Sexual revictimization risk reduction program: A proposal for the use of dialectical behavior therapy skills training groups for sexually victimized women

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Abstract
Women with histories of childhood sexual abuse or adult sexual victimization are at an increased risk of being sexually assaulted in the future, a phenomenon known as sexual revictimization. Although there are currently effective risk reduction programs for sexual victimization, those interventions fail to decrease the incidence of sexual revictimization. Therefore, a new sexual revictimization risk reduction program in the form of a dialectical behavior therapy (DBT) skills group was proposed. A review of the literature on childhood sexual abuse and sexual revictimization was conducted, including an examination of risk factors for sexual revictimization and existing risk reduction programs for revictimization. Key features of DBT were summarized, and the rationale for and a brief overview of the proposed risk reduction program were presented.

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SEXUAL REVICTIMIZATION RISK REDUCTION PROGRAM:
A PROPOSAL FOR THE USE OF DIALECTICAL BEHAVIOR THERAPY
SKILLS TRAINING GROUPS FOR SEXUALLY VICTIMIZED WOMEN

A THESIS
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Abstract

Women with histories of childhood sexual abuse or adult sexual victimization are at an increased risk of being sexually assaulted in the future, a phenomenon known as sexual revictimization. Although there are currently effective risk reduction programs for sexual victimization, those interventions fail to decrease the incidence of sexual revictimization. Therefore, a new sexual revictimization risk reduction program in the form of a dialectical behavior therapy (DBT) skills group was proposed. A review of the literature on childhood sexual abuse and sexual revictimization was conducted, including an exploration of risk factors for sexual revictimization and existing risk reduction programs for revictimization. Key features of DBT were summarized, and the rationale for and a brief overview of the proposed risk reduction program were presented.

Keywords: child sexual abuse, dialectical behavior therapy, group therapy, risk reduction, sexual victimization, sexual revictimization
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Approximately one in five of women will be raped in her lifetime, and the Rape, Abuse, & Incest National Network (RAINN) estimates that someone in the United States is sexually assaulted every 2 minutes (National Center for Injury Prevention and Control, 2010; RAINN, n.d.; U.S. Department of Justice, 2000). Rape, according to the Federal Bureau of Investigation, is defined as “‘the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim’” (UCR Program section, para. 1). The negative sequelae of rape varies and can include mental health concerns such as depression, posttraumatic stress disorder (PTSD), and substance use disorders as well as the engagement in health risk behaviors such as driving under the influence of alcohol, smoking cigarettes, and using substances before sexual intercourse (Brener, McMahon, Warren, & Douglas, 1999; Kaltman, Krupnick, Stockton, Hooper, & Green, 2005). However, according to the U.S. Department of Justice (2000), more than half of women who report being raped were assaulted before the age of 18. Being a victim of childhood sexual abuse (CSA) can result in a great number of social and psychological issues, and women with CSA histories are estimated to be at least twice as likely to be sexually assaulted in the future, or sexually revictimized (Trickett, Noll, & Putnam, 2011). This statistic is particularly alarming given the negative impact of sexual assault described. Furthermore, sexual revictimization has been shown to have a greater impact on overall function than a single assault (Maker, Kemmelmeir, & Peterson, 2001; Walsh, Danielson, et al., 2012).

Risk reduction and prevention programs have been developed for sexual abuse and sexual assault; however, researchers have found that programs aimed at a general audience—and not those with histories of sexual victimization—decrease the incidence of future sexual victimization only in those without victimization histories (Blackwell, Lynn, Vanderhoff, &
Gidycz, 2004); these programs did not have a similar effect on sexual revictimization. Moreover, existing programs do not target the myriad risk factors identified for revictimization. Therefore, the purpose of this literature review is to present an empirical base for the development of a new sexual revictimization risk reduction program using dialectical behavior therapy (DBT). This paper will examine the existing research on CSA, sexual revictimization, and risk factors for revictimization. Current revictimization risk reduction programs will be discussed, and evidence for the utility of a new intervention—a DBT skills training group—will be presented. An overview of DBT and rationale for using group DBT for risk reduction will be provided, and finally, the proposed sexual revictimization risk reduction DBT group will be outlined.

**Method**

The review utilized sources primarily from psychological literature published since 2000; however, publications beyond that score were included to provide a historical perspective or additional information integral to the topic at hand. Medical and legal research databases were also searched as sexual violence is a concern in these fields as well. Terminology is expounded upon in the relevant sections below.

**Childhood Sexual Abuse**

According to Lalor and McElvaney (2010), “the sexual exploitation of young people appears to be a universal phenomenon,” and statistics on child sexual abuse (CSA) certainly prove this to be true. In 2011, Child Protective Services (CPS) pursued over 61,000 unique reports of CSA in the United States (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2012); however, the rate of CPS-substantiated child maltreatment is estimated to be only one-
tenth of that reported by victims or parents (Gilbert et al., 2008). Researchers relying of self- or parent-report have found CSA prevalence rates ranging from 14% of females in a nationally representative sample of the general population to 37% in college samples (Arata, 2000; Molnar, Buka, & Kessler, 2001). A retrospective study of adult health maintenance organization (HMO) members found that one in four women and one in six men reported experiencing contact CSA (Dube et al., 2005). These high rates of abuse have serious impacts for children’s well-beings: CSA has been associated with numerous negative outcomes, including mental health disorders, risky sexual behavior, neurobiological changes, and increased risk of later sexual assault (Arata, 2000; Briere & Elliott, 2003; Dube et al., 2005; Fargo, 2009; Heidt, Marx, & Gold, 2005; Lalor & McElvaney, 2010; Lau & Kristensen, 2010; Maker et al., 2001; Molnar et al., 2001; Paolucci, Genuis, & Violato, 2001; Testa, Hoffman, & Livingston, 2010; Trickett et al., 2011).

Definitions.

Although CSA is a clear concern, researchers have been unable to agree upon a consistent definition of CSA. This may be partly due to the heterogeneous nature of CSA. CSA can involve non-contact sexual acts—exhibition, voyeurism, a sexual request, or viewing or participating in pornography—and sexual acts that involve contact, including kissing, fondling, oral sex, digital or object vaginal or anal penetration, and penile penetration of the vagina or anus (Putnam, 2003; U.S. Department of Health and Human Services, n.d.). Children can be abused by a single perpetrator or multiple abusers, and perpetrators can be family members, including father or father figures, peers (someone who is less than five years older than the victim), or non-peers (someone who is more than five years older than the victim; Maker et al., 2001; Putnam, 2003; Trickett et al., 2011). The abuse can occur as an isolated incident or can span many years (Putnam, 2003). Several studies have found that contact abuse, intrafamilial abuse, abuse of
longer duration, and abuse involving the use of force or violence is associated with more negative outcomes over the lifespan, including an increased risk of sexual revictimization (Arata, 2000; Dube et al., 2005; Heidt et al., 2005; Molnar et al., 2001; Putnam, 2003; Testa et al., 2010; Trickett et al., 2011). However, one meta-analysis of CSA research did not find any significant differences in outcomes based on the type of abuse, the victim’s relationship to the perpetrator, or the number of incidents of abuse (Paolucci et al., 2001).

The diverse nature of CSA can make researching this topic more complex, and the range of criteria used to define CSA in studies only compounds the complication. CSA criteria can vary based on the age-discrepancy between victim and abuser, the relationship of the perpetrator to the victim, the type of abuse (i.e., contact or noncontact), and whether or not force was used. Additionally, researchers have used a wide range of age cut-offs, with definitions of CSA including sexual activity before age 13 all the way up to age 18 (Lalor & McElvaney, 2010; Senn, Carey, & Vanable, 2008). As summarized by Senn and colleagues (2008), the measurement of CSA “is complicated, given the debate over case definitions, the stigmatizing nature of abuse experiences, and the controversial, private nature of the abuse event itself” (p. 753). These limitations likely contribute to the wide range of findings on CSA, including but not limited to prevalence rates.

Effects of CSA.

Although researchers may not be able to agree on a definition of CSA, they have been able to agree on the deleterious effects of sexual abuse. In one particularly methodologically strong investigation, Trickett and colleagues (2011) conducted a 23-year longitudinal study looking at CSA and its impact on female development. Eighty-four females, ages 6 to 16, who experienced substantiated intrafamilial contact sexual abuse were referred to the study from CPS
in the Washington D.C. metro area. A comparison sample of non-abused females was also recruited from the D.C. metro area. Assessments were conducted at six different time points and included interviews and assessment measures. The authors found that females who were abused for a longer period of time, experienced force during the abuse, or were abused by a father or father figure had overall worse outcomes. With regard to psychopathology, abused females were more likely to meet criteria for two or more mental health disorders and score higher on measures of depression, anxiety, dissociation, PTSD, and somatic symptoms. Dissociation was found to be related to sexual revictimization, domestic violence, and self-harm behaviors. In fact, females who were abused reported self-harm and suicidality at rates almost 4 times higher than that of the comparison group.

Trickett et al. (2011) also found that abused females were also more likely to display aggression, delinquent behaviors, and school problems. As adults, abused females were more likely to experience depression and substance abuse. The females who experienced CSA were nearly twice as likely to be sexually revictimized, and sexual revictimization was associated with symptoms of PTSD and dissociation. Over half of the sexually abused females reported at least one domestic violence experience compared to less than a quarter of comparison females, and the abused women were more likely to have reported experiencing severe domestic violence even after controlling for age, minority status, socioeconomic status (SES), and cohabitation status. CSA was associated with poorer social and learner competence, academic performance, receptive language skills, fluid and crystallized intelligence, and educational attainment in addition to more school avoidance behavior.

Sexual abuse was also linked to worse physical outcomes, including hypothalamic-pituitary-adrenal (HPA) axis regulatory problems, obesity, greater healthcare utilization, teen
pregnancy, preterm delivery, risky sexual behavior, and an earlier onset of puberty, which has been associated with a variety of poor psychosocial and health outcomes. Trickett et al. (2011) also compared the children of the abused females and the comparison females and found that children born to the abused females were more likely than the children born to comparison females to display an anxious attachment style and have involvement with CPS; however, the authors noted that the majority of CPS involvement with the abused females was due to neglect and that most did not go on to abuse or harm their own children.

Another study about the outcomes of CSA used self-reported experiences of CSA rather than cases that were reported to CPS agencies, which has a methodological advantage: using self-report measures, researchers have estimated only one in 20 CSA cases are reported to the appropriate agencies (Hornor, 2010). Dube and colleagues (2005) analyzed data from the Adverse Childhood Experiences Study to examine the relationship between CSA and later negative mental health outcomes. Between 1995 and 1997, adult members of an HMO in San Diego, California (n = 17,337) completed a survey that asked retrospectively about any experience of CSA as well as current mental health functioning. The authors found that approximately 25% of females and 16% of males reported experiencing contact sexual abuse before the age of 18. Compared to respondents who did not endorse experiencing CSA, men and women with histories of CSA were significantly more likely to report having an alcohol problem, using illicit drugs, attempting suicide, having current symptoms of depression, being married to an alcoholic at some point in their lives, and having current marriage and family problems. Of note, men and women who experienced CSA were twice as likely to have attempted suicide when compared to those who did not experience sexual abuse. The authors also found that CSA that involved oral, vaginal, or anal intercourse was associated with worse
outcomes in comparison to no sexual abuse or sexual abuse that did not include sexual intercourse.

In contrast to the previous two studies that looked at metropolitan areas, Molnar and colleagues (2001) analyzed data collected from 1990 and 1992 for the National Comorbidity Survey (NCS), a survey of a nationally representative sample of the general population. The authors found that approximately 14% of females and 3% of males endorsed experiencing contact sexual abuse before the age of 18. Women who reported CSA were significantly more likely than women without a history of CSA to meet criteria for the following disorders: depression, dysthymia, mania, agoraphobia, panic disorder, PTSD, social phobia, alcohol problems, alcohol dependence, drug problems, drug dependence, and severe drug dependence. Most notably, there was a tenfold increased risk for PTSD in women who endorsed experiencing sexual abuse when compared to non-abused women. Men with CSA histories were significantly more likely than men who did not report CSA to meet criteria for PTSD, alcohol dependence, drug problems, and drug dependence. Overall, 78% of females and 82% of males who endorsed experiencing CSA met criteria for at least one diagnosis, compared to 49% of females and 51% of males who did not report CSA. Additionally, the authors found that among women, chronic CSA and abuse perpetrated by someone close to the child had more deleterious outcomes than isolated abuse events perpetrated by strangers.

Briere and Elliott (2003) also used a national sample in their study in which they mailed a questionnaire to a geographically stratified, random sample of adults in the United States. The authors found that 14% of men and 32% of women reported experiencing CSA, and 22% of men and 20% of women reported experiencing physical abuse. Individuals who reported experiencing one form of abuse were more likely to report experiencing the other form of abuse.
as well, and individuals who reported sexual abuse or physical abuse in childhood were more likely to report experiencing interpersonal violence as an adult. CSA was associated with higher scores on a measure of trauma symptoms, and this result was found even when controlling for sociodemographic variables, victimization as an adult, and physical abuse as a child. Multiple perpetrators, abuse involving penetration, abuse that occurred at a later age, and reported greater emotional distress at the time of the abuse were all associated with higher trauma symptom scores.

In contrast to the previous studies that focused primarily on the psychological impact of CSA, Rohde and colleagues (2008) examined a physical health outcome of CSA—obesity—in addition to depression specific in a sample of females over 40 years of age enrolled in a regional health plan. Approximately 15% of women reported a history of CSA. The authors found that even when controlling for age and race, women who reported experiencing CSA were twice as likely to be obese and endorse having symptoms of depression when compared to women without CSA histories. Additionally, CSA victims were nearly 3 times as likely to engage in binge eating and nearly twice as likely to report body dissatisfaction.

Finally, a meta-analysis of CSA literature conducted by Paolucci and colleagues (2001) found that CSA, which was defined as contact abuse before the age of 18 perpetrated by a person in a position of power relative to the victim, was associated with an increased risk of depression, suicidal thoughts or actions, early sexual debut or involvement in prostitution, sexually victimizing others, and poorer academic performance.

