Psychosocial variables and PTSD following violence against women: An extension of Ullman et al.’s (2007) model

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Recommended Citation
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Abstract
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Degree Type
Thesis

Degree Name
Master of Science in Clinical Psychology (MSCP)

Committee Chair
Lisa R. Christiansen, PsyD

Subject Categories
Psychiatry and Psychology

Comments
Library Use: LIH

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PSYCHOSOCIAL VARIABLES AND PTSD FOLLOWING VIOLENCE AGAINST WOMEN:
AN EXTENSION OF ULLMAN ET AL. 'S (2007) MODEL

A THESIS
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY
HILLSBORO, OREGON

BY
ERIN MCCUTCHEON

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

JULY, 25 2011

APPROVED:

Lisa R. Christiansen, PsyD
Abstract

This literature review evaluates the utility of using Ullman et al.’s (2007) model for psychosocial variables and PTSD in victims of sexual assault within a larger population of violence against women. This review evaluates the relationship between PTSD and global support, self-blame, assault severity, negative social reactions and avoidance coping in victims of child physical and sexual abuse, intimate partner violence and stalking. Overall, the articles described in this review supported the use of Ullman et al.’s model with other forms of violence against women.

Key Words: Post-traumatic Stress Disorder, violence against women, psychosocial variables
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>i</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Rationale for Review</td>
<td>1</td>
</tr>
<tr>
<td>Definitions</td>
<td>1</td>
</tr>
<tr>
<td>Theoretical Model</td>
<td>3</td>
</tr>
<tr>
<td>Procedure and Outline</td>
<td>7</td>
</tr>
<tr>
<td>ASSAULT SEVERITY</td>
<td>8</td>
</tr>
<tr>
<td>SOCIAL SUPPORT</td>
<td>13</td>
</tr>
<tr>
<td>NEGATIVE SOCIAL REACTIONS</td>
<td>18</td>
</tr>
<tr>
<td>SELF-BLAME</td>
<td>21</td>
</tr>
<tr>
<td>AVOIDANCE COPING</td>
<td>26</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>33</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>40</td>
</tr>
</tbody>
</table>
I’d like to thank my parents, who have always encouraged me to succeed in all areas of life, as well as my sisters and nieces for their understanding and love throughout the writing of this thesis. I’d also like to thank Lisa Christianson for her patience, hard work and support. Finally I’d like to thank Niles who has helped me in every way throughout the process- I couldn’t have done it without you.
Psychosocial Variables and PTSD following Violence against Women: Extension of Ullman et al.’s (2007) Model

**Rationale for Review**

Violence against women (VAW) is a widespread societal issue. Conservative estimates show that 50% of women will be victims of child sexual assault, adult sexual assault, intimate partner violence or sexual harassment in their lives (Erdreich, Slavet, & Amador, 1995). Although men and women have been shown to experience similar amounts of traumatic experiences in their lives, women more often experience traumas by a person on whom the victim is dependent (DePrince & Freyd, 2002). Women also experience rape more often, which has been shown to be the highest conditional risk for the development of Post-Traumatic Stress Disorder (PTSD) in both men and women (Norris, Foster & Weishaar, 2003). Thus, since women appear twice as likely as men to meet all PTSD symptoms (Norris, Foster & Weishaar, 2003; Cortina & Pimlott, 2005) regardless of experiencing similar numbers of traumas (Kimerling et al., 2002) it is highly important to understand what factors mediate and moderate the development of PTSD in women following trauma.

**Definitions**

The current Diagnostic and Statistical Manual (DSM-IV-TR) describes PTSD as resulting from a traumatic event in which the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury to the
self or others, to which the person responded with intense fear, horror, or helplessness (American Psychiatric Association, 2000). To meet criteria for the diagnosis, the person must subsequently re-experience the traumatic event in some way (i.e., thoughts, dreams, or flashbacks), or persistently avoid stimuli associated with the trauma (i.e., avoiding discussing the trauma, forgetting important aspects of the trauma, or isolating from others). Persons with PTSD also experience increased arousal (i.e., hypervigilence, exaggerated startle response, or difficulty sleeping). These disturbances must last longer than one month, and must cause significant distress (American Psychiatric Association, 2000).

VAW has been defined in many different ways. The Task Force on Male Violence Against Women of the American Psychological Association defined it as “physical, visual, verbal, or sexual acts that are experienced by a woman or girl as a threat, invasion, or assault and that have the effect of hurting or degrading her and/or taking away her ability to control contact (intimate or otherwise) with another individual” (Koss et al., 1994, p. xvi). When viewed through the criminal code, the code by which events are defined as a crime in our legal system, VAW includes only acts of overt violence, but when it is viewed through public health forums it includes psychological abuse and stalking (Kilpatrick, 2004). Still others have argued that a new term, violence and abuse against women, should include stalking and psychological and emotional abuse while VAW should be restricted to just the threat or completion of physical or sexual violence (Saltzman, Fanslow, McMahon, & Shelley, 2002). It has also been proposed that prostitution be included under the umbrella of VAW (Farley, Barai, Kiremire, & Sezgiin,
1998; Jeffreys, 1997). However, while it is acknowledged that prostitution puts women at an increased risk of sexual and physical violence (Farley et al., 1998), this review will not include prostitution in its definition of VAW given the paucity of previous empirical support for its inclusion. Pimlott-Kubiak and Cortina (2003) found that it is difficult to tease apart emotional abuse especially from adult physical abuse as they are so commonly co-occurring. They concluded that parsing out emotional abuse would fail to capture the reality that this abuse is most commonly experienced concurrent to physical abuse. Thus, this review will not focus specifically on emotional abuse, but will remain cognizant that for women who have been physically abused in adulthood it may play a part in their outcomes. Adult physical abuse will be limited to intimate partner violence given that this is the most researched form of physical violence against women in the U.S. For the purpose of this literature review, VAW will be defined as female experience of child and adult sexual abuse or assault, child physical abuse, intimate partner violence, and stalking.

A Theoretical Model

Ullman, Townsend, Filipas, & Starzynski (2007) developed a model of the relationships between assault severity, social support, avoidance coping, and self-blame for female sexual assault survivors. They proposed two models that encompassed these factors and their relation to PTSD. In their original model they proposed that global support was a control variable. Specifically, this model hypothesized that as global support decreases and assault severity and negative social reactions increase, PTSD
symptoms would increase. Their alternative model suggested that global support is
directly related to negative social reactions, avoidance coping, and self-blame. This
model refined global support as central in affecting assault specific reactions from
victims, instead of simply as a control variable.

