, Widerstand gegen physische Gewalt in Beziehungen zu zeigen oder die gewaltausübende Person zu verlassen (Renner & Slack, 2006).

Weiterhin wird eine erhöhte *Präferenz für dominante Partner* als möglicher Erklärungsansatz für die physische Reviktimisierung bei Frauen diskutiert. Sozialpsychologische Überlegungen besagen, dass Frauen sich von dominanten Partnern insbesondere Schutz, aber auch eine soziale Statuserhöhung erhoffen (Giebel, 2013; Snyder et al., 2011). Es ließe sich daher vermuten, dass Menschen mit Misshandlungserfahrungen in der Kindheit Dominanz und somit Schutz und Statuserhöhung bei der Partnerwahl höher bewerten als andere Attribute. Besonders bei Männern, die in ihrem sozialen Umfeld durch physische Gewalt Dominanz erreichen, ist auch die Wahrscheinlichkeit erhöht, dass sie in ihrer Beziehung auf physische Gewalt zurückgreifen, da dies eine „effektive" Problemlösestrategie darstellt (Snyder et al., 2011). So könnte es zur physischen Reviktimisierung der Frauen innerhalb von Partnerschaften kommen.

Zusammenfassend gibt es also eine Anzahl von Variablen, welche theoretisch oder vereinzelt in Studien bestätigt einen vermittelnden Effekt beim sexuellen und physischen Reviktimisierungsphänomen einnehmen könnten. Bzgl. emotionaler Reviktimisierung kann aufgrund der bisherigen Aussparung in der Forschung weder auf Befunde noch auch theoretische Überlegungen abgeleitet aus anderen Befunden zurückgegriffen werden. Zusätzlich zu den unterschiedlich differenzierten Vorbefunden je nach Art der Gewalterfahrung, ist es weiterhin problematisch, dass in verschiedenen Studien immer nur isoliert einzelne mögliche Variablen untersucht worden sind. Dabei weisen die untersuchten Variablen zusätzlich teilweise große Überlappungen auf, wie z.B. bei den Konstrukten Selbstwirksamkeit und Selbstbehauptung. Um tatsächlich einen möglichen vermittelnden

Effekt einer Variablen in einem Reviktimisierungsprozess überprüfen zu können, ist also eine gemeinsame Überprüfung der Variablen notwendig. Ein vermittelnder Effekt von bestimmten Variablen muss sich auch dann noch zeigen, wenn auch andere mit dem Reviktimisierungsphänomen korrelierte Variablen in das Modell aufgenommen werden.

2.1.3 Gewalterfahrungen bei Männern

Wie bereits oben beschrieben, konzentrieren sich die Studien zum Reviktimisierungsphänomen fast ausschließlich auf Frauen. Gelegentlich zeigen Studien, dass sowohl Männer als auch Frauen ein erhöhtes Risiko haben, im Erwachsenenalter erneut Gewalt zu erleben, nachdem sie in der Kindheit Opfer waren (Desai, Arias, Thompson und Basile, 2002; Weiß, 2010). Allerdings ist ein mögliches Phänomen der Reviktimisierung bei Männern nicht annähernd so differenziert untersucht worden wie bei weiblichen Stichproben. Wenn Gewalterfahrungen in der Kindheit bei männlichen Stichproben untersucht wurden, dann vornehmlich vor der Fragestellung einer Transmission von Gewalt.

Hierzu zeigt die Forschungslage, für Opfer von Gewalterfahrungen in der Kindheit besteht im Erwachsenenalter ein erhöhtes Risiko, selbst zu Tätern zu werden (Schlack, Rüdel, Karger, & Hölling, 2013). Dieses Phänomen wird als Opfer-Täter-Zyklus oder Transmission von Gewalt bezeichnet. Insbesondere gibt es Forschungen zur Übertragung von sexueller Gewalt bei Männern. So zeigten Lambie und Kollegen (2002), dass 40% der männlichen Sexualstraftäter, die sexuelles Verhalten gegenüber Kindern an den Tag legten, selbst Opfer von sexueller Gewalt wurden. Dutton und Hart (1992) zeigten in ihrer Studie, dass die Wahrscheinlichkeit eines sexuellen Übergriffs auf Fremde um den Faktor 5 zunahm, wenn die Täter selbst Opfer sexueller Gewalt in der Kindheit wurden.

Es ließen sich auch Kreisläufe für andere Arten von Gewalt ableiten. Lansford und Kollegen (2007) zeigten, dass es einen physischen Kreislauf der Gewalt gibt. So steigt beispielsweise das Risiko, als Jugendlicher wegen eines Gewaltverbrechens verhaftet zu werden, wenn in den ersten fünf Lebensjahren körperliche Misshandlung erlebt wurde (Lansford et.al., 2007). Hinsichtlich der Übertragung von emotionaler Gewalt wurde ebenfalls ein Kreislauf identifiziert: Opfer von emotionaler Gewalt in der Kindheit haben ein erhöhtes Risiko, im Jugend- und Erwachsenenalter psychische Gewalt auf andere auszuüben (Ma, 2001).

Bei diesen drei Arten der Übertragung von Gewalt gibt es Hinweise darauf, dass die Art der primären Gewalterfahrung mit der Art der später ausgeübten Gewalt zusammenhängt. In den meisten Forschungsprojekten wurden die gefundenen Zusammenhänge jedoch nicht im Hinblick auf weitere Gewalterfahrungen überprüft. Zum Beispiel, ob im sexuellen Opfer-Täter-Zyklus die später sexuell angreifenden Täter auch emotionale oder physische Gewalt in der Kindheit erlebt hatten. Gelegentlich haben Studien die Gewaltformen separat erfasst, mit widersprüchlichen Ergebnissen. Dutton & Hart (1992) zeigten, dass die spezifischen Formen des Kindesmissbrauchs mit den gleichen Gewaltmustern verbunden sind: Personen, die in der Kindheit körperlich missbraucht werden, werden am ehesten körperlich gewalttätig, und Personen, die in der Kindheit sexuell missbraucht werden, werden am ehesten sexuell gewalttätig (Dutton & Hart, 1992). Eine Studie von Lambie und Kollegen (2002) fand jedoch heraus, dass die höchste Wahrscheinlichkeit, im Erwachsenenalter sexuell gewalttätig zu werden, dann gegeben ist, wenn körperlicher Missbrauch in der Kindheit und nicht sexueller Missbrauch stattgefunden hat.

Ähnlich wie bei dem Reviktimisierungsphänomen ist hier eine Konkretisierung möglicher spezifischer Zusammenhänge zwischen den Arten der Gewalterfahrung in der

Kindheit und der Gewaltausübung im Erwachsenenalter dringend nötig. Darin ließen sich nämlich wichtige Hinweise über die dem Opfer-Täter Zyklus unterliegenden psychologischen Prozesse finden.

Häufig werden die Begleitumstände der Missbrauchserfahrungen untersucht (Alter, Täterkonstellation & Familienkonstellation), inwiefern sie eine Ausübung von Gewalt wahrscheinlicher machen (Thomas & Fremouw, 2009, Cossins & Plummer, 2018). Ein solches Wissen ist jedoch bzgl. der Frage wie man ein Individuum davor schützen kann selbst zum Täter zu werden wenig hilfreich. Hier wäre eine Untersuchung von psychologischen Konstrukten wie bei dem Reviktimisierungsphänomen wie z.B. Emotionsregulationsdefizite unerlässlich. Bislang wurde der Frage nach möglichen vermittelnden Variablen beim Opfer-Täter Zyklus jedoch noch keine Beachtung geschenkt.

Ebenso ist es unerlässlich eine mögliche Reviktimisierung von Männern in einem ähnlich detaillierten Ausmaß wie bei Frauen zu untersuchen. Ziel sollte es sein herauszufinden, in welcher Art ein Reviktimisierungsphänomen auch bei Männern besteht und inwiefern es sich von einem Opfer-Täter Zyklus unterscheidet. Die Untersuchung von vermittelnden Variablen wäre somit auch hier unerlässlich.

Zusammenfassend aus dem angeführten Forschungshintergrund fehlen für eine differenzierte Betrachtung des Reviktimisierungsphänomens drei wichtige Informationsquellen: die Betrachtung von unterschiedlichen Arten von Gewalterfahrungen (sexuelle, physische und emotionale Gewalt) und ihre Zusammenhänge untereinander, mögliche vermittelnde Variablen in ihrem Zusammenwirken und die Untersuchung von Reviktimisierungsprozessen und Opfer-Täter Zyklen bei Männern.

2.2 Forschungsarbeit

In der vorliegenden Promotion werden ebendiese Forschungslücken genauer untersucht. So sollen bei Frauen und bei Männern spezifische Formen der Gewalterfahrung in der Kindheit und im Erwachsenenalter erfasst werden. Ebenso sollen spezifische Arten der Gewaltausübung im Erwachsenenalter erfasst werden. Zusätzlich soll die Ausprägung auf verschiedenen psychologischen Konstrukten erhoben werden, um diese später als mögliche vermittelnde Variablen zu überprüfen.

2.2.1 Zur Frage der Datenerhebung

Bei diesem Promotionsvorhaben ging es um die Erfassung hoch sensibler Daten. Wenn Probanden solche intimen Informationen wie sexuelle Gewalterfahrungen oder Gewaltausübung angeben sollen, sind mehrere Faktoren zu berücksichtigen: Einerseits ist es für die Betroffenen hoch schamhaft beispielsweise Gewalterfahrungen anzugeben. Insbesondere gleichzeitige Fragen über mangelnde Selbstbehauptung können als beleidigend wahrgenommen werden oder es besteht eine hohe Tendenz der sozialen Erwünschtheit solche Verhaltensweisen zu bejahen. Weiterhin kann ein erneutes Abfragen von Gewalterfahrungen für Probanden sehr belastend sein.

Eine mögliche Form der Datenerhebung wäre in psychiatrischen Kliniken die gewünschten Konstrukte im persönlichen Kontakt in Form eines Interviews abzufragen. Dies hätte den Vorteil, dass sichergestellt wird, dass alle Fragen richtig verstanden werden. Zusätzlich kann eine psychotherapeutische Einschätzung darüber gewonnen werden, welche Variablen besonders ausschlaggebend erscheinen. Gerade ein persönliches Gespräch bietet bei den oben genannten zu berücksichtigenden Faktoren jedoch auch viele Einschränkungen. Bei dem sensiblen Thema kann man davon ausgehen, dass bestimmte Antworten eher

bagatellisiert werden oder dass sozial erwünscht geantwortet werden könnte. Ebenso ist die Schwelle für einen Abbruch, falls sich die Person zu sehr belastet fühlt, in einem persönlichen Gespräch sehr hoch.

Weiterhin würde eine Erhebung in einer psychiatrischen Klinik bedeuten, dass die Stichprobe bereits in einem hohen Maße vorselektiert ist. Und zwar besteht in jedem Fall Psychopathologie. Zusätzlich haben sich die Betroffenen in irgendeiner Form bereits mit ihren Gewalterfahrungen auseinandergesetzt und wenn es nur zu dem Schritt gekommen ist, die Anbindung an das professionelle Hilfesystem zu suchen.

Eine andere Möglichkeit der Datenerhebung ist die Form der Online Datenerhebung, bei der in speziellen Foren oder in themenoffenen Austauschplattformen auf die Möglichkeit zur Teilnahme aufmerksam gemacht wird. Die Form der Datenerfassung erfolgt dann über online Fragebögen. In diesem Fall erfolgt die Datenerhebung völlig anonym, sodass Faktoren wie Bagatellisierung und soziale Erwünschtheit deutlich minimiert werden können. Ebenso sollte so eine breite und vielfältigere Stichprobe erreicht werden als in einer psychiatrischen Klinik. Ein weiterer Vorteil besteht darin, dass die Schwelle zu einem Abbruch bei zu hoher Belastung deutlich geringer ist, ebenso wie die Schwelle zur Teilnahme durch die Anonymisierung. Ein Nachteil bei online Erhebungen ist jedoch, dass beispielsweise nicht sichergestellt werden kann, dass die Fragen richtig verstanden werden.

Vor dem Hintergrund der hoch sensiblen Daten sahen wir die Form einer Online Datenerhebung als vorteilhaft an. Um einige der Nachteile abzumildern, entschlossen wir uns vor der eigentlichen Datenerhebung eine Vorstudie in einer psychiatrischen Klinik durchzuführen. Ziel hiervon sollte es sein die zu erfassenden Konstrukte dahingehend zu überprüfen, ob sie in einem Selbstberichtsfragebogen sicher verstanden werden können. Andererseits sollte durch den persönlichen psychotherapeutischen Kontakt eine Einschätzung

ermöglicht werden, welche Konstrukte als besonders relevant erscheinen und wie die Probanden eine solche belastende Erhebung absolvieren.

2.2.2 Vorstudie

Anhand von existieren Selbstberichtsfragebögen wurde ein semi-strukturiertes klinisches Interview erstellt. In diesem wurden folgende Konstrukte abgefragt: sexuelle, physische und emotionale Gewalterfahrungen in der Kindheit und im Jugend- und Erwachsenenalter, sexuelle, physische und emotionale Gewaltausübung im Erwachsenenalter, Emotionsregulationsdefizite (erfasst mittels 6 Skalen). Bindungsbezogene Einstellungen (erfasst mittels 3 Skalen), Selbstwirksamkeit, Selbstbehauptung, sexuelle Selbstbehauptung, Alexithymie, Präferenz für dominante Partner, und missbrauchsbezogene Schuld- und Schamgefühle. Ebenso wurden subjektive Theorien der Betroffenen über die Auswirkungen der Gewalterfahrungen auf ihr Leben und/oder Erklärung für die erneuten Gewalterfahrungen aus der Opfer- oder Täterperspektive erfragt. Zusätzlich erfolgten Informationen über die Forschungslage und den Inhalt dieser Studie mit dem Ziel, dass die gestellten Fragen nicht im Sinne einer Beschuldigung der Betroffenen interpretiert wurden.

Die Rekrutierung der Probanden erfolgte gezielt. Durch meine eigene psychotherapeutische Arbeit in der Klinik wurden mögliche Probanden angesprochen, ob sie auf freiwilliger Basis Interesse zu der Teilnahme an dem klinischen Interview hätten. Es wurde darauf geachtet nur Patienten anzusprechen, bei denen durch vorherige psychotherapeutische Behandlung schon eine therapeutische Beziehung aufgebaut wurde, sodass Bagatellisierungstendenzen im persönlichen Kontakt als geringer eingeschätzt werden konnten. Bei der Rekrutierung wurde darauf geachtet, wenn möglich eine gepaarte Stichprobe zu erstellen. Es wurde versucht jeweils einen Probanden mit beispielsweise nur sexueller

Vitkimisierungserfahrung in der Kindheit, mit einem Probanden mit sexuellen Viktimisierungserfahrungen in der Kindheit und im Jugend- oder Erwachsenenalter zu vergleichen.

Insgesamt nahmen 10 Probanden an der Vorstudie teil, aus diesen Probanden konnten 5 Paare direkt verglichen werden.

1. Eine Frau mit sexuellen und teilweise physischen und emotionalen Gewalterfahrungen in der Kindheit mit einer Frau mit sexuellen physischen und emotionalen Gewalterfahrungen in der Kindheit und sexuellen Gewalterfahrungen im Jugend- und Erwachsenenalter.
2. Eine Frau mit emotionaler Vernachlässigung in der Kindheit und später physischer Gewalt in der Partnerschaft und eine Frau mit physischer und emotionaler Gewalt in der Kindheit und späterer emotionaler und physischer Gewalt in der Partnerschaft.
3. Eine Frau mit emotionaler Gewalterfahrung in der Kindheit und eine Frau mit emotionaler Gewalterfahrung in der Kindheit und im Jugend- und Erwachsenenalter.
4. Ein Mann mit emotionaler und physischer Gewalterfahrung in der Kindheit und ein Mann mit emotionaler und physischer Gewalterfahrung in der Kindheit und emotionaler und physischer Gewalterfahrung im Jugend- und Erwachsenenalter.
5. Ein Mann mit sexuellen und physischen Gewalterfahrungen in der Kindheit und ein Mann mit sexuellen, physischen und emotionalen Gewalterfahrungen in der Kindheit und physischer Gewaltausübung im Erwachsenenalter.

Zuerst war auffällig, dass bei den meisten der Teilnehmer mehrere Arten von Gewalterfahrungen in der Kindheit parallel stattgefunden hatten und dass eine Isolierung an der Stelle schwer zu treffen war. Teilweise wurde den Schilderungen der Probanden gefolgt, welche Art der Gewalt für sie besonders belastend war. Bzgl. der Viktimisierung und

Reviktimisierung konnte so ein erster Überblick gewonnen werden. Bzgl. eines Opfer-Täter Zyklus gab es jedoch zu wenig Probanden, welche von eigener Gewaltausübung berichteten.

Aus diesen Interviews konnten letztendlich folgende Erkenntnisse gesammelt werden: Das abgefragte Konstrukt der Alexithymie war für die Probanden sowohl anhand der Fragebogen (TAS-20; Bagby, Parker & Taylor, 1994) schwer begreiflich. Sie benötigten immer wieder ergänzende Erklärungen. Ebenfalls verneinten alle Teilnehmer die gestellten Fragen. Ebenso verhielt es sich mit zwei Skalen (Schwierigkeiten bei zielgerichteten Verhalten, Fehlendes Bewusstsein von Emotionen) des Fragebogens zur Erfassung von Emotionsregulationsdefiziten (DERS; Gratz & Roemer, 2004). Alle anderen Fragebögen wurden ohne weitere Erklärungen begriffen. Wir entschieden uns daher das Konstrukt Alexithymie in der Hauptstudie nicht abzufragen und bei den Fragen zu Emotionsregulationsdefiziten auf die beiden genannten Skalen zu verzichten.

Bzgl. der subjektiven Theorien der Betroffenen über die Auswirkung von Gewalterfahrungen zeigten sich keine Parallelen. Vielmehr imponierte jeweils die Ratlosigkeit der Probanden, insbesondere bei Reviktimisierten bezüglich möglicher Verhaltensmuster. Hier ist ebenfalls anzumerken, dass zu manchen eigenen Verhaltensmustern kaum Zugang zu bestehen scheint oder diese intrapsychisch anders attribuiert werden. So berichteten beispielsweise zwei Probandinnen von stark beziehungsängstlichem Verhalten und darüber kaum Interaktionen zu potenziellen Partnern und keiner Präferenz von dominanten Partnern. In der Verhaltensbeobachtung im Stationsalltag war jedoch ein eher gegenteiliges Verhalten auffällig, im Sinne eins stark bindungssuchenden Verhaltens und eines direkten Ansprechens potenzieller Partner, insbesondere derer mit sozial dominanten Positionen.

In einer abschließenden psychotherapeutischen Begutachtung konnte man keine der abgefragten Variablen isoliert als besonders entscheidend beim Reviktimisierungsprozess

identifizieren. Es war jedoch auffällig, dass es unabhängig bei der Art der Gewalt bei denjenigen Probanden zu keiner erneuten Gewalterfahrung kam, bei denen die dysfunktionalen Muster früh korrigiert wurden. So berichtete beispielsweise eine Patientin davon, wie wichtig ihre ältere Schwester für sie gewesen sei, da diese ihr schon früh erklärt habe, dass das sexuell übergriffe Verhalten ihres Vaters falsch sei und dass sie keine Mitverantwortung daran trage.

2.2.3 Hauptstudie

Als Fazit aus der Vorstudie konnten die erprobten Instrumente mit den oben genannten Aussparungen eingesetzt werden. Für die Hauptstudie wurden die Internetplattform Facebook genutzt. Zusätzlich wurden Online Selbsthilfegruppen, die teilweise das Thema Gewalterfahrungen beinhalteten gezielt angeschrieben. Mit Erlaubnis wurde auf diesen Seiten ein Link veröffentlicht. Über diesen gelangten die Probanden direkt zur Eingabemaske. Selbstverständlich wurden sowohl mit dem Link als auch auf den ersten Seiten der Studie die Teilnehmer über die Art der Studie und die Freiwilligkeit informiert. Über die Eingabemaske wurden schließlich folgende Konstrukte abgefragt: Emotionsregulationsdefizite, bindungsbezogene Einstellungen, Selbstwirksamkeit, Selbstbehauptung, sexuelle Selbstbehauptung, Präferenz für dominante Partner, sexuelle, physische und emotionale Gewalterfahrungen in der Kindheit und im Jugend- und Erwachsenenalter, missbrauchsbezogene Schuld- und Schamgefühle und sexuelle, physische und emotionale Gewaltausübung im Erwachsenenalter. Erhoben wurden die Daten von volljährigen Männern und Frauen.

Mit den gewonnenen Daten sollen Aussagen zu den oben beschrieben Forschungslücken getroffen werden. Und zwar bei Frauen bzgl. des gewalttypspezifischen Zusammenhangs der

Arten von Gewalterfahrungen untereinander und möglicher vermittelnder Variablen bei dem Reviktimisierungsprozess. Bei Männern wurde ebenfalls der gewalttypspezifische Zusammenhang der Arten von Gewalterfahrungen untereinander betrachtet, und zwar sowohl im Sinne eines Reviktimisierungsprozesses als auch eines Opfer-Täter Zyklus. Beide Prozesse sollten in der Folge auf vermittelnde Variablen untersucht werden.

Nach der Erhebung der Online Studie zeigte sich, dass zwar eine beträchtliche Anzahl an weiblichen Probanden teilgenommen hatte (135 Teilnehmer), jedoch waren nur 12 Teilnehmer männlich. Aufgrund der breiten Rekrutierung online, gingen wir davon aus, dass diese Erhebungsform für eine männliche Stichprobe nicht geeignet schien. Um trotzdem eine ausreichend große männliche Stichprobe untersuchen zu können, wurde daher auf eine Rekrutierung männlicher Teilnehmer in der psychiatrischen Klinik zurückgegriffen. Um die Bedingungen hier möglichst gleich zur Online Studie zu gestalten, wurden dieselben Fragen und erklärenden Texte den Probanden in Papierform ausgehändigt. Die Teilnehmer wurden über die Möglichkeit zur Teilnahme informiert, eine tatsächliche Teilnahme erfolgte auf freiwilliger Basis ohne vorherige Ansprache, die Datenerfassung erfolgte ebenfalls in anonymisierter Form. Auf diese Weise konnten 35 weitere männliche Teilnehmer gewonnen werden, sodass die Gesamtstichprobe der männlichen Teilnehmer aus 47 Probanden bestand. Die so gewonnenen Daten wurden in insgesamt drei Artikeln veröffentlicht. Der erste Artikel handelt über die Gewalttypspezifischen Zusammenhang beim Reviktimisierungsphänomen bei Frauen und der zweite Artikel beinhaltet die vermittelnden Variablen beim Reviktimisierungsphänomen bei Frauen. Ein dritter Artikel beschäftigt sich mit derselben Fragestellung bei Männern, erweitert um eine differenzierte Untersuchung des Opfer-Täter Zyklus.