**Sexual Revictimization**

As Trickett et al. (2011) identified, women who have experienced CSA are more likely to be sexually assaulted when compared to women who have not experienced CSA. This
phenomenon, known as sexual revictimization, has also been found for women who were not sexually abused as children but instead were sexually assaulted as adolescents or adults (Raghavan, Bogart, Elliott, Vestal, & Schuster, 2004). In fact, studies sampling a variety of populations (e.g., a national sample of female adolescents, a community sample of adult females, a community sample of female children), both prospective and retrospective, have found that women who report prior sexual victimization are twice as likely to be sexually assaulted again when compared to women without a history of sexual victimization (Balsam, Lehavot, & Beadnell, 2011; Barnes, Noll, Putnam, & Trickett, 2009; Orcutt, Cooper, & Garcia, 2005; Raghavan et al., 2004; Trickett et al., 2011). As with prevalence of CSA, the odds ratio of revictimization varies by study: one group of researchers found that women who reported CSA were over 4 times more likely to experience adult sexual assault (Kimerling, Alvarez, Pavao, Kaminshi, & Baumrind, 2007).

In one of the first studies of sexual revictimization, Miller and colleagues (1978) analyzed information from the victim data forms completed by team members of the University of New Mexico School of Medicine Sexual Assault Response Team. They found that of the 341 sexual assault victims seen by the response team, 24% had been victimized in the past. Compared to individuals who were seen following their first assault, individuals who were seen following revictimization were significantly more likely to have received mental health treatment in the past. Revictimized individuals were also significantly more likely to be unemployed or receiving government assistance when compared to individuals who were assaulted for the first time. In the discussion, the authors noted that it was likely that more than 24% of those seen by the response team had been victimized in the past: many of the victims reported prior victimization during follow-up counseling sessions, and not all victims pursued follow-up care.
This line of research has been continued for over 30 years, with investigators studying sexual revictimization in a variety of settings, including community (Barnes et al., 2009; Fargo, 2009; Kimerling et al., 2007; Orcutt et al., 2005; Raghavan et al., 2004; Walsh, Danielson, et al., 2012) and college samples (e.g., Arata, 2000; Gidycz et al., 2007; Messman-Moore & Brown, 2006; Messman-Moore, Ward, & Zerubavel, 2012; Walsh, Danielson, et al., 2012); however, the majority of studies on revictimization focused on heterosexual victimization and revictimization. In contrast, Heidt and colleagues (2005) examined sexual revictimization in a sample of individuals who identify as gay, lesbian, or bisexual. Nearly two thirds of the sample endorsed experiencing some form of sexual victimization. Approximately 19% of all participants reported a history of CSA only, 19% reported a history of adult sexual assault (ASA) only, and 24% of all participants reported experiencing both CSA and ASA. Of those who reported some form of sexual victimization, 39% reported experiencing sexual revictimization. The authors found that gay men and bisexual men and women were significantly more likely to experience sexual revictimization when compared to lesbian women. Severity of CSA was associated with a greater risk of sexual revictimization in gay men, lesbian women, and bisexual men and women.

Balsam and colleagues (2011) also explored sexual revictimization in this much neglected community. In their study of a community sample of lesbian women, gay men, and their heterosexual sisters, nearly half of the lesbian women in the study reported experiencing CSA, which is a higher rate of childhood victimization than the gay men and heterosexual women. Lesbian women also reported higher rates of adult victimization compared to heterosexual women; however, this higher rate of lesbian victimization was no longer significant when CSA history was taken into account. Individuals who reported CSA histories, regardless
of sexual orientation, where 2.59 times more likely to experience adult sexual victimization compared to individuals without CSA histories.

**Effects of Revictimization**

As with CSA, sexual revictimization is associated with a variety of deleterious effects. Ellis, Atkeson, and Calhoun (1982), following the landmark study by Miller and colleagues (1978), were among the first to explore the effects of sexual revictimization. Ellis et al. (1982) examined data from female victims of rape seen at a hospital rape crisis center, over a fifth of whom had also been assaulted as an adolescent (age 13 and older) or adult prior to the victimization for which they sought treatment. The authors found that the revictimized women were significantly more likely than women without victimization histories to report difficulties with their social network, sexual adjustment, alcohol and drug use, depression or suicidal behavior, anxiety, and paranoia, anger, and hostility. Women who were revictimized were also significantly more likely to report a history of psychiatric treatment when compared to women who reported no prior victimizations.

**Mental health.** One area of sexual revictimization research has focused on the negative mental health outcomes associated with revictimization. Revictimized women have been found to have a significantly higher risk of suicide attempts and a lower level of functioning when compared to CSA victims who were not revictimized (Lau & Kristensen, 2010), and women who have been revictimized have been found to be 3 times more likely to report suicidal ideation and/or suicide attempts compared to women who report victimization in adulthood only and non-victims (Miner, Koltz Flitter, & Robinson, 2006). Revictimization has also been associated with symptoms and anxiety and depression and general distress (Heidt et al., 2005; Kimerling et al., 2007; Miner et al., 2006). In a sample of lesbian women, gay men, and heterosexual women,
revictimized individuals reported higher levels of psychological distress, alcohol use, drug use, suicidality, and self-harm behaviors compared to singly-victimized individuals, who reported higher levels of these mental health symptoms than non-victims (Balsam et al., 2011).

**Posttraumatic stress disorder.** In addition to these general mental health concerns, PTSD specifically has been found to be associated with sexual revictimization. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association [APA], 2000), PTSD can develop after an individual experiences or witnesses an event that threatens the life or physical integrity of the individual or others and the individual responds with fear, hopelessness, or horror. In order to meet criteria, individuals must re-experience the event in at least one of the following manners:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions…
2. recurrent distressing dreams of the event…
3. acting or feelings as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)…
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. (APA, 2000, p. 468)

Additionally, individuals must experience at least three of the following symptoms of avoidance or numbing:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. efforts to avoid activities, places, or people that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities
5. feeling of detachment or estrangement from others
6. restricted range of affect (e.g., unable to have loving feelings)
7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span). (APA, 2000, p. 468)
Finally, to meet diagnostic criteria, individuals must experience two or more of the following symptoms of increased arousal:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response. (APA, 2000, p. 468)

In order to qualify for a diagnosis of PTSD, these symptoms must last at least 1 month and must clinically impair the individual’s functioning. PTSD can greatly debilitate and even disable those affected by the disorder. In military veterans alone, the cost of PTSD and depression on society was estimated to range from four billion to over six billion dollars in 2007, and the cost of treating one individual with PTSD for 2 years was estimated to be between $5,904 to $10,298 (Assessing Combat Exposure, 2009). It was noted that the majority of the costs incurred were due to a loss of productivity.

Given the great impact that PTSD can have, it is important to consider its prevalence in sexually victimized women. Walsh, Danielson, and colleagues (2012) examined the relationship between PTSD and sexual revictimization in national probability samples of female adolescents, college students, and household-residing adults. They found that of females reporting sexual victimization, at least half of adolescents, college students, and adult household-residing women reported two or more victimizations. In all age groups, revictimized females were significantly more likely to report PTSD symptoms in the past 6 months when compared to singly victimized females. Compared to women who did not endorse experiencing sexual victimization, women who reported a single victimization and women who reported revictimization were 2 to 3 times and 4 to 8 times more likely to report experiencing PTSD symptoms in the past 6 months, respectively.
Revictimization has been found to be associated with PTSD symptoms in several other studies (Heidt et al., 2005; Kimerling et al., 2007; Noll, Horowitz, Bonanno, Tricket, & Putnam, 2003; Trickett et al., 2011), and in one prospective study, sexual revictimization was also found to predict PTSD symptoms in an ethnically diverse community sample of women with histories of CSA (Najdowski & Ullman, 2009).

Even nearly 30 years later, studies have supported the negative sequelae of revictimization: adult revictimization has been found to have a larger impact on overall functioning than CSA alone (Maker et al., 2001). Although treatment after revictimization is important, preventing the victimizations in the first place is also a priority. The development of effective risk reduction programs is a critical step in reducing the prevalence of sexual revictimization, and the identification of risk factors for revictimization is important to lend an empirical basis to any risk reduction program development.

**Risk Factors for Revictimization**

Sexual abuse or assault is never the victim’s fault: only the perpetrator is to blame. Sexual victimization is something that happens to an individual against his or her will, and as such nothing that the victim does can cause the assault; however, a variety of factors have been found to be associated with and increase the risk of sexual revictimization.

Of note, a large number of the studies described below utilize a prospective design, which is commonly considered superior to cross-sectional designs as it can demonstrate the temporal relationship between two or more factors; however, prospective studies cannot prove causality and are thus generally used to predict a specific outcome based on behaviors or traits of interest (Testa & Livingston, 2009). This information should be kept in mind when interpreting the research presented.
**Child sexual abuse.** CSA has been described as the single best predictor of sexual revictimization (Balsam et al., 2011; Walsh, Blaustein, Knight, Spinazzola, & van der Kolk, 2007). As stated earlier, women with a history of CSA are up to 4 times more likely to be sexually assaulted as adults when compared to women without CSA histories (Kimerling et al., 2007). Moreover, the severity of the sexual abuse in childhood—including the duration of the abuse and whether there was physical contact—has been associated with an increased risk of sexual revictimization (Arata, 2000; Heidt et al., 2005).

**Posttraumatic stress disorder.** PTSD, a common consequence of CSA as evidenced by findings discussed earlier (Briere & Elliott, 2003; Molnar et al., 2001; Trickett et al., 2011), has also been identified as a risk factor for sexual revictimization. PTSD symptoms have been found to predict prospective sexual revictimization, both perpetrated through the use of force as well as alcohol intoxication, in community samples of women with CSA histories (Littleton & Ullman, 2013; Najdowski & Ullman, 2009). Arata (2000) also found that posttraumatic symptoms—in addition to consensual sexual behavior and self-blame—mediated the relationship between CSA and sexual revictimization. PTSD symptoms have also been implicated in revictimization in domestic violence situations: in a predominantly African American sample of low-income women seeking help for domestic violence, hyperarousal and dissociation were both significant predictors of prospective physical interpersonal violence revictimization (Iverson et al., 2013).

The unfortunate fact is that these women did not choose to be sexually abused as children or develop symptoms of PTSD as a result of the abuse: sexual victimization is never the victim’s fault. These women cannot change their abuse histories; however, this does not mean that women with CSA histories are destined to be sexually revictimized. Many studies do not find a direct path from CSA or adolescent sexual victimization and adult sexual victimization (Arata,
REVICTIMIZATION AND DBT

2000; Fargo, 2009; Messman-Moore, Walsh, & DiLillo, 2010; Messman-Moore et al., 2012; Najdowski & Ullman, 2009). In fact, Fargo (2009) found in his study of a sample of predominantly African American females that “revictimization depended on intervening experiences and risk factors, rather than directly on prior experiences of sexual victimization” (p. 1786). Additionally, although CSA has been found to be associated with psychological distress, one study of female college students found that general avoidance actually contributed more than CSA history to the variance in psychological symptomology (Batten, Follette, & Aban, 2001). A wide variety of additional factors have been found to put women at risk of revictimization, and this is an area where victimized women can take control and change their behaviors in hopes of reducing their risk of revictimization. These risk factors can be divided into two overarching categories: maladaptive coping and skills deficits.

**Maladaptive coping.** Maladaptive coping, often operationalized as “behavioral disengagement, denial, humor, self-blame, self-distraction, and substance use” (Najdowski & Ullman, 2011, p. 219), has been associated with a variety of negative outcomes, including mental health symptoms, sexual revictimization, and physical interpersonal violence revictimization (Iverson et al., 2013; Najdowski & Ullman, 2011). In an ethnically diverse community sample of women with a history of sexual assault, women who reported higher levels of engagement in maladaptive coping were more likely to be prospectively sexually revictimized when compared to women who reported less maladaptive coping; moreover, maladaptive coping both predicted prospective revictimization and was a result of the sexual revictimization experienced (Najdowski & Ullman, 2011). While general maladaptive coping has been linked with sexual revictimization, more specific forms of maladaptive coping—substance use, risky sexual behavior, and avoidance—have also been demonstrated to be risk factors of revictimization.
Substance use. Women who were sexually abused in childhood are more likely to have substance use problems. In an analysis of a national survey on alcohol use, Lown, Nayak, Korcha, and Greenfield (2011) found that when controlling age, marital status, education, employment status, ethnicity, and parental alcohol problems, women who reported experiencing CSA more likely to report engaging in heavy episodic drinking—commonly defined for females as consuming four or more alcoholic beverages on a single occasion (Jackson, 2008)—and consuming more alcoholic drinks in the past year when compared to women without abuse histories (Lown et al., 2011). CSA victims were also more likely than non-victims to report experiencing the negative consequences of alcohol in the following domains: work problems, fights or arguments, family reactions, vehicular accidents or legal trouble, and health problems. In a national longitudinal study of adolescent females, Raghavan and colleagues (2004) found that alcohol use doubled an adolescent’s risk of sexual victimization, and adolescents who used cocaine were 5 times more likely to be victimized.

Using structural equation modeling, Fargo (2009) found that alcohol problems, which were associated with adolescent risk-taking behavior, indirectly predicted adult sexual revictimization through alcohol use before sex and risky sexual behavior. Gidycz and colleagues (2007) bolstered this finding through their prospective research with female college studies. When compared to non-victims who reported little or no alcohol use, women with sexual victimization histories who reported moderate and high alcohol use were more likely to be assaulted between baseline and the 2- and 6-month follow-ups. For women who reported sexual victimization prior to the study, alcohol use significantly predicted revictimization between baseline and the first follow-up.
In another prospective study, women with a history of incapacitated sexual assault (i.e., sexual assault involving alcohol or drug use) who were revictimized during the study were nearly 4 times more likely to endorse cannabis use (Messman-Moore et al., 2012). Additionally, PTSD symptoms and hazardous drinking have been found to predict incapacitated sexual assault in women with histories of CSA (Littleton & Ullman, 2013). Finally, Najdowski and Ullman (2009) found that for women with histories of CSA, problem drinking as well as PTSD symptoms, predicted prospective sexual revictimization. Problem drinking and symptoms of PTSD also predicted prospective problem drinking both directly and indirectly through sexual revictimization.

**Risky sexual behavior.** In addition to substance use concerns, women with a history of CSA are more likely to have a variety of sexual concerns, including engaging in risky sexual behavior. Lacelle, Hébert, Lavoie, Vitaro, and Tremblay (2012) found in their longitudinal study of abuse sequelae that women who reported CSA and at least one other form of childhood victimization (psychological abuse, physical abuse, witnessing psychological abuse, or witnessing physical abuse) were more likely to report risky sexual behavior, sexual problems, and negative sexual self-concept when compared to women who reported CSA only or women without a victimization history. In this sample, the severity of CSA significantly predicted risky sexual behavior, sexual problems, and negative sexual self-concept, even when controlling for the effect of other individual forms of abuse and multiple forms of abuse.