To test their proposed models, Ullman et al. (2007) conducted a study in which
female sexual assault survivors were recruited through flyers, mental health agencies, and
rape crisis centers in the Chicago metro area to complete a mail survey. The survey asked
about demographics, background, history of trauma, coping, social reactions,
psychological functioning and substance use. The participants were aged 18 to 71, and
slightly more than half the participants identified as an ethnic minority. In order to judge
assault characteristics, a modified version of the Sexual Experiences Survey (Koss,
Gidycz, & Wisniewski, 1985) was used. To assess for global support, the Social
Activities Questionnaire of the Rand Health Insurance Experiment (Donald & Ware,
1984) was used. Negative social reactions were assessed using the Social Reactions
Questionnaire (Ullman, 2000), and blame was gauged using the Rape Attribution
Questionnaire (Frazier, 2003) and the Brief Coping Orientations to Problematic
Experiences Scale (Brief COPE; Carver, Scheier, & Weintraub, 1989). Avoidance coping
was also evaluated using the Brief COPE. PTSD symptoms were measured using the
Posttraumatic Stress Diagnostic Scale (Foa, 1995). Structural equation modeling was then
used to examine the relationships between variables, and their fit to the model. The
findings suggested that social reactions and avoidance coping had the strongest
correlations with PTSD symptoms, and that negative social reactions served to increase
both self-blame and PTSD symptoms. In terms of global social support they found that higher degrees of global social support were actually related to more PTSD symptoms which was contrary to their hypothesis regarding this construct. They also found that their second, alternate model had better goodness of fit and so this literature review will focus on the relationships described in this second model (See Ullman et al., 2007, pg. 27).

While Ullman et al.’s model is well designed for survivors of sexual assault; it does not take into account other acts of VAW.

Saunders (2003) stated that focusing research on the impact of one form of violence in childhood abuse (i.e., sexual assault, witnessing violence, or physical assault) instead of focusing on the impact of multiple traumas is not particularly generalizable given that most victims of childhood abuse have experienced multiple forms of trauma. Victims of VAW also typically experience multiple traumas (Kilpatrick, Resnick, Saunders, & Best, 1998; Monnier, Resnick, Kilpatrick, & Seals, 2002). Campbell Greeson, & Bybee (2008) found that in a sample of 298 women seen at a Midwestern VA hospital, 26% had experienced both child sexual assault and adult sexual assault, 49% had experienced both child sexual assault and intimate partner violence, 48% had experienced both child sexual assault and sexual harassment, 32% had experienced both adult sexual assault and intimate partner violence, 32% had experienced both adult sexual assault and sexual harassment, and 59% had experienced both intimate partner violence and sexual harassment. Since many female victims tend to be re-victimized, it is important to understand the impacts of multiple forms of trauma on PTSD and its mediating and moderating factors. This review of the literature will serve to investigate
how other forms of VAW fit or fail to fit with Ullman et al.’s model. Given that similar psychological outcomes have been found to result from the major forms of interpersonal violence (Briere & Jordan, 2011), it is posited that the literature will support that different forms of VAW fit into Ullman et al.’s (2007) model.

This review will focus on the relationships of global support, self-blame, assault severity, negative social reactions, and avoidance coping with PTSD in victims of VAW. Specifically, Ullman et al.’s (2007) model will be related to child sexual assault, child physical abuse, intimate partner violence, and stalking. Adult sexual assault will not be included in this review because Ullman et al. (2007) already reviewed the research on this population in relation to the model, and found the model to be a good fit for these women.

**Procedure and Outline**

This review will cover articles, book chapters, and books primarily written since 1995. This search will provide an up-to-date review of current literature, but will include older publications if no recent publications can be found. The articles utilized were found using PsychInfo, APA Collections (E-Books), Annual Review of Clinical Psychology, Annual Review of Psychology and Google Scholar. Key phrases including “PTSD,” “intimate partner violence,” “child sexual abuse,” “child physical abuse,” “stalking,” “assault severity,” “social support,” “social reactions,” “negative social reactions,” “blame,” “self-blame,” “coping,” and “avoidance coping” were used.
This literature review will be structured into five sections covering the five psychosocial variables identified by Ullman et al. (2007) to be related to sexual assault and PTSD symptomatology. Each psychosocial variable (i.e., assault severity) will then be assessed in relation to the victims of child sexual assault, child physical abuse, intimate partner violence, and stalking. If no literature was found in relation to one of the forms of VAW, than this form will not be discussed. Following these five subsections a discussion and overview of other forms of VAW’s fit into Ullman et al.’s model will be evaluated and directions for further research will be discussed.

Assault Severity

The relationship between assault severity (frequency of violence, degree of offender violence, physical injury, or severity of sexual victimization) and PTSD has been a focus of some discrepancy within the literature (Astin, Lawrence, & Foy, 1993; Dunmore, Clark, & Ehlers 1999; Filipas & Ullman, 2006; Fortier, DiLillo, Messman-Moore, Peugh, DeNardi, & Gaffey, 2009; Kemp, Green, Hovanitz, & Rawlings, 1995; Kamphuis, Emmelkamp, & Bartak, 2003; Kushner, Riggs, Foa, & Miller, 1993; Ullman et al., 2007). Some studies have found that it is not the severity of the assault that is related to PTSD symptomatology, but the perception of controllability (Kushner, Riggs, Foa, & Miller, 1993). However, Ullman et al. (2007) found that assault severity was significantly linked to PTSD symptomatology in female victims of sexual assault, and included this psychosocial variable in their model. As such, the relationship between assault severity and PTSD in other victims of VAW should be considered to see if other
forms of VAW fit into Ullman’s conceptualization of this relationship. Studies describing this relationship in victims of child sexual assault, intimate partner violence and stalking will be reviewed.

Both Fortier et al. (2009) and Filipas and Ullman (2006) have evaluated the relationship between assault severity and PTSD in victims of child sexual assault. In their sample of 577 college students, Filipas and Ullman assessed the impact of assault severity and PTSD following child sexual assault. In order to assess PTSD symptomatology, the authors utilized Foa’s (1995) Posttraumatic Stress Diagnostic scale and to assess for assault severity they employed a child sexual assault questionnaire created by Banyard, Arnold, and Smith (2000; adapted from Finkelhor, 1979). They found that child sexual assault severity was significantly related to PTSD severity (p<.01) in that when assault severity increased so did symptoms of PTSD. Fortier et al. (2009) used a similar sample, 99 college women, but used different measures. To assess for child sexual assault severity, they used the Computer Assisted Maltreatment Inventory (DiLillio et al., 2009) which gives both a dichotomous score, whether or not the person has experienced child sexual assault, as well as a severity index. In order to assess trauma symptoms, this study used the Trauma Symptom Checklist-40 (Briere & Runtz, 1989). Despite using different measures this study also found that child sexual assault severity was significantly (p<.01) related to trauma symptoms. Thus, both studies found that when assault severity went up, so did trauma symptoms for victims of child sexual assault. Both of these studies use historical data that asked college students to recall details about their childhood abuse or assault. So, even though their results are encouraging, it is
important to be aware that the child sexual assault severity scores may be inaccurate given that they are based on the victim’s historical memory of the assault. This reliance on memory may skew the correlations found between assault severity and PTSD symptomatology. However, despite their limitations, these studies do provide further evidence for child sexual assault’s fit with Ullman et al.’s Model.

