Revictimization Risk Factors Following Childhood Maltreatment: A Literature Review

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Abstract
Revictimization research, to date, has primarily focused on sexual revictimization (i.e., child sexual abuse and adult sexual assault), which has resulted in a lack of understanding of trauma revictimization more generally. Specifically, it is unclear what factors are placing individuals with a history of child maltreatment (i.e., sexual abuse, physical abuse, and witnessing intimate partner violence [IPV]) at greater risk for subsequent adult victimization (i.e., sexual assault and IPV). Existing theoretical and empirical work on revictimization suggest that multiple risk factors are likely present within this framework (e.g., posttraumatic stress symptoms [PTSS], emotion dysregulation, and risk-taking behaviors). Prior research has suggested that PTSS are often linked with these other risk factors, and it is possible that the development of PTSS following child maltreatment may be related to the development or maintenance of additional factors that increase the likelihood of revictimization. The purpose of this review was to synthesize findings regarding risk factors that place maltreated individuals at greater risk for adult revictimization. Approximately 228 studies were identified following a thorough search of the peer-reviewed literature using multiple databases (PsycINFO, PILOTS, and Google Scholar). Each study was critically analyzed for relevance. The included studies were used in our review of prevalence, specific risk factors that have been identified, and unanswered questions in this literature. PTSS were noted to be particularly important in the revictimization framework, and thus, a novel model of revictimization was also proposed where PTSS are illustrated as being associated with the development and maintenance of other factors within the revictimization framework.

Keywords
child maltreatment, revictimization, risk factors, posttraumatic stress symptoms, posttraumatic stress disorder

Children’s exposure to maltreatment is a pervasive public health problem around the globe, with exact rates varying significantly based on maltreatment type and continent (World Health Organization [WHO], 2020). In the United States, specifically, 677,529 children were victims of substantiated maltreatment in 2018 alone (Department of Health and Human Services [DHHS], 2020), and comparable rates are found in other Western countries (for a review, see Moody et al., 2018). While this number is staggering, the rates of maltreatment are underestimated (Fang et al., 2012), partially due to relying solely on the report from either the caregiver or the child (Finkelhor et al., 2015) and concerns about the consequences of disclosure (Beddoe & De Haan, 2018). Maltreatment is related to a host of negative outcomes across the lifespan, including a greater risk for depression, anxiety, emotion dysregulation, posttraumatic stress disorder (PTSD), substance misuse (Fang et al., 2012; Pratchett & Yehuda, 2011; Young & Widom, 2014), as well as smaller brain volumes (Spies et al., 2016), lower IQ and academic difficulties (Cowell et al., 2015), and behavioral problems (Howell et al., 2016). Maltreatment survivors are also at greater risk for being victimized in adolescence and adulthood (Walker et al., 2019), a phenomenon known as revictimization. Much of the existing literature has focused on sexual revictimization (i.e., child sexual abuse [CSA] and adult sexual assault [ASA]), which is problematic as relations between non-sexual, interpersonal trauma in childhood and adult revictimization have also been revealed (Desai et al., 2002; Stroem et al., 2019; Widom et al., 2008). To date, very few studies have explored revictimization following non-sexual Criterion A traumatic events, such as child physical abuse (CPA; Desai et al., 2002; Stroem et al., 2019; Widom et al., 2008) and witnessing intimate partner violence (IPV; Werner et al., 2016).

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Maltreatment survivors are also more likely than non-maltreated individuals to engage in risk-taking behavior, such as using substances or engaging in risky sexual behavior. Rates of sexual revictimization are high, with meta-analytic findings indicating around 47.9% of CSA survivors also experience ASA, and several key risk factors have been identified (e.g., PTSS, emotion dysregulation, substance misuse, anger, and risk-taking behaviors). The revictimization literature is largely limited to college samples (e.g., White, female, and educated), and additional work that is more inclusive of males, LGBTQ+, and racial and ethnic minorities is essential, as these groups are also at risk for revictimization. Of the key risk factors, PTSS appear to be particularly salient in the revictimization framework as PTSS may develop first in response to victimization. Prior work has demonstrated that PTSS may drive, or at least exacerbate other difficulties and risk factors for revictimization. Notably, reductions in PTSS are often related to reductions of other challenges (e.g., emotion dysregulation).