3. Revictimization and the Specificity Hypothesis- Do Different Subtypes of Interpersonal Violence Predict Each Other?

3.1 Abstract

Revictimization refers to the finding that victims of child abuse have an increased risk of experiencing violence as adolescents and adults. To date, revictimization has been well documented for sexual violence. Recent findings show that the same phenomenon occurs for physical and emotional types of violence and indicate specificity in the relationship. In particular, childhood sexual abuse predicts sexual violence in adulthood and childhood physical abuse predicts future physical victimization (Langer & Catani, 2016). Although emotional violence is among the most harmful types of maltreatment, emotional revictimization has not yet been systematically documented. The aim of this study was to investigate how the three different types of childhood abuse (sexual, physical, and emotional) were related to the three different types of adult victimization (sexual, physical, and emotional). In an online survey of 135 adult women with high levels of victimization, sexual, physical and emotional experiences of violence were assessed separately for childhood and adulthood. Linear regressions indicated specific relationships between childhood sexual and physical abuse and sexual violence in adulthood (standardized beta coefficients .33*** and .21*), while childhood physical abuse predicts physical violence in adulthood (standardized beta coefficient .44***). Emotional violence experiences in adulthood were predicted by childhood sexual and emotional abuse (standardized beta coefficients .20*** and .08*). The findings partly support the specificity hypothesis of revictimization and have significant implications for practice, particularly for the development of more effective approaches to preventing repeated violence.

3.2 Introduction

Victims of childhood abuse have an increased risk of becoming victims of violence again in adolescence and adulthood (Bockers & Knaevelsrud, 2011). Two out of three individuals who have experienced abuse in childhood fall victim to sexual abuse again later in life (Classen, Pales & Aggarwal, 2005). Women who have experienced physical or sexual abuse in childhood are 3.5 times more likely to become victims of domestic violence (Coid et al., 2001). This phenomenon is called revictimization and has been recognized generating a considerable public-health burden (Bockers, Roepke, Michael, Renneberg & Knaevelsrud, 2014). However, the processes underlying revictimization have not yet been sufficiently researched. One factor to which little attention has been paid is whether there is a specific connection between the different types of violence. Understanding the links between childhood sexual abuse and adult sexual revictimization, and childhood physical abuse with adult physical revictimization experiences, would have two major functions. First, this understanding would serve to increase the predictive accuracy of a revictimization model. Second, understanding the links between abuse during childhood and revictimization during adulthood would clarify the mechanisms underlying revictimization, which offers an inroad to develop better prevention work for victimized individuals (Bornovalova, Gwadz, Kahler, Aklin, & Lejuez, 2008).

To date, the literature has largely focused on sexual revictimization (Widom, Czaja & Dutton, 2008). That is, the relationship between child sexual abuse and sexual victimization in adulthood. Research that targets physical violence is much more limited, and such studies mostly cover physical violence in addition to sexual violence. They revealed that the likelihood of sexual revictimization increases if, in addition to childhood sexual abuse, physical abuse also took place in childhood (Merrill et al., 1999; Messman-Moore, Walsh & DiLillo, 2010).

Further, research into inter-partner violence revealed that experiences of various types of abuse in childhood predict subsequent domestic violence (Coid et al., 2001). Unfortunately, these studies fall short of analyzing the specificity of the relationship between different types of abuse and adult victimization. This limitation is due, in part, to methodology. Many such studies do not record violent experiences in childhood separately according to different forms of violence (see Coid et al., 2001). Thus, the cumulative effect of types of childhood violence is known in the current research.

Scant attention has been paid to the specific effect of different types of abuse. However, there are indications that better understanding the roles of specific types of violence may be relevant because the type of violence experienced in childhood is related to the type of violence experienced later in adulthood (Blom, Högberg, Olofsson & Danielsson, 2014). For example, a recent study showed that experiences of childhood sexual abuse uniquely predicted adult sexual abuse (Langer & Catani, 2016) and that, similarly, childhood physical abuse predicted adult physical abuse. To describe these results, we coined the term "specificity hypothesis" which states that the types of violence experienced in childhood (sexual and physical) are specifically related to the types of violence experienced in adulthood (sexual and physical). As this hypothesis has so far only emerged from the work by Langer and Catani (2016), its verification in further studies is essential. Further research on the "specificity-hypothesis" has implications for the study of the mechanisms of revictimization, because specific relationships should be carried by specific processes of revictimization.

Thus far, support for the specificity hypothesis is still limited and restricted to physical and sexual types of violence. Emotional Violence has not yet been specifically investigated. In previous studies, emotional abuse in childhood has been considered only in combination with other types of violence; experiences of emotional violence in adulthood have not yet been

studied in the context of revictimization (Langer and Catani, 2016). Despite frequent co-occurrence with other forms of violence (Mullen, Martin, Anderson, Romans & Herbison, 1996), specific patterns of behavior and experience emerge, particularly in the wake of childhood emotional abuse, and differ from the psychological malfunction emerging from sexual and physical abuse (Briere & Runtz, 1990). Emotional violence in childhood is associated with low self-esteem (Briere & Runtz, 1990) and lack of social skills (Clausen & Crittenden, 1991). Low self-esteem, in combination with a lack of social skills, represents a predictor for later emotional victimization (Ma, 2001).

There is reason to assume that revictimization spans all types of violence and abuse, including emotional abuse. In addition, some findings suggest different revictimization processes and support the specificity hypothesis of revictimization. So far, studies that systematically record all three types of violent experiences in childhood, adolescence and adulthood are still lacking. However, a more nuanced knowledge of the processes of revictimization could offer the basis for a better understanding of the mechanisms underlying revictimization. The present study sought to address this gap in the literature. In particular, we aimed to determine the extent to which different types of childhood abuse (sexual, emotional and physical) are related to different types of adult violence (sexual, emotional and physical). For the present study, we suspected a specific connection between the different types of violence. Specifically, we hypothesized that childhood sexual abuse would predict adult sexual violence, that childhood physical abuse would predict adult physical violence, and that childhood emotional abuse would predict adult emotional violence. For this purpose, we studied a sample of adult women with a wide range of victimization experiences and recorded retrospective reports on childhood as well as adulthood victimization. We considered a web-based survey as particularly suitable for this study because it allowed us to include highly

affected individuals in our sample through the use of announcements in specific self-help groups and forums. In addition, web-based surveys allowed for full anonymity for respondents, which may have increased the participants' willingness to report sensitive content.

3.3 Method

3.3.1 Procedure

The data for this study was collected in an online survey created with the Unipark software (Unipark, E.F.S. Survey, version 7). The aim was to recruit a sample with a large variance on the study variables, including maltreatment and revictimization, without focusing primarily on a clinical population. For this purpose, the link for participation was published in numerous private Facebook accounts and in self-help groups on the Internet which are focused on the topic of traumatic life experiences. Those self-help groups were located by a Google search. First the moderators of active online self-help groups were contacted, the contents of the study were presented and a publication of the link for participation was requested. Of 19 online self-help groups 14 agreed to the publication of the link. The link´s publication was accompanied by brief information on the nature of the questions and the need for potential study participants to be of legal age. There was no incentive to participate. On the first page of the survey, the participants were informed about the contents and risks of the study, about the voluntary and anonymous nature of the survey, and the possibility to desist at any time without penalty. This was followed by a declaration of consent to participate in the study. The programming of the survey prevented the participants from seeing the contents of the study if they were underage.

First, demographic data (age, gender, education) were collected. Afterwards, the experience of different types of violence in childhood was investigated. In order to avoid closure effects, the pursue of various types of violence in adolescence and adulthood was only then examined. Subsequently, psychopathology was recorded. The average time taken to complete the survey was 23 minutes. The ethical considerations of this study were reviewed and approved by the Ethics Committee of the Department of Psychology at Bielefeld University. This study was part of a larger survey, that also included additional psychological variables that are not part of this analysis.

3.3.2 Participants

In total, N= 1062 participants commenced the study and of those n= 155 finished it, leaving the completion rate at 14.6%. Most drop-outs took place on the start page (n=789, 74.29 %). Under 3% (n= 26) of drop-outs occurred at the declaration of consent and n = 20, 1.88 % drop-outs occurred during the indication of socio-demographic data. For all other questions, there was no noticeably higher number of drop-outs. The study was active for a total of 182 days. The average number of participants per day was 7.08.

Of the 155 participants who completed the study, only female and adult participants were considered. Therefore, eight underage participants and twelve men were excluded. The final sample thus consisted of N=135 participants aged 19 to 67 years (*M* = 33.4; *SD* = 11.12). They had an average of 14 years (S*D* = 3.27) of formal education (primary school, secondary school, university).

3.3.3 Measures

Child abuse experiences. The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998; German version; Wingenfeld et al., 2010) is a self-assessment tool for the retrospective assessment of abuse and neglect in childhood. Due to the specific nature of the study, participants were instructed to click on items only if they were applicable before the age of 14. With 28 items, the questionnaire covers the subscales of sexual abuse (e.g., “when I grew up, someone tried to touch me sexually, or get me to touch him/her sexually”), emotional abuse (e.g., “when I grew up, people from my family said hurtful/offending things to me”), physical abuse (e.g., “when I grew up people from my family hit me so hard that I was bruised or scarred”), emotional neglect (e.g., when I grew up, I thought my parents wished I had never been born”) and physical neglect (e.g., “When I grew up, I had enough to eat”). The items were answered on a five-point Likert scale rated from 1 (not a bit) to 5 (very often). The CTQ showed good internal consistency for all scales in validation studies (Klinitzke, Romppel, Häuser, Brähler & Glaesmer, 2012) besides the scale of physical neglect. Due to the low internal consistency of this scale and its high intercorrelation with the other scales (Klinitzke et. al., 2012) it was not included for analysis in the present study. In the present study, good internal consistency for the four scales used was confirmed (Cronbach’s alpha coefficients: sexual abuse .97, physical abuse .93, emotional abuse .92, emotional neglect .92). The decision on the existence of the different types of abuse was made on the basis of the cut-off values for the summed item scores of Walker et al. (1999). However, the frequencies thus obtained were used only for the descriptive information. In all further analyses, the summed item scores of the individual scales were used, independent of the cutoff values.

Sexual Victimization in Adolescence and Adulthood. The Potsdam scales for recording sexual aggression and victimization (SEX_AGG_VIC; Krahé & Berger, 2014) are a self-report instrument for the assessment of sexual aggression and victimization in adolescence and adulthood (after the age of 14). For the purpose of this study only the sexual victimization subscale was used. The Potsdam scales record sexual victimization with three questions (e.g., “Since the age of 14, has anyone brought (or tried to bring) you into sexual contact by physically threatening or hurting you?”; “Since the age of 14, has anyone brought you (or tried to bring you) to sexual contact by pressuring you with words”). These questions were asked separately based on different potential offenders, which included the type of pre-relationship between offender and victim ((former) partners, acquaintances or strangers). In order to harmonize this instrument with the other assessments, the category "colleagues or supervisors at the workplace" was added here. Through the three questions combined with four possible perpetrators each, the instrument consists of 16 items. The items were answered on a four-point Likert scale regarding the frequency of occurrence rated from 1 (never) to 4 (three times or more). Three different strategies for exerting pressure were asked (use or threat of physical violence, exploitation of inability to resist, and verbal pressure). A more precise differentiation of forced sexual acts (sexual contact, attempted sexual intercourse, sexual intercourse and other sexual acts, e.g., oral sex) is mentioned in the explanatory text. This more precise differentiation is removed from the item query, as it is not relevant for the purpose of this study. As this is a newly developed instrument, no validity or reliability criteria were available. In the present study the scale was found to demonstrate a sufficiently good internal consistency (Cronbach’s alpha coefficient .71). People are considered victimized if they have been exposed to sexual aggression on at least one occasion. For the present

evaluation, the total scores of all items assessing victimization represented the experience of sexual violence in adolescence and adulthood.

Physical and Emotional Victimization in Adolescence and Adulthood. A recently created screening instrument was used to record and quantify the experience of physical and emotional violence in adolescence and adulthood. It was developed for one of the main German epidemiological studies on health, the "Study on Adult Health in Germany" (DEGS1) of the Robert Koch Institute (RKI; Schlack, Rüdel, Karger, & Hölling, 2013). It explores whether there have been physical or emotional experiences of violence, both from the victim's and the perpetrator's perspective. The preliminary relationship between perpetrator and victim is also recorded ((former) partners, acquaintances, work colleagues/supervisors at the workplace or strangers). In order to avoid confusion with experiences of intrafamily childhood violence, the category of "one person from the family" was omitted. For the same reason, participants were instructed to select the items only if the experience had taken place at or after the age of 14. An additional question on the burden of the respective experience of violence was removed as it was not relevant for the purpose of this study. In total the instrument consisted of eight items, four concerning physical violence and four concerning emotional violence (e.g., "Has an (ex-) partner physically attacked you from the age of 14 onwards (e.g., hit you, slapped you, pulled your hair, kicked you, threatened you with a gun or an object"; "Has a friend or an acquaintance devalued you from the age of 14 onwards (in terms of your appearance, the way you dress, the way you think, act or work, or possible disability? Or has a friend or acquaintance insulted, threatened, harassed or pressured you?"). The items were answered on a four-point Likert scale regarding the frequency of occurrence rated from 1 (never) to 4 (three times or more). As this study only considered the victim`s perspective, eight items about the perpetrator`s perspective were left out. Due to the recent development of this

instrument, no reliability or validity criteria was yet available for use. The internal consistencies identified in this study were considered sufficient in view of the low number of items (four per scale; Cronbach's alpha coefficients: physical violence .59, emotional violence .71). Participants were considered victimized if they had been exposed to physical or emotional aggression on at least one occasion. However, this information was used only for descriptive purposes. For the present evaluation, the total scores of all items concerning victimization represented the experience of physical or emotional violence in adolescence or adulthood.

PTSD Symptoms. The Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003) is a screening instrument for the detection of post-traumatic stress disorder (PTSD). The scale consists of four items in dichotomous response format (Yes/No). It asks whether a person has experienced four symptoms typical of PTSD in the last month: Re-experience, numbness, avoidance, and hyperarousal. The PC-PTSD has optimum efficiency in terms of the best possible combination of sensitivity and specificity at a cut-off value of three (Prins et al., 2003). The cut-off value was only used for descriptive purposes in this study. The summed item scores were used in the evaluation, representing a value for the exposure to symptoms of PTSD. The PC-PTSD has good retest reliability and correlates highly with the standard instrument for the detection of PTSD, the Clinician Administered PTSD Scale (CAPS; Prins et al., 2003).

Symptoms of Depression. The health questionnaire for patients (PHQ-9; Kroenke, Spitzer & Williams, 2001; German version Löwe, Spitzer, Zipfel & Herzog, 2002) is a screening instrument used for the detection of a depressive disorder. The self-report questionnaire contains nine items that assess whether typical symptoms of depression (based on the DSM-

IV criteria) have occurred in the last two weeks. The items were answered on a four-point scale regarding the frequency of occurrence rated from 1 (never) to 4 (almost every day). The PHQ-9 has previously demonstrated good validity and retest reliability (Kroenke et al., 2001). In addition, good values for sensitivity and specificity were confirmed for the stated cut-off values for the severity of depressive symptoms (Kroenke et al., 2001). These cut-off values were only used for descriptive purposes in this study. The summed item scores were used in the evaluation representing a value for the burden of symptoms of depression.

3.3.4 Statistical Analyses

The statistical analyses of the study were carried out with the statistical program IBM SPSS Statistics, version 21. All procedures refer to the significance level $\propto = .05$. To describe the sample characteristics, the variables of sexual, physical, emotional abuse, emotional neglect in childhood and sexual, physical, and emotional experiences of violence in adulthood were treated as dichotomous variables using the cut-off values described above. They were used as continuous variables in all further analyses. The scales of emotional abuse and emotional neglect were combined due to their high correlation (sum of the scores of the individual scales). The scale of emotional abuse reflected this composite value.

In order to test the predictors for the experience of violence in adulthood, linear regressions were calculated. To carry out the regression analyses, the normal distribution of the residuals was checked by visual inspection first. According to the question of what specific contribution different types of childhood abuse experiences make to the prediction of a subsequent revictimization, all potential predictors were simultaneously included in the regression model. In a first linear regression, the variable sexual experiences of violence in adulthood served as a dependent variable. Independent variables were sexual abuse,

emotional abuse, and physical abuse in childhood. In the following two linear regressions, the same independent variables were used. The dependent variables were experiences of physical violence in adulthood and experiences of emotional violence in adulthood.

3.4 Results

Overall, 83 % of the participants stated that they had experienced violence in adolescence or adulthood, with experiences of emotional violence occurring as the most frequent form in our sample (83%). Eighty-seven percent of the participants were victims of at least one subtype of interpersonal violence in childhood. For 81% of the participants, emotional abuse was the most frequent form of violence during childhood. Of the 117 participants who had experienced any form of violence in childhood, 115 re-experienced violence in adulthood. Those participants were regarded as revictimized.

The results of the short screenings suggest an increased psychopathological stress in the examined sample. Seventy-six percent of the participants answered in the affirmative to three out of four questions about post-traumatic symptoms and were thus above the cutoff value, which seems to indicate the possible presence of PTSD (Prins et al., 2003). When responding to the PHQ, 83 % of the participants were above the value of 15, which is considered to be indicative of a potential depressive risk; such as a moderate depressive episode. A complete overview of the descriptive statistics can be found in Table 1. A more detailed overview of the frequencies of different types of violence as well as the different perpetrators can be found in Figure 1.

Table 1

Descriptives

	M(SD)	*N* (%) above the cutoff value
Age	33.40 (11.12)	
Formal education	13.66 (3.27)	
Child emotional abuse	17.76 (6.47)	81
Child physical abuse	11.39 (6.30)	61
Child sexual abuse	14.84 (7.72)	70
Child emotional neglect	17.71 (5.93)	71
Child emotional abuse (composite)	35.47 (11.41)	
Adult sexual abuse	5.53 (5.42)	77
Adult physical abuse	2.29 (2.76)	61
Adult emotional abuse	5.65 (4.10)	83
PTSD symptoms	3.10 (1.47)	76
Depression symptoms	14.42 (7.63)	73

Note. N= 135.

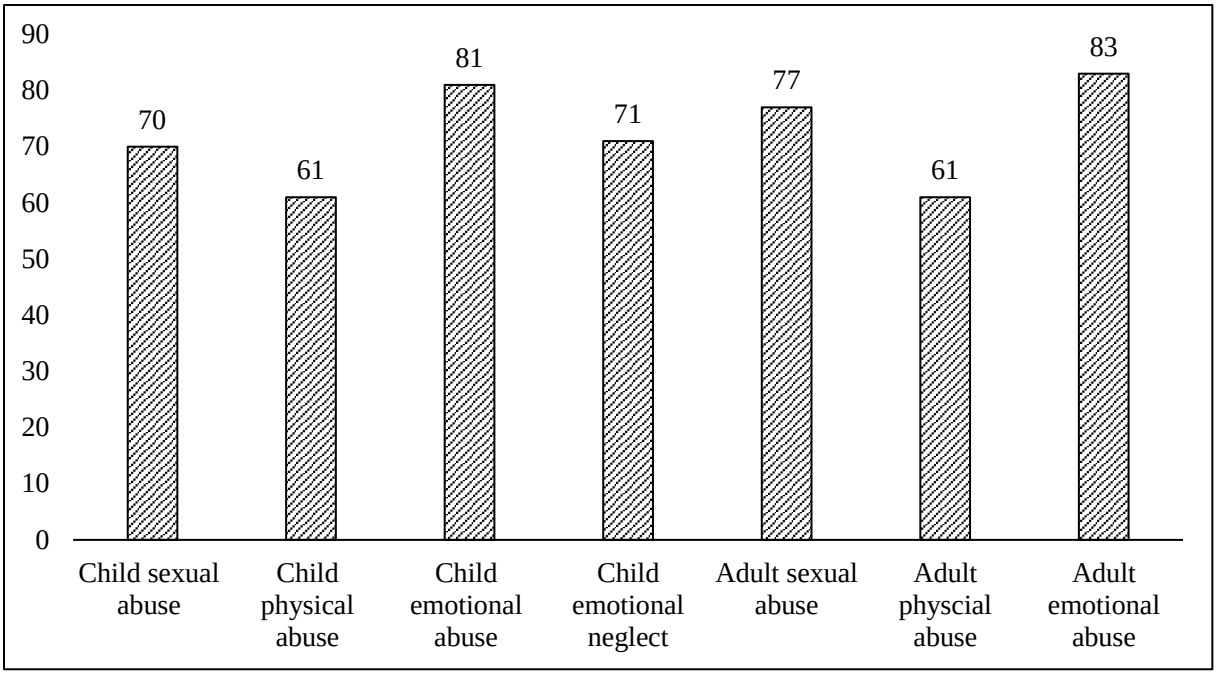

Figure 1. Frequencies of different forms of abuse experiences.

3.4.1 Predicting Sexual, Physical and Emotional Victimization in Adulthood from Abuse Experiences in Childhood

In all regression analyses conducted in this sample, the scatterplot of residuals did not indicate a deviation from the normal distribution. A test of the multicollinearity of the predictors showed that although the predictors correlated with each other, the assumption of multicollinearity was not violated. The regression analyses could therefore be carried out without restriction.

The results of the regression analyses for the variables adult sexual, physical, and emotional violence are shown in Table 2. Significant predictors of adult sexual violence were sexual abuse (β= .33; p < .001) and physical abuse (β= .21; p < .05) in childhood, F (3,131) =17.70, p < .001. Adult physical violence was significantly predicted by physical abuse (β= .44;

$p < .001$) in childhood, F (3,131) =19.97, $p < .001$. Significant predictors for adult emotional violence were sexual abuse (β= .20; $p < .001$) and emotional abuse (β= .08; $p < .05$) in childhood, F (3,131) =12.57, $p < .001$.

Table 2

Predictors of sexual, physical and emotional victimization (Predictors: Experiences of violence in childhood)

	Adult Sexual Violence[1]		Adult Physical Violence[2]		Adult Emotional Violence[3]	
Predictors	β	*r*	β	*r*	β	*r*
Child sexual abuse	.33 ***	.54 **	.16	.45**	.20***	.44**
Child phyiscal abuse	.21 *	.42 **	.44 ***	.55 **	-.05	.32**
Child emotional abuse	.03	.35 **	.001	.40 **	.08*	.37**

Note. N = 135. β*:* standardized beta coefficient*; r:* 0-order correlation (Spearman).

[1] corrected R^2 = .27, F (3,131) = 17.70, $p < .001$

[2] corrected R^2 = .30, F (3,131) = 19.97*,* $p < .001$

[3] corrected R^2 = .21*,* F (3,131) = 12.57, $p < .001$

* $p < .05$. ** $p < .0.1$. ***p < .001

3.5 Discussion

In an online survey with individuals with high rates of experiences of violence we found evidence to support the specificity hypothesis of revictimization. Across developmental stages, specific types of abuse were inter-correlated: childhood physical abuse predicted adult physical violence. The assumption of specificity could be extended, in part, to sexual and

emotional violence. Adult sexual violence was predicted by childhood sexual abuse and by childhood physical abuse. Adult emotional violence was predicted by childhood emotional abuse and by childhood sexual abuse.

In terms of sexual and physical revictimization, these results are consistent with the results of studies by Langer and Catani (2016), which also provided evidence of the specificity hypothesis. This study also predicted sexual violence in adulthood from sexual and physical abuse. However, sexual abuse turned out to be a significantly stronger predictor of sexual violence in adulthood compared to physical abuse (Langer & Catani, 2016). Other findings argue against differentiation based on the type of violence. Coid and colleagues (2001) showed that, although less severe forms of abuse in childhood are associated with similar forms of abuse in adulthood, more severe forms of abuse seemed to lead to a generalization effect. The more severe the childhood sexual or physical abuse was, the more generalized the revictimization experienced in adulthood was for sexual and physical assault. However, in the study by Coid and colleagues (2001), an increasing severity of childhood experiences of violence also involved the presence of more subtypes of childhood experiences of violence, which could explain that later experiences of victimization were both sexual and physical.