In regards to intimate partner violence, several studies have addressed the relationship between assault severity and PTSD symptomatology (Astin et al., 1993; Dunmore et al., 1999; Kemp et al., 1995). Astin et al. (1993) looked at a sample of 53 battered women from three Los Angeles shelters and a counseling center for battered women. While they did not specifically address assault severity, the authors did assess the severity of exposure to violence within intimate partner violence. Exposure to violence in this study was an assessment of the number of times the woman experienced violence and did not include a measure of how severe that violence was. PTSD symptomatology was evaluated using the PTSD Symptom Checklist (Foy, Sipprelle, Rueger, & Carroll, 1984) as well as the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979), and exposure to violence was studied using Form N of the Conflict Tactics Scale (Straus, 1979). The authors found that the severity of exposure to violence in the battering relationship was positively correlated PTSD symptomatology. Thus when women were more exposed to violence in their abusive relationships, they were more likely to exhibit more severe symptoms of PTSD. In a study which addressed assault severity more specifically, Kemp et al. (1995) considered a sample of 179 battered women drawn from shelters, battered women’s support groups, therapist referrals, and
newspaper advertisements. They also included a control sample of 48 non-battered women who had experienced verbal, but not physical abuse. Participants were evaluated for PTSD based on the Mississippi Scale for PTSD (Fairbank, n.d.) and the PTSD Self-Report Scale (Kemp, Rawlings, & Green, 1991). Physical abuse and verbal abuse characteristics and severity were measured by a later version of the Conflict Tactics Scale (Straus, 1990). The authors ascertained that greater injury, threat, and forced sex (their conceptualization of assault severity) were reported more often in those people who qualified for a diagnosis of PTSD than in those who did not meet criteria. Hence, they found a significant relationship between assault severity and PTSD symptomatology in their sample of intimate partner violence victims. Dunmore et al. (1999) also looked specifically at assault severity using a semi-structured interview designed for the study, but they did not find that it was specifically linked to PTSD symptomatology. PTSD symptomatology was assessed using the PTSD Symptom Scale: Self Report Version (Foa, Riggs, Dancu, & Rothbaum, 1993). The authors utilized a sample of 92 assault victims, one month following their assault, which was split into a no-PTSD and a PTSD group based on their PTSD Symptom Scale scores. Dunmore and colleagues found that there were no significant differences between groups in terms of assault severity. The only item that was more commonly endorsed by the PTSD group was one that assessed whether or not the victim had been hit by the assailant. Thus, this study did not find a significant correlation between assault severity and PTSD, except for in the case of having been hit. These three studies, taken together, suggest a need for further research to be done before assuming that intimate partner violence will fit into Ullman et al.’s (2007)
conceptualization of assault severity and PTSD. The fact that these studies conceptualized assault severity by utilizing completely different measures from each other, and different ones from those employed by Ullman et al. could mean that they are tapping into different constructs. Their mixed findings, that victims of intimate partner violence may or may not experience increased PTSD symptomatology following more severe assaults, could result from errors in construct validity.

Kamphuis, Emmelkamp, and Bartak’s (2003) study looked at the severity of stalking in relation to PTSD symptomatology. Their sample of 131 female members of a Dutch support group was used to assess the relationship between stalking severity and PTSD symptomatology. To quantify PTSD symptoms and stalking severity the authors used the Impact of Events Scale (Brom & Kleber, 1985) and a stalking inventory developed specifically for use in this study, which evaluated general demographic information about the victim and stalker, as well as the duration of stalking, respectively. The authors found that all indices of stalking severity were significantly correlated with PTSD symptomatology. Stalking violence was shown to be the most highly correlated stalking severity index. The results of this study provide preliminary support for stalking victim’s inclusion in Ullman et al.’s (2007) model, at least in terms of assault severity and PTSD.

Overall, the literature on the relationship between assault severity and PTSD in other forms of VAW has been variable (Astin et al., 1993; Dunmore et al., 1999; Filipas & Ullman, 2006; Fortier et al, 2009; Kemp et al., 1995; Kamphuis et al., 2003; Kushncer,
Riggs, Foa, & Miller, 1993; Ullman et al., 2007). No studies were found addressing this relationship in victims of child physical assault and there were limitations to the studies found on child sexual assault. Also, one of the studies regarding intimate partner violence stated that there was no relationship between assault severity and PTSD (Dunmore et al., 1999). These limitations and discrepancies do not necessarily mean that other forms of VAW will not fit into Ullman et al.’s (2007) conceptualization of assault severity and PTSD, but they do leave further questions to be addressed. Future research should further address the appropriateness and accuracy of using college age women to assess for child sexual assault severity. Further exploration of what measures are most appropriate to assess assault severity is also needed, both within the context of VAW but also within the population at large.

**Global Social Support**

Global social support can be conceptualized as the help given to individuals who are coping with stressful life events (Thoits, 1986). Ullman et al. (2007) expanded on that idea by including the “number of confidants women have, the frequency of their contact, and how they perceive themselves as getting along with others” (pg. 25) in their definition of social support. Although Ullman et al. found that increased social support was related to increased PTSD symptomatology in victims of sexual assault the literature on VAW in general has not supported this. Lack of social support has been shown to be related to distress and psychopathology (Sandler, Wolchik, MacKinnon, Ayers, & Roosa,
1997) and VAW may lead to loss of social resources (Hobfoll, 1991). In their review, Kessler, Price, and Wortman (1985) found that women may be especially impacted by social support given that they provide and receive more social support than men. As such, the effects of social support on psychological distress might be magnified for women as compared to their male counterparts. Thus, women experiencing VAW who are at a greater risk of losing social support following trauma may also be more vulnerable to the distress of this loss than men.

The effect of social support on PTSD symptomatology has been evaluated in both military and civilian studies. In military populations, lower amounts of unit support and post deployment social support have been associated with increased PTSD symptoms (Peitrzak et al., 2010). In terms of civilian populations, Scarpa, Haden, and Hurley (2006) looked at a sample of individuals who had experienced community violence. They found that high levels of perceived family and friend support predicted decreased PTSD scores. These findings support the theory that lack of social support is related to increased PTSD symptoms, which is contrary to Ullman et al.’s findings. For further understanding of how the different forms of VAW fit into Ullman’s model of social support and PTSD, studies looking at this relationship with child sexual assault, child physical assault, intimate partner violence and stalking will be reviewed.