Testa and colleagues (2010) further explored this association between alcohol use and risky sexual behavior in their prospective study of female college students. They found that sexual victimization in adolescence predicted an increase in risky behaviors including heavy episodic drinking, number of sexual partners, and number of hook-ups or casual sexual
encounters with strangers or acquaintances in the last year of high school. These high school risk behaviors then predicted risk behaviors in the first year of college, which in turn predicted sexual victimization in college. In other words, the relationship between adolescent sexual victimization and sexual victimization in the first year of college was partially mediated by engagement in risky behaviors in high school and college. Testa et al. also found that risky behaviors in college predicted sexual victimization in college equally well for women with and without histories of adolescent sexual victimization, demonstrating the significant impact of risky behaviors on sexual victimization for all women.

The relationship between risky sexual behavior and sexual revictimization has also been demonstrated in ethnically diverse samples of women. In a sample of low-income African American women, revictimized women reported a younger age at first pregnancy, higher engagement in prostitution-type behaviors, and less consistent condom usage when compared to CSA-only victims of and non-victims (Miner et al., 2006). Furthermore, risky sexual behavior—measured by number of consensual sex partners, participation in prostitution, and problematic behaviors and beliefs surrounding sex—mediated the relationship between adolescent revictimization and adult revictimization in a primarily African American sample of female CSA victims (Fargo, 2009).

Use of sex to reduce negative affect. One particular form of risky sexual behavior is the use of sex to reduce negative affect. Briere and Elliott (1994) noted in their report on the impacts of CSA that sex may be used by victims of sexual abuse as a form of avoidance:

Sexual arousal and positive sexual attention can temporarily mask or dispel chronic abuse-related emotional pain by providing more pleasurable or distress-incompatible experiences… frequent sexual activity may represent a consciously or unconsciously chosen coping mechanism, invoked specifically to control painful internal experience. (p. 61)
The work of Orcutt and colleagues (2005) supported this concept of using sex to reduce negative affect. They found that psychological distress and the use of sex to reduce negative affect partially mediated the relationship between CSA and ASA. Specifically, CSA was found to be associated with psychological distress, which was associated with ASA. Psychological distress was associated with use of sex to reduce negative affect, which was associated with ASA, thus indicating an indirect mediation between the use of sex to reduce negative affect and ASA. The path from use of sex to reduce negative affect to ASA was found to be partially mediated by the number reported of sexual partners between Time 2 (T2) and Time 3 (T3) reported, though the direct relationship between use of sex to reduce negative affect to ASA was still significant even when including this mediator. Use of sex to reduce negative affect nearly doubled women’s risk of ASA between T2 and T3, even when controlling for age, race, socioeconomic status (SES), childhood physical abuse, and childhood psychological abuse. Alcohol use during sexual intercourse was significantly related with use of sex to reduce negative affect but not ASA. Of note, Black women in this study were more likely to report a history of CSA, experiencing ASA between T2 and T3, and using sex to reduce negative affect when compared to non-Black women.

Avoidance. Avoidance, defined as “the tendency to deliberately avoid or escape from unpleasant internal experiences (e.g., thoughts, feelings, sensations),” is another form of maladaptive coping that has been linked with sexual revictimization (Rosenthal, Rasmussen Hall, Palm, Batten, & Follette, 2005). Women with histories of CSA are more likely use avoidance compared to women who have not experienced CSA, and this engagement in avoidant forms of coping has been associated with higher levels of trauma symptomology and general psychological distress (Briere & Rickards, 2007; Gibson & Leitenberg, 2001; Mouilso, Calhoun,
& Gidycz, 2011; Rosenthal et al., 2005). Moreover, avoidant coping has been found to mediate the relationship between CSA severity and severity of coercive sexual revictimization through its association with trauma symptoms (Fortier et al., 2009).

Skills deficits. In addition to maladaptive coping, skills deficits have been found to increase women’s risk of sexual revictimization, and researchers have identified two separate skills deficits—difficulties with emotion regulation and difficulties with interpersonal effectiveness—as risk factors for sexual revictimization.

Interpersonal effectiveness. Revictimized women, when compared to women who reported CSA but not adult victimization, have been found to be more likely to anticipate “that others would treat them in a hostile and controlling way” (Lau & Kristensen, 2010, p. 8). Revictimized women endorse having more interpersonal problems overall and are more likely to identify themselves as being overly responsible, overly nurturing, socially avoidant, and as having more difficulty being assertive than women with CSA histories who were not revictimized (Classen, Field, Koopman, Nevill-Manning, & Speigel, 2001). Revictimized women’s interpersonal difficulties may not only impact their ability to be assertive in their day to day lives but may also impair their ability to be assertive in sexual contexts. In fact, women with a history of sexual revictimization have been found to report lower levels of sexual refusal assertiveness, and low levels of sexual refusal assertiveness predicted prospective sexual victimization (Livingston, Testa, & VanZile-Tamsen, 2007). This prospective sexual victimization then predicted lower levels of sexual refusal assertiveness at the end of the study, indicating a reciprocal relationship between sexual victimization and sexual refusal assertiveness: women who experience sexual victimization are more likely to have low levels of
sexual refusal assertiveness, and this low level of sexual refusal assertiveness then puts them at risk for later victimization (Livingston et al., 2007).

Kearns and Calhoun’s (2010) cross-sectional study of female undergraduate students supports Livingston and colleagues’ (2007) finding. Kearns and Calhoun found that revictimized women had significantly lower scores on sexual refusal assertiveness when compared to women who reported only one incident of adult victimization, CSA-only victims, and non-victims. Additionally, when compared to CSA-only victims and non-victims, women who reported revictimization also had significantly lower scores on sexual self-efficacy.

Difficulties with assertiveness have also been linked to sexual revictimization in a common aspect of revictimization research: risk recognition. Messman-Moore and Brown (2006) conducted a prospective study of female college students to examine the relationship between risk perception and sexual revictimization. Over half the participants reported experiencing at least one form of unwanted sexual contact before the study, with 10% reporting a history of CSA. Of the women who reported being raped as an adult prior to the study, one in five also experienced CSA. Additionally, more than half of the women who reported prospective rape reported prior victimization, either as an adult, a child, or both.

During the study, women were asked to read two vignettes ending in forced intercourse, one with an acquaintance and one with a stranger, and indicate at what point they would feel uncomfortable during the proposed scenario and at what point they would leave the scenario. Messman-Moore and Brown (2006) found that women who reported revictimization were more likely to leave the acquaintance rape scenario later than women who reported no victimization or victimization prior to the study. Women who reported experiencing a single victimization and women reporting revictimization were more likely to leave the stranger rape scenario later than
women without a history of victimization. Prior victimization and impaired risk perception (as defined as late leaving) were found to be significant predictors of sexual victimization. However, significant differences in when women reported feeling uncomfortable in the hypothetical scenarios were not found; prospective victimization was better predicted by behavioral response, not threat identification. This finding suggests that women who are better able to use assertive behavior to leave a situation in which they feel uncomfortable are less likely to experience sexual assault, again indicating the importance of interpersonal effectiveness skills in sexual situations.

**Emotion regulation.** In addition to difficulties interpersonal effectiveness skills, emotional dysregulation has been identified as a risk factor for sexual revictimization. CSA has been found to be associated with emotion dysregulation in a community sample of males and females (Briere & Rickards, 2007), and revictimization has also been linked with emotion regulation difficulties. In an ethnically diverse sample of female prisoners, Walsh, DiLillo, and Scalora (2011) found that, compared to CSA-only or non-victims, revictimized women had more difficulties with emotion regulation overall and with nonacceptance of emotions and lack of emotional clarity specifically. Revictimized women also reported more difficulties with impulse control when compared to women who reported adult-only victimization.

Emotion dysregulation has not only been found to be correlated with revictimization but also predictive of it. Messman-Moore and colleagues (2012) used a prospective study to assess whether emotion regulation difficulties impact a woman’s risk for sexual revictimization when substance use is taken into account. Of the 229 female undergraduate participants, nearly one third reported experiencing incapacitated sexual assault, or sexual assault involving alcohol or drug use, prior to the study, and 8% of the sample reported revictimization during the study.
Women who reported revictimization endorsed having greater difficulties with emotion regulation when compared to women who were never victimized or women who reported only prior victimization. Emotion dysregulation—both overall and impulsivity alone—was found to predict sexual revictimization even when controlling for problems related to alcohol use, cannabis use, and negative affect.

Further, Walsh, DiLillo, and Messman-Moore (2012) explored the relationship between emotion regulation difficulties, sexual risk perception, and sexual victimization in a large sample of college women. Nearly 21% of the women reported experiencing CSA only, 33% reported experiencing adolescent sexual victimization only, 23% reported experiencing adult sexual victimization only, and 23% reported experiencing sexual revictimization. A history of sexual victimization was associated with leaving a sexual risk vignette later and with difficulties with emotion regulation. Emotional nonacceptance, impulse control problems, difficulties with emotional awareness, restricted emotion regulation strategies, lack of emotional clarity, and problems with goal-directed behavior were all associated with leaving the sexual risk scenario later. Moreover, impulse control difficulties and limited access to emotion regulation strategies partially mediated the relationship between history of sexual victimization and leaving the risk scenario later.

**Risk Reduction and Prevention Efforts**

Given the prevalence and great negative impact of sexual victimization and revictimization, researchers have attempted to develop programs to reduce the risk of sexual assault. In a review of 126 studies of risk reduction programs for sexual assault published from 1984 to 2001, Blackwell et al. (2004) found that nearly all programs were superior to no intervention in changing attitudes about sexual assault, especially acceptance of rape myths.
They also found that programs that presented information in multiple formats, including discussions, role plays, and lectures were more successful in changing attitudes when compared to programs that presented information in a single format, such as a lecture. Additionally, programs with positive results provided information about sexual assault as well as encouraged the development of assertiveness, communication, and problem solving skills.

While the majority of the studies examined by Blackwell and colleagues (2004) focused on the effects of risk reduction programs for participants without a history of sexual victimization, only two methodologically rigorous studies (Marx, Calhoun, Wilson, and Meyerson, 2001 and Calhoun et al., as cited in Blackwell et al., 2004, discussed below) focused on interventions with women who reported sexual victimization. Blackwell et al. found that in programs targeted to a general audience—not specifically for sexually victimized women—women with histories of sexual victimization did not have a decreased incidence of sexual victimization following these programs even though women without histories of sexual victimization sometimes did. This lack of success in decreasing sexual revictimization suggests that programs that are developed specifically for sexually victimized women may be needed.

Iverson and colleagues (2011) explored an intervention with a related population—women with histories of interpersonal trauma—to determine whether cognitive processing therapy (CPT), a cognitive behavior therapy (CBT) treatment for PTSD, could decrease the incidence of intimate partner violence revictimization with these women. In the study, 150 adult women who met criteria for PTSD related to sexual or physical victimization as a child or adult received one of three possible forms of CPT: full CPT, the cognitive part of CPT only, or the written account aspect of CPT only. The full CPT model aims to help individuals identify and challenge cognitive distortions and includes writing detailed accounts of the trauma as well as
cognitive therapy. On average, women attended 9.5 hr of treatment, and 57% of the women completed the full 12 hr of treatment. Follow-up assessments were conducted 6 months after treatment, and the authors found that there was a positive relationship between PTSD and depression symptoms and level of intimate partner violence: women whose PTSD and depression symptoms decreased the most from treatment reported less intimate partner violence during the follow-up period compared to women who saw less symptoms reduction with treatment. These findings indicate that “treating PTSD and depression symptoms among interpersonal trauma survivors can function to reduce risk for future IPV [intimate partner violence] and interrupt or prevent this cycle of abuse” (Iverson et al., 2011, p. 200). The success of this program is encouraging and suggests that the treatment of symptoms of PTSD and depression may also be effective in reducing rates of sexual revictimization.

Iverson and colleagues’ (2011) success with women with histories of interpersonal trauma has also been found with victims of sexual violence. Marx, Calhoun, Wilson, and Meyerson (2001) evaluated the effects of a sexual revictimization prevention program presented to undergraduate women who reported experiencing sexual victimization after the age of 14. Participants were assigned to either the intervention or control group. The prevention program, which consisted of two, 2-hr sessions, used psychoeducation and skills training to (a) increase knowledge of sexual violence, (b) increase “understanding of social forces that foster a rape-supportive environment,” (c) increase skills to reduce the risk of unwanted sexual contact, including those skills used in dating situations, and (d) improve “risk-recognition, problem-solving, assertiveness, and communication skills” (Marx et al., 2001, p. 26).

Marx and colleagues (2001) found that 27% of the women reported revictimization during the 2-month follow-up period. Although the intervention and control groups were not
revictimized at statistically significantly different rates when all forms of victimization were considered (i.e., unwanted sexual contact, sexual coercion, attempted rape, or completed rape), the women in the intervention group reported significantly lower rates of completed rape compared to the women in the control group. Additionally, when compared to women in the control group, women in the intervention group reported greater self-efficacy in sexual situations and lower levels of psychological distress. There were no significant between group differences in risk recognition as measured by when participants indicated they would leave a hypothetical date rape scenario, nor were there significant differences in risk recognition between women who were revictimized during the follow-up period and those who were not. However, women who specifically reported being the victim of completed rape during the follow-up period indicated that they would have left the date rape scenario significantly later than women who did not report experiencing completed rape during the same time period. Overall, the authors concluded that the sexual revictimization prevention program was “effective in reducing the incident of rape revictimization” and “significantly increased self-efficacy and decreased overall ratings of distress” (Marx et al., 2001, p. 30).

Marx and colleagues’ (2001) study was followed by Calhoun et al. (as cited in Blackwell et al., 2004), who presented a poster on their extension of Marx et al.’s prevention program. Calhoun and colleagues added a video of sexual assault survivors sharing their stories to the curriculum and presented the program to a larger sample of college women with histories of sexual victimization. They found that, compared to women in the wait-list control group, women who participated in the program reported higher levels of self-efficacy and improved risk perception at the 4-month follow-up assessment. Additionally, the intervention group reported lower rates of sexual revictimization overall during the follow-up period than the control group,
and only the control group, not the intervention group, reported experiencing forcible rape during the follow-up period.