Contrary to the specificity hypotheses, adult emotional violence was predicted by childhood sexual abuse as well as childhood emotional abuse. In contrast to the prediction of sexual violence in adulthood, there is no stronger effect of emotional violence in childhood indicated. Because this is, to the best of our knowledge, the first investigation of emotional violence and revictimization, it is not yet possible to refer to confirmatory or contradictory research results.

The processes underlying the revictimization phenomenon are not yet sufficiently understood. One can only rely on suppositions, particularly when considering the specific

connections between the types of violence found in this study. Similar to other studies that investigated the revictimization phenomenon, we refer to the contribution of attachment to maltreatment and attachment theory in trying to explain the results (Bowlby, 1988).

Children form mental representations of themselves in relationships and of others as their relationship partners, based on their previous history with important reference persons (Bowlby, 1988). These experiences remain stable individual working models about relationships into adulthood and influence the way children design certain model-consistent interaction dynamics (Wekerle & Wolfe, 1998). Through childhood experiences of abuse, distorted cognitions about power, control, attachment, trust, and possibly intimacy emerge (Cloitre, Scarvalone, & Difede, 1997). These distorted cognitions thus also have an effect in adulthood. In case of childhood physical abuse, such an effect can be seen, for example, in increased attachment anxiety, i.e. the exaggerated fear of being abandoned with a simultaneous strong need for closeness (Bockers & Knaevelsrud, 2014). For individuals with strong attachment anxiety, the personal costs of distancing themselves from their interaction partners in high-risk situations, as well as the costs of offering resistance, are correspondingly higher (Bockers & Knaevelsrud, 2014). It could therefore be assumed that victims of childhood physical abuse are more likely to accept physical violence from their partners in order not to endanger the relationship and the associated closeness.

With regard to childhood emotional abuse, it could be assumed that the children have internalized the derogatory statements about themselves and perceive themselves as "worthless", "stupid", "lazy" or "ugly" (Briere & Runtz, 1990). Such self-perception prevents normal interaction with the environment and promotes social withdrawal (Briere & Runtz, 1990). As described above, additional social skills are not learned (Clausen & Crittenden, 1991), which is often accompanied by exclusion from "normal groups" (Sandberg et al., 2016).

This exclusion alone can be an experience of emotional violence in and of itself. Furthermore, such persons are often regarded as "easy victims" of experiences of emotional violence in social groups or in partnerships. Following childhood sexual abuse there may be two paths: on the one hand to sexual revictimization, on the other hand to emotional revictimization. With regard to the connection between childhood sexual abuse and sexual violence in adulthood, it can be assumed that distorted cognitions exist about sexuality, intimacy, and power (Cloitre et al., 1997). If caring and abusive behavior take place simultaneously in families, abuse may even be confused with sexuality and intimacy (Downs, 1993). In the context of emotion regulation, distorted cognitions make dysfunctional sexual behavior (i.e. using sexual activity to meet nonsexual needs e.g., affect regulation, having sex with someone under the influence of alcohol/drug frequency, increased number of sexual partners or sexual intercourse with strangers) more likely (Messmann-Moore et al., 2008). This behavior can be misinterpreted as consenting to sexual contact, or, on the other hand, it can lead to a person being regarded as an "easy victim" of sexual violence (Noll Trickett, & Putnam, 2000).

Another possible impact of childhood sexual abuse, beyond potential dysfunctional sexual behavior, may be shown in internalized feelings of shame. The decisive factor for whether externalization tendencies or internalization tendencies arose could be represented in the processing or explanation at that time by the family or perpetrator of the sexual abuse. An internalization of self-deprecating cognitions can lead to a similar self-perception as described above concerning adult emotional violence and thus lead to a social withdrawal. Social isolation increases the risk of being seen as an "easy victim" of negative behaviors such as bullying or emotional violence in partnerships.

When considering the impact of the findings of the present study, it is critical to consider the strengths and weaknesses of the study design itself. The strength of this study

lies in the systematic recording of all three types of violent experiences (sexual, emotional, and physical) both in childhood and in adulthood. The results therefore represent an extension of the current state of knowledge in the field of revictimization research, which has so far largely concentrated on sexual and physical abuse in childhood. Only this approach allows statements to be made about specific relationships between certain types of violence in childhood and adulthood and thus provides valuable insights for the development of specially tailored prevention approaches for victims of sexual, physical, or emotional violence. Similarly, the form of the online survey could be considered advantageous as it minimalizes the tendency towards socially desirable answers by the anonymity of this form of survey. In addition, this procedure allows accessing a wide variety of subjects. In contrast to studies recruiting college students or clinical samples only, we had hardly any barrier with regard to study participation other than access to the internet. However, this ease of entry also presented a limitation of our methodology. An online survey´s major disadvantage is that there is no way to authenticate who is providing the data.

As previously mentioned, the procedure allows accessing a wide variety of subjects. However, we refrained from explicitly asking for indicators of diversity such as sexual orientation, disability, and migration background. We did this in an effort to boost participant retention in our study. Detailed questions about migration, sexual orientation or income could be perceived as offensive and could lead to an early termination of the study. Because of these limitations on demographic data we cannot exclude that the sample may be more homogenous than intended, and the generalizability of the results is therefore also lower. Another point that limits the generalizability of the results of the sample is the high psychopathological burden of the sample, which is shown by the results of the PHQ and PC_PTSD. For these reasons, caution should be exercised when generalizing the results of this

study to the general public. This finding may indicate that there may also have been a self-selection bias in participants, as the subject matter associated with the survey may have offered survivors of abuse and violence to provide information regarding their experiences.

With regard to the recording of physical and emotional violence in adulthood, the newly developed instrument does not yet provide valid cutoff values for frequencies. In accordance with the assessment of sexual violence, a cutoff value of 1 was chosen. However, it can be assumed that the frequencies of emotional violence are distorted. Nor can bullying experiences at school be depicted with the instrument used. Experiences of violence were examined retrospectively. This method has been questioned with regard to the validity of retrospectively reported memories (Schumacher, Hinz, & Brähler, 2002). However, Barnes, Noll, Putnam, and Trickett (2009) showed that retrospective recording of sexual or physical (re)victimization in a test-retest recording was stable over two years. The cross-sectional design used does not permit reliable statements about causal relationships between the recorded variables. Information from longitudinal studies with large, ideally representative samples would certainly be desirable here.

In summary, the results of the study provide an important confirmation of the specificity hypothesis and show that the processes underlying the revictimization phenomenon must be viewed in a more differentiated way. In a field which is dominated by research on sexual violence and partly physical violence, particularly novel and valuable are the findings on emotional violence, which suggest that this form of violence should not be neglected in research and clinical practice. Future studies, ideally with a longitudinal design, should be devoted to the further investigation of these connections in order to be able to make valid statements regarding the consequences of child abuse for the later revictimization of those affected. Similarly, future research should also address the question of what other

factors, such as socioeconomic status, racism or gender, contribute to experiences of repeated violence.

In spite of the relationships found between the experiences of violence, it is still possible to speculate about the specific mechanisms of action as to why revictimization occurs at all. We hope that the differentiated consideration of specific revictimization processes will enable conclusions to be drawn about possible mediators in a next step. Ideally, this research will provide the basis for further research showing that different types of childhood violence are followed by different meditative variables, making it more likely that different types of victimization will occur. Such knowledge would be indispensable in specifying prevention approaches for the victims of experiences of violence. Although much more research is needed, we believe that this research topic has the potential to significantly reduce the revictimization phenomenon in the long term by means of constructive therapy approaches.

4. The Mediating Processes of Revictimization after Child Abuse in a Sample of Adult Women

4.1 Abstract

Women who survived abuse as children are more likely to be victimized again as adults. To date, this association, also referred to as revictimization, is not well understood. Several mediators have been identified as playing a role in this relationship. The aim of this study is to investigate the extent to which revictimization following different types of maltreatment is mediated by difficulties in emotion regulation, attachment-related cognitions, self-efficacy, preference for dominant partners, self-assertiveness, sexual self-assertiveness, and abuse-related self-blame and shame. In an online survey 135 women with a large variance of experiences of victimization (e.g., sexual, physical and emotional experiences of violence), separated by their occurrence during childhood and adulthood, were assessed. In addition, potential mediators were investigated. Mediation analyses based on bootstrapping tests showed that abuse-related feelings of self-blame and shame were the most consistent mediators of revictimization across all types of violence, with indirect effects ranging from .08 to .24. The prominence of self-blame and shame related to experiences of abuse as mediators in revictimization processes has significant implications for practice, particularly for the development of more effective approaches to preventing repeated violence.

4.2 Introduction

Victims of childhood abuse are at an increased risk of becoming victims of violence again during their adolescent and adult years (Bockers & Knaevelsrud, 2011). This phenomenon is called revictimization and has been identified as a highly relevant social phenomenon due to its considerable prevalence and injuriousness (Bockers et. al., 2014). Two out of three women who have experienced sexual abuse during childhood fall victim to sexual abuse again later in life (Classen, Palesh, & Aggarwal, 2005). Women who have experienced childhood physical or sexual abuse are 3.5 times more likely to become victims of domestic violence than women without experiences of childhood abuse (Coid et al., 2001). Studies have repeatedly shown that revictimization is not isolated within the domain of sexual violence. Indeed, a specific relationship between types of violence has been demonstrated, with child sexual abuse predicting sexual revictimization later in life, and physical abuse in childhood predicting later physical revictimization (Langer & Catani, 2016). Revictimization also occurs in the domain of emotional violence, as emotional violence in adulthood was predicted by both sexual and emotional abuse in childhood (Langer & Neuner, 2020).

Despite the growing evidence of the phenomenon, the underlying mechanisms of revictimization remain unclear (Cloitre, Scarvalone & Difede 1997). Researchers have, however, suggested several variables as potential mediators of sexual revictimization. Messman-Moore and colleagues (2010) found that impaired emotion regulation partly mediates the relationship between childhood sexual abuse and adult sexual violence in women. In particular, dysfunctional sexual behavior that results from inadequate emotion regulation was considered as one possible mechanism. Dysfunctional sexual behavior includes such behaviors as using sexual activity to meet nonsexual needs such as affect regulation, having sex with someone under the influence of alcohol/drug frequently, an increased

number of sexual partners, or sexual intercourse with strangers (Messmann-Moore et al., 2008). Sexual behaviors which emerge from impaired emotion regulation, in particular, may be misinterpreted as consent for sexual contact (Noll, Trickett, & Putnam, 2000), or that survivors of previous abuse may be perceived as "easy victims" by potential perpetrators. In another study, a lack of self-assertiveness in sexually risky situations was identified as a mediator in the sexual revictimization process (Livingston, Testa, & VanZile-Tamsen, 2007). The researchers theorized that women with a history of child abuse may experience communication deficits in high-risk sexual situations, rendering them less capable of vehemently demonstrating their refusal. Ultimately, this lack of assertiveness may contribute to a misinterpretation of consent, or, again, the perception of the individual being an "easy victims" who can be violated with little risk to the perpetrator (Livingston et al., 2007).

In the context of low sexual self-assertiveness, the role of abuse-related self-blame and feelings of shame were also discussed. Self-blame involves pejorative cognitions about the self where the survivor holds themselves responsible for the abuse. The concept of shame is about protecting the damaged self from being exposed by others (Feiring, Simon & Cleland, 2009). Self-blame and feelings of shame related to abuse are associated with dysfunctional core beliefs about the self that were developed as the result of growing up in an abusive context. These core beliefs include the perception of being worthless and deserving violation by others. Furthermore, those beliefs continue to persist years after the original abuse and its possible detection (Feiring et al., 2009). Such beliefs contribute to the difficulty such individuals may experience in defending themselves and asserting refusal in high risk sexual situations, which in turn increases the probability of experiencing sexual victimization. Researchers have found that self-recriminating attributions with regard to the primary abuse indirectly predicted the

later experience of sexual revictimization via a low level of sexual self-assertiveness (Katz, May, Sörensen & DelTosta, 2010).

Revictimization after childhood physical abuse has been studied in the context of intimate partner violence. An increased preference for dominant partners seems to be related to both a history of victimization in childhood and victimization in adulthood (Snyder et al., 2011). Social-psychological research has indicated that victimized women may prefer dominant partners as a possible strategy to both ensure their own physical safety and to increase their social status, which may also have protective benefits (Giebel, 2013; Snyder et al., 2011). Following these findings, people with experiences of maltreatment in childhood may be more attuned to threats to their physical and social integrity, and choose dominant partners as a survival strategy. However, men who achieve dominance and status in their social environment through physical violence are also more likely to resort to physical violence in their relationship (Snyder et al., 2011). As a result, seeking such partners as a protective strategy could, in turn, put survivors at greater risk of experiencing revictimization within their partnerships.

High attachment-related anxiety has also been associated with both childhood physical abuse as well as with adult physical violence. It has been suggested that women with attachment anxiety have difficulties leaving a violent partner due to excessive fears of rejection and loneliness (Smith & Stover, 2015). In addition, individuals with high attachment anxiety may also show behavioral tendencies that contribute to relationship dissatisfaction and interpersonal conflict (Sandberg, Valdez, Engle, & Menghrajani, 2016).

Furthermore, the expectation of low self-efficacy has been identified as a possible explanation for physical revictimization. The lack of control during childhood abuse may lead to survivors holding the perception of themselves as helpless, weak, and without influence

(Renner & Slack, 2006). In high-risk interpersonal situations during adulthood, this self-perception may be activated. Similar to the construct of learned helplessness, survivors may not hold the belief that they have the ability to avert such situations. This negative self-appraisal could be accompanied by limited self-assertion and thus lead to an inability to show overt resistance to physical violence in relationships or to leave the violent person (Renner & Slack, 2006).

Revictimization is not restricted to sexual and physical violence, but also occurs after emotional maltreatment. However, this phenomenon has been identified only recently (Langer & Neuner, 2021a) and there is little information on potential mechanisms. Researchers have speculated that the typical consequences of emotional maltreatment, such as a lack of effective social skills, frequent social isolation, or low self-esteem (Briere & Runtz, 1990; Clausen & Crittenden, 1991) may increase the likelihood of further victimization and reduce survivors' self-assertion against an emotionally violent partner. In addition, insecure individuals are often perceived as "easy victims" of emotional violence.

4.2.1 Current Study

Taken together, there are a number of variables that could plausibly mediate the relationship between experiences of victimization in childhood and adulthood. To date, the potential mediators have been studied separately which does not allow for the determination of the relative importance of each variable. To compare the specific effects of potential mediators, this study examines potential variables simultaneously across types of revictimization. For this purpose, we studied four types of revictimization phenomena identified in a previous study (Langer & Neuner, 2021a):

i) Childhood sexual abuse increasing the risk of experiencing sexual violence in adulthood;

ii) Childhood physical abuse increasing the risk of experiencing physical violence in adulthood;

iii) Childhood emotional violence increasing the risk of experiencing sexual violence in adulthood

iv) Childhood emotional violence increasing the risk of experiencing emotional violence in adulthood.

We included a range of potential mediators, including emotion regulation deficits, attachment-related dysfunctional cognitions, self-efficacy, self-assertiveness, sexual self-assertiveness, preference for dominant partners, and abuse-related self-blame and feelings of shame. Based on previous findings, we hypothesized that:

i) Internalized feelings of abuse, self-blame and shame, and a lack of sexual self-assertiveness mediate sexual revictimization; and

ii) Preference for dominant partners and high attachment anxiety plays a significant role for physical revictimization.

Due to the lack of previous research on revictimization following experiences of emotional violence, no hypotheses regarding potential mediators were made.

4.3 Method

4.3.1 Procedure

The data for this study was collected in an online survey created with the Unipark software (Unipark, E.F.S. Survey, version 7). Online surveys offer access to economically and

educationally diverse and non-clinical samples (Heiervang & Goodman, 2011). Such surveys also enable researchers to obtain fully anonymous data, which is especially advantageous when collecting sensitive data (Iffland, Sansen, Catani, & Neuner, 2012). Seeking to recruit a sample with a large variance on the study variables, including maltreatment and revictimization, the survey link was posted on through Facebook with requests to share the link widely. In addition, the link was published in web-based self-help groups that are related to traumatic life experiences. Those self-help groups were located by a Google search. First the moderators of active online self-help groups were contacted, the contents of the study were presented and a publication of the link for participation was requested. Of nineteen online self-help groups 14 agreed to the publication of the link. The link was posted with brief information on the nature of the questions and the need for potential study participants to be of legal age. No incentives were offered for participation. On the first page of the survey, the participants were informed about the contents and risks of the study, about the voluntary and anonymous nature of the survey, and participants' right to quit the survey at any time. This was followed by a declaration of consent to participate in the study. First, demographic data (age, gender, education) were collected. This was followed by questionnaires which recorded the characteristics of the above-mentioned constructs (emotion regulation difficulties, attachment-related dysfunctional cognitions, self-assertion, self-efficacy, preference for dominant partners, and abuse related feelings of self-blame and shame). Afterwards, childhood experiences of different types of violence were investigated. In order to avoid closure effects, the presence of various types of violence in adolescence and adulthood were only examined following the assessment of childhood experiences. Subsequently, psychopathology was recorded. The programming of the survey was such that underage participants were not granted access to the questionnaires. Participants took, on average, 23

minutes to complete the survey. The survey period extended from January to June 2018. The study design was reviewed and approved by the Ethics Committee of the Department of Psychology at Bielefeld University.

4.3.2 Participants

In total, N= 1062 participants began the study. Of those, n= 155 finished it, resulting in a completion rate of 14.6%. Most drop-outs took place on the start page (n=789, 74.29%). Less than 3% (n= 26) of drop-outs occurred at the declaration of consent, and 1.88% (n = 20) of drop-outs occurred during the socio-demographic section. For all other questions, the attrition rate was not notably higher. The study was active for a total of 182 days. The average number of participants per day was 7.08.

Of the 155 participants who completed the study, only female and adult participants were considered for inclusion. Therefore, eight underage participants and twelve men were excluded. As a result, the final sample consisted of N=135 participants aged 19 to 67 years (*M* = 33.4; *SD* = 11.12). They had an average of 14 years (S*D* = 3.27) of formal education (primary school, secondary school, university).

4.3.3 Measures

Child abuse experiences. The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998; German version; Wingenfeld et al., 2010) is a self-assessment tool for the retrospective assessment of abuse and neglect in childhood (up to the age of 14). With 28 items, the questionnaire covers the subscales of sexual abuse, emotional abuse, physical abuse, emotional neglect, and physical neglect. The items are answered on a five-point scale. The CTQ showed good internal consistency for all scales in validation studies (Klinitzke, Romppel,

Häuser, Brähler, & Glaesmer, 2012) except for the scale of physical neglect. Due to the low internal consistency of this scale and its high intercorrelation with the other scales (Klinitzke et al., 2012), it was not included for analysis. In the present study, good internal consistency for the four scales used was confirmed (Cronbach's alpha coefficients: sexual abuse .97, physical abuse .93, emotional abuse .92, emotional neglect .92). The decision on the existence of the different types of abuse was made on the basis of the cut-off values for the summed item scores used by Walker et al. (1999). However, the frequencies thus obtained were used only for descriptive information. In all further analyses, the summed item scores of the individual scales were used, independent of the cutoff values.

Sexual Victimization in Adolescence and Adulthood. The Potsdam scales for recording sexual aggression and victimization (SEX_AGG_VIC; Krahé & Berger, 2014) are a self-report instrument used to assess experiences of sexual aggression and victimization after the age of 14. For the purpose of this study only the sexual victimization subscale was used. The Potsdam scales record sexual victimization with sixteen items, each using a four-point scale to measure the frequency of the violence. The scales include several relationship dynamic types when assessing violence between the offender and victim (intimate partners or former partners, acquaintances, or strangers). In order to harmonize this instrument with the other assessments, the perpetrator category "colleagues or supervisors at the workplace" was added. Three different strategies for exerting pressure were investigated (physical violence or threat of physical violence, exploitation of the inability to resist, and verbal pressure). A more precise differentiation of forced sexual acts (sexual contact, attempted sexual intercourse, sexual intercourse, and other sexual acts, such as oral sex) is mentioned in the explanatory text. This more precise differentiation was removed from the item query, as it was not relevant for the purpose of this study. As this instrument has only recently been developed,

no validity or reliability criteria were available. In the present study the scale was found to demonstrate a sufficiently good internal consistency (Cronbach's alpha coefficient .71). People were considered victimized if they had been exposed to sexual aggression on at least one occasion. For the present evaluation, the total summed scores of all items assessing victimization represented the experience of sexual violence in adolescence and adulthood.

Physical and Emotional Victimization in Adolescence and Adulthood. A recently created screening instrument was used to record and quantify the experience of physical and emotional violence in adolescence and adulthood. It was developed for one of the main German epidemiological studies on health, the "Study on Adult Health in Germany" (DEGS1) of the Robert Koch Institute (RKI; Schlack, Rüdel, Karger, & Hölling, 2013). We modified several aspects to harmonize it with the other instruments used. On this instrument, the preliminary relationship between perpetrator and victim is recorded ((former) partners, acquaintances, work colleagues/supervisors at the workplace or strangers). The instrument consisted of eight items in total, four concerning physical violence and four concerning emotional violence (e.g., "Has an (ex-) partner physically attacked you from the age of 14 onwards;" "Has a friend or an acquaintance devalued you from the age of 14 onwards"). The items were answered on a four-point Likert scale regarding the frequency of occurrence rated from 1 (never) to 4 (three times or more). Due to the recent development of this instrument, no reliability or validity criteria was yet available for use. The internal consistencies identified in this study were considered sufficient in view of the low number of items (four per scale; Cronbach's alpha coefficients: physical violence .59, emotional violence .71). Participants were considered victimized if they had been exposed to physical or emotional aggression on at least one occasion. However, this information was used only for descriptive purposes. For the present

evaluation, the total scores of all items concerning victimization represented the experience of physical or emotional violence in adolescence or adulthood.

Preference for Dominant Partners (PDP). This instrument was developed as part of a study on partner preference (Giebel, 2013). It consists of six items, such as "dominant women/men are fascinating." The items were answered on a seven-point scale rated from 1 (does not apply at all) to 7 (is absolutely true). In previous studies, the PDP achieved good values for internal consistencies (Giebel, 2013), which were confirmed in the present study (Cronbach's alpha = .87).

Self-Efficacy. The Scale for the general expectation of self-efficacy assesses respondents' expectations of self-efficacy. It consists of ten items that are answered on a four-point scale rated from 1 (is not true) to 4 (is exactly right; Jerusalem & Schwarzer, 1999). Validation studies have repeatedly confirmed good internal consistency (Hinz, Schumacher, Albani, Schmid & Brähler, 2006), which was confirmed in the present study (Cronbach's alpha = .92). The summed item scores were used in the present evaluation.

Self-assertiveness. We used the self-assertiveness sub-scale from the Inventory of Interpersonal Problems (Barkham, Hardy & Startup, 1996). The full instrument records difficulties experienced by individuals in their interpersonal relationships. The self-assertiveness subscale consists of four items that are answered on a five-point scale rated from 1 (it's not hard for me) to 5 (it's very hard for me). In the evaluation, the sum score of these items was used to represent the difficulty of self-assertion in interpersonal relationships. Validation studies showed both good internal consistency and good retest reliability for the IPP and the assertiveness subscale (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). This study also showed good internal consistency for the scale (Cronbach's alpha = .82).