PTSS have been closely tied to difficulties with emotion regulation, and it is unclear whether they develop concurrently or as a cause or consequence of one another. Emotion dysregulation has been linked with greater engagement in risk-taking behaviors, which increases one's risk for additional trauma exposure. Like PTSS, emotion dysregulation often has a “dose-response” relationship with other psychological difficulties, where emotion dysregulation severity is also related to increased severity in the other risk factors (e.g., substance misuse). Anger, a symptom of PTSD, is a specific emotion that is also related to risk for revictimization, although anger has primarily been examined in male-only samples. Male survivors are at risk for having more challenges managing anger and aggressive behavior, as victimization experiences may conflict with one’s cultural views of masculinity (e.g., men are strong and invulnerable).

Maltreatment survivors may have difficulties with assessing risk and safety, which is problematic as accurate risk assessment may protect against revictimization. Further, PTSD symptoms, such as dissociative or numbing symptoms, may negatively impact one’s awareness, thereby exacerbating risk identification challenges. Maltreatment survivors are also more likely than non-maltreated individuals to engage in risk-taking behavior, such as using substances or engaging in risky sexual behavior. Longitudinal findings indicate that substance misuse typically begins after the onset of PTSS, rather than before or simultaneously, suggesting that survivors may use substances to help cope with their trauma-related distress. Unfortunately, greater substance misuse has been tied to impairments in self-protective behaviors and being perceived as vulnerable, which may increase one’s risk for revictimization.

CSA has specifically been associated with greater engagement in risky sexual behaviors. Like substance misuse, it is understood that survivors may engage in these behaviors to attempt to mitigate trauma-related distress. However, engagement in risky sexual behavior after CSA is also strongly related to both ASA and IPV in adulthood. CSA survivors also have an increased propensity for nonassertiveness when they are confronted with potential threatening situations. Many of these survivors are socialized into a victim role early in life and may react more passively due to fear of violence or loss of affection/relationship status. Dissociation, or emotional detachment, has also been tied to both sexual and IPV revictimization. Interpersonal trauma survivors have increased rates of PTSD with dissociative symptoms, which has been tied to greater difficulties with information processing, fewer self-protective behaviors, and more difficulty with accurately perceiving risk. Many of the aforementioned risk factors for revictimization have been largely studied within the context of sexual trauma. Notably, risk factors for other types of revictimization, or cumulative revictimization, may be different in both form and severity for individuals who experienced CSA versus other maltreatment types or polyvictimization. Research is still needed to explore these nuanced relationships.

Across the existing revictimization literature, PTSS have been consistently established as important to consider given that maltreatment survivors experience elevated PTSS. Therefore, it is important that the role of PTSS is investigated further, in tandem with other risk factors, given that PTSS may be closely tied to the presence and/or intensity of other factors.

Table 1. Key Findings of the Literature Review of Risk Factors for Trauma Revictimization.

- Children who experience maltreatment are at increased risk for victimization, such as ASA and IPV, in subsequent developmental time periods (e.g., adolescence and adulthood). Much of the current revictimization work is specifically focused on sexual revictimization, and thus, much less is known regarding prevalence rates and risk factors for other types of revictimization (e.g., IPV revictimization), as well as cumulative trauma revictimization. However, it has been estimated that anywhere from 24% to 90% of individuals who experience multiple maltreatment types may experience adult revictimization.

- Rates of sexual revictimization are high, with meta-analytic findings indicating around 47.9% of CSA survivors also experience ASA, and several key risk factors have been identified (e.g., PTSS, emotion dysregulation, substance misuse, anger, and risk-taking behaviors).

- The revictimization literature is largely limited to college samples (e.g., White, female, and educated), and additional work that is more inclusive of males, LGBTQ+, and racial and ethnic minorities is essential, as these groups are also at risk for revictimization.