Senn, Gee, and Thake (2011) evaluated the impact of a different intervention for women with histories of sexual victimization, a revised version of the *Assess, Acknowledge, Act* (AAA) sexual assault resistance program originally developed by Rozee and Koss (2001). The program aimed to increase participants’ ability to detect risky situations and effectively use sexual assault resistance behaviors, including the use of verbal and physical force. The responses of 214 first-year undergraduate women were analyzed in this study, over half of whom reported experiencing sexual victimization in some form (i.e., unwanted sexual contact, sexual coercion, attempted rape, or completed rape) prior to the start of the program.

Senn et al. (2011) evaluated two forms of the AAA program: Basic AAA and Enhanced AAA. The Basic AAA program involved identifying risky sexual situations and coercive behavior, problem-solving ways to decrease one’s risk of assault, overcoming emotional barriers to using force to resist sexual assault, and learning resistance behaviors including physical self-defense. The Basic AAA program was presented in three 3-hr sessions. The Enhanced AAA program added an addition session before the Basic AAA program that focused on identifying women’s values, boundaries, and safety needs surrounding sex, practicing assertively communicating this information, and exploring the women’s own ideas of what a healthy sexual relationship looks like.

Before the study, Senn and colleagues (2011) randomly assigned participants to either the control group, the Basic AAA group, or the Enhanced AAA group. Assessments were completed before the program as well as 1 week, 3 months, and 6 months after the program. The Basic and Enhanced AAA groups had significantly different attrition rates, with 13% of
participants dropping out of the Basic AAA group and 33% dropping out of the Enhanced AAA group. The authors indicated that the majority of the participants in the Enhanced AAA group who did not continue the program dropped out after the sexuality-focused session.

After completing statistical analyses, Senn et al. (2011) found that the Enhanced AAA group indicated feeling uncomfortable and leaving a hypothetical sexual risk scenario earlier than women in the Basic AAA group or the control group. Both intervention groups reported higher self-defense self-efficacy than the control group at the 3-month follow-up point, and women in the Enhanced AAA group continued to having significantly higher self-defense self-efficacy scores at the 6-month follow-up while the Basic AAA group and the control group were no longer significantly different. Compared to the control group, women in the Basic and Enhanced AAA group reported that they would use more direct or forceful resistance techniques one week after the program. Additionally, both intervention groups reported a greater likelihood of using verbal force at the 3-month follow-up, and the Basic AAA program reported greater likelihood of using physical force at the 6-month follow-up. As a whole, the Basic AAA group identified more resistance techniques involving verbal or physical force compared to the Enhanced AAA group and the control group. Possibly due to the small sample size, no significant effects were found for either group in the reduction of rape; however, more women in the Basic AAA group reported that they were successful in avoiding or resisting sexual victimization during the follow-up period than those in the control group.

Overall, Senn and colleagues (2011) found that the AAA sexual assault resistance programs were successful in increasing sexual assault risk perception, self-defense self-efficacy, knowledge of self-defense techniques, and use of these techniques to avoid or resist sexual assault in participants’ own lives. The authors concluded that the AAA programs were shown to
meet “the needs of previously victimized and non-victimized women,” and this effectiveness with previously victimized women is critical as they were found to have “slower risk perception, lower self-defense efficacy, lower intentions to use direct assertiveness self-defense tactics, and lower sexual refusal assertiveness” prior to the program (Senn et al., 2011, p. 87).

Finally, Hill, Vernig, Lee, Brown, and Orsillo (2011) took a different approach and developed a brief acceptance and mindfulness-based intervention designed to reduce rates of sexual assault in college women with and without histories of CSA. Interestingly, although the previously described interventions included explicit sexual assault components, this program, advertised as a stress-reduction workshop, contained no information specific to sexual victimization in order to target a wide range of problems and make the program more applicable to all students. The mindfulness-based workshop consisted of two sessions that focused on psychoeducation and experiential exercises designed to increase participants’ willingness to observe any unpleasant cognitions, emotions, or bodily sensations without avoiding or suppressing them. This decrease in avoidant coping was hypothesized to result in a reduction in sexual victimization.

A total of 12 women with histories of CSA and 21 women without CSA histories participated in the mindfulness program, and 20 women with histories of CSA and 24 women without histories of CSA comprised the no-intervention control group (Hill et al., 2011). Assessments were completed prior to and 2 months after the intervention. Approximately 21% of the women with CSA histories were sexually revictimized during the follow-up period compared to 7% of the women without CSA histories, indicating that CSA tripled women’s risk of sexual victimization in any form (unwanted sexual contact, sexual coercion, attempted rape, or completed rape) during the follow-up period. Although this finding had a moderate effect size, it
was not statistically significant. Women in the control group were also more likely to report specifically being raped compared to women in the intervention group (10% vs. 0%), and again although this finding had a moderate effect size, it was not statistically significant. Furthermore, when comparing only women with CSA histories, those in the control group were more likely to report being raped compared to women in the intervention group (80% vs. 0%). This finding had a large effect size but was not statistically significant.

Although the program increased women’s scores on the observing subscale of the mindfulness measure, Hill and colleagues (2011) found that overall the program did not increase overall acceptance and mindfulness scores in women with CSA histories. However, women who reported using a mindfulness exercise at least once between the workshop and the follow-up assessment were significantly less likely to report being sexually victimized when compared to those women who did use any mindfulness exercises. As a whole, even though the program had few statistically significant results—likely due to the small sample size—the effect sizes found were mainly medium to large, and women with CSA histories in the intervention group were revictimized at notably lower rates compared to women with CSA histories in the control group. These findings suggest that acceptance and mindfulness-based programs may be effective in decreasing rates of sexual revictimization in women with CSA histories.

Even though the results of these studies are promising and indicate that risk reduction programs may be successful in reducing rates of sexual revictimization, the fact is that victims do nothing to cause the attack and cannot truly prevent another person from committing the volitional act of assault. As sexual revictimization is not completely preventable, it is important to determine what effect, if any, these risk reduction programs have on women who are revictimized. Mouilso and colleagues (2011) did just that in their study of the effects of
participating in a sexual assault risk reduction program on psychological distress in women who were sexually revictimized after the program. A total of 491 female college students with reported histories of sexual victimization were randomly assigned to either the intervention or wait-list control group. The sexual assault risk reduction program consisted of two, 2-hr sessions that focused on psychoeducation, personal risk assessment, assertiveness, and problem solving. Additionally, participants were invited to evaluate the factors that may contribute to their own revictimization in the future.

At the 4-month follow-up, nearly 30% of the sample reported experiencing sexual revictimization since the program, with significantly fewer women in the intervention group reporting revictimization than the control group, and those in the intervention group tended to report less severe sexual revictimization. Furthermore, the intervention group had a significant decrease in psychological distress and posttraumatic symptoms from the initial assessment to the 4-month follow-up while the control group exhibited no change in psychological distress or posttraumatic symptoms. Even though avoidant coping was still a significant predictor of psychological distress for both groups, Mouilso and colleagues (2011) also found that participation in the program helped mitigate the impact of self-blame on psychological distress. The findings of this study lend credence to the importance of prevention programs for sexual revictimization: women who participate in risk reduction programs tend to be revictimized at lower rates, and they experience less severe mental health symptoms even if they are revictimized.

The findings presented above demonstrate the promising effects of sexual revictimization risk reduction programs, and this form of victimization is clearly a concern given the prevalence of CSA and the increased risk it imbues. While the programs described primarily focus on
providing sexual assault information and some skill building—with the exception of the program by Hill and colleagues (2011), which targeted acceptance and mindfulness alone—none completely address the myriad risk factors for sexual revictimization explored earlier: posttraumatic symptoms, interpersonal relationship difficulties, emotion dysregulation, and maladaptive coping including substance use, risky sexual behavior, and avoidance.

Researchers who study sexual victimization and revictimization have even called for interventions that emphasize these areas. Livingston and colleagues (2007) appealed for programs that target interpersonal effectiveness and improve participant’s ability to successfully refuse unwanted sexual advances, adding that programs that target distress and coping mechanisms “may be particularly beneficial for women who have already experienced sexual victimization because they are likely to be low in refusal assertiveness and are at heightened risk of revictimization” (p. 310). Orcutt and colleagues (2005) petitioned for interventions that reduce distress and teach women more effective forms of self-soothing, noting that if women are using sex to reduce negative affect resulting from CSA, such programs “may be more effective in reducing risks for sexual revictimization” (p. 737). Gidycz et al.’s (2007) research on alcohol use furthers this idea of promoting effective forms of self-soothing, noting that even though women with histories of sexual victimization are at greater risk of sexual victimization, “lowered levels of drinking appear to decrease their risk for subsequent assault” (p. 13).

Further, the studies on risk reduction programs described found that the interventions presented were not as effective in decreasing rates of sexual assault in women with victimization histories. Because of this, Blackwell and colleagues (2004) have called for a new form of intervention with women who have been sexually victimized in the past. They posited that due to possible information processing impairments resulting from the posttraumatic effects of sexual
victimization, “previously victimized women may require more intensive and extensive interventions…than women who have never been victimized” and appealed for more rigorous interventions that may be “more akin to group therapy with a clinical population than to risk-reduction programming with a general student or community population” (Blackwell et al., 2004, pp. 290-291).

When considering the information given, the need for a new form of risk reduction intervention for sexually victimized women becomes clear—an intervention that targets not only mental health symptoms including PTSD but also difficulties with interpersonal relationships, emotion regulation, and using adaptive forms of coping in a group therapy format. Thus, the use of a dialectical behavior therapy (DBT) skills group for women with histories of CSA and sexual assault to reduce their risk of future revictimization is proposed

**Group Dialectical Behavior Therapy for Sexual Revictimization Risk Reduction**

**Dialectical Behavior Therapy**

DBT is a cognitive-behavioral treatment created by Marsha Linehan (1993a, 1993b) that was originally developed to treat suicidal and self-injurious behavior in women with borderline personality disorder (BPD). In the *DSM-IV-TR*, BPD is conceptualized as a “pervasive pattern of instability of interpersonal relationships, self-image, and affects” with “marked impulsivity beginning by early adulthood and present in a variety of contexts” (APA, 2000, p. 710). To qualify for a diagnosis of BPD, individuals must display at least five of the following nine criteria:

1. frantic efforts to avoid real or imagined abandonment…
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least two areas that are potentially self-damaging…
5. recurrent suicidal behavior, gestures, or treats, or self-mutilating behavior
Linehan (1993a) conceptualized BPD differently and described the disorder as a “pattern of behavioral, emotional, and cognitive instability and dysregulation” (p. 11) and identified six specific behavioral patterns in BPD: (a) emotional vulnerability, (b) self-invalidation, (c) unrelenting crises, (d) inhibited grieving, (e) active passivity, and (f) apparent competence. Because of these patterns, individuals with BPD often have multiple complex problems, which can make treatment difficult, and these treatment difficulties led Linehan to create an alternative to standard treatment: DBT (Koerner & Dimeff, 2007).

Dialectics. DBT is based on principles not only from cognitive behavioral therapy but also dialectical philosophy (Lynch, Trost, Salsman, & Linehan, 2007; Robins & Chapman, 2004). Dialectics is the process of holding two or more contradictory or conflicting views in balance (Moonshine, 2008). In DBT, dialectics are seen as the nature of reality and the basis of persuasion (Linehan, 1993a,b). The dialectical nature of reality can be summed up by three basic principles: (a) interrelatedness and wholeness, (b) polarity, and (c) continuous change. The principle of interrelatedness and wholeness means that looking at only individual or micro aspects of a reality does not provide the whole picture. Instead, we must examine the micro as well as the macro aspects of the system in context and consider the interrelatedness of the patterns in the system to have a more accurate view of reality.

The principle of polarity dictates that reality is not static; it is composed of “internal opposing forces (thesis and antithesis) out of whose synthesis evolves a new set of opposing forces” (Linehan, 1993b, p. 2). This dynamic nature of reality challenges us to not just look at...
the whole but also examine the complexity of the whole, realizing that “all propositions contain within them their own oppositions” (Linehan, 1993a, p. 32). Thus, there is function found within dysfunction; there is truth found within distortions.

The final principle of the dialectical world view is that of continuous change. The tension between two opposing forces in a system produces change; however, “the new state following change…is also comprised of polar forces” (Linehan, 1993a, p. 33). Therefore, change is an ongoing process in reality.

In DBT, dialectics are also used in persuasion. Often in therapy, clients are stuck in extremes—the thesis and antithesis—and are unable to move forward toward a synthesis of these opposing forces (Linehan, 1993b). By using dialectics, the therapist can engage a stuck client in a conversation, taking the client and the system as a whole into account. In this dialogue, neither the thesis nor the antithesis is considered the absolute truth as truth is “neither absolute nor relative” (Linehan, 1993a, p. 34). The therapist can help the client get “unstuck” by reconciling their strongly held yet contradictory view points and moving toward a balance, or synthesis, of the two positions.

**Biosocial theory.** Within the context of this dialectical world view, Linehan (1993a,b) proposed a biosocial theory of BPD. According to this theory, emotion dysregulation is the core of BPD, and this emotion dysregulation is brought about by a biologically-based emotional vulnerability and an invalidating environment. Due to genetics or other biological factors, some individuals are more sensitive to emotional stimuli, respond to it with very strong emotions, and take longer to return to baseline after such a strong affective response. The social component of the biosocial theory focuses on an invalidating environment, where caregivers respond to a child’s thoughts and feelings in a way that communicates that these thoughts and feelings are
invalid, inappropriate, or wrong. In an invalidating environment, children fail to learn skills of emotion identification or modulation, and they may learn to not trust their emotional experience as valid and therefore invalidate themselves. This combination of emotional vulnerability and an invalidating environment—and the interaction between them—thus brings about the emotion dysregulation that is at the core of borderline personality disorder.

**DBT Assumptions.** Based on this biosocial theory of BPD, Linehan (1993a) identified eight assumptions about clients with BPD and therapy with them. These assumptions can help guide treatment and form the context within which treatment planning is completed. The first assumption is that clients are doing the best that they can given their history, learning, and current situation. The next assumption, that clients want to improve, supports this validating view of the client. These points, however, are balanced by the assumption that clients still “need to do better, try harder, and be more motivated to change” (Linehan, 1993a, p. 106). Linehan notes that the first two assumptions form a dialectic with the third: although they may appear contradictory, all are true, and therapists must synthesize these assumptions in their treatment with clients.