Emotion Regulation Difficulties. The Difficulties in Emotion Regulation Questionnaire (DERS; Gratz & Roemer, 2004) assesses emotion regulation difficulties on six scales. The following four scales were used for this study: Non-acceptance of emotional reactions, impulse control difficulties, limited access to emotion regulation strategies, and lack of emotional clarity. The other two scales, "lack of emotional awareness" and "difficulties with targeted behavior," were omitted as they were not relevant for the purposes of this study. The items are answered on a scale which assesses the frequency of experienced difficulties. The five point scale was rated from 1 (almost never (0-10%)) to 5 (almost all the time (91-100%)). Validation studies showed good internal consistency and good retest reliability (Gratz & Roemer, 2004), which were confirmed in the present study (Clarity Subscale: Cronbach's alpha = .88; Acceptance Subscale: Cronbach's alpha = .87; Impulse Subscale: Cronbach's alpha = .89; Strategies Subscale: Cronbach's alpha = .90). The evaluation included the four scales mentioned above as well as an overall value for emotion regulation difficulties, which was obtained from the summed score of all four scales.

Attachment. The Adult Attachment Scale (AAS; German version Schmidt, Strauß, Höger & Brähler, 2004) is a self-report instrument which assesses attachment-related cognitions. These cognitions are divided into three categories: Trust, proximity, and fear. Three scales were based on these categories: attachment anxiety, low confidence in other people, and fear of closeness. The items are answered on a five-point scale rated from 1 (is not true at all) to 5 (is exactly right). Validation studies confirmed that the AAS has sufficient internal consistency (Schmidt et al., 2004). The present study showed good internal consistencies for the subscales: Attachment Anxiety Cronbach's alpha = .81; Fear of Closeness Cronbach's alpha = .89; Confidence Cronbach's alpha = .91). All three scales were included in the present evaluation.

Abuse-Related Feelings of Self-Blame and Shame. Feiring, Simon, and Cleland (2009) developed items for retrospectively assessing abuse-related feelings of self-blame and shame. The items assessed typical self-accusations and cognitions of shame with regard to possible experiences of violence in childhood or adulthood (e.g., "it happened because I wasn't smart enough to stop it"). The items were rated on a three-point scale, from 1 ("is not true") to 3 ("is absolutely true"). Since this is not an official instrument, no quality criteria were available, but the items showed a good internal consistency (Feiring et al., 2009), which was confirmed in the current study (Cronbach's alpha coefficients: self-blame .85, shame .83). The sum scores of the scale feelings of shame and self-blame were included in the present analysis.

Sexual Assertiveness. The Sexual Assertiveness Scale (Morokoff et al., 1997) is a self-report instrument for measuring sexual assertiveness. The instrument includes three sub-scales. For the present study, only the "rejection/refusal" scale was used. The "rejection/refusal" scale consists of six items, which are answered on a five-point scale rated from 1 ("I do not agree at all") to 5 ("I totally agree"). To avoid conflating responses with sexual abuse experiences, scale instructions emphasized that these were situations in which sexual contact occurred on a voluntary basis. The Sexual Assertiveness Scale showed good internal consistency and good retest reliability in validation studies (Morokoff et al., 1997), which were confirmed in the present study (Cronbach's alpha = .87). In the present evaluation, the summed item scores were used to indicate levels of sexual self-assertiveness.

PTSD Symptoms. The Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003) is a screening instrument for the detection of post-traumatic stress disorder (PTSD). The scale consists of four dichotomous response items (Yes/No). It asks whether a person has experienced four symptoms typical of PTSD in the last month: Re-experiencing, numbness, avoidance, and hyperarousal. The PC-PTSD has optimum efficiency in terms of the best

possible combination of sensitivity and specificity utilizing a cut-off value of three (Prins et al., 2003). The cut-off value was only used for descriptive purposes in this study. The summed item scores were used in the evaluation, representing a value for exposure to symptoms of PTSD. The PC-PTSD has demonstrated good retest reliability and correlates highly with the standard instrument for the detection of PTSD, the Clinician Administered PTSD Scale (CAPS; Prins et al., 2003).

Symptoms of Depression. The Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer & Williams, 2001; German version Löwe, Spitzer, Zipfel, & Herzog, 2002) is a screening instrument used for the detection of a depressive disorder. The self-report questionnaire contains nine items that assess whether typical symptoms of depression (based on the DSM-IV criteria) have occurred in the last two weeks. The items were answered on a four-point scale. The PHQ-9 has previously demonstrated good validity and test-retest reliability (Kroenke et al., 2001). In addition, previous research has confirmed good values for the sensitivity and specificity of the stated cut-off values for the severity of depressive symptoms (Kroenke et al., 2001). These cut-off values were only used for descriptive purposes in this study. The summed item scores were used in the present study to represent the overall burden of symptoms of depression.

4.4 Statistical Analyses

The statistical analyses of the study were carried out with the statistical program IBM SPSS Statistics, version 21, at a significance level of $\propto = .05$. To describe the sample characteristics, experiences of sexual, physical, and emotional abuse and emotional neglect in childhood, and sexual, physical and, emotional experiences of violence in adulthood were

treated as dichotomous variables using the cut-off values described above. They were used as continuous variables in all other analyses. The scales of emotional abuse and emotional neglect were combined due to their high intercorrelation. The scale of emotional maltreatment represents this composite value.

The present study is based on a larger survey in which the specific interrelations between the experiences of violence were examined. A previous analysis showed four specific relationships between experiences of violence: childhood sexual abuse and sexual violence in adulthood, childhood physical abuse and physical violence in adulthood, childhood sexual abuse and emotional violence in adulthood, and childhood emotional abuse and emotional violence in adulthood (Langer & Neuner, 2021a). Those four relationships were examined for mediation effects. In addition, we examined the connection of violence in childhood and revictimization in adulthood across all types of violence for mediation effects. In a first step, bivariate correlations between the independent variables (different types of maltreatment in childhood), the proposed mediators (manifestation of psychological constructs) and the dependent variables (different types of victimization during adulthood) were calculated.

As a second step we aimed to determine the relative importance of each mediator in comparison to the other potential mediators. Given the restrictions of the sample size, we refrained from calculating multiple mediation models. Instead, we calculated a linear relationship between sexual abuse and all potential mediators that were positively correlated with sexual abuse entered simultaneously into a linear model. This calculation was repeated for physical and emotional maltreatment. Following the same logic, the independent associations between all single mediators and adult victimization (separately for emotional, physical, and sexual violence) were analyzed using regression analyses. To test the

assumptions of the regression analyses, the normal distribution of the residuals was checked by visual inspection.

As a third step, all variables that maintained a significant association with abuse and adult victimization were then tested in mediation models. Separate mediation effects were tested for each type of maltreatment. Mediation effects were examined following the method of Preacher and Hayes (2008). With this method, bootstrapping samples (5000) are used to calculate the total and indirect effects for all mediators. Point estimates (beta coefficients), standard errors, Z-values, and confidence intervals for the total and indirect effects were also calculated.

4.4 Results

Overall, 83% of the participants reported experiencing violence in adolescence or adulthood, with emotional violence endorsed most frequently in our sample (83%). Eighty-seven percent of the participants were victims of at least one subtype of interpersonal violence in childhood. Seventy-six percent of the participants were thus above the cutoff value for probable PTSD, 83% of the participants were above the cut-off for probable depressive disorder. An overview of the descriptive statistics can be found in Table 3.

Table 3

Descriptives

	M(SD)	Range	*N* (%) above the cutoff value
Age	33.40 (11.12)	19-67	
Years of Formal Education	13.66 (3.27)	9-23	
Child Emotional Abuse	17.76 (6.47)	5-25	81
Child Physical Abuse	11.39 (6.30)	5-25	61
Child Sexual Abuse	14.84 (7.72)	5-25	70
Child Emotional Neglect	17.71 (5.93)	5-25	71
Child Emotional Abuse (composite)	35.47 (11.41)	10-50	
Childhood Abuse Experiences (composite)	61.70 (21.86)	20-100	
Adult Sexual Violence	5.53 (5.42)	0-22	77
Adult Physical Violence	2.29 (2.76)	0-12	61
Adult Emotional Violence	5.65 (4.10)	0-12	83
Adult Violence Experiences (composite)	13.47 (10.50)	0-42	
PTSD Symptoms	3.10 (1.47)	0-4	76
Depression Symptoms	14.42 (7.63)	0-27	73
Accept (Difficulties in Emotion Regulation Scale)	19.24 (3.27)	6-30	
Impuls (Difficulties in Emotion Regulation Scale)	15.93 (5.90)	6-30	
Strategies (Difficulties in Emotion Regulation Scale)	24.69 (7.85)	8-40	

Clarity (Difficulties in Emotion Regulation Scale)	14.10 (4.84)	5-25
Emotion Regulation Difficulties (composite)	74.0 (4.84)	27-119
Low Confidence (Adult Attachment Scale)	19.78 (6.26)	6-30
Fear of Closeness (Adult Attachment Scale)	17.28 (5.48)	5-25
Attachment Anxiety (Adult Attachment Scale)	13.74 (5.29)	5-24
Preference for Dominant Partners	19.53 (9.00)	6-40
Self-efficacy	23.50 (6.43)	10-39
Self-assertivness	9.27 (4.00)	0-16
Sexual Self-assertivness	16.27 (7.00)	1-30
Abuse-related Self-blame and Shame	18.08 (5.72)	9-27

Note. N = 135.

4.4.1 Regression Analyses

The results of the regression analyses are shown in Table 4 and 5. Variables that did not significantly predict sexual, physical, or emotional abuse in childhood or adulthood are not included.

The following mediators reached independent significant associations with any type of child abuse in the regression analyses: Abuse-related feelings of self-blame and shame were associated with sexual, physical, and emotional abuse in childhood. Fear of proximity was associated with childhood physical abuse. Attachment anxiety was associated with childhood sexual abuse. Experiences of sexual, physical and emotional violence in adulthood were significantly predicted by the following mediators: Abuse-related feelings of self-blame and shame. Low confidence in other people predicted experiences of adult sexual and emotional

violence. Low levels of assertiveness and attachment anxiety predicted physical victimization in adulthood.

Table 4

Predictors of childhood sexual, physical, and emotional abuse (predictors: potential mediating variables)

Model	Child Sexual Abuse[1]		Child Physical Abuse[2]		Child Emotional Abuse[3]	
Predictors	*β*	*r*	*β*	*r*	*β*	*r*
Abuse-related Self-blame & Shame	.60 ***	.38**	.43***	.44**	.29**	.51**
Attachment Anxiety	-.19*	-16	-.10	.17	-.06	.29
Fear of Proximity	.20	.50**	.30*	.50**	.18	.52**

Note. β: standardized beta coefficient*; r:* 0-order correlation (Spearman).

[1] corrected R^2 = .38, F (9,125) = 10.29, p < .001

[2] corrected R^2 = .30, F (9,125) = 7.24, p < .001

[3] corrected R^2 = .44, F (9,125) = 12.85, p < .001

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

Table 5

Predictors of sexual victimization, physical victimization and emotional victimization in adulthood (predictors: potential mediating variables)

Model	Sexual Victimization[1]		Physical Victimization[2]		Emotional Victimization[3]	
Predictors	*β*	*r*	*β*	*r*	*β*	*r*
Abuse-related Self-blame & Shame	.55 ***	.60**	.47***	.44**	.40**	.51**
Low Confidence	-.25 *	.27**	-.01	.22	.03	.39
Low Assertiveness	-.01	.26**	-.20*	.10	-.12	.17*
Attachment Anxiety	-.06	.15	-.21*	.04	-.01	.26**

Note. β: standardized beta coefficient*; r:* 0-order correlation (Spearman).

[1] corrected R^2 = .32, F (9,125) = 8.02, p < .001

[2] corrected R^2 = .19, F (9,125) = 4.43, p < .001

[3] corrected R^2 = .24, F (9,125) = 5.62, p < .001

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

4.4.2 Mediation Analyses

The regression analyses indicated that only abuse-related feelings of self-blame and shame turned out to be independent significant predictors of different types of childhood and adulthood abuse. As a result, only this variable was considered in the mediation analyses. The results are shown in Figures 2-6. The relationship between childhood sexual abuse and adult

sexual abuse was partially mediated by abuse-related self-blame and feelings of shame. The bootstrapped completely standardized indirect effect was .23 and the 95% confidence intervals ranged from .14 to .35. The model explained 21% of the variance in the variable sexual violence in adulthood.

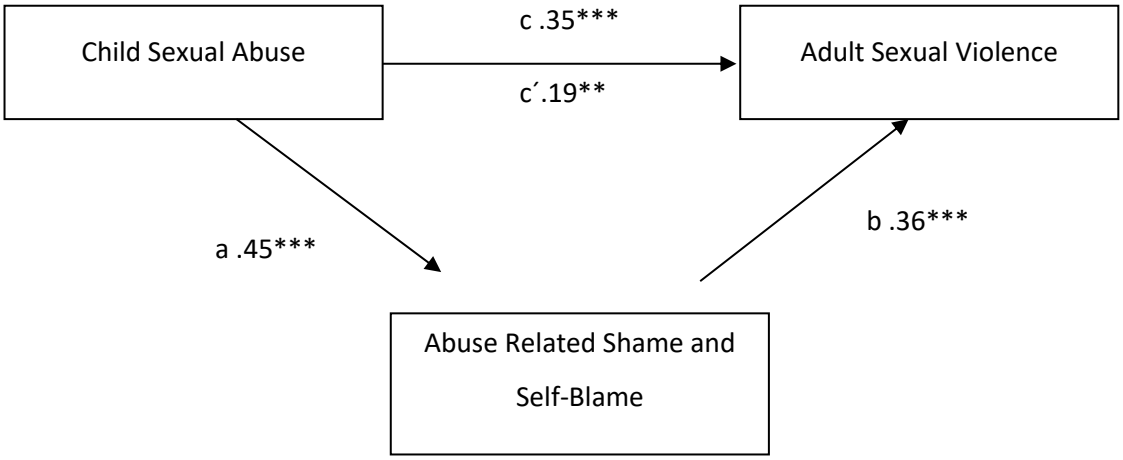

Figure 2. Mediation model of the effect of childhood sexual abuse on adult sexual violence mediated by abuse related self-blame and feelings of shame. Effect size (comp. Stand.) .23; CI .14-.35; R^2.21).

The relationship between childhood physical abuse and adult physical abuse was partially mediated by abuse-related self-blame and feelings of shame. The bootstrapped completely standardized indirect effect was .08 and the 95% confidence intervals ranged from .01- .17. The model explains 14% of the variance in the variable experiences of physical violence in adulthood.

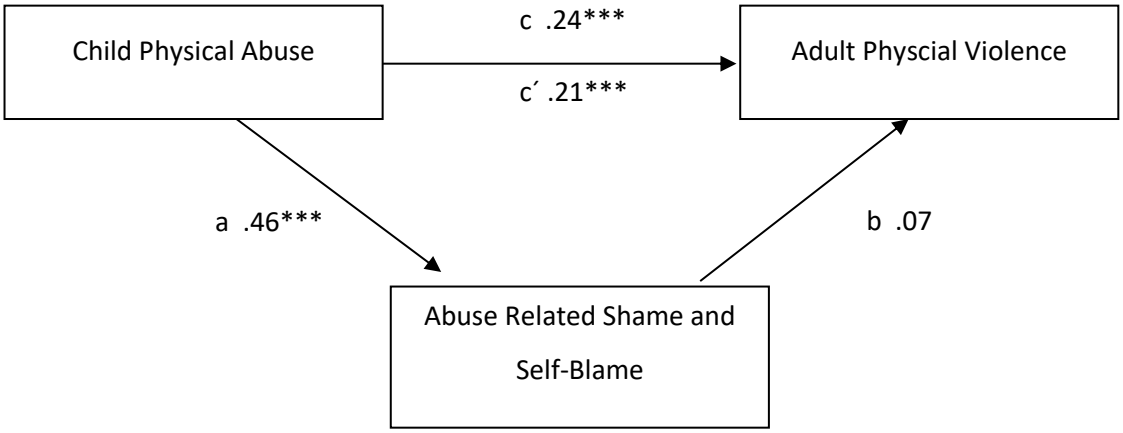

Figure 3. Mediation model of the effect of childhood physical abuse on adult physical violence mediated by abuse related self-blame and feelings of shame. Effect size (comp. stand.) .08; CI .01- .17; R^2.14).

The relationship between childhood sexual abuse and adult emotional abuse was partially mediated by abuse-related self-blame and feelings of shame. The bootstrapped completely standardized indirect effect was .22 and the 95% confidence intervals ranged from .11-.36, making the effect statistically significant. The model explains 16% of the variance in the variable experiences of emotional violence in adulthood.

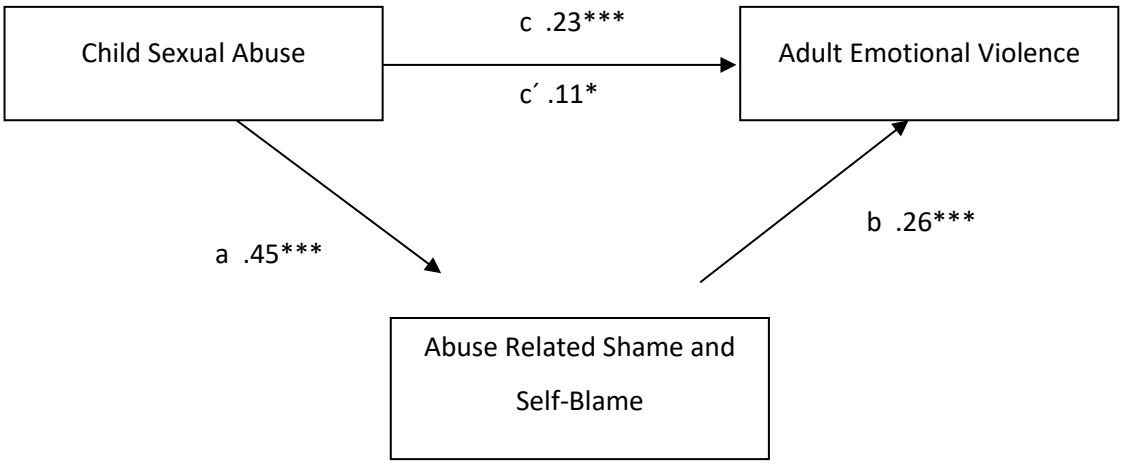

Figure 4. Mediation model of the effect of childhood sexual abuse on adult emotional violence mediated by abuse related self-blame and feelings of shame. Effect size (comp. stand.) .22; CI .11- .36; R^2.16).

The relationship between childhood emotional abuse and adult emotional abuse was also mediated by abuse-related feelings of self-blame and shame. The bootstrapped completely standardized indirect effect was .25 and the 95% confidence intervals ranged from.14 to .40. Thus, the effect was statistically significant. Further, as the direct effect loses its significance if one considers the mediating effect, it is a complete mediation. The model explains 13% of the variance in the criterion variable emotional experiences of violence in adulthood.

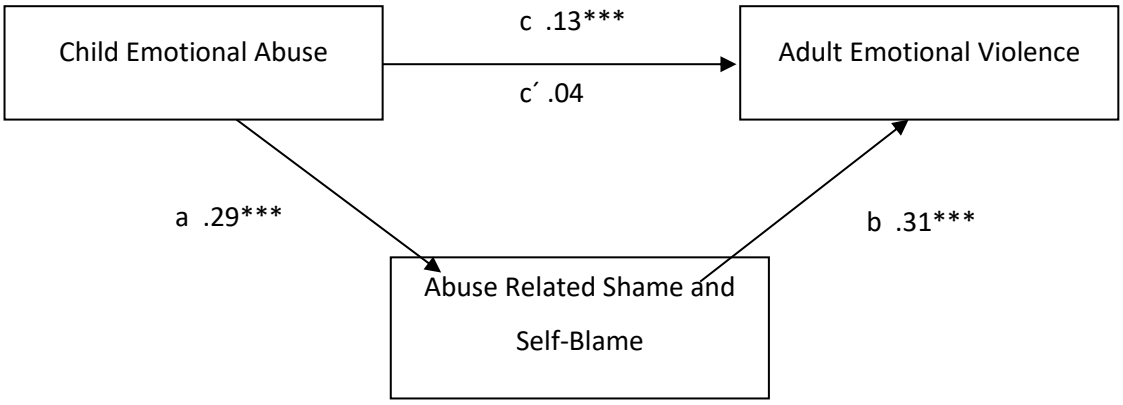

Figure 5. Mediation model of the effect of childhood emotional abuse on adult emotional violence mediated by abuse related self-blame and feelings of shame. Effect size (comp. stand.) .25; CI .14- .40; R^2.13).

Last, the relationship between overall scores of childhood abuse and adult abuse was partially mediated by abuse-related self-blame and feelings of shame. The bootstrapped completely standardized indirect effect was .25. and the 95% confidence intervals ranged from .11 to .39. Thus, the effect is statistically significant. The model explained 26% of the variance in the variable violence in adulthood.

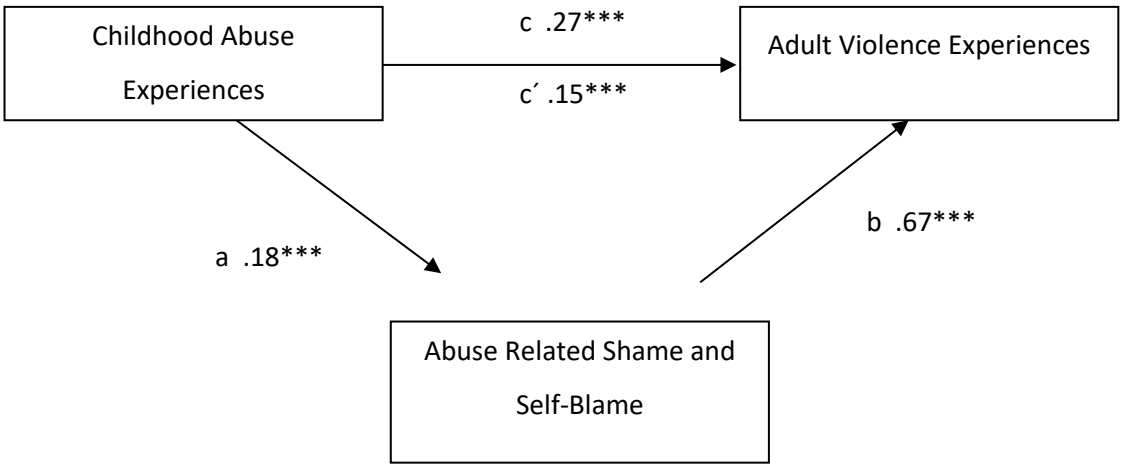

Figure 6. Mediation model of the effect of child abuse experiences across all three subtypes on adult violence experiences across all three subtypes, mediated by abuse related self-blame and feelings of shame. Effect size (comp. Stand.) .25; CI .11-.40; R^2.26).

4.5 Discussion

This study shows that, although sexual, emotional and physical revictimization can be traced back to different types of abuse in childhood, the mediating processes between violence in childhood and adulthood seem to be similar. Contrary to our specific hypotheses, abuse-related self-blame and feelings of shame turned out to be the most consistent and robust mediator across all types of violence, being independently associated with all types of abuse and adult victimization and demonstrating a statistically significant mediation effect.