- Of the key risk factors, PTSS appear to be particularly salient in the revictimization framework as PTSS may develop first in response to victimization. Prior work has demonstrated that PTSS may drive, or at least exacerbate other difficulties and risk factors for revictimization. Notably, reductions in PTSS are often related to reductions of other challenges (e.g., emotion dysregulation).

- PTSS have been closely tied to difficulties with emotion regulation, and it is unclear whether they develop concurrently or as a cause or consequence of one another. Emotion dysregulation has been linked with greater engagement in risk-taking behaviors, which increases one’s risk for additional trauma exposure. Like PTSS, emotion dysregulation often has a “dose-response” relationship with other psychological difficulties, where emotion dysregulation severity is also related to increased severity in the other risk factors (e.g., substance misuse).

- Anger, a symptom of PTSD, is a specific emotion that is also related to risk for revictimization, although anger has primarily been examined in male-only samples. Male survivors are at risk for having more challenges managing anger and aggressive behavior, as victimization experiences may conflict with one’s cultural views of masculinity (e.g., men are strong and invulnerable).

- Maltreatment survivors may have difficulties with assessing risk and safety, which is problematic as accurate risk assessment may protect against revictimization. Further, PTSD symptoms, such as dissociative or numbing symptoms, may negatively impact one’s awareness, thereby exacerbating risk identification challenges.

- Maltreatment survivors are also more likely than non-maltreated individuals to engage in risk-taking behavior, such as using substances or engaging in risky sexual behavior.

- Longitudinal findings indicate that substance misuse typically begins after the onset of PTSS, rather than before or simultaneously, suggesting that survivors may use substances to help cope with their trauma-related distress. Unfortunately, greater substance misuse has been tied to impairments in self-protective behaviors and being perceived as vulnerable, which may increase one’s risk for revictimization.

- CSA has specifically been associated with greater engagement in risky sexual behaviors. Like substance misuse, it is understood that survivors may engage in these behaviors to attempt to mitigate trauma-related distress. However, engagement in risky sexual behavior after CSA is also strongly related to both ASA and IPV in adulthood.

- CSA survivors also have an increased propensity for nonassertiveness when they are confronted with potential threatening situations. Many of these survivors are socialized into a victim role early in life and may react more passively due to fear of violence or loss of affection/relationship status.

- Dissociation, or emotional detachment, has also been tied to both sexual and IPV revictimization. Interpersonal trauma survivors have increased rates of PTSD with dissociative symptoms, which has been tied to greater difficulties with information processing, fewer self-protective behaviors, and more difficulty with accurately perceiving risk.

- Many of the aforementioned risk factors for revictimization have been largely studied within the context of sexual trauma. Notably, risk factors for other types of revictimization, or cumulative revictimization, may be different in both form and severity for individuals who experienced CSA versus other maltreatment types or polyvictimization. Research is still needed to explore these nuanced relationships.

- Across the existing revictimization literature, PTSS have been consistently established as important to consider given that maltreatment survivors experience elevated PTSS. Therefore, it is important that the role of PTSS is investigated further, in tandem with other risk factors, given that PTSS may be closely tied to the presence and/or intensity of other factors.

Previous reviews of the revictimization literature have focused on specific forms (e.g., sexual revictimization, Messman-Moore & Long, 2003), and thus, a review was needed to synthesize our growing knowledge of trauma revictimization more generally, in addition to specific types. Moreover, risk factors for revictimization have been studied extensively over the past two decades, and an updated review was essential to reflect more recent findings. This article provided a focused review of the leading theories and research on trauma revictimization. Approximately 228 studies on maltreatment and revictimization were identified by a thorough search of several databases (PsycINFO, PILOTS, and Google Scholar). Each study was analyzed for its relevance to this review. The authors reviewed risk factors for and outcomes of Criterion A child maltreatment, including those tied to adult revictimization. This paper also detailed previously identified risk factors from the revictimization framework and proposed a model by which PTSS may be a critical component in the development and maintenance of other factors that may increase the risk for revictimization. Unanswered questions in

Note. CPA = child physical abuse, CSA = child sexual abuse, IPV = intimate partner violence, ASA = adult sexual assault; PTSS = posttraumatic stress symptoms; PTSD = posttraumatic stress disorder.
the literature were also posed. Please see Table 1 for a summary of key findings from this review.