The fourth assumption delineated by Linehan (1993a) is that even though clients may not have caused all of their problems, they still have to solve them. This assumption underlines the fact that clients must make changes in their own responses as well as in their environment to change their circumstances. Clients must save themselves; therapists cannot do this for them.

The change prescribed in Linehan’s (1993a) fourth assumption is critical given the fifth assumption: the lives of clients with BPD are unbearable as they currently are. Often, clients with BPD describe their lives as a living hell, and the only way for clients to get out of this hell is to change their environment as well as their response to it. Given that change is necessary for
these individuals whose lives are a daily struggle, clients must therefore adopt new behaviors and skills in all relevant contexts, which is the sixth assumption. Only practicing new behaviors within the therapy office or when clients are in a state of emotional equilibrium is not enough; they must be able to employ these behavioral changes in all settings and emotional states, including—or especially—during a crisis.

The seventh assumption of DBT is that clients cannot fail in therapy (Linehan, 1993a). If clients drop out of treatment, fail to meet treatment goals, or get worse during treatment, it is assumed that the therapy or the therapist have failed—not the client. This encourages the treatment team to reevaluate their approach rather than blame the client or dismiss the treatment failure as a lack of motivation on the part of the client. As so much weight is put on therapists and the treatment team, therapists working with clients with BPD need support, which is the eighth and last assumption. This support can be found in the form of supervision, consultation, or a treatment team and is designed to help keep therapists on track and working effectively within the framework of DBT.

**Treatment strategies.** Based on the dialectical world view and the above assumptions, Linehan (1993a) identified four main treatment strategies used in DBT. The two core strategies, between which therapists must find a balance, are validation, or acceptance, and problem solving, or change (Linehan 1993a; Robins & Chapman, 2004). Therapists are to not only validate that clients’ emotional, behavioral, and cognitive responses make sense given their history and current situation but also validate that clients have to ability to fix their problems and start building a life worth living. That is, “the therapist both believes and believes in the patient” (Linehan, 1993a, p. 99).
Such validation is balanced with problem solving strategies, including conducting a behavioral analysis, conducting a solution analysis, orienting clients to possible treatment solutions, encouraging and obtaining clients’ commitment to treatment procedures, and applying the treatment (Linehan, 1993a). A behavioral analysis, or chain analysis, is used to evaluate events and situations that led up to a problematic behavior, such as cutting, and explore possible reinforcements for that behavior. After the chain analysis is completed, the client and therapist can begin a solution analysis, identifying points in the chain of events where alternative behaviors could be used to avoid the problematic behavior in the future.

In addition to balancing the core strategies of validation and problem solving, DBT therapists must also balance two communication styles: irreverent and reciprocal communication (Linehan, 1993a). A reciprocal communication style demonstrates acceptance (Robins & Chapman, 2004); therapists using this communication style may employ warmth, empathy, appropriate self-disclosure, and direct responsiveness to the client (Linehan, 1993a). This reciprocity is balanced with irreverence, which can be used to encourage change, especially when clients are “stuck.” As summarized by Koerner and Dimeff (2007), an irreverent communication style can include “using a confrontational tone, using humor or unconventional phrasing, oscillating intensity, or at times expressing omnipotence or impotence in the face of the client’s problems” (p. 13).

Finally, DBT therapists employ two case management strategies: serving as a consultant to clients to empower them to be their own case managers and performing interventions in the environment (Linehan, 1993a). Whenever possible, therapists encourage clients to advocate for themselves when working with other providers by coaching clients on how to effectively have these interactions. In this way, therapists help clients solve their own problems rather than
solving them for clients. However, therapists do employ more direct strategies of intervention, including directly coordinating with other treatment providers, when clients are currently unable to effectively do so themselves or when the consequences or outcome are critical to the health and safety of the client or the treatment process.

Balancing these treatment strategies while working with difficult clients can be quite challenging for therapists; therefore, “treatment of the therapist by the supervision, case consultation or treatment team” is crucial to holding the therapist inside the framework of treatment (Linehan, 1993a, p. 101).

**Stages of treatment.** In addition to these guiding treatment strategies, Linehan (1993a,b) organized treatment into four stages. Treatment was delineated in such a fashion because one of the main difficulties in working with clients with BPD is the myriad problems they present with in a variety of domains. Treatment priorities were thus delineated in order to direct therapists where to start (Robins & Chapman, 2004). Before treatment begins, the client and the therapist must first come to an agreement on the essential goals and methods of treatment (Koerner & Dimeff, 2007). From there, clients start at the most appropriate stage of treatment.

The first stage of treatment is for clients who in the most distress and may be engaging in self-injurious behavior, severe eating disorder behavior, or severe substance abuse (Robins & Chapman, 2004). The goal of stage one is to address the following concerns, listed in order of priority: (a) suicidal behaviors, (b) therapy-interfering behaviors, (c) behaviors that interfere with quality of life, such as problematic substance use, and (d) skills deficits (Linehan, 1993a). The goal of the second stage of treatment is to “increase appropriate experiencing of emotions,” including treating PTSD (Robins & Chapman, 2004, p. 75). The third stage of treatment focuses on general problems of daily life, such as relationship concerns, career problems, self-esteem
issues, and less complicated mental health concerns such as anxiety and depression (Lynch et al., 2007). Finally, the fourth stage of treatment aims to help clients develop feelings of interconnectedness, happiness, and freedom (Lynch et al., 2007; Robins & Chapman, 2004).

DBT is able to be tailored to individual clients in that not all clients will start treatment at the same stage—clients begin treatment at the most appropriate stage, which may result in bypassing earlier stages of treatment (Lynch et al., 2007).

Treatment functions and modes. Linehan (1993a) developed DBT as a comprehensive treatment with five main functions, each with a corresponding mode of treatment. The first function of treatment is increasing clients’ motivation, which is addressed through individual therapy. The individual therapist in this model would monitor therapy goals, ensure the integration of all treatment modes, and aid the client in managing crises as well as life-threatening behaviors. The second function of DBT is enhancing clients’ capabilities, which is accomplished through group skills training. Skills training groups focus on four categories of skills—mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness—that will be discussed later. The third function of treatment is enhancing skills generalization to clients’ daily lives, which is accomplished by telephone coaching calls between sessions as needed. The fourth function of DBT is enhancing therapists’ capabilities and motivation through the use of a therapist consultation team. The final function of DBT is structuring the environment, which is accomplished through working with other healthcare providers and client supports (Lynch et al., 2007).

Group skills training. As stated above, skills training is used to enhance clients’ capabilities. According to Linehan (1993b), “skills training is necessary when solutions to an individual’s problems and attainment of her desired goals require behavioral skills not currently
in her behavioral repertoire” (p. 8). In DBT, the goal is the replace maladaptive or less effective behaviors with more skillful or effective behavior. Skills training is done in a group environment to take advantage of the fact that clients tend to help each other stay motivated, support each other, and learn from each other. Moreover, therapists are able to observe clients interacting in a social setting, and clients are able to receive feedback on their interpersonal style not only from the therapist but also other group members. Groups are also more economical: therapists are able to provide services to multiple clients at one time and at a lower rate for the individual.

In the traditional treatment model laid out in Linehan’s (1993b) skills training manual, the four skills modules are presented over 6 months, and clients typically attend two cycles of the group, or 1 year of skills training. The group is held weekly, lasts approximately two and a half hours, and is run by two therapists, a primary leader and a co-leader. The format of the group is as follows: approximately one hour for homework review, a 10 to 15 min break, about one hour for teaching new material, and a 15 min wind-down, which can include processing reactions to the group or guided relaxation or meditation.

Skills training modules. Linehan (1993b) outlined four skills training modules: mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. Mindfulness is the core of DBT and is typically taught first, though these skills are highlighted throughout the group. The mindfulness skills are based on Zen practices and focus on being in the here and now, doing one thing at a time, taking a non-judgmental stance, and being as effective as possible. An example of a mindfulness skill is Wise Mind, which encourages clients to integrate their emotional experience with their ability to be rational and logical, maintaining a balance between the two.
Emotion regulation, another skills module, aims to help clients cope with their day-to-day emotional experience by identifying and labeling emotions, reducing emotional vulnerability, and decreasing emotional distress (Linehan, 1993b). Building positive experiences is an example of an emotion regulation skill and helps clients engage in pleasurable activities as well as make changes in their lives that will increase life satisfaction in the long term.

In contrast to emotion regulation, which is used for day-to-day emotions, distress tolerance skills are to be used when clients are in crisis (Linehan, 1993b). Distress tolerance skills can be used to not only tolerate and survive crises but also accept life as it is. Pros and cons lists are utilized in distress tolerance in order to analyze the benefits and drawbacks, both in the short term and in the long term, of engaging in harmful or ineffective behavior to cope with the crisis.

The last skills module in Linehan’s (1993b) manual is interpersonal effectiveness, which teaches clients to ask to get their needs met, say no to others, and better cope with conflict in relationships. The effectiveness aspect of interpersonal effectiveness speaks to clients’ ability to obtain the changes they want in the relationship while maintaining that relationship and maintaining their self-respect. An example of an interpersonal effectiveness skill is the acronym FAST, which stands for “be fair to yourself and to the other person,” “no overly apologetic behavior,” “stick to your own values,” and “be truthful” (Linehan, 1993b, p. 128).

**Empirical support for DBT.** DBT has been found to be effective in treating women with BPD in multiple randomized controlled trials (RCTs) from different institutions in which DBT was compared to a variety of treatments, including treatment as usual (TAU) in the community, TAU at a Veterans Affairs Medical Center, and community treatment by experts, (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006;
Verheul et al., 2003). RCTs of DBT have also been conducted with women with BPD and comorbid drug dependence, in which DBT was found to be effective in reducing substance use (Linehan et al., 1999; Linehan et al., 2002). Given this demonstrated efficacy of DBT, the APA has designated it as an empirically supported treatment for BPD (Robins & Chapman, 2004).

RCTs have also been conducted for modified versions of DBT with populations other than women with BPD, including major depressive disorder in older adults, women with binge eating disorder, and women who reported binging and purging at least once a week for 12 weeks (Lynch et al., 2006; Lynch, Morse, Mendelson, & Robins, 2003; Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001). Additionally, quasi-experimental studies of DBT have been conducted with suicidal adolescents and with adults and female adolescents in forensic settings (McCann, Ball, & Ivanoff, 2000; Rathus & Miller, 2002; Trupin, Stewart, Beach, & Boesky, 2002). Overall, these studies have demonstrated the effectiveness of DBT in a variety of settings and with a variety of populations, not just adult women with BPD, for whom this treatment was originally designed.

**Group DBT for Sexual Revictimization Risk Reduction**

As discussed, there is a dearth of sexual victimization risk reduction programs that have been found to be effective with women with histories of sexual victimization. General risk reduction programs that do not target sexual revictimization have been found to be successful in decreasing rates of sexual assault in women without victimization histories (Blackwell et al., 2004). This suggests that programs aimed for women with victimization histories may be effective in reducing their rates of sexual revictimization as well, and this hypothesis has been somewhat supported. The limited number of studies that tested sexual revictimization risk reduction programs did have some success (e.g., Senn et al., 2011), although many failed to find...
statistically significant differences in revictimization rates between intervention and control groups or found significant differences when considering only rape revictimization and excluding other forms of victimization from analysis (e.g., Hill et al., 2011 and Marx et al., 2001).

Additionally, none of sexual revictimization risk reduction programs reviewed address the wide range of revictimization risk factors listed above, including posttraumatic symptoms, difficulties in interpersonal relationships, difficulties regulating emotions, and the use of maladaptive coping strategies such as substance use, risky sexual behavior, and avoidance. However, a DBT-based skills group may be effective in not only targeting these risk factors but also reducing women’s risk of sexual revictimization.

**Rationale.** Although to this author’s knowledge no specific research has been conducted on the use of DBT as a risk reduction program for sexual revictimization, there are two main factors that justify the use of a DBT skills group for this purpose: the ability of DBT to address sexual revictimization risk factors and the therapeutic nature of group treatment.

**Addressing risk factors.** A history of CSA, one of the best predictors for sexual revictimization, is unfortunately a factor that cannot be addressed through treatment. All of the other risk factors reviewed, though, can be targeted with DBT. Symptoms of PTSD have been identified as a risk factor for sexual revictimization in several studies (Arata, 2000; Littleton & Ullman, 2013; Najdowski & Ullman, 2009). In the full DBT model described by Linehan (1993a), reducing PTSD symptoms is the target of the second stage of treatment; however, research suggests that there may be benefits of group therapy alone for PTSD, Zlotnick and colleagues’ (1997) work supports the utility of group treatment focusing on emotion regulation for PTSD. The authors randomly assigned women with CSA histories who met criteria for
PTSD to either a 15-week group on affect management or a waitlist control. Throughout the study, all participants received individual therapy and pharmacotherapy. The authors found that women who completed the group reported significantly fewer posttraumatic symptoms and less dissociation when compared to women in the waitlist control condition.

Cloitre, Koenen, Cohen, and Han (2002) also explored emotion regulation skills training for abuse-related PTSD. They implemented a 16-week cognitive-behavioral treatment for women with PTSD resulting from childhood physical or sexual abuse that consisted of 8 weeks of emotion regulation and interpersonal skills training and 8 weeks of prolonged exposure, both delivered in an individual therapy format. They found, compared to the waitlist control group, women in the treatment group showed a significant increase in emotion regulation and interpersonal skills and a significant decrease in PTSD symptoms, and these benefits were maintained 3 and 9 months after treatment.

Mindfulness, which is the focus of another DBT skills module, has also been shown to be beneficial for symptoms of PTSD. In a sample of military veterans with PTSD in residential cognitive-behavioral treatment, changes in facets of mindfulness accounted for 19% of the variance in PTSD severity posttreatment (Boden, Bernstein, Walser, Bui, Alvarez, & Bonn-Miller, 2012). Additionally, acting with awareness—one aspect of mindfulness—significantly predicted PTSD severity posttreatment.