Although Katz and colleagues (2010) provided some evidence for the contribution of self-blame and shame, this study, to our knowledge, is the first which identifies the prominent role of this mechanism even when controlling for the effects of other variables. This finding allows a new perspective on previous studies that emphasized emotion regulation deficits and sexual self-assertiveness as mediators (Messmann-Moore et.al., 2010; Livingston et al., 2007). In these studies, these variables were considered in isolation. Given the conceptual and statistical intercorrelation of different constructs such as self-blame, self-assertion, fear of closeness, and emotion regulation deficits, a considering the variables concurrently is necessary in order to reveal the independent contribution of each concept controlling for the effects of the other variables.

From a theoretical perspective, the strong mediating roles of abuse-related self-blame and feelings of shame are consistent with assumptions drawn from attachment theory as well as knowledge about the effects of maltreatment on the survivor's self-concept. Children form mental representations of themselves in relationships based on their previous history with important reference persons (Bowlby, 1988). These representations extend to include others beyond the child's initial immediate relationships. Such mental representations may include cognitive distortions about power, control, intimacy, and trust in experiences of violence

within the family context (Cloitre et al., 1997). These cognitions and experiences can facilitate the development of a negative self-concept that involves a subjective devaluation of oneself, including the perception that the abuse was consistent with their own self-image of being worthless (Peichelt, 2007). Without correction, this self-concept remains stable into adulthood, as does the dysfunctional working model of relationships, and influences the way children design certain model-consistent interaction dynamics (Wekerle & Wolfe, 1998). On the one hand, this affects the choice of their interaction partners, preferring partners who are complementary to their own self-image. It seems that children's motivation to maintain consistency with their stable, albeit negative, self-concept interferes with selecting caring partners in favour of partners from a similar biographical background (Sandberg et al., 2016) with similarly dysfunctional attachment styles (Bockers & Knaevelsrud, 2014; Sandberg et al., 2016). In addition, a negative self-concept affects how individuals behave within their relationships. If they are exposed to sexual, physical, or emotional violence again, the negative self-concept they hold could suggest self-blaming and thoughts of shame which would favor a more passive role in navigating the abuse. Thus, a sexually, physically, or emotionally violent person would not be abandoned or avoided and the violence would be endured.

Through the previous study (Langer & Neuner, 2021a) and the literature research, we assumed that it is important to look at the different types of violent experiences separately, since specific contexts should be conveyed by different mediators. The dominance of abuse-related self-blaming and feelings of shame as a mediator in all four types of revictimization seems to contradict this assumption and suggests that the different types of violent experiences should not be given priority in the revictimization process. However, it should be noted that the effect size of the models changed depending on which specific type of violence was considered. In addition, the connection between emotional violence in childhood and

emotional violence in adulthood showed a complete mediation, while the other associations demonstrated only a partial mediation. The present findings indicate that the distinction between the different processes and types of violence is indeed important. For example, it is likely that in the sexual revictimization process, in addition to abuse-related feelings of self-blame and shame, there are other mediating variables that are different from those that may be involved in the emotional or physical revictimization process. It should also be noted that several types of violence often occur simultaneously. This could also have influenced the similar mediation of the different processes.

Although the findings of the present study extend previous findings from the literature in important ways, there are limitations that must be noted. The findings of the present study must be considered in light of the study's cross-sectional design, which does not permit conclusions about causal relationships between the recorded variables. In addition, due to the lack of well-established instruments addressing the variables of interest, our assessment of physical and emotional violence in adulthood does not allow us to evaluate the frequency of experiences in our sample relative to other populations. In accordance with the assessment of sexual violence, a cutoff value of 1 was chosen. However, it can be assumed that the frequencies of emotional violence are distorted.

Furthermore, we were able to only collect a limited amount of demographic data on the participants. For example, the race of the participants was not asked due to cultural prohibitions. Because of these limitations on demographic data we cannot exclude that the sample may be more homogenous than intended, and the generalizability of the results is therefore also lower. Another point that limits the generalizability of the results of the sample is the high mental health burden of the sample, which is indicated by the results of the PHQ and PC_PTSD. For these reasons, caution should be exercised when generalizing the results of

this study to the general public. This finding may indicate that there may also have been a self-selection bias in participants, as the subject matter associated with the survey may have offered survivors of abuse and violence an opportunity to provide information regarding their experiences.

In addition, we must strongly emphasize that this study focused exclusively on the mediating mechanisms in women from the perspective of the victim. Although the perspective and psychological factors at play in survivors of abuse are a critical component of any understanding of revictimization, when investigating the revictimization phenomenon more broadly it is also essential to investigate potential mechanisms experienced by perpetrators. Revictimization cannot be prevented solely through the use of therapy to address the negative self-image of female survivors, for example. In order to find more comprehensive strategies to prevent revictimization, in which the present study may play a role, studies that look at the revictimization phenomenon from a more holistic perspective and examine both the victims and the perpetrators of such violence are urgently needed.

A particular strength of this study is the recording of several variables as potential mediators and all three types of violence in one model. The present results therefore represent an extension of the current body of knowledge in revictimization research, which has so far predominantly isolated potential mediators and considered them for a single type of violence only. Despite its limitations (Langer & Neuner, 2021a), the use of an online survey to collect data is also advantageous, since a broad and diverse sample can be achieved in this way.

Given the limitations and promise of the present study, there are clear recommendations for future investigations. Research studies drawing upon longitudinal studies with large, representative samples would be suitable for further examination and

possible replication of our findings. In addition, explicitly assessing participants' conceptualizations of their sense of self could represent a potentially fruitful avenue of future research investigating the relationships between shame and self-blame and revictimization.

In summary, the findings of the present study represent novel and valuable findings. In particular, the findings hold clear implications for both assessment and therapeutic interventions for victims of childhood abuse. We would recommend assessing victimization in childhood and adulthood in sufficient detail. Once there is an indication of re-victimization, we would recommend assessing the specific mediators as potential targets for intervention. Such interventions could clearly benefit from the concretization of the results found here. The more specifically these can be tailored, the more successfully preventive treatments can be implemented and further experiences of revictimization prevented.

5. The cycle of violence reconsidered, in a sample of male survivors of child abuse

5.1 Abstract

The cycle of violence hypothesis refers to the assumption that male survivors of child abuse have an increased risk of perpetrating violence as adolescents and adults. However, this hypothesis has commonly been restricted to sexual and physical types of abuse, despite the increasing knowledge about the detrimental impacts of emotional types of child maltreatment. At the same time, little attention has been paid to the question of whether violence in childhood among men may not only increase perpetration, but also adult re-victimization, an effect that has been commonly observed among female victims of child abuse. The aim of this study was to investigate how three types of childhood abuse (sexual, physical, and emotional) are related to the three different types of adult victimization and adult perpetration. Forty-seven adult victims of child abuse who were recruited in an online survey as well as in a psychiatric hospital were assessed for sexual, physical, and emotional experiences of violence in childhood and for perpetration or victimization of sexual, physical, and emotional abuse in adulthood. Linear regressions indicated specific relationships between childhood sexual abuse and sexual re-victimization, sexual perpetration, and physical perpetration in adulthood. Childhood emotional abuse predicted adult physical and emotional abuse. The connection between childhood sexual abuse and adult physical perpetration was partly mediated by attachment anxiety. The connection between childhood emotional abuse and adult emotional violence was completely mediated by abuse related feelings of self-blame and shame. The findings are discussed with regard to underlying processes in repeated experiences of violence and their implications for practice, particularly for the development of more effective approaches to preventing repeated violence.

5.2 Introduction

Male victims of violence in childhood may have an increased risk of becoming perpetrators of violence in adulthood (Schlack, Rüdel, Karger, & Hölling, 2013). This hypothesis has been called the victim-perpetrator cycle of violence. This effect has been consistently confirmed in relation to sexual abuse. For example, Lambie and colleagues (2002) found that 40% of male sex offenders who engaged in sexual behavior towards children had themselves been victims of sexual abuse as children. Dutton and Hart (1992) showed that the probability of sexually assaulted behavior towards strangers increased by a factor of 5 if the perpetrators themselves were victims of sexual violence in childhood.

Cycles of other types of violence were also confirmed. Lansford and colleagues (2007) found evidence for a cycle of physical violence. For example, the risk of being arrested as a young person for a violent crime increases if there had been experiences of physical abuse in the first five years of life (Lansford et.al., 2007). With regard to the transmission of emotional violence, there is initial evidence for the so-called victim-bully cycle: victims of emotional violence in childhood have an increased risk of exerting psychological violence on others in adolescence and adulthood (Ma, 2001).

The current data suggest that within the domains of sexual, physical and emotional violence three independent and specific cycles of violence drive a transition from victimhood to perpetration. However, it is premature to approve of the specificity of the relationships, since previous studies fell short of testing associations across types of violence. For example, it is possible that the perpetration of sexual violence is not only related to a history of sexual abuse, but also emotional or physical violence in childhood. A few studies have assessed the types of violence separately, with inconsistent results. Dutton & Hart (1992) showed that the specific forms of child abuse are associated with the same patterns of violence: Individuals

physically abused in childhood are most likely to become physically violent and individuals sexually abused in childhood are most likely to become sexually violent (Dutton & Hart, 1992). However, the highest probability of becoming sexually violent in adulthood was when childhood physical abuse had occurred, rather than sexual abuse (Lambie et al., 2002).

Clarifying the specificity of the cycles of violence is important since it is relevant for the presumed mechanisms of the relationships. For example, one theory of the transmission of sexual violence in men asserts that the perpetration of sexual violence is caused by an identification with the perpetrator of one's own sexual victimizations, which allows survivors to downplay the childhood abuse as a normal action and deny the trauma (Falshaw, Browne, & Hollin, 1997). To explain the physical victim-perpetrator cycle, the social learning theory (Bandura, 1993) has commonly been used. From physically abusive role models, children learn that violence is a possible problem-solving strategy (Falshaw et al., 1997). This increases their probability of resorting to this type of conflict resolution (violence) in later conflict situations (Falshaw et al., 1997). The implicit assumption of both theories is the specificity of the cycle of violence, since both assumptions fall short of explaining relationships across types of violence, for example why victims of emotional abuse would also perpetrate sexual offenses later in life.

Although some theories provide plausible explanations for the victim-perpetrator cycles, there has been little research to date on mediating variables underlying the transmission of violence. More focus has been on moderator variables, such as situational or personal factors, to determine which constellation increases or reduces the risk. For example, masturbation fantasies and enjoyment of past abuse, as well as family factors such as the loss of a parent, family support, or the experience of several types of violence in childhood, play a moderating role in the victim-perpetrator cycle (Thomas & Fremouw, 2009). Cossins and

Plummer (2018) showed that male victims of childhood sexual violence were more likely to become offenders if the abuse took place at the age 12 or older, if it was frequent and severe sexual assault, and if the abuse was committed by a person with whom the child had a dependent father-like relationship. Meta-analyses have been valuable in gaining a holistic perspective of the factors that promote the transmission of violence in the context of perpetrators and society. However, they have a limited utility for prevention measures on individual once an abuse has taken place.

So far, the victim-perpetrator cycle has been related mainly to men. Some theories and findings indicate a stability of violence across development, although in a different direction. The revictimization hypothesis assumes that, among women, child victimization is related not to adult perpetration but to continued victimization. In fact, some studies support this hypothesis since they find higher prevalence rates of child abuse among adult victims of interpersonal violence (Classen, Pales &Aggarwal, 2005; Coid et al. 2001; Bockers & Knaevelsrud, 2011).

It is remarkable that, so far, very few studies have examined the presence of both types of cycles, the victim-perpetrator and the victim-victim cycle within one gender. A few studies have indicated an increased risk among men of re-experiencing violence in adulthood after having been victims in childhood (Desai, Arias, Thompson and Basile, 2002; Weiss, 2010). However, a possible revictimization phenomenon has not been investigated in men in nearly as differentiated a manner as in female samples. Here, too, it would be essential to examine the role of mediating variables to examine, for example, which factors lead to someone having renewed experiences of victimization or perpetration in adulthood after violent experiences in childhood.

In summary, there are clear research gaps in the extent to which the types of violence men experience in childhood are related to the types of violent experiences in adulthood, both in terms of repeated experiences of victimization and in perpetrating violence. It is also essential to examine the interrelationships of violent experiences with each other in terms of possible underlying mediating variables. Examining these possible relationships is the only way to derive specifically tailored prevention strategies.

The present study sought to determine the extent to which different types of violent experiences in childhood were related to violent experiences in adulthood as victims or the exercise of violence as perpetrators. In a next step, the relationships found were checked for mediating variables. In the absence of preliminary studies and previous findings, we tested a range of variables developed during the investigation of the revictimization phenomenon in women: emotional regulation deficits, dysfunctional attachment related cognitions, sexual self-assertiveness, self-assertion, self-efficacy, preference for dominant partners and abuse related feelings of self-blame and shame were examined as possible mediating variables (Langer & Neuner, 2021b). We relied on a combination of an online survey and a clinical sample from a psychiatric hospital with the aim of recruiting a sample of men with a high range of violence in both childhood and adulthood.

5.3 Method

5.3.1 Procedure

The data for this study was collected in two different ways. One part of the sample was collected in an online survey created with the Unipark software (Unipark, E.F.S. Survey, version 7). The online survey´s aim was to recruit a sample with a large variance in the study variables, including maltreatment and revictimization. For this purpose, the link for

participation was published in numerous private Facebook accounts and in self-help groups on the Internet which were addressing the topic of traumatic life experiences. Those self-help groups were located by a google search. First the moderators of active online self-help groups were contacted, the contents of the study were presented and a publication of the link for participation was requested. Of 19 online self-help groups 14 agreed to publish the link. The link´s publication was accompanied by brief information on the nature of the questions and the need for potential study participants to be of legal age. This study was part of a larger survey in which male and female participants were included. Unfortunately, although the online survey recruited many women, few male participants agreed to enroll. Parallel to the online survey, participants were also recruited for the study in a psychiatric hospital. Most of the recruitment took place in a psychotherapy ward. On this ward, the focus was on patients with depression, anxiety disorders, post-traumatic stress disorder and personality disorders. Patients were briefly informed about the possibility of participating in the study and the content and nature of the questions. Participation was on a voluntary basis and anonymous. Both the clinical and the online sample received the same materials and information.

There was no incentive to participate. On the first page of the survey, participants were informed about the contents and risks of the study, about the voluntary and anonymous nature of the survey, and the opportunity to withdraw at any time without penalty. This was followed by a declaration of consent to participate in the study. The programming of the survey prevented the participants from seeing the contents of the study if they were underage. In the clinical population this was ensured as the psychiatric hospital served adults only.

First, demographic data (age, gender, education) were collected. Demographic information was followed by questionnaires which recorded the characteristics of the

variables of interest (emotion regulation difficulties, attachment related dysfunctional cognitions, self-assertion, self-efficacy, preference for dominant partners, and abuse related feelings of self-blame and shame). Further, childhood experiences of different types of violence were investigated. In order to avoid disclosure effects, the experience of various types of violence in adolescence and adulthood from a victim´s and a perpetrator´s perspective was only examined following the assessment of childhood experiences. In addition, presence of probable psychopathology was recorded. The average time required to complete the survey was 23 minutes. This study's protocol was reviewed and approved by the Ethics Committee of the Department of Psychology at Bielefeld University.

5.3.2 Participants

In total, N=1,062 participants commenced the online version of the study, n=155 of those completed the survey, resulting in a completion rate of 14.6%. Most drop-outs took place on the start page (n=789, 74.29 %). Under 3% (n= 26) of drop-outs occurred at the declaration of consent and n=20 (1.88%) drop-outs occurred during the indication of socio-demographic data. For all other questions, there was no noticeably higher number of drop-outs. The survey link was active for a total of 182 days. The average number of participants per day was 7.08.

Of the 155 participants who completed the study, twelve participants were male. For this study, only the male participants were included. The clinical sample consisted of 35 men. The final sample of *N* = 47consists of the online sample and the clinical sample. The participants aged 18 to 64 years (*M* = 34.9; *SD* = 13.2). They had an average of 12 years (S*D* = 3.9) of formal education (primary school, secondary school, university).

5.3.3 Measures

Child abuse experiences. The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998; German version; Wingenfeld et al., 2010) is a self-assessment tool for the retrospective assessment of abuse and neglect experienced during childhood. Due to the specific nature of the study, participants were instructed to endorse items only if they were experienced prior to the age of 14. With 28 items, the questionnaire covered the subscales of sexual abuse (e.g., "when I was growing up, someone tried to touch me sexually, or get me to touch him/her sexually"), emotional abuse (e.g., "when I was growing up, people from my family said hurtful/offending things to me"), physical abuse (e.g., "when I was growing up people from my family hit me so hard that I was bruised or scarred"), emotional neglect (e.g., when I was growing up, I thought my parents wished I had never been born") and physical neglect (e.g., "When I was growing up, I had enough to eat"). The items were answered on a five-point Likert scale rated from 1 (not a bit) to 5 (very often). The CTQ showed good internal consistency for all scales in validation studies (Klinitzke, Romppel, Häuser, Brähler & Glaesmer, 2012) except for the scale of physical neglect. Due to the low internal consistency of this scale and its high intercorrelation with the other scales (Klinitzke et. al., 2012) it was not included for analysis in the present study. In the present study, good internal consistency for the four scales was confirmed (Cronbach's alpha coefficients: sexual abuse .97, physical abuse .93, emotional abuse .92, emotional neglect .92). The decision on the existence of the different types of abuse was made on the basis of the cut-off values for the summed item scores of Walker et al. (1999). However, the frequencies thus obtained were used only for the descriptive information. In all further analyses, the summed item scores of the individual scales were used independent of the cutoff values, and provided a range of possible scores from 28-240, with higher scores indicating higher levels of abuse.

Sexual Victimization in Adolescence and Adulthood. The Potsdam scales for recording sexual aggression and victimization (SEX_AGG_VIC; Krahé & Berger, 2014) are a self-report instrument for the assessment of sexual aggression and victimization in adolescence and adulthood (after the age of 14). The Potsdam scales record sexual victimization with three questions each (e.g., “Has anyone since the age of 14 brought (or tried to bring) you into sexual contact by physically threatening or hurting you?”). These questions had specific phrasing for possible offenders, which included the type of pre-existing relationship between offender and victim ((former) partners, acquaintances, or strangers). In order to harmonize this instrument with the other assessments, the category "colleagues or supervisors at the workplace" was added. The same three questions were then asked again from the perspective of the offender (e.g., “Did you, since the age of 14, bring (or tried to bring) someone into sexual contact with you by physically threatening or hurting you?”). Here too, the same four different types of pre-existing relationships between perpetrator and victim were asked. Through the six questions combined with four possible perpetrators/victims each, the instrument consists of 24 items. The items were answered on a four-point Likert scale regarding the frequency of occurrence rated from 1 (not even) to 4 (three times or more). Three different strategies for exerting pressure were investigated (use / threat of physical violence, exploitation of inability to resist, and verbal pressure). A more precise differentiation of forced sexual acts (sexual contact, attempted sexual intercourse, sexual intercourse, and other sexual acts, such as oral sex) is mentioned in the explanatory text. This more precise differentiation was removed from the item query, as it was not relevant for the purpose of this study. As this is a newly developed instrument, no validity or reliability criteria were available. In the present study a sufficient internal consistency was attested for the scale (Cronbach’s alpha coefficient .55). People are considered victimized or as perpetrators if they have been exposed to sexual aggression on at

least one occasion. For the present evaluation, the total scores of all items assessing victimization represented the experience of sexual violence in adolescence and adulthood. The total scores of all items assessing aggression represented the exercise of sexual violence in adolescence or adulthood.

Physical and Emotional Victimization in Adolescence and Adulthood. A recently created screening instrument was used to record and quantify the experience of physical and emotional violence in adolescence and adulthood. It was developed for one of the main German epidemiological studies on health, the "Study on Adult Health in Germany" (DEGS1) conducted by the Robert Koch Institute (RKI; Schlack, Rüdel, Karger, & Hölling, 2013). It explores whether there have been physical or emotional experiences of violence from the perspective of both the victim and the perpetrator. The relationship between perpetrator and victim is also recorded (e.g., (former) partners, acquaintances, work colleagues/supervisors at the workplace or strangers). In order to avoid confusion with experiences of intrafamily childhood violence, the category of "one person from the family" was omitted. For the same reason, participants were instructed to select the items only if the experience had taken place at or after the age of 14. An additional question on the burden of the respective experience of violence was removed as it was not relevant for the purpose of this study. In total the instrument consisted of 16 items, eight investigating experiences of violence and eight investigating perpetration of violence. Of those items investigating experiences of violence, four addressed physical violence and four addressed emotional violence (e.g., "Has an (ex-) partner physically attacked you from the age of 14 onwards (e.g. hit you, slapped you, pulled your hair, kicked you, threatened you with a gun or an object"; "Has a friend or an acquaintance devalued you from the age of 14 onwards (in terms of your appearance, the way you dress, the way you think, act or work, or possible disability? Or has a friend or

acquaintance insulted, threatened, harassed or pressured you?"). The same items were then presented again from the perpetrator´s perspective. The items were answered on a four-point Likert scale assessing the frequency of the experiences, rated from 1 (not even) to 4 (three times or more). People were considered victimized if they had been exposed to physical or emotional aggression on at least one occasion. This information was used only for descriptive purposes. For the present evaluation, the total scores of all items concerning victimization represented the experience of physical or emotional violence in adolescence or adulthood. The total scores of all items concerning aggression represented the exercise of physical or emotional violence in adolescence or adulthood.

Preference for Dominant Partners (PDP). This instrument was developed as part of a study on partner preference (Giebel, 2013). It consists of six items, such as "dominant women/men are fascinating." The items were answered on a seven-point scale rated from 1 (does not apply at all) to 7 (is absolutely true). In previous studies, the PDP achieved good values for internal consistencies (Giebel, 2013), which were confirmed in the present study (Cronbach's alpha = .77).

Self-Efficacy. The Scale for the general expectation of self-efficacy assesses respondents' expectations of self-efficacy. It consists of ten items that are answered on a four-point scale rated from 1 (is not true) to 4 (is exactly right; Jerusalem & Schwarzer, 1999). Validation studies have repeatedly confirmed good internal consistency (Hinz, Schumacher, Albani, Schmid & Brähler, 2006). The summed item scores were used in the present evaluation.

Self-assertiveness. We used the self-assertiveness sub-scale from the Inventory of Interpersonal Problems (IPP; Barkham, Hardy & Startup, 1996). The full instrument records

difficulties experienced by individuals in their interpersonal relationships. The self-assertiveness subscale consists of four items that are answered on a five-point scale rated from 1 (it's not hard for me) to 5 (it's very hard for me). In the evaluation, the sum score of these items was used to represent the difficulty of self-assertion in interpersonal relationships. Validation studies showed both good internal consistency and good retest reliability for the IPP and the assertiveness subscale (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988).

Emotion Regulation Difficulties. The Difficulties in Emotion Regulation Questionnaire (DERS; Gratz & Roemer, 2004) assesses emotion regulation difficulties across six scales. The four of the six scales were used for this study: Non-acceptance of emotional reactions, impulse control difficulties, limited access to emotion regulation strategies, and lack of emotional clarity. The other two scales, "lack of emotional awareness" and "difficulties with targeted behavior," were omitted as they were not relevant for the purpose of this study. The items were answered on a scale which assesses the frequency of experienced difficulties. The five point scale was rated from 1 (almost never (0-10%)) to 5 (almost all the time (91-100%)). Validation studies showed good internal consistency and good retest reliability (Gratz & Roemer, 2004). The evaluation included the four scales mentioned above as well as an overall value for emotion regulation difficulties, which was obtained from the summed score of all four scales.