Children who have been sexually assaulted may experience a double-edged sword following sexual assault; they can lose social support resources following their abuse, and this lack of social support can make them more vulnerable to distressing symptoms.
(Hyman, Gold, & Cott, 2003; Schumm, Hobvoll, & Kroegh, 2004; Tremblay, Herbert, & Piche, 1999). Schumm et al. (2004) evaluated 105 women from outpatient community and drug treatment centers in a Midwestern city, 49% of which had experienced either child physical assault or child sexual assault. They found that child sexual assault, but not child physical assault, was significantly related to interpersonal resource loss, or loss of social support, and that this loss of support was significantly related to increased PTSD symptoms. Further, Tremblay et al. (1999) evaluated the relationship between social support and negative outcomes (low self-worth, internalizing behaviors and externalizing behaviors) for 50 children (11 boys and 39 girls) who were referred to a child protection hospital in Montreal. All children reported sexual abuse, and their ages ranged from 7 to 12 years old. In order to assess children’s outcomes as well as their levels of social support, they were given the Child Behavior Checklist (CBCL; Achenbach, 1991), the global self-worth scale of the Perceived Competence Scale for Children (Harter, 1985), the Self-Report Coping Scale (Causey & Dubow, 1992), the Perceived Social Support Scale (Harter, 1985) and the History of Victimization form (Parent & Hérbert, 1995). In terms of social support, the authors aimed to evaluate the impact of perceived social support on internalizing and externalizing symptoms as well as self-worth ratings. Their evaluation of social support focused on support in general and not on assault-specific support. They found that more support from parents was related to both decreased externalizing behaviors and increased global self-worth. They did not find a significant relationship between peer support and any outcomes, possibly due to this group’s reliance on parents as their main source of support. These results illustrate how failing to have
positive supportive relationships can put children at a greater risk of experiencing negative sequelae following sexual assault. Although this does not fit with Ullman’s model, these results do fit with general findings in social support research both with adults (Sandler et al., 1997) as well as with children (Dubow & Tisak, 1989).

Coker et al. (2002) evaluated the relationship between social support and poor perceived mental health, specifically including PTSD symptomatology in female victims of intimate partner violence. The participants were 1,152 women seeking medical care in two family practice clinics associated with a university. Women were screened for intimate partner violence in-clinic and then were given 30-45 minute telephone interviews which assessed for physical and sexual intimate partner violence, psychological intimate partner violence, demographics, mental health, and social support. Social support was evaluated using the Social Support Questionnaire-Short Form (Sarason, Shearin, Pierce & Sarason, 1987) which measures women’s perceptions about whether or not they have someone they can count on. Women were also asked how frequently their friends, family members or current partners gave them support and were asked how often they talked with others about their abuse. Results indicated that women who had higher levels of social support were both less likely to experience poor mental health and to have fewer PTSD symptoms than women reporting lower levels of social support. Additionally, women who felt that their friends were “always supportive” were less likely to report poor mental health or PTSD symptoms. These results show the importance of social support in women experiencing intimate partner violence, and its possible buffering effects against PTSD symptomatology as well as poor mental health in
general. This does not fit with Ullman’s model, though it is consistent with previous social support research.

Very little research has been done regarding the psychological effects of stalking in relation to social support. One study, however, found that there was no association between social support and post-traumatic stress in victims of stalking (Kamphius et al., 2003). This study used a sample of 131 female stalking victims from the “Stichting Anti-Stalking” survey (StAS; Anti-Stalking Foundation) who were compared to a normal control group consisting of undergraduate female psychology students, 119 of which had experienced violence in the past and 42 of which had never experienced violence. Social support was measured using the Social Support Inventory (Timmerman, Emanuels-Zuurveen, & Emmelkamp, 2000) and PTSD was measured using a Dutch adaptation of the Impact of Events Scale (Brom & Kleber, 1985; Horowitz, Wilner, & Alvaraz, 1979). They did not find a significant relationship between scores on these measures, thus they did not find a significant relationship between social support and PTSD symptomatology. These results might mean that stalking does not fit into Ullman et al.’s (2007) model as they found a significant positive relationship between social support and PTSD symptoms. However, more studies should be done before it is concluded that stalking does not fit into Ullman’s conceptualization of the relationship between social support and posttraumatic stress symptoms.

The literature on the relationship between social support and PTSD in victims of VAW, as a whole, has some flaws that that should be considered. In terms of what
“social support” means, different studies conceptualize this construct differently, and use different measures to address it. To really understand the relationship between social support and PTSD in women, authors of various studies need to agree upon a definition of social support. In regards to children, samples used in studies about social support may be inaccurate given that child abuse (both physical and sexual) often goes unreported. Thus, this sample may not be an accurate representation of the population of childhood victims. It is possible that children with more social support are more likely to have their abuse reported by those from whom they are receiving social support. Children without social support may be without an advocate, and thus may not be incorporated into the participant pool of various studies. Finally, the paucity of research on stalking and social support is a limitation of the literature on this topic. Overall, given the research available, all the types of VAW, except stalking, showed a negative relationship between PTSD and social support. This brings up some questions as to whether VAW could fit into Ullman’s conceptualization of social support and PTSD. However, these relationships might need to be tested in more cross-sectional designs as Ullman et al. hypothesized that their findings about this relationship might be the result of highly symptomatic people seeking more social support. This discrepancy will be further addressed in the discussion section.

**Negative Social Reactions**

While women may experience a great amount of social support following a trauma, they can also encounter negative social reactions to their trauma. Many types of VAW have been underreported and stigmatized which might cause some of these
victims’ social networks to respond in ways that are unsupportive. When a victim feels that she is not believed, blamed for the assault, or treated differently because of it there can be an increase in psychological distress (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001).

The literature, reviewed above, found that women were more greatly affected by their social support networks than men (Kessler, Price, & Wortman, 1985). Given that negative social reactions fit into the construct of social support, it is possible that women are also more impacted by these negative reactions then men. Andrews, Brewin, and Rose (2003) investigated the relationship between negative social reactions and PTSD symptomatology in a sample of 118 male and 39 female victims of violent crime, identified as actual or attempted physical or sexual assault, or bag snatching. They utilized the Crisis Support Scale (Joseph, Andrews, Williams, & Yule, 1992) to assess for assault-specific social support, and the Posttraumatic Stress Disorder Symptom Scale-Self Report (Foa, Riggs, Dancu, & Rothbaum, 1993) to assess for PTSD symptomatology. They found that for both genders negative responses posed an initial risk for PTSD, as well as an exacerbating effect over the course of PTSD. Specifically, the authors found that women were more likely to report negative social reactions from their family and friends, and that they were also more likely to be impacted by the assault-specific reactions of their social networks. This helps to illuminate the importance of understanding the relationship between negative social reactions and PTSD for victims of VAW. However, since negative social reactions are often encompassed under the larger umbrella of social support, there has not been a great deal of research on this
specific psychosocial variable. Studies have been found pertaining to child sexual assault
and intimate partner violence, but not for child physical assault or stalking victims.