Overall, the results of these studies suggest that improvements in emotion regulation, interpersonal effectiveness, and mindfulness may decrease symptoms of PTSD and support the use of a DBT skills group to help address PTSD symptoms; however, all treatments described above included individual therapy. Thus, clients with significant posttraumatic symptomatology may require individual therapy in addition to the proposed group skills training. Of note, in
Zlotnick et al.’s (1997) study, all participants, including those in the waitlist control condition, were in individual therapy and continued any existing psychotropic medication regimes. The significant improvements in PTSD symptoms and dissociation, therefore, were found above and beyond any improvements made through individual treatment or pharmacotherapy. This finding clearly illustrates the benefit of group treatment even for those receiving individual therapy and medication.

In addition to posttraumatic symptoms, two of the major revictimization risk factors described are directly addressed by DBT skills training groups: difficulties with interpersonal relationships and emotion dysregulation. The skills training modules of interpersonal effectiveness and emotion regulation teach clients a variety of strategies to help bolster their ability to manage their emotions and get their needs met in relationships while still maintaining the respect of themselves and others (Linehan, 1993b).

The other main category of sexual revictimization risk factors reviewed earlier was maladaptive coping and consisted of the following behaviors: substance use, risky sexual behavior, and avoidance. Although these behaviors are all separate, they can be conceptualized as serving one purpose: to regulate emotions. According to Axelrod, Perepletchikova, Holtzman, and Sinha (2011), emotion regulation “includes processes for amplifying, attenuating, or maintaining affective responses,” and “the capacity to regulate emotion has been identified as central to mental health” (p. 38). Risky sexual behavior has been identified as a method sometimes used to cope with, or regulate, negative emotions, and adolescents and adults have highlighted reducing negative affect is one motivation for sex and risky sexual behavior (Cooper, Agocha, & Sheldon, 2000; Cooper, Shapiro, & Power, 1998). Briere and Elliot (1994) posited that sexual behavior may serve as a distraction from and avoidance of distress for some victims
of CSA. They hypothesized that this behavior could assuage abuse-related emotional pain and may be used as a coping mechanism to regulate painful internal experiences. Orcutt and colleagues’ (2005) work supported this idea: they found that “dysphoria secondary to CSA increases risk for ASA via use of affect regulation strategies (e.g., use of sex to reduce negative affect) which, in turn, heighten exposure and vulnerability to sexual assault” (Orcutt et al., 2005, p. 737).

In addition to risky sexual behavior, problematic alcohol use, a risk factor for sexual revictimization, has been demonstrated to be used to cope with negative affect (Cooper et al., 2000). In fact, Briere (1992) explained that “in the face of extreme abuse-related distress, often restimulated by revictimization,” the survivor may use risky sexual activity and substance use to “anesthetize, soothe, interrupt, or forestall painful affect” (p. 63). To further flesh out the relationship between substance use and emotion regulation, Axelrod and colleagues (2011) examined a 20-week DBT treatment program with 27 women meeting criteria for substance dependence and BPD. The treatment involved 1 hr of individual therapy and 90 min of group skills training each week as well as phone coaching between sessions as needed and a 1 hr weekly consultation group for therapists. The authors found a significant reduction in depressive symptoms, difficulties with emotion regulation, and substance use. Furthermore, improvements in emotion regulation explained the variance in decreased substance use, though improvements in depression did not. These findings not only demonstrate the relationship between emotion regulation and substance use but also support the use of DBT to address these areas.

The final risk factor reviewed, avoidance, can also be viewed as technique to regulation emotional experiences through the attenuation of distressing emotions. Kashdan, Barrios, Forsyth, and Steger (2006) explained that some attempts at emotion regulation, including
“[becoming] independent from aversive events and accompanying emotions (detached coping), or [inhibiting] the expression of emotions (emotional suppression) can be considered component processes of experiential avoidance” (p. 1303). Linehan (1993a) also indicated that avoidance of situations that create aversive emotions is done to regulate emotions.

If risky sexual behavior, substance use, and avoidance are all conceptualized as attempts to regulate emotions, then an intervention designed to teach more adaptive emotion regulation skills (i.e., DBT) may help victimized women decrease their engagement in these behaviors and thus decrease their risk of revictimization.

**Group treatment.** According to the U.S. Department of Health and Human Services (n.d.), group therapy is considered “the treatment of choice for sexual abuse” (Treatment Modalities section, para. 3). This intervention prescription is easily understood given that women with histories of sexual victimization tend to have more difficulties with interpersonal functioning. CSA victims have been found to be more mistrustful of others, fearful of interpersonal closeness, and have difficulties maintaining friendships and romantic relationships (Briere, 1992). Furthermore, women with histories of CSA have been found to have poorer social adjustment and may have more issues with trust and communication in relationships. They have been found to be more likely to have difficulties in relationships with female friends and were more likely to report discomfort with parenting roles, possibly developing impaired parenting skills because of this (DiLillo, 2001). As discussed earlier, in a study of women with CSA histories who met criteria for PTSD, women who reported sexual revictimization during the study on average reported more interpersonal difficulties at baseline compared to women who were not revictimized (Classen et al., 2001). This research highlights the importance of social
functioning in the prevention of revictimization, and group therapy can be a prime venue for honing such skills.

In their much lauded book on group psychotherapy, Yalom and Leszcz (2005) identified a myriad of benefits of group treatment, including improvement in interpersonal functioning. Group allows for the development of social skills and provides a unique opportunity to receive interpersonal feedback. Moreover, Yalom and Leszcz recognized that those with interpersonal concerns may have difficulties developing intimate relationships and can thus feel isolated and alone. They noted that “the disconfirmation of a client’s feelings of uniqueness is a powerful source of relief” (Yalom & Leszcz, 2005, p. 6), and this can be especially true in victims of sexual abuse. Members of sexual abuse groups “can encounter others who have suffered similar violations as children, who were not responsible for what happened to them, and who have also suffered deep feelings of shame, guilt, rage, and uncleanness” (Yalom & Leszcz, 2005, p. 8).

Yalom and Leszcz (2005) further described how group therapy can instill hope in clients who see others in various stages of coping and witness the improvement of others in the group. Additionally, group members can benefit from receiving support themselves while also supporting others. Often group members “have long considered themselves as burdens, and the experience of finding that they can be of importance to others is refreshing and boosts self-esteem” (Yalom & Leszcz, 2005, p. 13). Finally, groups not only offer mutual support but also provide psychoeducation about clients’ circumstance and can provide a space to examine misconceptions about the life situation.

The research summarized thus far indicate that an intervention targeted at emotion regulation, interpersonal effectiveness, and mindfulness—such as a DBT skills group—may effectively reduce the risk of revictimization in women with histories of CSA or sexual assault.
through addressing revictimization risk factors such as posttraumatic symptomology, substance use, risky sexual behavior, and avoidance. Furthermore, the therapeutic nature of the group setting may benefit these women above and beyond the content of the skills learned. This supposition is supported by Orcutt and colleagues (2005), who stated that “interventions designed to increase distress tolerance, improve emotion regulation, and reduce experiential avoidance may have preventative utility” for sexual revictimization (p. 737). To this author’s my knowledge there may been no studies examining the utility of a DBT skills group for sexual revictimization risk reduction; however, there have been two studies using DBT in related manners.

**Related studies.** Iverson, Shenk, and Fruzzetti (2009) piloted a 12-week DBT group program for women who have experienced domestic violence. The group focused on skills training, targeting, chain analysis, problem solving, validation, and skill generalization in the form of skill usage in everyday life and diary card tracking as well as phone coaching. Forty-six women who reported lifetime domestic violence participated in the 12-week DBT group, which was facilitated by master’s-level therapists, though only 31 women completed the group. Women’s scores on measures of depression, hopelessness, overall distress, and social adjustment significantly decreased from pretest to posttest with moderate to large effect sizes, and many of the women’s scores reached the normal range at the end of the group. There was a high level of satisfaction with the treatment, although about a third of the women who started the group did not complete treatment. Iverson and colleagues’ findings demonstrate the success of a DBT skills group in improving symptomology, including social adjustment, in a related population (women who have experienced domestic violence) and support the use of such a group with sexually victimized women.
Steil, Dyer, Priebe, Kleindienst, and Bohus (2011) explored the use of DBT with a similar population, women with PTSD related to CSA. They developed a 3-month DBT program called DBT-PTSD, which was designed for a residential treatment setting and aimed to “(a) reduce [clients’] fear of trauma-associated primary emotions, (b) question secondary emotions like guilt and shame, and (c) radically accept trauma facts” (Steil et al., 2011, p. 102). DBT-PTSD involved three stages: 6 weeks of identifying and controlling escape and avoidance behaviors using DBT skills, a 4 week exposure protocol that incorporated skill usage in exposure sessions and homework, and 2 weeks targeted at radically accepting facts of the trauma as well as focusing on other psychosocial areas of clients’ lives, such as work and relationships. The sample consisted of 29 females from European countries who were referred to residential treatment for PTSD by their psychiatrists. All women met criteria for PTSD as well as at least one other disorder. Over half the sample were on antidepressant medication during the study, and approximately one-third were on antipsychotics. None of clients received benzodiazepines during the study.

Steil and colleagues (2011) found significant decreases in posttraumatic symptoms, depression symptoms, and trait anxiety from baseline to the end of treatment as well as from baseline to follow-up 6 weeks after treatment ended. Overall distress decreased significantly from baseline to the 6-week follow-up, and posttraumatic symptoms continued to decrease from when treatment ended to the 6-week follow-up. Changes in medication and treatment after discharge from the program were not found to be significantly related to posttraumatic symptoms, although the authors indicated that the sample size was too small to rule out the effect of such variables. The results of this study indicate that “DBT-PTSD might represent a promising treatment for severe CSA-related chronic PTSD” (Steil et al., 2011, p. 105). This is
especially true considering none of the clients dropped out of treatment or showed an exacerbation of symptoms during treatment. Additionally, over half of the clients demonstrated reliable change at the 6-week follow-up mark.

The overall success of these two studies further validates the use of a dialectical behavior therapy skills group for sexual revictimization risk reduction. In both investigations, women with histories of interpersonal victimization benefited from DBT as evidenced by decreases in overall distress, posttraumatic symptomology, and social maladjustment. In addition to the possibility of a DBT skills group helping victimization women, there are indications that it likely would not harm clients either: both of the related studies had high treatment satisfaction, and Steil et al.’s (2011) intervention did not result in the worsening of clients’ symptoms of PTSD. Further, as described earlier, Mouilso and colleagues (2011) found that women who participated in their risk reduction intervention and were revictimized after the program experienced less severe mental health symptoms when compared to revictimized women who did not participate in the risk reduction program. These findings lend additional support to the use of a DBT skills training group for sexual revictimization risk reduction.

This literature review thus far has summarized the devastating impact of childhood sexual abuse in virtually all areas of victims’ lives, especially when considering that women with histories of CSA are between 2 and 4 times more likely to be sexually revictimized (Balsam et al., 2011; Barnes et al., 2009; Kimerling et al., 2007; Orcutt et al., 2005; Raghavan et al., 2004; Trickett et al., 2011). Sexual revictimization, which has been researched since the late 1970s, is associated with its own disastrous effects, including social difficulties, sexual problems, substance use, mental health concerns including PTSD, and suicidality (Balsam et al., 2011; Ellis et al., 1982; Lacelle et al., 2012). In an effort to determine possible aims for intervention, risk
factors for revictimization were explored. Although a history of CSA has been found to be a significant predictor of sexual revictimization (Balsam et al., 2011; Walsh et al., 2007), other risk factors that can be targeted through intervention were discussed, including PTSD, substance use, risky sexual behavior, avoidance, emotional dysregulation, and interpersonal difficulties.

Existing sexual revictimization risk reduction programs were then reviewed; however, none of the programs fully addressed the risk factors for revictimization mentioned in this review, and some programs even failed to find statistically significant results, possibly due to small sample sizes. This relative lack of success in revictimization risk reduction programming as well as programs’ lack of intervention for known risk factors prompted the proposal of a new form of risk reduction programming: group dialectical behavior therapy.

An overview of DBT (Linehan 1993a,b) and its treatment components, strategies, and assumptions was provided, including an explanation of group skills training and the four skills training modules, mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. Empirical studies of DBT for a variety of disorders were also highlighted. Next, a rationale for the use of a DBT skills group for sexual revictimization risk reduction was provided. Namely, all of the revictimization risk factors covered earlier can be addressed by DBT, and by doing so in a group format, clients would benefit from the therapeutic nature of group therapy. Two studies examining the use of DBT with related populations—female victims of domestic violence and women with PTSD related to CSA—were summarized (Iverson et al., 2009; Steil et al., 2011), and the results of these investigations were promising.

**Proposed intervention.** Given this information, a 12-week DBT skills group for adult women who report histories of sexual victimization, including CSA and ASA is proposed as a possible form of revictimization risk reduction programming. The suggested length of the group...
is based on the success of Iverson et al. (2009) and Steil et al.’s (2011) use of a 12-week DBT intervention, and a female-only environment is recommended due to the nature of the women’s trauma history and the fact that the majority of perpetrators of CSA are male (American Psychological Association, n.d.; Dube et al., 2005). Two-hr sessions are advised based on Marx et al. (2001) and Hill et al.’s (2011) success with this session length. This once weekly group may be best operated as a closed group given the sensitive nature of the information group members may divulge. Two therapists are suggested to co-lead the group as described in Linehan’s (1993b) skills training manual. Following the recommendations of Blackwell and colleagues (2004), information should be presented in multiple formats, such as didactic lectures, discussions, and role plays.

Given the nature of group skills training and the lack of individual attention, it is not recommended to accept group members who are currently in crisis, actively suicidal, or abusing drugs or alcohol and instead refer these individuals to a higher level of care. Additionally, other studies implementing prevention programs or DBT programs have used exclusionary criteria for the following disorders, which is also to be taken into consideration: thought disorders including schizophrenia, mental retardation, and severe psychopathology that requires attention in another setting, such as a Body Mass Index less than 16 (Mouilso et al., 2011; Steil et al., 2011). Group leaders may decide to require members to see an individual therapist while attending the group, as Linehan (1993b) suggests.

Following Linehan’s (1993b) group outline, it is proposed that the first half of group would be spent reviewing homework and group members’ successes and struggles in using their skills over the previous week. After a short break, the second half of group would focus on learning new skills and engaging in discussions, role plays, and activities related to the skills.
Members’ use of skills could be tracked using a diary card. A diary card can take many formats, the most basic of which is a piece of paper upon which group members record what skills they used each day.