Attachment. The Adult Attachment Scale (AAS; German version Schmidt, Strauß, Höger & Brähler, 2004) is a self-report instrument which assesses attachment-related cognitions. These cognitions are divided into three categories: Trust, proximity, and fear. Three scales were based on these categories: attachment anxiety, low confidence in other people, and fear of closeness. The items were rated on a five-point scale from 1 (is not true at all) to 5 (is exactly

right). Validation studies confirmed that the AAS has sufficient internal consistency (Schmidt et al., 2004). All three scales were included in the present evaluation.

Abuse-Related Feelings of Self-Blame and Shame. Feiring, Simon, and Cleland (2009) developed items for retrospectively assessing abuse-related feelings of self-blame and shame. The items assessed typical self-accusations and cognitions of shame with regard to possible experiences of violence in childhood or adulthood (e.g., “it happened because I wasn't smart enough to stop it”). The items were rated on a three-point scale, from 1 (“is not true”) to 3 (“is absolutely true”). Since this is not an official instrument, no quality criteria were available, but the items showed a good internal consistency (Feiring et al., 2009), which was confirmed in the current study (Cronbach’s alpha coefficients: self-blame .82, shame .75). The sum scores of the scale feelings of shame and self-blame were included in the present analysis.

Sexual Assertiveness. The Sexual Assertiveness Scale (SAS; Morokoff et al., 1997) is a self-report instrument for measuring sexual assertiveness. The instrument includes three sub-scales. For the present study, only the “rejection/refusal” scale was used, which consists of six items. Items are answered on a five-point scale rated from 1 (“I do not agree at all”) to 5 (“I totally agree”). To avoid conflation with sexual abuse experiences, scale instructions emphasized that these were situations in which sexual contacts happened on a voluntary basis. The SAS showed good internal consistency and good retest reliability in validation studies (Morokoff et al., 1997). In the present evaluation, the summed item scores were used to indicate levels of sexual assertiveness, with higher scores indicating higher levels of assertiveness.

PTSD Symptoms. The Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003) is a screening instrument for the detection of post-traumatic stress disorder (PTSD). The scale

consists of four dichotomous (Yes/No) items. The PC-PTSD asks whether a person has experienced four symptoms typical of PTSD in the last month: Re-experiencing, numbness, avoidance, and hyperarousal. The PC-PTSD has optimum efficiency in terms of the best possible combination of sensitivity and specificity at a cut-off value of three (Prins et al., 2003). The cut-off value was only used for descriptive purposes in this study. The summed item scores were used in the evaluation, representing a value for the exposure to symptoms of PTSD. The PC-PTSD has good retest reliability and correlates highly with the standard instrument for the detection of PTSD, the Clinician Administered PTSD Scale (CAPS; Prins et al., 2003).

Symptoms of Depression. The health questionnaire for patients (PHQ-9; Kroenke, Spitzer & Williams, 2001; German version Löwe, Spitzer, Zipfel & Herzog, 2002) is a screening instrument used for the detection of a depressive disorder. The self-report questionnaire contains nine items that assess whether typical symptoms of depression, based on the DSM-IV criteria, have occurred in the last two weeks. The items were answered on a four-point scale regarding the frequency of occurrence rated from 1 (not even) to 4 (almost every day). The PHQ-9 has previously demonstrated good validity and retest reliability (Kroenke et al., 2001). In addition, good values for sensitivity and specificity were confirmed for the stated cut-off values for the severity of depressive symptoms (Kroenke et al., 2001). These cut-off values were only used for descriptive purposes in this study. The summed item scores were used to represent a value for the burden of symptoms of depression.

5.3.4 Statistical Analyses

Statistical analyses were carried out with the statistical program IBM SPSS Statistics, version 21. All procedures refer to the significance level $\propto = .05$. To describe the sample characteristics, the variables of sexual, physical, emotional abuse, emotional neglect in childhood, and sexual, physical, and emotional experiences of violence in adulthood were treated as dichotomous variables using the cut-off values described above. They were used as continuous variables in all further analyses. The scales of emotional abuse and emotional neglect were combined due to their high correlation (sum of the scores of the individual scales). The scale of emotional abuse reflected this composite value.

In order to test the predictors for the experience of violence in adulthood, linear regressions were calculated. To carry out the regression analyses, the normal distribution of the residuals was first checked by visual inspection. To address the question of what specific contribution different types of childhood abuse experiences make to the prediction of a subsequent revictimization, all potential predictors were simultaneously included in the regression model. In a first linear regression, the variable sexual experiences of violence in adulthood served as a dependent variable. Independent variables were sexual abuse, emotional abuse, and physical abuse in childhood. In the following two linear regressions, the same independent variables were used. The dependent variables were experiences of physical violence in adulthood and experiences of emotional violence in adulthood. This procedure was repeated with the dependent variables of sexual, physical, and emotional perpetration in adulthood. In addition, regression analyses were calculated in which experiences of violence in childhood across all three types of violence represented the independent variable. Dependent variables were previous experiences of violence in adulthood independent of the subtype of violence and experiences of perpetration independent of the subtype of violence.

In a next step, the relationships found between different types of violence were examined for mediation effects. For this purpose, bivariate correlations between the independent variables (different types of maltreatment in childhood), the proposed mediators (manifestation of psychological constructs) and the dependent variables (different types of victimization and perpetration during adulthood) were calculated. All variables that maintained a significant association with childhood abuse and adult victimization or perpetration were then tested in mediation models. Mediation effects were examined following the method of Preacher and Hayes (2008). With this method, bootstrapping samples (5000) are used to calculate the total and indirect effects for all mediators. Point estimates (beta coefficients), standard errors, Z-values, and confidence intervals for the total and indirect effects were also calculated.

5.4 Results

The frequency of different experiences of violence determined by the cut-off values are presented in Table 6. Overall, 96 % of the participants stated that they had experienced violence in adolescence or adulthood, with experiences of emotional violence occurring as the most frequently experienced violence across our sample (83%). Eighty-seven percent of the participants were victims of at least one subtype of interpersonal violence in childhood. For 72% of the participants, emotional abuse was the most frequent form of violence during childhood. Of the 41 participants who had experienced any form of violence in childhood, 40 re-experienced violence in adulthood, and 37 endorsed having committed some form of adult violence.

Table 6

Experiences of Violence

Types of Violence	Frequency	Percent frequency
Childhood sexual abuse	6	13
Childhood physical abuse	30	64
Childhood emotional abuse	34	72
Childhood emotional neglect	26	55
Adult sexual victimization	18	39
Adult phsical victimization	41	87
Adult emotional victimization	42	89
Adult sexual aggression	14	30
Adult physical aggression	35	75
Adult emotional aggression	33	70
Abuse experiences in childhood	41	87
Abuse experiences in adulthood	45	96
Perpetration of violence in adulthood	41	87
Victimization in childhood and in adulthood	40	
Victimization in childhood and aggression in adulthood	37	

Note. N = 47

The results of the short screenings suggest an increased psychopathological stress in the examined sample. Forty-nine percent of the participants answered in the affirmative to

three out of four questions about post-traumatic symptoms and were thus above the cutoff value, which indicated the possible presence of PTSD (Prins et al., 2003). When responding to the PHQ, 55 % of the participants were above the value of 15, which is considered to be indicative of a potential depressive risk; such as a moderate depressive episode. A complete overview of the descriptive statistics can be found in Table 7.

Table 7

Descriptives

	M	*SD*
Age	34.91 (SD)	13.20
Formal education	12.26	3.91
Child emotional abuse	13.38	5.56
Child physical abuse	10.57	5.77
Child sexual abuse	6.79	4.70
Child emotional neglect	15.11	5.91
Child emotional abuse (composite)	28.49	10.02
Adult sexual abuse	1.36	2.53
Adult physical abuse	3.00	2.28
Adult emotional abuse	6.15	3.74
Adult sexual aggression	2.00	5.67
Adult physical aggression	2.74	2.87
Adult emotional aggression	3.94	4.22
Emotion Regulation Difficulties (DERS)	71,72	20.54

Low Confidence_AAS	18,08	7.79
Fear of Closeness_AAS	14,67	7.15
Attachment Anxiety	14,36	5.38
Preference for Dominant Partners	17,96	8.17
Self-efficacy	24,89	7.38
Self-assertivness	8,09	4.23
Sexual Self-assertivness	13,28	4.83
Abuse related feelings of Self-blame and Shame	13.70	4.12
PTSD (PC-PTSD)	2.15	1.49
Depression (PHQ)	14.43	6.17

Note. N = 47.

5.4. 1 Predicting Sexual, Physical and Emotional Violence in Adulthood from Abuse Experiences in Childhood

In all regression analyses conducted in this sample, the histogram of residuals did not indicate a deviation from the normal distribution. A test of the multicollinearity of the predictors showed that although the predictors correlated with each other, the assumption of multicollinearity was not violated. The regression analyses could therefore be carried out without restriction.

The results of the regression analyses for the variables adult sexual, physical, and emotional violence and perpetration are presented in Table 8 and 9. A significant predictor of adult sexual violence was sexual abuse during childhood. Adult physical and emotional

violence was significantly predicted by emotional abuse in childhood. Adult sexual and physical perpetration was significantly predicted by sexual abuse in childhood. None of the factors in the present study were significant predictors of perpetration of adult emotional violence.

Table 8

Predictors of adult sexual, physical and emotional violence

	Adult Sexual Violence[1]		Adult Physical Violence[2]		Adult Emotional Violence[3]	
Predictors	β	*r*	β	*r*	β	*r*
Child sexual abuse	.47 **	.40**	-.28	.09	-.06	.12
Child phyiscal abuse	.01	-.03	.06	.29	-.22	.09
Child emotional abuse	-.11	.02	.37*	.30*	.52**	.32*

Note: N = 47; β*:* standardized beta coefficient*; r:* 0-order correlation (Spearman).

[1] corrected R^2 = .14, F (3,43) = 3.58, p < .05

[2] corrected R^2 = .10, F (3,43) = 2.75, p = .054

[3] corrected R^2 = .13, F (3,43) = 3.36, p < .05

* p < .05. ** p < .01. ***p < .001

Table 9

Predictors of sexual, physical and emotional aggression

	Adult Sexual Aggression[1]		Adult Physical Aggression[2]		Adult Emotional Aggression[3]	
Predictors	β	*r*	β	*r*	β	*r*
Child sexual abuse	.53 **	.07	.59***	.33*	.19	.07
Child phyiscal abuse	.07	-.11	-.15	-.01	-.22	-.14
Child emotional abuse	-.24	.02	.04	.06	-.05	-.17

Note: N = 47; β*:* standardized beta coefficient*; r:* 0-order correlation (Spearman).

[1] corrected R^2 = .22, *F* (3,43) = 5.39, *p* < .01

[2] corrected R^2 = .24, *F* (3,43) = 5.84*, p* < .01

[3] corrected R^2 = -.02*, F* (3,43) = 0.7, *n.s.*

* *p* < .05. ** *p* < .01. ***p < .001

The results of the regression analyses for childhood and adult violence experiences composed of all three types of violence experiences show the following results: Adult abuse experiences were significantly predicted by childhood abuse experiences (*β*= .32; *p*< .05; *F* (1,45) = 5.26, *p* <.05). The corrected R^2 was .09. Adult perpetration experiences were not significantly predicted by childhood abuse experiences (*β*= .16; *n.s.*; *F* (1,45) = 1,17, *n.s)*.

5.4.2 Mediation Analyses

Significant mediation could only be identified for two relationships described in the regression analyses. Those results are shown in Figures 7 and 8. The relationship between childhood emotional abuse and adult emotional abuse was mediated by abuse-related

feelings of self-blame and shame. The bootstrapped completely standardized indirect effect was .26 and the 95% confidence interval ranged from .11 to .46. Thus, the effect was statistically significant. Further, as the direct effect loses its significance if one considers the mediating effect, it is a complete mediation. The model explains 13% of the variance in the variable emotional experiences of violence in adulthood.

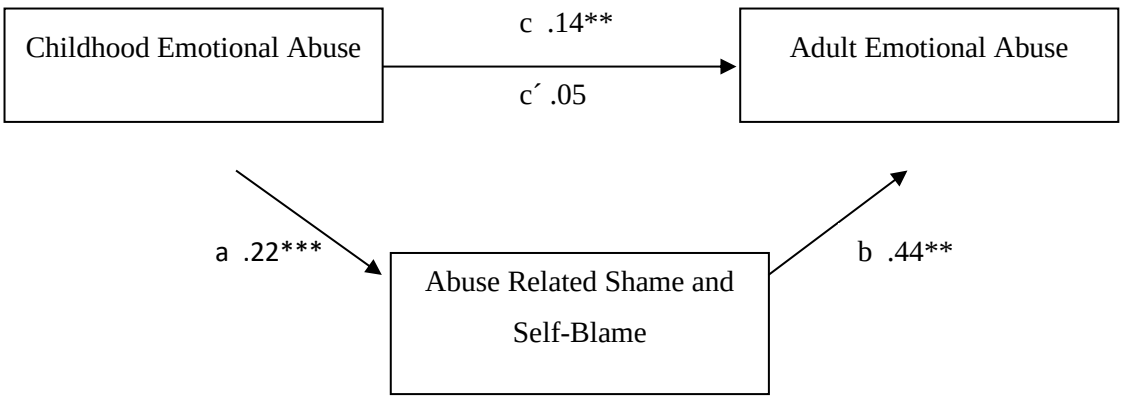

Figure 7. Mediation model of the effect of childhood emotional abuse on adult emotional violence, mediated by abuse related self-blame and feelings of shame. Effect size (comp. stand.) .26; CI .11- .46; R^2.13).

The relationship between childhood sexual abuse and adult physical perpetration was partially mediated by attachment anxiety. The bootstrapped completely standardized indirect effect was .08. and the 95% confidence intervals ranged from .01 to .20. The model explained 10 % of the variance in the variable sexual violence in adulthood.

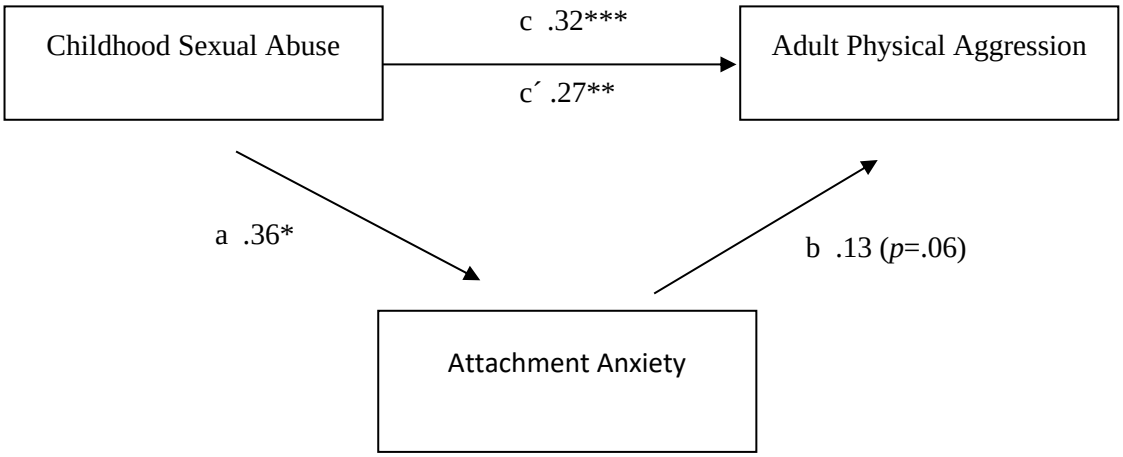

Figure 8 Mediation model of the effect of childhood sexual abuse on adult physical aggression, mediated by attachment anxiety. Effect size (comp. stand.) .08; CI .01- .20; R^2.10).

5.5 Discussion

In a sample of men with high exposure to violence we found evidence for both the revictimization phenomenon and the victim-offender cycle. The regression analyses identified a trend that emotional experiences of violence in childhood tended to be associated with experiences of violence in adulthood. Over and above the roles of emotional and physical types of child abuse, sexual abuse turned out to be the most important predictor of perpetration and victimization of sexual and physical violence in adulthood.

The results are in partial agreement with the existing literature. We could confirm the transmission of violence via sexual abuse, which has been repeatedly indicated in studies (Lambie et. al., 2002, Dutton & Hart, 1992). However, contrary to the assumption of a specific correlation of the types of violence in the transmission of violence, physical perpetration was also associated with sexual violence in childhood and not with physical violence experienced during childhood, as would be expected from the study of Lansford and colleagues (2007). This finding shows the importance of assessing multiple types of abuse, since there is a high co-occurrence of sexual and physical abuse in childhood that might contribute to confounding effects (Tourigny, Hébert, Joly, Cyr, & Baril, 2008).

Despite the large number of possible mediators examined, significant mediations were found for only two associations. The complete mediation of emotional violence experiences in childhood to emotional violence experiences in adulthood through abuse-related feelings of guilt and shame was found in this male sample, as well as in the female sample (see: Langer & Neuner, 2021b). Attachment anxiety showed a mediating effect of sexual abuse experiences in childhood and physical perpetration in adulthood.

In order to explain the present results, we refer to the phenomenon of externalizing problem solving after interpersonal experiences of violence, which has been described

previously in the literature (Brady & Donenberg, 2006; McGee, Davis & Brisbane, 2001). This phenomenon states that adolescents and men, unlike women, tend to externalize behavior, such as risky, provocative behavior, delinquency, brawls or substance abuse, within the framework of a coping strategy following interpersonal experiences of violence during childhood (Brady & Donenberg, 2006). Within this framework it can be assumed that a person exercises and experiences physical and emotional violence himself, for example through brawls or provocative contact with other persons. This assumption is also supported by the fact that men are more likely to experience violence in adulthood perpetrated by strangers (Schlack et al., 2013; Desai et al., 2002). The connection found between childhood sexual abuse and adult physical perpetration can also be classified as a coping strategy for sexual abuse experiences within the framework of externalizing problem solving. Considering the use of externalizing behaviors to cope with negative symptoms of experienced violence, the mediating role of attachment anxiety is interesting. Attachment anxiety is expressed via increased fear of being abandoned and is also associated with behaviors that lead to dissatisfaction in relationships and interpersonal conflicts (Sandberg, Valdez, Engle, & Menghrajani, 2016). It may be that physical violence in relationships occurs in the context of increased interpersonal conflicts. At this point, however, it should also be noted that this is a partial mediation with a relatively small effect, suggesting that other mechanisms are at work in this context as well.

Since childhood sexual abuse does not exclusively predict sexual violence in adulthood, but also physical violence in adulthood, we cannot speak to a violence type-specific relationship as has been suggested in previous studies (Falshaw et al., 1997; Lambie et al., 2002). Rather, there seems to be a trend that experiences of childhood sexual abuse are more likely to be associated with the perpetration of violence, both sexual and physical. We place

this trend in the context of the externalizing behaviors described above following childhood experiences of violence (Brady & Donenberg, 2006; McGee, Davis & Brisbane, 2001). As has been repeatedly confirmed in female samples, there are also indications of a sexual revictimization process in the male sample. It has often been suspected that men are also affected to a high degree by sexual violence, but do not report it to the same extent as women (Donne et al., 2018). It is therefore possible to speculate that repeated experiences of sexual violence in men could be mediated by the same processes that are also speculated in women, such as delayed risk recognition (Bockers, Roepke, Michael, Renneberg & Knaevelsrud, 2014).

The association between emotional experiences of violence in childhood and physical and emotional revictimization could be attributed to the particular effects of emotional abuse. Emotional violence in childhood is particularly associated with the development of a highly negative self-concept (Briere & Runtz, 1990). Without correction the individual's negative self-concept could influence the choice of partner. For example, partners with a similarly negative self-concept may be favored. Such relationships have been associated with higher levels of physical and emotional violence (Bockers & Knaevelsrud, 2014; Sandberg et al., 2016). However, there are also connections between a negative self-concept and experiences of social exclusion and bullying as a form of emotional violence (Langer & Neuner, 2021b). The fact that the negative self-concept plays an important role in explaining the connections between repeated emotional victimization can also be seen in the mediating role of abuse-related feelings of self-blame and shame, which are a representation of a negative self-concept.

When considering the impact of the findings of the present study, it is critical to consider the strengths and weaknesses of the study design itself. The strength of this study lies in the systematic recording of all three types of violence experiences (sexual, emotional,

and physical) both in childhood and in adulthood, and that participants are considered as holding the potential to be both victims and perpetrators. The results therefore represent an extension of the current body of knowledge in the field of men´s repeated experiences of violence which has so far primarily focused on sexual and physical abuse in childhood and sexual perpetration in adulthood. The approach taken in the present study allows statements to be made about specific relationships between certain types of violence in childhood and adulthood and thus provides valuable insights for the development of specifically tailored prevention approaches for victims of sexual, physical, or emotional violence.

However, the findings of the present study must be considered in light of the study's cross-sectional design, which does not permit conclusions about causal relationships between the recorded variables. Furthermore, it is important to note the small sample size, which prevents a generalizing effect of the results found here. In addition, due to the lack of well-established instruments addressing the variables of interest, our assessment of physical and emotional violence in adulthood does not allow us to evaluate the frequency of experiences in our sample relative to other populations. In accordance with the assessment of sexual violence, a cutoff value of 1 was chosen. However, given the high frequencies of physical and emotional violence in this sample, we assume that the cut-off value for physical and emotional violence is too low to generate meaningful results.

In summary, the results of the study provide important findings that men who have experienced violence in childhood are at risk of adult experiences of victimization and/or use violence themselves. In a field which is dominated by research on sexual abuse and later sexual perpetration and partly on physical violence, particularly novel and valuable are the findings on the connection of different subtypes of violence while considering a victim´s and a perpetrator's perspective. Future studies, ideally with a longitudinal design, should be

devoted to further investigating these connections in order to be able to make valid statements regarding the consequences of child abuse for the later revictimization or perpetration of those affected. This study may provide the basis for further research showing that different types of childhood violence are followed by different meditative variables, making it more likely that different types of victimization or perpetration will occur. Such knowledge would be indispensable in specifying prevention approaches for the victims of experiences of violence. Although much more research is necessary, we believe that this research topic has the potential to illuminate and significantly reduce the revictimization phenomenon and the victim-offender cycle in the long term by means of constructive therapy approaches.