Ullman & Filipas (2005) looked at the effects of social reactions in victims of
child sexual assault in a sample of 733 college students, 71% of which were female. To
assess for PTSD, disclosure characteristics, and social reactions the authors utilized the
Posttraumatic Stress Symptom Severity Scale (Foa, 1995), questions asking about the use
and timing of disclosures, and the Social Reactions Questionnaire (Ullman, 2000)
respectively. The authors found that PTSD symptom severity was negatively related to
the extent of disclosure. Hence, when one disclosed more he or she had less severe PTSD
symptomatology. However, they found that negative social reactions were related to
increased PTSD symptomatology. Negative social reactions were found to be more
prevalent if the victim-offender relationship was less known, if the victim blamed himself
or herself, and if the victim disclosed more quickly following the abuse. These findings
point out both the positive impacts of disclosure (with more disclosure leading to less
severe PTSD symptomatology) as well as the deleterious effects of negative social
reactions. When victims were confronted with negative social reactions their PTSD
symptoms were more likely to be increasingly severe. These findings support the
inclusion of child sexual assault victims in Ullman et al.’s (2007) conceptualization of
negative social reactions and PTSD symptomatology.

Dunmore et al. (1999), whose study was cited earlier in this review, used a sample
of 92 victims of intimate partner violence, either physical or sexual assault, to investigate
the relationship between negative social reactions and PTSD symptomatology. The PTSD Symptom Scale: Self-Report Version (Foa et al., 1993) was used to assess for PTSD symptomatology. Based on the scores on this measure participants were put into either a PTSD group, for those who met criteria for PTSD, or a no PTSD group, for those who did not meet criteria. A 20 item self-report questionnaire developed for the study was used to assess the victim’s perception of other people’s reactions. The first 13 items assessed victims negative perceptions of reactions (alpha=0.91) and the second 7 items assessed positive perceptions of reactions (alpha= .89). Using a chi squared ($\chi^2$) analysis to assess for differences between the no-PTSD and PTSD group, this study found significant differences between the groups in terms of negative social reactions. Specifically, the PTSD group was more likely than the non-PTSD group to have perceived others’ reactions to their trauma as negative, and less likely to have perceived others’ reactions as positive. Thus, those who qualified for a diagnosis of PTSD were more likely to have experienced negative social reactions, or at least to have perceived these reactions as negative. Based on these results, victims of intimate partner violence have a greater likelihood of fitting into Ullman et al.’s (2007) model in relation to negative social reactions and PTSD.

The literature on this topic is new and scattered. One limitation is that negative social reactions and social support are such close constructs. In order for researchers to be effective in looking at the impacts of negative social reactions they will need to appropriately define negative social reactions as separate from social support. Another limitation is that negative social reactions are largely based on perception. Different types
of personalities may be more inclined to view reactions as negative; it may be the 
presence of these personality traits, and not negative social reactions themselves, that put 
these women and girls at risk of developing PTSD. Finally the literature on this topic is 
incredibly limited given how few studies have considered the ramifications of negative 
social reactions for victims of VAW. Despite the paucity of research on this specific 
topic, the above studies provide preliminary evidence that other forms of VAW will fit 
into Ullman et al.’s conceptualization of negative social reactions and PTSD 
symptomatology. While more research is needed, these studies add to the evidence for 
the use of Ullman et al.’s model with other forms of VAW.

**Self-Blame**

Ullman et al.’s (2007) study argued for the importance of understanding self-
blame in relation to PTSD symptomatology in victims of sexual assault. Ullman et al. 
pointed out the importance of both behavioral self-blame (the belief that the victim’s own 
behavior led to the assault) as well as characterological self-blame (the idea that the 
victim’s own character or personality led to the assault). Both forms of self-blame have 
been found to have negative psychological effects for different populations of women 
(Glinder & Compas, 1999; Silver, Holman, McIntosh, & Gil-Rivas, 2002). Glinder and 
Compas (1999) found that behavioral self-blame was related to increased distress at 
diagnosis for women with breast cancer and that characterological self-blame predicted 
increased distress in the 6 months following diagnosis. Further, Silver et al. (2002) 
looked at women’s responses to the attacks of September 11th and found that women who
reported higher levels of self-blame were more likely to be experiencing higher levels of PTSD symptomatology. These studies point out the deleterious effects that self-blame can have on female victims of trauma in general, but do not point out the gender differences in the amount of self-blame utilized. However, Tolin and Foa (2002) looked at these gender differences in their meta-analysis assessing 120 males and 183 females reporting negative life events. They found that women were significantly more likely to endorse self-blame then were men. However, this study did not assess the impacts of different types of trauma, and so the gender differences found might have been in relation to different experiences of trauma, instead of unique differences in gender. Given that self-blame has been found to lead to greater psychological distress in female victims of trauma, and that it tentatively seems women utilize self-blame more frequently than men, the relationship between self-blame and PTSD in forms of VAW beyond sexual assault should be examined.

Both Filipas and Ullman (2006) and Hazzard, Celano, Gould, Lawry, and Webb (1995) have evaluated the amount of self-blame common to victims of childhood sexual assault, and the impact of self-blame on psychological distress for this population. Filipas and Ulmann’s study, which was described earlier in this review, utilized a sample of 577 college women, 28.7% of which had experienced child sexual assault. PTSD was quantified using Foa’s (1995) Posttraumatic Stress Diagnostic Scale and attribution of blame was evaluated using a Likert scale assessing how much the victims blamed themselves, the perpetrator, society, and someone else for their abuse. Results indicated that self-blame during child sexual assault was significantly (p<.01) related to PTSD.
symptomatology. Thus, when children blamed themselves for their sexual abuse, they were more likely to experience increasingly severe PTSD symptomatology. Hazzard et al. (1995) had similar findings. They studied 56 female children who had recently experienced sexual abuse, as well as their non-abusing female caregivers. Each child completed Kaslow’s Attributional Style Questionnaire for Children (Kaslow, Tanenbaum, & Seligman, 1978) which assesses for the child’s attribution of blame as well as the self-blame/guilt, betrayal, traumatic sexualization, and powerlessness subscales of the Children’s Impact of Traumatic Events Scale-Revised (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991). Each girl’s functioning was also assessed by a psychiatrist using the Children’s Global Assessment Scale (Shaffer et al., 1983). They found that self-blame was significantly correlated with the girls’ scores on the Children’s Global Assessment Scale. Thus, they found that girls who reported more self-blame also had higher ratings of maladjustment. While this study did not specifically address PTSD symptoms, its findings regarding maladjustment help to support the understanding of child sexual assault victims amount of self-blame, and its negative sequelae. Taken together, these studies provide evidence for child sexual assault’s inclusion in Ullman et al.’s conceptualization of self-blame and PTSD.