In order to target revictimization risk reduction, discussions, examples, and role plays may include topics related to romantic relationships or dating. For example, one particular aspect of interpersonal difficulties that has been found to be a risk factor for revictimization is sexual refusal assertiveness. While learning the interpersonal effectiveness skills FAST and DEAR WOMAN (Linehan, 1993b; Moonshine, 2008), described later, group members could brainstorm and practice ways to assertively say no to sex that preserves their self-respect while maintaining the relationship.

**Group outline.** Below is an example of a possible outline for the 12-week DBT skills group sessions, with skills taken from Linehan (1993b) and Moonshine (2008):

Session 1: *Introduction to group:* Overview of program and goals, introduction to DBT, psychoeducation on the effects of sexual victimization, introduction to diary cards; skills Observe, Describe, Participate

Session 2: *Self-care:* Psychoeducation on the importance of self-care; skill MEDDSS

Session 3: *Mindfulness:* Skills Effectively, One-Mindfully

Session 4: *Mindfulness:* Skill Non-Judgmental, Moment to Pause

Session 5: *Mindfulness:* Skills Wise Mind

Session 6: *Interpersonal effectiveness:* Introduction to interpersonal effectiveness; skill DEAR (WO)MAN

Session 7: *Interpersonal effectiveness:* Skills GIVE, FAST
Session 8: *Emotion regulation*: Introduction to emotion regulation; skills Getting to Know Emotions, Exploring Your Emotions

Session 9: *Emotion regulation*: Skills Ride the Wave, Opposite to Emotions

Session 10: *Distress tolerance*: Introduction to distress tolerance; skill Radical Acceptance

Session 11: *Distress tolerance*: Skills Crisis Survival Network, Self Soothe First Aid Kit

Session 12: *Wrap-up*: Review skills, process group ending, identify maintenance strategies

*Session one.* In the first session, group members would receive an overview of the group format and goals as well as an introduction to DBT. As the group is specifically designed for victims of sexual violence, psychoeducation of the impacts of sexual victimization would also be provided. Diary cards, discussed earlier, are critical to tracking and generalizing skills usage into everyday life. Therefore, they would also be introduced. Based on the outline above, the skills Observe, Describe, and Participate would be taught during the first session as well. Observe encourages clients to simply notice their internal experiences and external world (Linehan, 1993b; Moonshine, 2008). Describe focuses on placing an objective verbal label, without judgments, on these internal experiences and external events. To Participate means to mindfully and fully engage in an activity without the distractions of modern life or our internal dialogue, including judgments.

These three mindfulness skills help build a foundation for not only other mindfulness skills but also skills in all modes, which is why they would be introduced at the beginning of skills training. Fostering mindfulness, including through the use of the skills Observe, Describe, and Participate, may be critical to reducing victimized women’s risk of sexual revictimization:
Hill and colleagues (2011) found that women with CSA histories who participated in a mindfulness-based intervention were reported sexual revictimization at dramatically lower rates compared to victimized women in the control group (0% vs. 80%). Additionally, Observe, Describe, and Participate can help victims of sexual violence be more aware of their experiences and environment and potentially ward off attack.

Session two. The second session would focus on self-care and the emotion regulation skill MEDDSS (Moonshine, 2008). Although the rest of the emotion regulation skills are not taught until weeks eight and nine, MEDDSS is introduced in the second session because it can help group members establish a solid emotional foundation in their lives, which can make engaging in all other skills easier and more effective. In general, it is more difficult for clients to be effective and regulate their emotions when they are tired, hungry, under the influence of drugs or alcohol, not taking their prescription medication as directed, or feelings run down. The acronym MEDDSS, which stands for mastery, exercise, diet, drugs (prescription), sleep, and spirituality, can help clients take care of themselves and decrease their emotional vulnerability.

When group members use mastery, they engage in or think of an activity that gives them a sense of accomplishment or pride. For example, clients may choose to take time for a hobby that makes them feel successful and capable, such as working on a sewing project or going for a hike, or think about a past accomplishment, such as obtaining a degree or raising a child. Exercise can be incorporated into group members’ lives not just through going to the gym. Little changes like taking the stairs instead of the elevator or walking during a lunch break can help clients become more physically active and expend energy. Dietary changes can also be small, such as consuming less caffeine and eating more fruits and vegetables. It is important to
encourage group members to make changes that are realistic for their lifestyle so that they are able to be successful in maintaining a healthy, solid foundation of emotional stability.

Taking any medication as prescribed by a doctor is also important to reducing emotional vulnerability. In addition, group members are encouraged to minimize or eliminate the use of alcohol and illicit drugs as these substances can make it more difficult for clients to make effective decisions in their lives. Adequate sleep is also important for building a strong emotional base. Getting a healthy amount of sleep—not too little or too much—can be made easier through the use of sleep hygiene and the establishment a sleep routine. Finally, spirituality in whatever form group members prefer—through participating in an organized religion or finding a sense of connection and meaning in their lives independently—is promoted.

Researchers have found that sexually victimized women tend to report more difficulties with emotion regulation (Briere & Rickwards, 2007; Messman-Moore et al., 2012, Walsh et al., 2011), and without a solid base of a healthy diet, exercise, and adequate sleep, regulating emotions and being effective in all areas of life—including being assertive in risky situations—can be even more difficult for these women, which is why the skill MEDDSS is proposed for this population.

Session three. The third week of group would concentrate on the mindfulness skills Effectively and One-Mindfully (Linehan, 1993b; Moonshine, 2008). Effectively encourages group members to act skillfully in order to reach their goals. Instead of focusing on what is right or wrong, or how clients think things should be, they are urged to focus on doing what works in for the situation and for them. By acting effectively, sexually victimized women may be more likely to engage in safety behaviors in order to reduce their risk of revictimization in circumstances under which they normally would not. For example, women may choose to
consume less alcohol at a party or assert themselves in a dating situation—even if they do not necessarily want to—in order to lessen the chance of revictimization.

When group members use the skill One-Mindfully (Linehan, 1993b), they do one thing at a time instead of multi-tasking or worrying and making judgments while engaging in an activity. They let go of distractions, both internal and external, and concentrate on the task at hand. This skill can help women with sexual victimization histories to fully attend to whatever they are doing rather than mindlessly performing a task while simultaneously ruminating on the past, including their trauma, or worrying about the future. This attention to the present moment may decrease their distress and help them be more effective in daily lives.

Session four. The fourth week of the group would focus on the skills Non-Judgmental and Moment to Pause (Linehan, 1993b; Moonshine, 2008). By taking a non-judgmental stance, group members can accept themselves and others for who they are rather than assigning value to someone as good or bad, right or wrong. When clients make negative judgments about themselves, they may develop low self-worth and depression. When clients judge others, they may set themselves up for disappointment when others do not live up to overly positive judgment. Conversely, group members may feel frustrated with those around them when they make negative judgments about others. The skill Non-Judgmental would help women with histories of sexual victimization decrease feelings of worthlessness and guilt resulting from their trauma, which may in turn increase their confidence in their ability to assert themselves in sexual situations. Moreover, being non-judgmental with others can increase this population’s ability to be effective in interpersonal situations, thus increasing social supports that can be critical in building a life worth living.
Moment to Pause, another mindfulness skill, involves group members taking a moment to check in with their internal experiences—thoughts, feelings, physical sensations—and their environment in order to best respond to the situation and act in their best interests (Moonshine, 2008). This skill may help sexually victimized women tune in to their reactions and any gut feelings they may have as well as identify risk in their environment, which may help decrease their vulnerability to revictimization.

Session five. The fifth session of the group would cover the last mindfulness skill, Wise Mind (Linehan, 1993b; Moonshine, 2008). Wise Mind can aid group members in noticing their emotional and reasonable mind states and work toward being in balance with these two, which is known as wise mind. Although both our reasonable mind, which is the rational and logical part of our mind, and our emotional mind, which is the feeling part of our mind, are important, we want to utilize both rather than one or the other so that we can make decisions that are in line with our values (emotional mind) and lead to the best outcome (reasonable mind). Through using the skill Wise Mind, victims of sexual violence can temper any emotional dysregulation—a risk factor of sexual revictimization—with the objective facts of the situation in order to act in their best interests.

Session six. Interpersonal effectiveness skills would first be taught in session six. An introduction to interpersonal effectiveness would be provided, including goals of interpersonal effectiveness, factors that can reduce group members’ ability to be effective in interpersonal situations, and situations in which to practice interpersonal effectiveness skills (Linehan, 1993b). The skill DEAR WOMAN (Moonshine, 2008) would also be taught during the sixth session. Linehan (1993b) originally created the skill DEAR MAN in order to help clients get their needs met in relationships. Moonshine (2008) later modified this skill to DEAR WOMAN, which may
be more appropriate for the female-only group proposed. The acronym DEAR WOMAN stands for “describe what is wanted,” “encourage others to help,” “ask for what is wanted,” “reinforce others,” “willingness to tolerate not always getting it my way,” “observe what is going on inside and around me,” “mindfully present in the current moment,” “appear confident,” and “negotiate with others” (Moonshine, 2008, p. 196). This skill may help women with histories of sexual victimization in seeking assistance from social supports as well as in being assertive in dating and sexual situations, which may decrease the risk of revictimization: low sexual refusal assertiveness has been identified as a risk factor for sexual revictimization (Kearns & Calhoun, 2010; Livingston et al., 2007).

Session seven. Session seven would further address interpersonal effectiveness through the skills GIVE and FAST (Linehan, 1993b; Moonshine, 2008). GIVE, a skill to build and maintain good relationships, stands for “gentle in relationships,” “interest in others,” “validate,” and “easy manner” (Moonshine, 2008, p. 192). The acronym FAST stands for “fair to self,” “apologize less,” “stick to values,” and “truthful with self” and can be used to develop self-respect and set boundaries in relationships (Moonshine, 2008, p. 194). These skills would be important for sexually victimized women to learn because, as stated earlier, women who are revictimized have been found to have more difficulties with being effective in interpersonal relationships. Specifically, GIVE could help group members develop and bolster their social contacts, which can help strengthen their support system. As with the skill DEAR WOMAN, using the skill FAST may increase women’s sexual refusal assertiveness, an area of interpersonal effectiveness that has been linked with sexual revictimization.

Session eight. In the eighth session, emotion regulation would be introduced and the skills Getting to Know Emotions and Exploring Your Emotions would be taught (Moonshine,
Before covering any specific emotion regulation skills, it would be important to orient group members to the topic and discuss the goals of emotion regulation. Specifically, through using emotion regulation skills, group members should be better able to understand their emotional experience, reduce their emotional vulnerability, and decrease their emotional suffering (Linehan, 1993b). The purpose of emotions can also be explored before going into any specific emotion regulation skills. For example, emotions can be used to communicate with others, emotions can motivate us and help organize our actions, and emotions can be self-validating (Linehan, 1993b).

The two skills taught in week eight, Getting to Know Emotions and Exploring Your Emotions, would also serve as introductions to emotion regulation and would help bring greater awareness to group members’ emotional experiences (Moonshine, 2008). Getting to Know Emotions asks clients to identify their emotions and any physical sensations, thoughts, and behaviors related to the emotion. Group members are also encouraged to identify any environmental antecedents to the emotion and think what happened after the emotional situation. This step of exploring the emotional experience and identifying emotions is important for the population at had as sexually revictimized women have reported a lack of emotional clarity (Walsh et al., 2011). Moreover, lack of emotional clarify and difficulties with emotional awareness have been found to be associated with leaving a hypothetical sexual risk scenario later (Walsh, DiLillo, et al., 2012).

Exploring Your Emotions, the other emotion regulation skill for session eight, can help group members further examine their emotional experience by identifying and challenging maladaptive thought patterns, such as making assumptions about the self and others, “future tripping,” and making judgments about the self, others, and the emotional experience
(Moonshine, 2008). This skill also encourages clients to make changes to their posture, energy level, facial expressions, and behaviors in order to make changes in their emotional experience. Exploring Your Emotions not only aids group members if further analyzing their emotional experience, which is critical for women with histories of sexual victimization as discussed above, but also increases the number of possible strategies they have for emotion regulation. Restricted emotion regulation strategies has been related to leaving a hypothetical sexual risk scenario later, so it is important to provide victimized women with a number of skills to use (Walsh, DiLillo, et al., 2012).

Session nine. Week nine of the DBT skills training group would focus on two additional emotion regulation skills, Ride the Wave and Opposite to Emotion (Linehan, 1993b; Moonshine, 2008). Ride the Wave teaches clients to be mindfully and nonjudgmentally present with their emotional experience—not trying to suppress or amplify it—and to sit with the emotion rather than acting on it. This skill was chosen for women with histories of sexual victimization because revictimized women have been found to have more difficulties with nonacceptance of emotions and impulse control when compared to singly victimized women (Walsh et al., 2011).

Impulsivity has also been found to predict sexual revictimization above and beyond the effects of alcohol and cannabis use and negative affect (Messman-Moore et al., 2012).

Opposite to Emotion (Linehan, 1993b; Moonshine, 2008) would also be introduced in the ninth session. Opposite to Emotion encourages group members to identify what emotion they are experiencing and then act in a manner that is opposite to that emotion. For example, if a client was feeling fearful, she could use Opposite to Emotion and approach the thing she is afraid of instead of avoiding it. The idea with Opposite to Emotion is not to suppress or ignore one’s internal experience but instead act in a manner that is contrary to the emotion while still
experiencing the emotion. This skill can help clients choose more adaptive behaviors when they have the urge to engage in a potentially harmful or ineffective behavior while still honoring their emotional experience. Sexually victimized women in particular may benefit from Opposite to Emotion because of this: when experiencing emotional distress, these women may be better able to engage in more effective behavior and avoid some of the behaviors that have been found to be risk factors for sexual revictimization, including substance use, risky sexual behavior, and avoidance.

**Session ten.** In the tenth week of group, distress tolerance would be introduced. The goals of distress tolerance and when to use this skills module would be discussed. The skill for session ten would be Radical Acceptance, which involves accepting reality as it is and focusing on what we do have control over—ourselves—instead of spending a lot of time and energy focus on what we do not have control over, including others and our environment (Linehan, 1993b; Moonshine, 2008). This skill would be important for sexually victimized women. It would encourage stop dwelling on any thoughts they may have about how unfair their situation is or wishing they would have done something differently to possibly prevent their attack and instead accept the reality of the situation and take control of their lives. Women with victimization histories could also use Radical Acceptance to accept themselves for who they are, regardless of what has happened in the past.