6. Ergebnisse aus den drei Artikeln

Durch die drei Artikel konnte das Wissen bzgl. der Reviktimisierungsforschung und des Opfer Täter Zyklus um mehrere Punkte erweitert werden. Bei Frauen standen über die verschiedenen Entwicklungsstadien hinweg bestimmte Arten von Gewalterfahrungen in spezifischer Beziehung zueinander: Körperliche Misshandlung in der Kindheit sagte körperliche Gewalt im Erwachsenenalter voraus. Sexuelle Gewalt im Erwachsenenalter wurde durch sexuellen Missbrauch in der Kindheit und durch körperlichen Missbrauch in der Kindheit vorhergesagt. Emotionale Gewalt im Erwachsenenalter wurde durch emotionalen Missbrauch in der Kindheit und durch sexuellen Missbrauch in der Kindheit vorhergesagt. Bei Männern zeigten sich ebenfalls spezifische Zusammenhänge beim Reviktimisierungsprozess. Sexuelle Gewalt in der Kindheit sagte sexuelle Gewalt im Erwachsenenalter voraus. Emotionale Gewalterfahrungen in der Kindheit sagten sowohl physische als auch emotionale Gewalterfahrungen im Erwachsenenalter voraus. Bzgl. eines möglichen Opfer-Täter Zyklus zeigten sich folgende Zusammenhänge: Sexueller Missbrauch in der Kindheit sagte sowohl sexuelle als auch physische Gewaltausübung im Erwachsenenalter voraus. Bzgl. emotionaler Gewaltausübung konnte keine der Arten von Gewalterfahrung in der Kindheit als signifikanter Prädiktor identifiziert werden.

Bzgl. vermittelnder Variablen zeigte sich bei Frauen eine tragende Rolle von missbrauchsbezogenen Schuld- und Schamgefühlen. Und zwar wurden folgende Reviktimisierungsprozesse teilweise von dieser Variable mediiert: Der Zusammenhang von sexueller Gewalt in der Kindheit und sexueller Gewalt im Erwachsenenalter, der Zusammenhang von sexueller Gewalt in der Kindheit und emotionaler Gewalt im Erwachsenenalter und der Zusammenhang von physischer Gewalt in der Kindheit und

physischer Gewalt im Erwachsenenalter. Bei dem Zusammenhang von emotionaler Gewalt in der Kindheit und emotionaler Gewalt im Erwachsenenalter zeigten sich sogar eine vollständige Mediation von missbrauchsbezogenen Schuld- und Schamgefühlen. Diese komplette Mediation eines emotionalen Reviktimisierungsprozesses zeigte sich sowohl bei Frauen als auch bei Männern. Bei der männlichen Stichprobe wurden insgesamt sonst keine der Reviktimisierungsprozesse von einer der untersuchten Variablen mediiert. Bzgl. der unterschiedlichen Opfer-Täter Zyklen zeigte sich ebenfalls nur bei einem ein Medikationseffekt. Der Zusammenhang von sexuellem Missbrauch in der Kindheit und physischer Gewaltausübung im Erwachsenenalter wurde teilweise durch Bindungsangst mediiert.

7. Übergreifende Diskussion

Bzgl. der Stichprobe von Männern und der von Frauen zeigten sich insgesamt starke Unterschiede, welche sich auch in der unterschiedlich differenzierten vorherigen Studienlage begründen lassen. Aus diesem Grund werden die Ergebnisse für die männliche und die weibliche Stichprobe getrennt diskutiert.

7.1 Viktimisierungserfahrungen bei Männern

Bei der männlichen Stichprobe wurde zunächst die Existenz eines Opfer-Täter Zyklus bestätigt. Interpersonelle Gewalterfahrungen in der Kindheit sagten die Ausübung von sexueller und physischer Gewalt im Erwachsenenalter voraus. Ebenso sagten unterschiedliche Arten von Gewalterfahrung jedoch auch unterschiedliche Arten von Gewalterfahrungen aus der Opferperspektive voraus. Somit konnte auch die Existenz eines Reviktimisierungsprozesses für Männer gezeigt werden. Eine Spezifität der unterschiedlichen Arten von Gewalterfahrungen in der Kindheit und später im Erwachsenenalter konnte hingegen nicht so klar aufgezeigt werden. Es zeigte sich jedoch ein Trend. Emotionale Gewalterfahrungen in der Kindheit scheinen eher mit erneuten Opfererfahrungen im Erwachsenenalter assoziiert zu sein und sexuelle Gewalterfahrungen in der Kindheit waren mit der Ausübung von Gewalt im Erwachsenenalter assoziiert.

Insgesamt ist es interessant festzustellen, dass trotz der großen Zahl möglicher vermittelnder Variablen (emotionale Regulationsdefizite, dysfunktionale bindungsbezogene Einstellungen, Selbstbehauptung, sexuelle Selbstbehauptung, Selbstwirksamkeit, Präferenz für dominanter Partner und missbrauchsbedingte Schuld- und Schamgefühle) für die Mehrzahl der Beziehungen keine signifikanten vermittelnden Variablen gefunden werden

konnte. Da sich Studien bisher kaum mit der Frage der vermittelnden Variablen bei Reviktimisierungsphänomenen und Opfer-Täter-Zyklen bei Männern beschäftigt haben, wurde dieser Variablensatz übernommen, der aus theoretischen Überlegungen und vorläufigen Erkenntnissen für die weibliche Stichprobe entwickelt worden war. Die eher begrenzte Erklärungskraft dieses Satzes von möglichen vermittelnden Variablen ist einerseits auch in der kleinen Stichprobengröße zu verorten. Ebenso ist es aber ein Hinweis darauf, dass beide Phänomene dringend noch genauer untersucht werden müssen. Dafür müssen sie einerseits mehr in den Fokus der Forschung gebracht werden, da viele der hier zitierten Forschungsergebnisse teilweise über 30 Jahre zurückliegen. Andererseits lassen sich gerade weitere Hinweise für mögliche vermittelnde Variablen kaum aus der aktuellen Forschung ableiten. Hier wäre das persönliche Gespräch mit den Betroffenen aber auch mit Behandlern beispielsweise aus forensischen Einrichtungen eine wichtige Quelle für erste Hinweise.

Eine weitere Herausforderung für eine ausführlichere Forschungslage ist die Rekrutierung möglicher Probanden, welche sich auch bei der vorliegenden Arbeit als herausfordernder herausstellte als eine weibliche Stichprobe zu rekrutieren. Es ist allgemein bekannt, dass sich das Hilfesuchverhalten von Männern deutlich von dem der Frauen unterscheidet. Dies ist vermutlich auch einer der Gründe, warum die Teilnehmerrekrutierung in den Online-Selbsthilfeforen für interpersonelle Gewalterfahrungen für eine männliche Stichprobe wenig erfolgreich war. Ebenso muss die Enttabuisierung von Männern als Opfer interpersoneller Gewalt weiter gefördert werden. Auch vor dem Hintergrund, dass diese Studie deutlich auch ein Reviktimisierungsphänomen bei Männern zeigt, sollten Psychotherapeuten beispielsweise bei bereits bekannten interpersonellen Gewalterfahrungen in der Kindheit gezielt nach interpersonellen Gewalterfahrungen im Erwachsenenalter fragen.

Studien zu wiederholen Opfererfahrungen könnten daher von Rekrutierungen in psychotherapeutischen Behandlungssettings profitieren. Hingegen zeigte sich jedoch auch bei dieser Studie, dass die Tätererfahrungen in einem solchen Setting nicht übermäßig stark vertreten sind oder nicht berichtet werden. Hier wäre es vorteilhaft an anderen Stellen Teilnehmer zu rekrutieren, beispielsweise in forensischen Einrichtungen.

Weiterhin ist zu bemerken, dass sich die Forschung zu Viktimisierungserfahrungen bei Männern zwar vermehrt mit möglichen wiederholten Opfererfahrungen beschäftigen sollte, da bislang bei Männern überwiegend Tätererfahrungen untersucht wurden. Es könnte jedoch ebenso wichtig sein, beide Phänomene nicht nur dichotom zu betrachten. Männliche Opfer von Gewalterfahrungen in der Kindheit könnten später sowohl Opfer von erneuten Gewalterfahrungen werden als auch selbst Täter sein. Ein weniger eingeschränkter Blickwinkel an dieser Stelle könnte sowohl bei der Rekrutierung von Probanden als auch bei der Ausweitung der Forschungslage von großer Bedeutung sein.

7.2 Viktimisierungserfahrungen bei Frauen

Auch bei der weiblichen Stichprobe hat diese Forschungsarbeit erneut das Reviktimisierungsphänomen bestätigt. Teilweise zeigten sich hierbei spezifische Zusammenhänge der unterschiedlichen Arten von Gewalterfahrungen untereinander. Körperliche Misshandlung in der Kindheit sagte körperliche Gewalt im Erwachsenenalter voraus. Sexuelle Gewalt im Erwachsenenalter wurde durch sexuellen Missbrauch in der Kindheit und durch körperlichen Missbrauch in der Kindheit vorhergesagt. Emotionale Gewalt im Erwachsenenalter wurde durch emotionalen Missbrauch in der Kindheit und durch sexuellen Missbrauch in der Kindheit vorhergesagt. Auffällig war an der Stelle jedoch

besonders, dass die mediierenden Prozesse zwischen Gewalterfahrungen in der Kindheit und im Erwachsenenalter ähnlich zu verlaufen scheinen. Missbrauchsbezogene Schuld- und Schamgefühle erwiesen sich als konsistenter Mediatoren für alle vier der oben beschriebenen Zusammenhänge. Dies scheint zunächst gegen die Behauptung zu stehen, dass es wichtig ist die einzelnen Arten von Gewalterfahrungen differenziert zu betrachten.

Es ist jedoch zu beachten, dass sich die Effektgröße der Modelle in Abhängigkeit davon änderte, welche spezifische Art von Gewalt in Betracht gezogen wurde. Darüber hinaus zeigte der Zusammenhang zwischen emotionaler Gewalt in der Kindheit und emotionaler Gewalt im Erwachsenenalter eine vollständige Mediation, während die anderen Verbände nur eine teilweise Mediation zeigten. Daher ist eine Unterscheidung zwischen den verschiedenen Prozessen und Arten von Gewalt doch nicht zu vernachlässigen. Zum Beispiel ist es wahrscheinlich, dass es im Prozess der sexuellen Reviktimisierung zusätzlich zu den missbrauchsbezogenen Schuld- und Schamgefühlen andere vermittelnde Variablen gibt, die sich von denjenigen unterscheiden, die am emotionalen oder physischen Reviktimisierungsprozess beteiligt sein können. Es ist auch zu beachten, dass oft mehrere Arten von Gewalt gleichzeitig auftreten. Dies könnte auch die ähnliche Vermittlung der verschiedenen Prozesse beeinflusst haben.

Auch wenn die Rolle der unterschiedlichen Arten von Gewalterfahrungen und ihre Zusammenhänge untereinander somit ein nicht zu vernachlässigendes Thema darstellen, so bestehen die Hauptergebnisse dieser Forschungsarbeit jedoch in der Prominenz von missbrauchsbezogenen Schuld- und Schamgefühlen als vermittelnde Variable. Hierbei ist zu beachten, dass diese Variable nicht nur jeden der gefundenen Zusammenhänge mediierte, sondern auch einen Mediationseffekt aufwies, wenn das Reviktimisierungsphänomen unabhängig von den Arten der Gewalterfahrung betrachtet wurde. Ebenso ist

bemerkenswert, dass missbrauchsbezogene Schuld- und Schamgefühle nicht wie in anderen Studien isoliert betrachtet wurden, sondern ihre Bedeutsamkeit gegen ein Set von sieben anderen möglichen Variablen bewiesen haben. Teilweise zeigten auch andere Variablen isoliert betrachtet einen vermittelnden Effekt. Dieser verlor jedoch jeweils seine Signifikanz, wenn missbrauchsbezogene Schuld- und Schamgefühle mit in das Medikationsmodell aufgenommen wurden. Es liegen somit einige Hinweise dafür vor, dass in der vorliegenden Arbeit eine sehr wichtige Variable beim Reviktimisierungsprozess zu Tage gebracht wurde.

Aus theoretischer Sicht stimmt die starke vermittelnde Rolle von missbrauchsbezogenen Schuld- und Schamgefühlen mit Annahmen aus der Bindungstheorie sowie mit dem Wissen über die Auswirkungen von Misshandlungen auf das Selbstkonzept der Überlebenden überein. In Beziehungen bilden Kinder mentale Repräsentationen auf der Grundlage ihrer Vorgeschichte mit wichtigen Bezugspersonen (Bowlby, 1988). Diese Repräsentationen sind stabile Arbeitsmodell darüber, wie Beziehungen funktionieren. Im Fall von interpersonellen Gewalterfahrungen in der Kindheit können diese Arbeitsmodelle von Beziehungen kognitive Verzerrungen über Macht, Kontrolle, Intimität und Vertrauen beinhalten (Cloitre et al., 1997). Solche Kognitionen und Erfahrungen können die Entwicklung eines negativen Selbstkonzepts begünstigen, das eine subjektive Abwertung der eigenen Person einschließt, einschließlich der Wahrnehmung, dass der Missbrauch mit dem eigenen Selbstbild der Wertlosigkeit übereinstimmt (Peichel, 2007). Ohne Korrektur bleibt dieses Selbstkonzept bis ins Erwachsenenalter stabil, ebenso wie das dysfunktionale Arbeitsmodell von Beziehungen, und beeinflusst die Art und Weise, wie Kinder bestimmte modellkonsistente Interaktionsdynamiken gestalten (Wekerle & Wolfe, 1998). Dies wirkt sich einerseits auf die Wahl ihrer Interaktionspartner aus, wobei sie Partner bevorzugen, die komplementär zu ihrem eigenen negativen Selbstbild sind. Konkret führt ein negatives, selbstabwertendes

Selbstbild dazu, dass bei der Partnerwahl automatisch Partner mit einem ähnlichen biographischen Hintergrund (Sandberg et al., 2016) und mit ähnlich dysfunktionalen Bindungsstilen (Bockers & Knaevelsrud, 2014; Sandberg et al., 2016) gegenüber potentiell fürsorglichen Partnern bevorzugt werden. Darüber hinaus beeinflusst ein negatives Selbstkonzept, wie sich Individuen innerhalb ihrer Beziehungen verhalten. Wenn sie erneut sexueller, körperlicher oder emotionaler Gewalt ausgesetzt sind, könnte ihr negatives Selbstkonzept Selbstvorwürfe und Schamgefühle suggerieren, die eine passivere Rolle beim Umgang mit dem Missbrauch begünstigen würden. Auf diese Weise würde eine sexuell, körperlich oder emotional gewalttätige Person nicht verlassen oder gemieden und die Gewalt erduldet.

In diesen Erklärungsansätzen wird davon ausgegangen, dass missbrauchsbezogene Schuld- und Schamgefühle am besten ein allumfassendes negatives Selbstkonzept einhergehend mit selbstabwertenden Kognitionen und Gefühlen der Wertlosigkeit abbilden, welches sich häufig bei Opfern interpersoneller Gewalterfahrungen in der Kindheit finden lässt. Vor diesem Hintergrund können missbrauchsbezogene Schuld- und Schamgefühle sowohl erklären, warum aus Seiten der Opferperspektive Kontakte zu möglichen Tätern hergestellt werden. Ebenso wird ein Verweilen in dysfunktionalen interpersonellen Beziehungen erklärt, welche andauernde Viktimisierungserfahrungen beinhalten. Der ursprünglichen Idee, dass die psychologischen Prozesse, welche dem Reviktimisierungsphänomen unterliegen besser nachvollzogen werden müssen, wurde somit zu einem großen Teil Rechnung getragen.

7.3 Grenzen und Herausforderungen für die Forschung

Auch wenn die Ergebnisse dieser Promotionsarbeit die Forschungslage erweitern, müssen auch Grenzen der vorliegenden Arbeit benannt werden. Wie bereits bei der männlichen Stichprobe angeführt, wäre es wichtig bei der Forschung nicht nur dichotom erneute Opfer- oder erneute Tätererfahrungen zu untersuchen. Stattdessen erscheint es sinnvoll die Möglichkeit in Betracht zu ziehen, dass Opfer interpersoneller Gewalterfahrungen in der Kindheit später sowohl Opfer als auch Ausüber von Gewalt sein könnten. Bei diesen Überlegungen wäre es ebenso sinnvoll nicht nur bei einer männlichen Stichprobe mögliche Tätererfahrungen zu erfassen, sondern ebenso zu überprüfen, inwiefern sich ein möglicher Opfer-Täter Kreislauf auch bei Frauen zeigt. Im selben Rahmen wären Untersuchungen wünschenswert, inwiefern man unterscheiden kann, wer zu erneuten Opfererfahrungen und wer zu erneuten Tätererfahrungen neigt. Ebenso muss auch hier die Möglichkeit in Betracht gezogen werden, dass Opfer- und Tätererfahrungen gemeinsam vorliegen können. Für die Rekrutierung von Stichproben in welchen Tätererfahrungen genauer untersucht werden sollen, wäre jedoch eine andere Art von Stichprobe als in er vorliegenden Arbeit notwendig, beispielsweise in forensischen Einrichtungen.

Prinzipiell handelt es sich bei der vorliegenden Untersuchung um ein querschnittliches Design. Dies führt dazu, dass Kausalfolgerungen nur mit Vorsicht zu treffen sind. Hier wären zukünftig Daten aus Längsschnitterhebungen wichtig. Vorzugsweise sollten hierbei die unterschiedlichen Entwicklungsabschnitte beobachtet werden. Also sollte eine Untersuchung in der Kindheit starten und beobachten, bei welchen Individuen es im Jugend- und Erwachsenenalter zu erneuten Gewalterfahrungen kommt. Solche Untersuchungen erscheinen aufschlussreicher als die bisher existierenden Längsschnittstudien, welche untersuchen, ob es bspw. bereits im Erwachsenenalter innerhalb eines Jahres zu erneuten

Gewalterfahrungen kommt. Jedoch werden Misshandlungserfahrungen in der Kindheit zu einem großen Teil nicht zu diesem Zeitpunkt schon aufgedeckt, sondern werden später berichtet. Eine solche Stichprobe zu finden und über einen langen Zeitraum zu belgeiten erscheint daher sehr herausfordernd. In den meisten Fällen kommt es jedoch nicht nur zu einer Reviktimisierungserfahrung, sondern es werden Muster entwickelt, welche beispielsweise immer wieder die Wahl ungünstiger Partner favorisieren. Somit kommt es beim Reviktimisierungsphänomen in der Regel zu häufigeren Gewalterfahrungen über die Jahre. Somit wären Längsschnittstudien bereits im Erwachsenenalter durchaus interessant zu beobachten auch im Hinblick auf mögliche erste therapeutische Interventionen bzgl. der unterliegenden Muster.

Zuletzt sollte auch die Variable missbrauchsbezogene Schuld- und Schamgefühle zukünftig genauer betrachtet werden als sie es in der vorliegenden Arbeit als eine von 8 möglichen Variablen wurde. Wie bereits in den Erklärungsansätzen beschrieben zeigen die dort abgefragten Konstrukte Hinweise auf unterliegende negative Selbstkonzepte, welche über den Kontext der expliziten Viktimisierung hinaus wirken. Zukünftige Studien sollten daher darauf aufbauend differenziert das Selbstkonzept der Betroffen erfragen, um die Bezüge von Schuld- und Scham und den Viktimisierungserfahrungen näher zu fassen.

7.4 Nutzen für die wissenschaftliche und psychotherapeutische Arbeit

Zusammenfassend lässt sich sagen, dass die Ergebnisse der vorliegenden Arbeit neuartige und wertvolle Erkenntnisse darstellen. Dem Ziel das Reviktimisierungsphänomen besser zu verstehen, konnte sich deutlich angenähert werden. Es wurde gezeigt, dass die aktuelle Fokussierung der Forschung auf sexuelle Reviktimisierung bei Frauen, das Phänomen aus einem zu engen Blickwinkel betrachtet. Ebenso wichtig ist es, die anderen Formen von

Gewalterfahrungen sowohl in der Kindheit als auch im Erwachsenenalter systematisch mit zu erfassen und hier nicht nur weibliche, sondern auch männliche Stichproben zu untersuchen. Besonders die vermittelnde Rolle von missbrauchsbezogenen Schuld- und Schamgefühlen bietet einen enormen Wissenzuwachs über die bisherige Forschungslage hinaus. Wie zuvor bemängelt sind die dem Reviktimisierungsphänomen unterliegenden Prozesse nicht ausreichend bekannt. Durch die konsistente vermittelnde Rolle dieser Variablen, kann diese Behauptung so nicht mehr bestehen bleiben. Zumindest ein wichtiger Wirkmechanismus kann nun als bekannt vorausgesetzt werden, auch wenn selbstverständlich die Replizierung dieses Befundes noch aussteht. Dies bietet wie oben bereits beschrieben wichtige weitere Ansatzpunkte für die Forschung, jedoch ebenso für die psychotherapeutische Arbeit. Eine klare Empfehlung wäre hier differenziert bei männlichen und weiblichen Patienten die unterschiedlichen Arten von Gewalterfahrungen zu erfassen. Sobald sich Hinweise auf missbrauchsbezogene selbstbeschuldigende Attributionen zeigen, sollte an dieser Stelle klar sein, dass ein erhöhtes Risiko für eine Reviktimisierung besteht. Die diese selbstbeschuldigenden Attributionen müssen im nächsten Schritt therapeutisch bearbeitet und wenn möglich modifiziert werden.

7.5 Weiterentwicklung der psychotherapeutischen Arbeit

An dieser Stelle möchte ich über die wissenschaftliche Lage hinaus noch einmal auf die Beschreibung der psychotherapeutischen Herausforderungen bei den gerade genannten Implikationen eingehen. Dabei ist zu bemerken, dass es sich hierbei um subjektive Einschätzungen aus der eigenen therapeutischen Arbeit handelt. Teilweise sind viele der Ansichten zwar mit praktizierenden Kollegen im Austausch entstanden, eine tatsächliche

wissenschaftliche Fundierung steht jedoch noch aus. In der Forschung hat sich jedoch gezeigt, dass zur Vorhersage oder zur Urteilsbildung bestimmter psychologischer Ereignisse z.B. Straffälligkeit bei Bewährungsauflagen die höhere Genauigkeit bei den Modellen besteht, die klinische und statistische Urteilsbildung in einer Form kombinieren (Grove, Zald, & Lebow, 2000). Dies bedeutet es kommen sowohl statistische Berechnung bestimmter Variablen zum Einsatz aber auch die klinische Einschätzung wird aufgenommen. Daher halte ich es an dieser Stelle für wichtig auf ebendiese klinische Einschätzung zu nennen.

Oben wurde beschrieben, dass missbrauchsbezogene Schuld- und Schamgefühle therapeutisch bearbeitet werden müssen. Hierzu wird bislang in der kognitiven Verhaltenstherapie auf Methoden der kognitiven Umstrukturierung zurückgegriffen (sokratischer Dialog, Perspektivwechsel, „Schuldkuchen"). Insgesamt ist mein Eindruck, dass diese Methoden bzgl. der Hartnäckigkeit des unterliegenden negativen Selbstkonzeptes kaum Wirksamkeit zeigen. Häufig berichten Patientinnen in den Therapien zu diesem Thema folgendes: „Ich habe das schon so oft durchgesprochen, ich weiß vom Kopf her, dass es nicht meine Schuld gewesen ist. Wenn ich mich aber wieder so schlecht fühle, oder ich wieder in einer bestimmten Situation bin, ich mir das nicht zugänglich. Das Wissen hilft nicht dagegen, dass ich genau fühle, dass ich schuldig/schlecht/wertlos bin." Auch darauffolgende Interventionen, welche beispielsweise eine emotionale Beweisführung wie bei der Pat. beschrieben, tangieren, bleiben letztendlich doch eher erfolglos, wenn es um die Modifikation dieser dysfunktionalen Kognition geht.