In terms of intimate partner violence and self-blame, Berger (1998) used a Chi square analysis to compare levels of self-blame between sexual assault victims and victims of domestic violence. She did not find a significant difference between rape victims’ incidence of resolved or unresolved self-blame and the incidence of this blame in victims of domestic violence. This study provides some evidence for intimate partner
violence’s inclusion in Ullman’s model, at least in that intimate partner violence victims are as likely to blame themselves as sexual assault victims, though the study does not look at the relationship between self-blame and PTSD. Dunmore et al.’s (1999) study, which was described earlier in this review, looked at the relationship between self-blame and PTSD in victims of intimate partner violence. Their study analyzed PTSD and self-blame in 92 victims of assault using the PTSD Symptoms Scale: Self-Report Version (Foa et al., 1993) as well as an appraisal of actions questionnaire designed for the study. The authors found a non-significant (p=.052) correlation between negative appraisal of one’s own actions and persistent PTSD. These results are nearing significance, and while they do not fully meet criteria for statistical significance (p<.05), they still provide some evidence that victims of intimate partner violence might fit in with Ullman et al.’s (2007) hypothesis regarding self-blame and PTSD, specifically that increased self-blame within these victims is correlated with increased PTSD symptomatology.

In terms of stalking, little research has been done regarding self-blame and PTSD. Kamphius’s (2003) study, which was described earlier in this review, assessed the amount of self-blame that stalking victims’ experience, but not its correlation to PTSD. The authors found that women who had been stalked were more likely than both controls as well as victims of sexual assault to engage in self-blame. These results, while not specifically addressing the relationship between PTSD and self-blame, support the argument that stalking victims will fit into Ullman et al.’s (2007) conceptualization of self-blame and PTSD. This argument is supported by showing that stalking victims not only engage in self-blame, but that they do so to even a greater extent than sexual assault
victims. Given self-blame’s known impacts on psychological distress, it would be fair to hypothesize that this increased self-attribution of blame could lead to increased psychological distress, if not PTSD (Glinder & Compas, 1999; Silver, Holman, McIntosh, & Gil-Rivas, 2002).

The literature on the relationship between self-blame and PTSD for victims of VAW has several limitations. While Ullman et al. (2007) pointed out the importance of both behavioral and characterological self-blame, they were not evaluated separately in any of the studies about victims of VAW reviewed here. This may be a limitation as Ullman et al.’s conceptualization of self-blame might have impacted their use of this construct in their model. Another limitation involves the representativeness of the samples utilized in these studies. It is possible that those who blame themselves may be more or less likely to participate in research than those who blame external sources. Finally, the mere lack of studies to review is a serious limitation. Due to this, studies such as Dunmore et al.’s (1999) had to be utilized to convey the importance of this relationship, even though the study did not find a clinically significant relationship between self-blame and PTSD. Overall, however, these studies support the inclusion of other forms of VAW into Ullman et al.’s conceptualization of self-blame and PTSD. More research would be ideal, but these studies provide a rationale for understanding victims of VAW’s use of self-blame as a psychosocial correlate to PTSD symptomatology.
Avoidance Coping

A common response to trauma is the utilization of avoidance coping - a method of coping which is characterized by avoidance of the stimuli related to trauma. Hayes, Wilson, and Strosahl (1996) defined this avoidance as the “phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them” (p. 1154). Our society might dispose people to utilize avoidance coping through social encouragement and modeling that tells people to “control” their emotions (Hayes et al., 1996). Avoidance is also intrinsically motivating immediately following trauma, as avoiding traumatic stimuli can in turn avoid anxiety related to those stimuli. However, while avoidance might be adaptive and motivating in the short term, it has been shown to lead to more psychological distress long term.

Several studies have evaluated the negative psychological sequelae of avoidance coping. For example, Littleton, Horsley, John, and Nelson (2007) performed a meta-analysis of 44 studies assessing trauma coping and distress in over 6,500 individuals following interpersonal violence or severe injury. They found a significant association between overall distress (defined as general distress, depression, or post-traumatic stress symptoms) and avoidance coping. Bryant and Harvey (1995) looked at avoidance coping in the wake of motor vehicle accidents. They surveyed 56 patients who had been hospitalized following a motor vehicle accident and found that avoidance coping was the
main predictor of intrusive symptoms. Further, Scarpa, Haden, and Hurley (2006) also examined the relationship between avoidance coping and distress. They looked at avoidance coping as a moderator between exposure to community violence and PTSD symptomatology. Examining 372 volunteer psychology students who had experienced violent or non-violent trauma, the authors found that those who engaged in avoidance coping had more severe PTSD than those who did not. Since avoidance coping is associated with negative psychological effects it is important to understand the frequency with which women employ this coping method, and the impact that this frequency has on their functioning.

One step towards understanding the frequency with which women employ avoidance coping is to compare women’s use of avoidance coping to men’s use of avoidance coping following similar traumas. Coker et al. (2005) conducted a cross-sectional analysis of the National Violence against Women Survey in which the authors sought to characterize the symptoms of PTSD that both male and female victims of intimate partner violence experienced. The study included 185 men and 369 women who had previously experienced intimate partner violence, which the authors defined as physical violence, sexual violence, stalking, or psychological abuse perpetrated by an intimate partner (cohabitating partner or spouse). Demographics of the participants and their partners’ age and race were assessed during an interview. The Conflict Tactics Scale (Straus, 1979), the National Women’s Study (1992), Tjeden and Thoenne’s Stalking Measure (1998), and the Impact of Event Scale-Revised (IES-R; Weis & Marmar, 1997) were used to evaluate participants’ history of child physical assault, current experience of
physical intimate partner violence, current sexual intimate partner violence, and current stalking victimization. This study found that women who had experienced physical, psychological, sexual abuse, or stalking had greater levels of avoidance (based on the IES-R avoidance subscale) than men who experienced the same types of victimization from their intimate partners. This suggests that women are more likely to engage in avoidance coping than men, even if similar traumas are experienced. Given this disparity, it is important to understand the pathways that lead women to utilize avoidance.