**Session eleven.** The last two skills, Crisis Survival Network and Self-Soothe First Aid Kit, would be covered in the eleventh session (Moonshine, 2008). Group members can create their own Crisis Survival Network by compiling a list of people whom they could call when in a crisis. Crisis line numbers can also be included in the last. Clients are encouraged to utilize the whole list and not just rely on one or two people as this can be trying on relationships. Women
who have been sexually victimized may benefit from this skill as it provides them with a physical list of people to contact when in crisis. These women may not normally reach out to others in times of difficulty because of their tendency to be overly responsible, overly nurturing, and socially avoidant (Classen et al., 2001). Sexually victimized women may decide to weather the storm themselves rather than possibly burden those around them.

If group members choose not to call a member of their Crisis Survival Network, they can still manage their distress level by using their Self-Soothe First Aid Kit (Moonshine, 2008). A Self-Soothe First Aid Kit is a collection of things that clients can use to help soothe and calm themselves when they are stressed out, in a crisis, or have an urge to engage in unsafe behavior. Clients could place items such as a stress ball, a scented sachet, a crossword puzzle book, and a healthy snack in a desk drawer, or they could put pictures of pets and loved ones, favorite songs, and games on their cell phone to serve as a mobile Self-Soothe First Aid Kit. It is crucial that group members are instructed not to place harmful items, such as razor blades or alcohol, in their Self-Soothe First Aid Kit as distress tolerance skills are to be used to reduce engagement in such problematic coping behaviors. This skill would benefit sexually victimized women because it would give them a way to regulate distressing emotions during a crisis without engaging in any of the maladaptive coping methods discussed earlier.

Session twelve. In the last session of the group, clients would review the skills that were learned and make a plan of how to continuing using these skills in the future. Members would have the opportunity to discuss and process the ending of the group, and ways to maintain the gains made in the group would be explored.

Even with this description, a DBT skills group for sexual revictimization risk reduction needs to be further developed, including the writing of a treatment manual and piloting of the
group. However, this brief overview provides a foundation for the creation of a risk reduction program that is economical to the client and therapists, utilizes the therapeutic nature of group treatment, and addresses the identified risk factors for sexual revictimization, lending an empirical base to the targets of treatment. A sexual revictimization risk reduction DBT skills group may be able to not only decrease the incidence of sexual revictimization in women who are already living with the repercussions of sexual violence but also help these women improve their functioning overall and start creating a life worth living.

Discussion

The purpose of this literature review was to provide a foundation, based on empirical findings, for the development of a sexual revictimization risk reduction program using a DBT skills training group. Childhood sexual abuse was first discussed, and the effects of CSA were explored. Across studies, it is quite clear that CSA is associated with a variety of negative outcomes: mental health disorders, risky sexual behavior, neurobiological changes, and physical health issues (Briere & Elliott, 2003; Dube et al., 2005; Molnar et al., 2001; Paolucci et al., 2001; Rohde et al., 2008; Trickett et al., 2011). However, possibly the most distressing impact of CSA is the increased risk of later sexual assault (Arata, 2000; Balsam et al., 2011; Heidt et al., 2005; Lalor & McElvaney, 2010; Kimerling et al., 2007; Lau & Kristensen, 2010; Trickett et al., 2011; Walsh et al., 2007). In fact, women with a history of sexual victimization are between 2 and 4 times more likely to be assaulted again when compared to women without a history of victimization (Balsam et al., 2011; Barnes et al., 2009; Kimerling et al., 2007; Orcutt et al., 2005; Raghavan et al., 2004; Trickett et al., 2001). Sexual revictimization also has a negative impact on women. Revictimized women are more likely to have mental health concerns including PTSD, interpersonal problems, and sexual concerns (Balsam et al., 2011; Ellis et al., 1982; Heidt
et al., 2005; Kimerling et al., 2007; Lau & Kristensen, 2010; Miller et al., 1978; Miner et al.,
2006; Najdowski & Ullman, 2009; Noll et al., 2003; Tricket et al., 2011; Walsh, Danielson, et
al., 2012).

In an effort to determine appropriate targets for intervention for sexual revictimization
risk reduction programs, revictimization risk factors were explored next. Even though CSA,
which has been classified by researchers as the single best predictor of sexual victimization
(Balsam et al., 2011; Walsh et al., 2007), cannot be treated, the rest of the risk factors can. PTSD
symptoms have been found to predict sexual revictimization as well as mediate the relationship
between CSA and revictimization (Arata, 2000; Littleton & Ullman, 2013; Najdowski & Ullman,
2009). Maladaptive coping has also been associated with revictimization, both generally
(Najdowski & Ullman, 2011) and in the specific forms of substance use, risky sexual behavior,
and avoidance.

Women with histories of CSA were found to be at increased risk for substance use
problems (Lown et al., 2011), and problematic alcohol use was reported to predict sexual
revictimization (Fargo, 2009; Gidycz et al., 2007; Littleton & Ullman, 2013; Najdowski &
Ullman, 2009). Further, studies indicated that women who experienced sexual victimization
before the age of 18 are more likely to engage in risky sexual behavior (Lacelle et al., 2012;
Testa et al., 2010). Risky sexual behavior was found to partially mediate the relationship
between adolescent victimization and revictimization in adulthood (Fargo, 2009; Testa et al.,
2010). One particular form of risky sexual behavior, use of sex to reduce negative affect, was
also found to mediate the relationship between CSA and ASA (Orcutt et al., 2005). Finally,
avoidance, the last method of maladaptive coping discussed, was also found to be associated
with revictimization. Women who have experienced CSA are more likely to engage in
avoidance, a behavior that has been linked with higher levels of psychological distress and posttraumatic symptomology (Briere & Rickards, 2007; Gibson & Leitenberg, 2001; Mouilso et al., 2011; Rosenthal et al., 2005), and avoidance was demonstrated to serve as a mediator between CSA severity and the severity of coercive sexual revictimization (Fortier et al., 2009).

In addition to symptoms of PTSD and maladaptive coping, two areas of skills deficits were also identified as revictimization risk factors: difficulties with interpersonal effectiveness and emotional dysregulation. Revictimized women were found to have more interpersonal problems and difficulties with being assertive (Classen et al., 2001; Lau & Kristensen, 2010), and low levels of sexual refusal assertiveness were associated with sexual revictimization (Kearns & Calhoun, 2010; Livingston et al., 2007). Lastly, emotion regulation difficulties were demonstrated to increase the risk for sexual revictimization. CSA was found to be associated with emotion dysregulation (Briere & Rickards, 2007), and emotion regulation difficulties were not only linked to sexual revictimization but also found to predict it (Messman-Moore et al., 2012; Walsh, DiLillo, et al., 2012; Walsh et al., 2011).

Following this exploration of risk factors for revictimization, existing sexual revictimization risk reduction programs were discussed. Blackwell and colleagues’ (2004) review of sexual assault risk reduction programs found that interventions designed for a general audience and not adapted for those with sexual victimization histories were only successful in decreasing the incidence of sexual assault in women without victimization histories; sexual revictimization incidences were not affected. The decreased rate of sexual assault in non-victims suggests that risk reduction programs targeted at sexually victimized women may be able to decrease the incidence of revictimization as well.
Three different risk reduction interventions for women with histories of sexual victimization (Hill et al., 2011; Marx et al., 2001; Senn et al., 2011) and one intervention for women with histories of interpersonal trauma (Iverson et al., 2011) were summarized next. The findings of these studies were promising overall. Iverson and colleagues (2011) demonstrated that reductions in symptoms of PTSD and depression from the intervention were associated with lower levels of intimate partner violence. Marx and colleagues’ (2001) program resulted in a lower rate of completed rape for women in the intervention group compared to the control group. Calhoun et al. (as cited in Blackwell et al., 2004) presented a poster on their adaptation of Marx and colleagues’ program—Calhoun et al. added a video to the curriculum—and, possibly due to the larger sample size of Calhoun and colleagues’ study, they found a decreased rate of sexual revictimization in the intervention group compared to the control group.

Senn and colleagues’ (2011) sexual assault resistance programs had several positive results, including increases in sexual assault risk perception, self-defense self-efficacy, knowledge of self-defense techniques, and the use of these techniques to resist sexual assault. However, there was no reduction in the rate of sexual assault, which the authors posited could be due to the small sample size. Hill and colleagues’ (2011) also suffered from a small sample size and were thus only able to demonstrate moderate effect sizes in decreased rates of sexual revictimization, not statistically significant results. Finally, Mouilso and colleagues (2011) found that not only did women in their intervention group report lower rates of revictimization, but the women in the intervention group who were revictimized reported less psychological distress compared to revictimized women in the control group.

Although the findings of these sexual revictimization risk reduction programs are promising, there is still room for improvement, especially considering the lack of statistically
significant results in some studies. The programs described focused primarily on sexual assault
psychoeducation and some skill building; however, none completely address the risk factors for
sexual revictimization explored earlier. Further, researchers in the field (Gidycz et al., 2007;
Livingston et al., 2007; Orcutt et al., 2005) have appealed for risk reduction programs to do so,
and there has been a recommendation that interventions targeted at victimized women be more
intensive, possibly looking more like group therapy than a traditional risk reduction program
(Blackwell et al., 2004). Therefore, the use of a dialectical behavior therapy DBT skills training
group for women with victimization histories to reduce their risk of sexual revictimization was
proposed.

An overview of DBT was provided in order to give context to this proposed intervention.
This discussion of Linehan’s (1993a,b) treatment included a review of dialectical philosophy,
Linehan’s biosocial theory of borderline personality disorder, DBT assumptions, treatment
strategies, stages of treatment, and treatment functions and modes, including group skills
training. Additionally, the four skills training modules—mindfulness, emotion regulation,
distress tolerance, and interpersonal effectiveness—were summarized. The empirical support for
DBT was also examined.

Next, the rationale for the use of a DBT skills group was presented. Specifically, DBT is
able to address the risk factors for revictimization described in this review. DBT has been shown
to effectively treat PTSD symptoms (Boden et al., 2012; Cloitre et al., 2002; Zlotnick et al.,
1997) as well as improve interpersonal effectiveness and emotion regulation skills (Linehan,
1993b). Further, the maladaptive coping techniques identified as revictimization risk factors—
substance use, risky sexual behavior, and avoidance—can be conceptualized as attempts to
regulate emotions. These maladaptive emotion regulation techniques can also be addressed and
replaced by healthier methods of emotion regulation through the use of DBT. In addition to the ability of DBT to target revictimization risk factors, a DBT skills training group is able to capitalize on the therapeutic nature of group treatment (Yalom & Leszcz, 2005).

To further support the use of a DBT skills group for sexual revictimization risk reduction, two related studies were reviewed. Iverson and colleagues (2009) found that women in their 12-week DBT group program for victims of domestic violence showed improvements in depression, hopelessness, overall distress, and social adjustment. Steil and colleagues (2011) were also able to demonstrate success with their 3-month DBT program for women with CSA-related PTSD. They found significant decreases in symptoms of depression and PTSD, trait anxiety, and overall distress. Together, these two studies validate the use of DBT with women with histories of sexual victimization, and the success in symptom reduction bodes well for the ability of DBT to also possibly address revictimization risk factors including posttraumatic symptomology, emotion regulation difficulties, interpersonal difficulties, and maladaptive coping.

Finally, a brief overview of the proposed use of a 12-week DBT skills group for sexual revictimization risk reduction with women with victimization histories was presented. A closed group meeting once a week for 2 hour sessions, led by two therapists, was recommended, and it was suggested that individuals with more severe psychopathology be referred to higher levels of care. An example of a possible group outline was provided, listing the skills that could be taught each week, and the format of the group was discussed.

Although this proposal is only the first step in the development of a DBT skills group risk reduction program, it appears that the research examined supports its use. However, this literature is not without its limitations. First, all studies described are correlational in nature, and therefore causation cannot be assumed. The direction of the relationship cannot be determined
through correlational research, and a third factor not identified may mediate the relationship. Even those investigations that used the methodologically stronger prospective design can only establish a timeline of events and cannot prove that one factor caused the other, just predict a certain outcome based on behaviors of interest. Thus, the exact relationship between the risk factors identified and sexual revictimization is unknown, and other factors not explored here may impact that relationship.

Furthermore, the majority of studies reviewed relied on female college students, many of whom participated in the research studies in order to fulfill course credit or receive modest monetary incentives. Therefore, samples in these studies were composed of primarily European American, middle class young adults, presumably high functioning, and it is unclear how these results will generalize to the general population, including women from other ethnic backgrounds and socioeconomic statuses as well as other age ranges. Not all women with histories of sexual victimization may be functioning at the high level of the average college student either.

In addition to these limitations, it should be noted that many of the studies described in this literature review relied upon measures of sexual victimization that are inherently heterosexual, such as the Sexual Experiences Survey (Koss & Oros, 1982). In this measure, all questions assume that the victim is female and the perpetrator is male. The following is an example of a question from the Sexual Experiences survey (note that the female version of the question is given and the male wording is in parentheses): “Have you had sexual intercourse when you (a woman) didn’t want to because a man (you) threatened or used some degree of physical force—twisting your (her) arm, holding you (her) down, etc.—to make you (her)?” (Koss & Oros, 1982, p. 422). Even though the majority of perpetrators of sexual violence are
male and the majority of victims are female, there are female perpetrators and male victims: Dube and colleagues (2005) found that of 16% of the men in their sample of HMO members in California reported a history of CSA, and 39% of them reported having female only or both male and female perpetrators. Nearly 6% of the women reporting histories of CSA in this study also endorsed having female only or both male and female perpetrators. A measure such as the Sexual Experiences Survey that assumes a female victim and male perpetrator may alienate and invalidate those who do not fit this conceptualization of sexual victimization, thus introducing bias into studies that utilized such measures.

Even with these limitations, this literature review provides a strong empirical basis for the development of a DBT skills training group for sexual revictimization risk reduction. Much still needs to be done before this program can start helping women whose lives have been interrupted by sexual violence: a treatment manual needs to written and reviewed, and the intervention needs to piloted. However, this review and proposal have laid the foundation for the creation of a program that could not only decrease the incidence of sexual revictimization but also aid women with victimization histories in developing skills to help them more effectively navigate their world and begin building a life worth living.
References