Dies ist ein Hinweis darauf, dass es sich an dieser Stelle nicht nur um eine alleinstehende Kognition handelt, sondern dass es sich hier um ein unterliegendes Schema handelt. Schema bedeutet eine Verknüpfung mehrerer dysfunktionaler Gedanken (beispielsweise der Wertlosigkeit, Schuld an bestimmten Ereignissen zu haben, beschmutzt zu

sein) mit emotionalen Gefühlszuständen (Trauer, Wut, Verzweiflung). Ebenso sind in diesem Netzwerk einhergehende Körperempfindungen oder bestimmte Situationsmerkmale abgespeichert. Durch Aktivierung einer dieser Komponenten wird das ganze unterliegende Netzwerk aktiviert und Prägen die subjektive Erlebenswelt der Betroffenen sowie ihr Verhalten. Vor diesem Hintergrund sollte man davon ausgehen, dass die abgefragten missbrauchsbezogenen Schuld- und Schamgefühle nur am besten einen Teil dieses umfassenden negativen Selbstkonzeptes abbilden.

Wenn man nun davon ausgeht, dass bei den Betroffenen Personen unterliegende negativ besetze Schemata oder Selbstkonzepte bestehen, ist es auch erklärend, dass Methoden der kognitiven Umstrukturierung wenig wirksam sind. Denn die Betroffenen sind zu dem Zeitpunkt der kognitiven Arbeit normalerweise nicht „schemaaktiviert“ und das Erfassen einer oder zwei dysfunktionaler Kognitionen wie es normalerweise erfolgt, ist nicht ausreichend für das umfassende unterliegende Schema. In der Folge wäre also eine Modifikation der unterliegenden Schemata wichtig und Interventionen müssen im „schemaaktivierten“ Zustand der Betroffenen erfolgen. Es wäre daher sinnvoll bei der Behandlung auch Elemente der Schematherapie mit einfließen zu lassen.

Zusätzlich zu schematherapeutischen Behandlungselementen muss jedoch in jedem Fall auch eine traumafokussierte Behandlung erfolgen. Dadurch kann erreicht werden, dass sich die Betroffenen überhaupt den entsprechend wichtigen Situationen stellen können, welche die Grundlage für schematherapeutische Interventionen darstellen. Hier ist noch ein weiterer Faktor zu bedenken. Und zwar konzentrieren sich traumafokussierte Interventionen in der Regel auf sexuelle oder auch auf physische Gewalterfahrungen, da diese gemäß den Kriterien der PTBS als traumatisch eingeschätzt werden können. Häufig sind es aber gerade die Situationen von emotionaler Gewalt oder Vernachlässigung, welche eng mit der

Entwicklung dysfunktionaler negativer Schemata zusammenhängen. Daher sollten unbedingt auch solchen Erfahrungen ein höheres Maß an Aufmerksamkeit geschenkt werden.

Zusammenfassend auf den Grenzen der bisherigen therapeutischen Interventionen und notwendigen Interventionen würde ich zukünftig für die Opfer von wiederholten interpersonellen Gewalterfahrungen folgendes Behandlungsverfahren vorschlagen, welches selbstverständlich in der Forschung überprüft werden sollte: In einem ersten Behandlungsschritt sollte eine traumafokussiertes Verfahren Anwendung finden. An dieser Stelle wird die Narrative Expositionstherapie (Schauer, Neuner, & Elbert, 2011) empfohlen. Mit diesem Verfahren wird es nämlich ermöglicht traumatische Erfahrungen in ihrer Gesamtheit über die Lebensspanne zu erfassen. Mit einem traumakonfrontativen Narrativ bzgl. der traumatischen Situationen kommt es zu einer Vervollständigung des autobiographischen Gedächtnisses. Die Wirksamkeit der NET in Hinblick auf eine Reduktion von intrusivem Erleben und Belastung von PTBS Symptomatik wurde bereits mehrfach nachgewiesen (Jacob, Wilker & Isele, 2017). Zusätzlich ermöglicht es die Gestaltung der NET jedoch auch, dass auch Situationen emotionaler Gewalt mit in das Narrativ aufgenommen werden. Solche Situationen sind nicht als traumatisch im engen Sinne der Definition einzuordnen. Demnach wäre auch die Empfehlung diese nicht traumakonfrontativ zu bearbeiten aber trotzdem den Betroffenen Raum zu geben darüber zu berichten und diese Erfahrungen so mit in das Narrativ der Lebensgeschichte aufzunehmen. dadurch werden ebenfalls dringend nötige validierende Erfahrungen für die Betroffenen ermöglicht. Nach der Narrativen Expositionstherapie gibt es demnach ein Skript der Lebensgeschichte mit den besonders einschneidenden Erfahrungen emotionaler, physischer und sexueller Gewalt. Der Behandler kann gemeinsam mit dem Patienten in einem nächsten Schritt festlegen, welche diese Situationen als besonders ausschlaggebend in Hinblick auf die Entwicklung der

negativen dysfunktionalen Schemata angesehen werden. Bei diesen Situationen kann im nächsten Schritt zu dem „emotionalen Hotspot“ der entsprechenden Situation zurückgekehrt werden. Mit dem emotionalen Hotsport ist im Unterschied zum traumatischen Hotspot nicht der Punkt des höchsten Arousals/des größten Entsetzen gemeint. Stattdessen soll hier der Punkt gefunden werden, welcher für die betroffene Person als besonders erniedrigend/schamhaft/beschuldigend wahrgenommen wurde. Durch das in der NET erstellte Skript lässt sich zu diesem Punkt in der Imagination zurückkehren und eine Schemaaktivierung des Patienten hervorrufen. An dieser Stelle sollten dann die schematherapeutischen Elemente zur Modifikation des dysfunktionalen Schemas zum Einsatz kommen.

Es wird vermutet, dass durch eine solche Bearbeitung sowohl des traumatischen Erlebens als auch der unterliegenden Schemata der Patient in die Position gebracht wird, welche es ihm ermöglicht sich insgesamt von der Vergangenheit zu lösen und dieser weniger Bedeutsamkeit über das aktuelle Leben zu geben. Dies sollte mit einer Verhaltensänderung gerade im Bereich der interpersonellen Gestaltung einhergehen und somit auch das Reviktimisierungsrisiko reduzieren. Selbstverständlich sollte das oben beschriebene Vorgehen in der Forschung genau konzeptualisiert und mehrfach überprüft werden.

7.6 Ausblick

Zusammenfassend leistet diese Arbeit einen großen Beitrag dazu, das Reviktimisierungsphänomen differenzierter zu betrachten und in der Folge auch die unterliegenden Prozesse besser zu verstehen. Die hier vorgestellten Forschungsbefunde überschreiten die aktuelle Wissenslage deutlich und erweitern sie auch mit Blick auf weitere Forschung bzgl. der Rolle emotionaler Gewalt und männlicher Stichproben an vielen wichtigen

Punkten. Hervorzuheben ist dabei insbesondere, dass diese Arbeit mit dem Ziel erstellt wurde, die dem Reviktimisierungsphänomen unterliegenden Prozesse besser zu verstehen, um somit Behandlungsansätze zielgerichteter zu gestalten. Das Hauptergebnis dieser Arbeit besteht darin, dass eine Variable gefunden wurde, die eine konsistente mediierende Funktion beim Reviktimisierungsprozess einnimmt. Eine Ableitung von zugeschnittenen therapeutischen Interventionen ist somit aus dieser Arbeit direkt möglich. Dies ist ein bemerkenswertes Ergebnis, welches sich selten in so direkter Form nach einer Forschungsarbeit zeigt. Das Hauptergebnis der Arbeit besteht somit in einer therapeutischen Implikation. An dieser Stelle halte ich es für ein weiteren großen Vorteil, dass ich zuletzt bei dieser Arbeit die eigenen intensiven therapeutischen Erfahrungen mit Opfern interpersoneller Gewalt in die Entwicklung eines möglichen therapeutischen Einsatzes einfließen lassen konnte. Die Kombination aus psychologischer Forschung und psychotherapeutischer Erfahrung bereichert diese Arbeit und gibt ihr ein Alleinstellungsmerkmal gegenüber gängigen Forschungsarbeiten.

Auch wenn noch einiges an weiterführender, replizierender Forschung und Konzeptualisierung therapeutischer Interventionen notwendig ist, bietet diese Arbeit eine sehr wichtige Grundlage. Durch das bessere Verständnis der psychologischen unterliegenden Prozesse und Ideen der therapeutischen Modifikationen ist ein Grundstein geschaffen worden zukünftig das Reviktimisierungsphänomen in seinem Ausmaß deutlich abzumildern. Erneute Gewalterfahrungen könnten sogar verhindert werden. Nicht zuletzt kann der zu Anfang geschilderte Leidensdruck von Patientinnen wie Frau X deutlich abgemildert werden und gerade für solche Patientinnen werden neue Perspektiven geschaffen.

8. Literaturverzeichnis

Bagby, R. M., Parker, J. D., & Taylor, G. J. (1994). The twenty-item Toronto Alexithymia Scale—I. Item selection and cross-validation of the factor structure. *Journal of psychosomatic research*, *38*(1), 23-32.

Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. *Educational psychologist*, *28*(2), 117-148.

Barkham, M., Hardy, G. E., & Startup, M. (1996). The IIP-32: A short version of the Inventory of Interpersonal Problems. *British Journal of Clinical Psychology*, *35*(1), 21-35.

Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. *International journal of public health*, *58*(3), 469-483.

Barnes, J. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2009). Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child abuse & neglect*, *33*(7), 412-420.

Bernstein, D. P., & Fink, L. (1998). *Childhood trauma questionnaire: A retrospective self-report: Manual*. Harcourt Brace & Company.

Blom, H., Högberg, U., Olofsson, N. & Danielsson, I. (2014). Strong association between earlier abuse and revictimization in youth. BMC Public Health, 14, 715–725.

Bockers, E., & Knaevelsrud, C. (2011). Reviktimisierung: Ein bio-psycho-soziales Vulnerabilitätsmodell. *PPmP-Psychotherapie Psychosomatik Medizinische Psychologie*, *61*(09/10), 389-397.

Bockers, E., & Knaevelsrud, C. (2014). Sexuelle Reviktimisierung. *Psychotherapie im Dialog, 15*(1), 78-80.

Bockers, E., Roepke, S., Michael, L., Renneberg, B., & Knaevelsrud, C. (2014). Risk recognition, attachment anxiety, self-efficacy, and state dissociation predict revictimization. *PloS one*, *9*(9): e108206. doi:10.1371/journal.pone.0108206

Bornovalova, M. A., Gwadz, M. A., Kahler, C., Aklin, W. M., & Lejuez, C. W. (2008). Sensation seeking and risk-taking propensity as mediators in the relationship between childhood abuse and HIV-related risk behavior. *Child abuse & neglect*, *32*(1), 99-109.

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New York: Basic Books.

Brady, S. S., & Donenberg, G. R. (2006). Mechanisms linking violence exposure to health risk behavior in adolescence: Motivation to cope and sensation seeking. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(6), 673-680.

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child abuse & neglect*, *14*(3), 357-364.

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child abuse & neglect*, *27*(10), 1205-1222

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: a review of the empirical literature. *Trauma, Violence, & Abuse*, *6*(2), 103-129.

Clausen, A. H. & Crittenden, P.M. (1991). Physical and psychological maltreatment: Relations among types of maltreatment. *Child abuse & neglect, 15(1),* 5-18.

Cloitre, M., Tardiff, K., Marzuk, P. M., Leon, A. C., & Portera, L. (1996). Childhood abuseand subsequent sexual assault among female inpatients.Journal of TraumaticStress,9(3), 473-482

Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self-and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress*, *10*(3), 437-452.

Cloitre, M., & Rosenberg, A. (2006). Sexual Revictimization: Risk Factors and Prevention. In V.C. Folette & J.I. Ruzek (Eds.), *Cognitive-behavioral therapies for trauma* (2nd ed., pp. 321-361). New York: The Guilford Press.

Coid, J., Petruckevitch, A., Feder, G., Chung, W. S., Richardson, J., & Moorey, S. (2001). Relation between childhood sexual and physical abuse and risk of revictimization in women: a cross-sectional survey. *The Lancet*, *358*(9280), 450-454.

Cossins, A., & Plummer, M. (2018). Masculinity and sexual abuse: Explaining the transition from victim to offender. *Men and masculinities*, *21*(2), 163-188.

Desai, S., Arias, I., Thompson, M. P., & Basile, K. C. (2002). Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men. *Violence and victims*, *17*(6), 639-653.

Donne, M. D., DeLuca, J., Pleskach, P., Bromson, C., Mosley, M. P., Perez, E. T., ... & Frye, V. (2018). Barriers to and facilitators of help-seeking behavior among men who experience sexual violence. *American journal of men's health*, *12*(2), 189-201.

Downs, W. R. (1993). Developmental considerations for the effects of childhood sexual abuse. *Journal of Interpersonal Violence*, *8*(3), 331-345.

Dutton, D. G., & Hart, S. D. (1992). Evidence for long-term, specific effects of childhood abuse and neglect on criminal behavior in men. *International Journal of Offender Therapy and Comparative Criminology*, *36*(2), 129-137.

Falshaw, L., Browne, K. D., & Hollin, C. R. (1997). Victim to offender: A review.*Aggression and Violent Behavior*, *1*(4), 389-404.

Feiring, C., Simon, V. A., & Cleland, C. M. (2009). Childhood sexual abuse, stigmatization, internalizing symptoms, and the development of sexual difficulties and dating aggression. *Journal of consulting and clinical psychology*, *77*(1), 127.

Giebel, G. (2013). *Partnerpräferenzen von Frauen: Die Rolle männlicher Dominanz* (Doctoraldissertation). Universität Konstanz.

Gratz, K.L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41-54.

Grove, W. M., Zald, D. H., Lebow, B. S., Snitz, B. E. & Nelson, C. (2000). Clinical versus Mechanical Prediction: A MetaAnalysis. Psychological Assessment, 12, 19-30.

Häuser, W., Schmutzer, G., Brähler, E., & Glaesmer, H. (2011). Misshandlungen in Kindheit und Jugend. *Deutsches Ärzteblatt*, *108)1*7), 287-294.

Hinz, A., Schumacher, J., Albani, C., Schmid, G. & Brähler, E. (2006). Bevölkerungsrepräsentative Normierung der Skala zur allgemeinen Selbstwirksamkeitserwartung. *Diagnostica 52 (1),* 26-32.

Heiervang, E., & Goodman, R. (2011). Advantages and limitations of web-based surveys: evidence from a child mental health survey. *Social psychiatry and psychiatric epidemiology*, *46*(1), 69-76.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., &Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*(6), 885-892

Iffland, B., Sansen, L. M., Catani, C., & Neuner, F. (2012). Emotional but not physical maltreatment is independently related to psychopathology in subjects with various degrees of social anxiety: a web-based internet survey. *BMC psychiatry*,*12*(1), 49-57.

Jacob, N., Wilker, S., & Isele, D. (2017). Narrative Expositionstherapie zur Behandlung von Traumafolgestörungen. *Swiss Archives of Neurology, Psychiatry and Psychotherapy*, *168*(04), 99-106.

Jerusalem, M., & Schwarzer, R. (1999). Skala zur allgemeinen Selbstwirksamkeitserwartung. *Skalen zur Erfassung von Lehrer-und Schülermerkmalen. Dokumentation der psychometrischen Verfahren im Rahmen der Wissenschaftlichen Begleitung des Modellversuchs Selbstwirksame Schulen. Berlin: Freie Universität Berlin*.

Katz, J., May, P., Sörensen, S., & DelTosta, J. (2010). Sexual revictimization during women's first year of college: Self-blame and sexual refusal assertiveness as possible mechanisms. *Journal of Interpersonal Violence*, *25*(11), 2113-2126.

Klinitzke, G., Romppel, M., Häuser, W., Brähler, E.&Glaesmer, H. (2012). Die deutsche Version des Childhood Trauma Questionnaire (CTQ)–psychometrische Eigenschaften in einer bevölkerungsrepräsentativen Stichprobe. *Psychotherapie, Psychosomatik, medizinische Psychologie*, *62*(2), 47-51.

Krahé, B.& Berger, A. (2014). Potsdamer Skalen zur Erfassung sexueller Aggression und Viktimisierung (Sex_Agg_Vik). In B. Strauß, E. Brähler& D. Richter (Hrsg.), *Sexualwissenschaftliche Testverfahren* (S. 162-167). Göttingen: Hogrefe.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, *16*(9), 606-613.

Lambie, I., Seymour, F., Lee, A., & Adams, P. (2002). Resiliency in the victim–offender cycle in male sexual abuse. *Sexual Abuse: A Journal of Research and Treatment*, *14*(1), 31-48.

Langer, L., & Catani, C. (2016). Kindesmissbrauch und Reviktimisierung: Die Bedeutung unterschiedlicher Gewalttypen. *Zeitschrift für Klinische Psychologie und Psychotherapie*, *45*(4), 279-289.

Langer, L., & Neuner, F., (2021a). Revictimization and the Specifity Hypothesis-Do Different Subtypes of Interpersonal Violence Predict each other? Manuscript submitted for publication.

Langer, L., & Neuner, F., (2021b). The Mediating Processes of Revictimization after Child Abuse in a sample of Adult Women. *Journal of Family Trauma, Child Custody & Child Development*, 1-22.

Lansford, J. E., Miller-Johnson, S., Berlin, L. J., Dodge, K. A., Bates, J. E., & Pettit, G. S. (2007). Early physical abuse and later violent delinquency: A prospective longitudinal study. *Child maltreatment*, *12*(3), 233-245.

Livingston, J. A., Testa, M., & VanZile-Tamsen, C. (2007). The reciprocal relationship between sexual victimization and sexual assertiveness. *Violence Against Women*, *13*(3), 298-313.

Löwe, B. L. S. R., Spitzer, R. L., Zipfel, S., & Herzog, W. (2002). Gesundheitsfragebogen für Patienten (PHQ-D). *Komplettversion und Kurzform. Testmappe mit Manual, Fragebögen, Schablonen*, *2*, 5-7.

Ma, X. (2001). Bullying and being bullied: To what extent are bullies also victims? *American Educational Research Journal*, *38*(2), 351-370.

McGee, Z. T., Davis, B. L., Brisbane, T., & Collins, N. (2001). Urban stress and mental health among African-American youth: Assessing the link between exposure to violence, problem behavior, and coping strategies. *Journal of cultural diversity*, *8*(3), 94.

Merrill, L. L., Newell, C. E., Thomsen, C. J., Gold, S. R., Milner, J. S., Koss, M. P. et al. (1999). Childhood abuse and sexual revictimization in a female Navy recruit sample. *Journal of Traumatic Stress, 12*, 211–225.

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women: An empirical review and theoretical reformulation. *Clinical psychology review*, *23*(4), 537-571.

Messman-Moore, T. L., Coates, A. A., Gaffey, K. J., & Johnson, C. F. (2008). Sexuality, substance use, and susceptibility to victimization: Risk for rape and sexual coercion in a prospective study of college women. *Journal of interpersonal violence*, *23*(12), 1730-1746.

Messmann-Moore, T. L., Walsh, K. L. & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child abuse & neglect, 34,* 967–976.

Morokoff, P. J., Quina, K., Harlow, L. L., Whitmire, L., Grimley, D. M., Gibson, P. R., & Burkholder, G. J. (1997). Sexual Assertiveness Scale (SAS) for women: development and validation. *Journal of personality and social psychology*, *73*(4), 790-804.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child abuse & neglect*, *20*(1), 7-21.

Noll, J. G., Trickett, P. K., & Putnam, F. W. (2000). Social network constellation and sexuality of sexually abused and comparison girls in childhood and adolescence. *Child maltreatment*, *5*(4), 323-337.

Peichl, J. (2007). *Innere Kinder, Täter, Helfer und Co: Ego-State-Therapie des traumatisierten Selbst* (Vol. 202). Klett-Cotta.

Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior research methods*, *40*(3), 879-891.

Prins, A., Ouimette, P., Kimerling, R., Camerond, R. P., Hugelshofer, D. S., Shaw-Hegwer, … Sheikh, J. I. (2003). The primary care PTSD screen (PC PTSD): development and operating characteristics. *Primary Care Psychiatry*, *9*(1), 9-14.

Renner, L. M., & Slack, K. S. (2006). Intimate partner violence and child maltreatment: Understanding intra-and intergenerational connections. *Child abuse & neglect*, *30*(6), 599-617.

Sandberg, D. A., Valdez, C. E., Engle, J. L., & Menghrajani, E. (2016). Attachment Anxiety as a Risk Factor for Subsequent Intimate Partner Violence Victimization A 6-Month Prospective Study Among College Women. *Journal of interpersonal violence*, doi:0886260516651314.

Schauer, M., Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders*. Hogrefe Publishing.

Schlack, R., Rüdel, J., Karger, A. &Hölling, H. (2013). Körperliche und physische Gewalterfahrungen in der deutschen Erwachsenenbevölkerung. *Bundesgesundheitsblatt 56,* 755-764.

Schmidt, S., Strauß, B., Höger, D., & Brähler, E. (2004). Die adult attachmentscale (AAS)-teststatistische Pruefung und Normierung der deutschen Version. *PPmP-Psychotherapie· Psychosomatik· Medizinische Psychologie*, *54*(09/10), 375-382.

Schumacher, J., Hinz, A., & Brähler, E. (2002). Zur Validität retrospektiver Datenerhebungen - Das elterliche Erziehungsverhalten in der Erinnerung junger Erwachsener und ihrer Eltern im Vergleich. *Zeitschrift für Differentielle und Diagnostische Psychologie*, *23*(4), 459-474.

Smith, L. S., & Stover, C. S. (2015). The moderating role of attachment on the relationship between history of trauma and intimate partner violence victimization. *Violence against women*, 1077801215610863.

Snyder, J. K., Fessler, D. M., Tiokhin, L., Frederick, D. A., Lee, S. W., & Navarrete, C. D. (2011). Trade-offs in a dangerous world: Women's fear of crime predicts preferences for aggressive and formidable mates. *Evolution and Human Behavior*, *32*(2), 127-137.

Thomas, T. A., & Fremouw, W. (2009). Moderating variables of the sexual "victim to offender cycle" in males. *Aggression and Violent Behavior*, *14*(5), 382-387.

Tourigny, M., Hébert, M., Joly, J., Cyr, M., & Baril, K. (2008). Prevalence and co-occurrence of violence against children in the Quebec population. *Australian and New Zealand journal of public health*, *32*(4), 331-335.

Walker, E. A., Gelfand, A., Katon, W. J., Koss, M. P., Von Korff, M., Bernstein, D.& Russo, J. (1999). Adult health status of women with histories of childhood abuse and neglect. *The American journal of medicine*, *107*(4), 332-339.

Weiss, K. G. (2010). Male sexual victimization: Examining men's experiences of rape and sexual assault. *Men and Masculinities*, *12*(3), 275-298.

Wekerle, C., & Wolfe, D. A. (1998). The role of child maltreatment and attachment style in adolescent relationship violence. *Development and psychopathology*, *10*(3), 571-586.

Widom, C. S., Czaja, S. J., & Dutton, M. A. (2008). Childhood victimization and lifetime revictimization. *Child abuse & neglect*, *32*(8), 785-796.

Wingenfeld, K., Spitzer, C., Mensebach, C., Grabe, H. J., Hill, A., Gast, U., & Driessen, M. (2010). Die deutsche Version des Childhood Trauma Questionnaire (CTQ): Erste Befunde zu den psychometrischen Kennwerten. *PPmP-Psychotherapie· Psychosomatik· Medizinische Psychologie*, *60*(11), 442-450.