The pathways that lead women to engage in avoidance coping have not been widely studied; however, Higgins (1999) did look at the relationship between historical trauma and subsequent coping. Their participants included 102 women from a community-based sample, all of whom were over the age of 60. The authors found that individuals with a history of trauma showed higher levels of general avoidance than those without a history of trauma, though this result was not statistically significant. They also found a statistically significant effect of avoidance coping on increased PTSD symptomatology. Given the increased utilization of avoidance coping in women exposed to violence as well as the cumulative effects of historical traumas on avoidance, there is a need for an increased understanding of the specific impact that avoidance coping has when related to different forms of VAW. Thus, studies addressing the relationship between child sexual assault, intimate partner violence, and stalking with avoidance coping are further addressed.
Filipas and Ullman (2006), Fortier et al. (2009) and Tremblay et al. (1999) considered the relationship between child sexual assault and avoidance coping. Tremblay et al. (1999) evaluated the relationship between avoidance coping and negative outcomes (low self-worth, internalizing behaviors and externalizing behaviors) for 50 children (11 boys and 39 girls) who were referred to a child protection hospital in Montreal. All children reported sexual abuse, and their ages ranged from 7 to 12 years old. In order to assess children’s outcomes as well as the coping strategies they utilized, they were given the Child Behavior Checklist (Achenbach, 1991), the global self-worth scale of the Perceived Competence Scale for Children (Harter, 1985), the Self-Report Coping Scale (Causey & Dubow, 1992), and the History of Victimization form (Wolfe et al., 1987). In terms of coping strategy, the study aimed to evaluate the impact of avoidance coping on Internalizing and Externalizing symptoms as well as self-worth ratings. They found that avoidance coping was related to externalizing behaviors, internalizing behaviors, and global self-worth. While this study did not look specifically at PTSD symptomatology, its findings that avoidance coping was related to psychological distress helps to support the idea that avoidance coping may be related to increased PTSD symptomatology for this population. Filipas and Ullman (2006) evaluated how maladaptive coping, defined in their study as use of alcohol or drugs, withdrawal from others, failing to talk about the experience or trying to forget the experience, in response to child sexual assault was related to PTSD. They surveyed 577 participants recruited from introductory psychology classrooms who completed a 20-page long survey about stressful life experiences. Coping was evaluated using yes or no questions (i.e., Have you withdrawn from people?) and the
Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) was used to assess for PTSD. Results demonstrated a significant correlation between the use of maladaptive coping and PTSD severity. Fortier et al. (2009) found similar results in their sample of 99 female undergraduates who had previously experienced child sexual assault. They found that disengagement coping was significantly related to trauma symptoms in victims of child sexual assault (p < .01). These studies, taken together, show that it is likely victims of child sexual assault would fit in with Ullman’s model, in terms of the relationship between avoidance coping and PTSD symptomatology.

Kemp et al. (1995) studied the impact of avoidance coping on PTSD symptomatology in a sample of women affected by intimate partner violence. Their sample of 179 battered women was drawn from shelters, battered women’s support groups, therapist referrals, and newspaper advertisements. They also had a non-battered sample of 48 women who had experienced verbal, but not physical, abuse. Participants were evaluated for PTSD based on the Mississippi Scale for PTSD (Fairbank, n.d.) and the PTSD Self-Report Scale (Kemp, Rawlings, & Green, 1991). Physical abuse and verbal abuse were measured by the Conflict Tactics Scale (Straus, 1990) and coping strategies were measured by the Coping Strategies Inventory (Tobin, Holroyd, & Reynolds, 1984). They found that the use of disengagement coping (avoidance coping) was related to greater amounts of PTSD symptomatology at a .001 level of significance. This study provides evidence that the impact of avoidance coping on female victims of intimate partner violence would most likely fit with Ullman et al.’s (2007) model,
specifically that intimate partner violence victims would evidence a positive relationship between avoidance coping and PTSD symptoms.

Dunmore et al. (1999) looked at the relationship between avoidance coping and the onset and maintenance of PTSD following either physical or sexual assault. They recruited and gave questionnaires to a sample of 92 assault victims three or more months after the assault occurred. The questionnaires were made up of questions drawn from the PTSD Symptom Scale: Self-Report Version (Foa et al., 1993), questions created for the study involving cognitive and behavioral factors involved in the onset and maintenance of PTSD, as well as appraisals of the assault. Results showed that those who reported enough symptoms to qualify for PTSD in the month following their assault were more likely to report having utilized avoidance coping and to have tried to undo the memories of their assault than those who did not have PTSD. They also found that those who had persistent PTSD (still qualified for a PTSD diagnosis at assessment) were more likely to have used avoidance coping in the month following their assault than the recovered group. No differences were found between those who developed PTSD and those who did not on the basis of assault type. This study is important because it not only points out that those who utilize avoidance coping following intimate partner violence have increased PTSD, but it studies these victims at the same time as it studies victims of sexual assault, the group of victims for which Ullman et al.’s (2007) model was created. In finding that there were no significant differences between the PTSD and no PTSD groups in relation to type of assault (sexual versus physical) this study provides evidence that intimate partner violence will fit not only with Ullman et al.’s conceptualization of
avoidance coping and PTSD, but that it may very well fit with other parts of Ullman et al.’s model as well.

The relationship between post-traumatic stress and avoidance coping in response to stalking was analyzed by Kamphuis et al. (2003). This study used members of the Dutch “Stichting Anti-Stalking” (StAS; Anti-Stalking Foundation) 131 female stalking victims from the StAS were compared to a normal control group consisting of undergraduate female psychology students, 119 of which had experienced violence in the past and 42 of which had never experienced violence. Participants were given the IES-R (Weis & Marmar, 1997) to quantify trauma related symptoms, and the Utrecht Coping List (Schreurs et al., 1988) which looked at specific coping behaviors utilized by the victims. Kamphuis et al. found that passive coping (coping that included withdrawal, avoidance, and/or rumination) was associated with higher post-traumatic stress within this population. This association provides evidence that victims of stalking also utilize avoidance coping, and experience greater post-traumatic symptoms as a result. Thus, this group would also fit with Ullman et al.’s (2007) conceptualization of avoidance coping and PTSD symptoms.

Avoidance coping and PTSD are fairly well studied in the literature. Despite this, there is room for improvement. No studies were found concerning child physical abuse and avoidance coping so the relationship between these variables is still unknown for this population. Improvement is also needed in the definition of avoidance coping. Different studies conceptualized this construct differently (i.e., drinking versus withdrawing from
people versus trying to forget the event). For a clearer understanding of the relationship between avoidance coping and PTSD both in general, and for this population, a more concrete understanding of avoidance coping would be necessary. Despite these limitations, the results of the above studies are encouraging. All of these studies have found that the use of avoidance coping was related to increased levels of PTSD, which fits with Ullman et al. (2007)’s model. These studies looked at different types of VAW and each type had a positive relationship between increased avoidance coping and PTSD symptoms. Thus, these studies provide support for the use of Ullman’s model with other forms of VAW in relation to avoidance coping.

**Discussion**

This review has provided evidence for the inclusion of other forms of VAW in Ullman et al.’s (2007) model of PTSD symptomatology and psychosocial variables. Ullman et al. posited that assault severity, global social support, negative social reactions, self-blame, and avoidance coping would be related to the development of PTSD following sexual assault. This review sought to extend Ullman et al.’s model by considering its utility beyond sexual assault with victims of other forms of VAW.

Ullman et al. (2007) found that assault severity was significantly related to PTSD in their sample of sexual assault victims. They found that increased negative social reactions mediated this relationship, whereby when assault severity increased there were more negative social reactions and less self-blame. In this review, assault severity was found to be correlated with PTSD symptomatology in victims of child sexual assault and
stalking. Studies on this relationship in victims of child physical abuse were not found and studies were contradictory in terms of intimate partner violence. Given discrepancies between studies, it is still unclear if victims of child physical abuse and intimate partner violence will fit into Ullman et al.’s conceptualization of the relationship between assault severity and PTSD. However, given the mediating relationships that Ullman et al. found between assault severity, negative social reactions, and less self-blame, these forms of VAW should not be assumed to fit poorly with Ullman et al.’s model. It could be that different types of assaults would elicit different social reactions and self-blaming reactions and thus assault severity might impact different VAW victims differently while still fitting into Ullman et al.’s model.

Ullman et al. (2007) hypothesized that global social support would be related to decreased PTSD symptoms in victims of sexual assault. In this review, social support was found to be correlated with PTSD symptoms in studies regarding victims of child physical assault, child sexual assault, and intimate partner violence. Victims of stalking were not well studied in this area, but one study found that stalking victims did not demonstrate a relationship between global social support and PTSD symptomatology. Although the overall findings of this review support Ullman et al.’s hypothesis, their findings within the 2007 study were contradictory to their hypothesis regarding this relationship. Despite the fact that previous research in sexual assault and other forms of VAW have found that increased social support leads to decreased PTSD symptoms, Ullman et al. found the opposite. In their discussion they posited that this might be due to symptomatic people trying to obtain more social support by underreporting the social
support that they currently had. Despite this conclusion it is unknown, based on the research, whether other forms of VAW would fit into Ullman’s conceptualization of global social support and PTSD.

Ullman et al. (2007) hypothesized and found that higher levels of self-blame would be related to higher levels of PTSD in female victims of sexual assault. Study results showed that controlling for social reactions lessened the impact of self-blame on PTSD to a non-significant level. The authors theorized this showed that self-blame itself did not have a significant effect on PTSD symptomatology, but instead that negative social reactions increased both self-blame and PTSD symptomatology. This review does not provide evidence for the mediation of negative social reactions on self-blame, though this relationship was not specifically evaluated. However, this review did find that self-blame was correlated with PTSD in victims of child sexual assault, intimate partner violence and stalking. Despite Ullman et al.’s theory regarding the mediating relationship of negative social reactions on self-blame, this review provides rationale for the inclusion of these victims in Ullman et al.’s model.

Ullman et al. (2007) found that negative social reactions and avoidance coping had the strongest effect on PTSD symptoms, when compared with other constructs. A review of the literature tentatively supported the effect of negative social reactions on PTSD symptomatology for other forms of VAW. Negative social reactions were not well studied, but preliminary findings demonstrated a correlation between negative social reactions and PTSD symptomatology. This provides evidence for the inclusion of VAW.
in Ullman et al.’s conceptualization of negative social reactions and PTSD, though the amount of literature is severely limited.

In terms of avoidance coping and PTSD symptomatology, there was significantly more research to be reviewed and all studies found a relationship between avoidance coping and PTSD in each form of VAW studied. Ullman et al. (2007) posited that negative social reactions might lead to more avoidance coping, and more avoidance coping might lead to more negative social reactions. This was not within the scope of this review, but it is possible that this would be true for other forms of VAW as well.

While these results are for the most part encouraging in providing general support for the extension of Ullman et al.’s (2007) model to other forms of VAW, there are some limitations. First, much of the literature regarding Ullman et al.’s psychosocial variables do not include studies on child physical abuse, especially as seen separately from child sexual abuse. Even among the studies which did assess child abuse, most were dependent on the historical recollections of adults instead of the reports of children. This type of data collection presents an entirely different set of problems that would need to be assessed and considered. The small amount of research, and the issues concerning data collection do not mean that child physical abuse will not fit into Ullman et al.’s model, but they do illustrate the need for more research to be done with this population. Second, this review does not assess the relationships between the psychosocial variables evaluated in Ullman’s model. One of the strengths of Ullman’s model is the many connections that it illustrates between variables, and this review is able only to look at each psychosocial
variable’s separate relationship to PTSD symptomatology. In order to truly understand if other forms of VAW would fit into this model one would have to further understand the relationships between each of the different psychosocial variables. This could be done through further literature review on the connections between psychosocial variables or through testing Ullman et al.’s (2007) model on different populations of victims. Another limitation is the different use of assessment instruments throughout studies. It is difficult to say that other forms of VAW would fit into Ullman’s model when the measures used in the literature are not always consistent with the assessments used in Ullman’s model. Further the variables are consistently not well defined or are defined differently from study to study, meaning that as well as using different measures to assess constructs, the literature may also be aiming to measure different constructs themselves.

Due to the discrepancy between Ullman et al.’s (2007) findings regarding social support and the hypothesis that they had prior to running their model, as well as the discrepancy between the author’s findings and the review of the literature for other forms of VAW, this relationship would need to be further understood before assuming that other forms of VAW would fit into Ullman et al.’s model. Given Ullman et al.’s hypothesis that this discrepancy may be due to those in great distress trying to seek more social support it is possible that other forms of VAW would have similar results. Using a different measure to assess social support might also be helpful in illustrating the true meaning of this relationship.
Despite limitations of the literature this review helps to support the hypothesis that other forms of VAW (child sexual abuse, child physical abuse, intimate partner violence, and stalking) would fit into Ullman et al.’s (2007) model. These findings would be important to clinical applications because understanding the similarities between different types of VAW might help to make treatment more universal. Also, understanding the impacts of these psychosocial variables can help to narrow the focus of treatment. For instance, if self-blame is related to increased PTSD symptomatology, interventions that focus on alleviating self-blame could be incredibly useful. This model’s inclusion of other forms of VAW might also help to account for those who have experienced multiple or complex traumas. Victims of VAW often experience multiple traumas (Kilpatrick, Resnick, Saunders, & Best, 1998; Monnier, Resnick, Kilpatrick, & Seals, 2002) and a model of VAW that includes several different types of traumas might be more applicable to this ever-growing population.

While this review provides preliminary evidence for the inclusion of other forms of VAW into Ullman et al.’s (2007) model, more research needs to be done to see if similar model fits will be found with other forms of VAW. Future research should use similar assessments and test the full model (with its variable connections) in relation to each of the different forms of VAW, as well as with a group of VAW victims as a whole. This type of research would be much more definitive in explaining this model’s utility for other forms of VAW. Even if all forms of VAW were found to fit perfectly with Ullman et al.’s model, more research would need to be done which focused on interventions for the specific variables assessed in this model.
Overall this review helps to point out the possible utility of Ullman et al.’s (2007) model with victims of VAW. The assessment of VAW as a group, instead of as separate victims may be warranted given that similar outcomes of different interpersonal traumas have been found (Briere & Jordan, 2011) and this review helps to support the use of Ullman et al.’s model for this purpose. Except for global social support, all of the psychosocial variables assessed were found to fit into Ullman et al.’s conceptualization of the pathways to PTSD symptomatology. Thus this review is a tentatively hopeful analysis, and a call for further research regarding this large population of victims.
References