Child Maltreatment

Due to the substantial maltreatment and revictimization literature, this review focused solely on Criterion A traumatic events (i.e., CPA, CSA, and witnessing IPV), as these events may result in the development of PTSD and PTSS, based on the diagnostic criteria in the DSM-5 (APA, 2013). However, it is notable that emotional abuse and neglect have also been associated with many damaging mental and physical health consequences (DHHS, 2020; Widom et al., 2012). Maltreatment types frequently overlap as opposed to occurring as a singular incident (i.e., polyvictimization), and the cumulative impact often leads to more serious and chronic outcomes than a single episode of maltreatment (Finkelhor et al., 2011). For instance, 48.4% of children experienced more than one type of violence exposure over a 1-year period (Finkelhor et al., 2015). Thus, when studying maltreatment in a singular way, the consequences may be attributed to an individual incident of victimization, when the totality of one’s experience is actually responsible (Finkelhor et al., 2015).

Risk Factors for Child Maltreatment

Maltreatment often takes place within the context of other adversity (e.g., poverty), and there are numerous risk factors that have been identified. At the individual level, gender, age, race, and ethnicity have been linked with maltreatment through potentially complex interactions between these factors and specific maltreatment types (Finkelhor et al., 2015; Hamby et al., 2011; Moody et al., 2018). For instance, females are generally more likely to experience CSA than males, specifically in Western countries, whereas males tend to have higher rates of CPA (for a review, see Moody et al., 2018). Younger children are more vulnerable to maltreatment in general, and in 2018, approximately one quarter (28.7%) of victims were younger than 3 years old (DHHS, 2020). Although older children (i.e., age 14–17) may be more likely to witness IPV than younger children (Hamby et al., 2011). Race and ethnicity have also been linked with a greater risk for maltreatment, while accounting for SES (Kim & Drake, 2018). In the U.S., Black and Hispanic/Latino children are overrepresented among those being reported as victims of maltreatment (DHHS, 2020). It has been suggested that these increased rates may be the result of racial biases and greater exposure to risk factors, such as poverty, low parental education, single parent homes, and other disparities (Lanier et al., 2014).

Within the family system, children living in poverty are overrepresented among abused children (for a review, see Drake & Jonson-Reid, 2014). However, the relationship between family poverty and maltreatment appears to be far more complex than a direct link. Other factors, including parental education, stress, and psychological challenges, may be strengthening this association (Drake & Jonson-Reid, 2014). In fact, parents with lower educational attainment are more likely to endorse stress in the home that is related to economic difficulties, which may elevate maltreatment risk (Euser et al., 2011). Furthermore, poverty can be discussed based on neighborhoods where residents make an average income that falls below the poverty line. In these disadvantaged neighborhoods, residents are more likely to experience exposure to community violence, unemployment, and inequities based on their SES and/or cultural background, which are related to a greater risk for maltreatment (Drake & Jonson-Reid, 2014; WHO, 2020). In the U.S. and Europe, research indicates that children living in poverty are more likely to be involved with child protective services compared to those in higher income areas (Bywaters et al., 2016; World Health Organization (WHO), 2020). In general, lower SES has been tied to greater maltreatment risk in both Eastern and Western countries (for a meta-analysis, see Stith et al., 2009), as well as among indigenous peoples (Ma et al., 2013).

Caregivers who perpetrate maltreatment may also be survivors themselves, as maltreatment has been previously tied to a greater likelihood of perpetrating violence in adulthood, a concept often referred to as the intergenerational transmission of abuse (Widom, 1989). Although experiencing maltreatment is a risk factor for abusing one’s own children, the size of this risk appears to be small and there is significant variability in this literature, as rates of the intergenerational transmission of abuse range from 6.75% to 70% (for a review, see Berzenski et al., 2014). CPA appears to have the most consistent transmission rates compared with other maltreatment types (Berzenski et al., 2014); however, a history of CSA (Widom et al., 2015) and witnessing severe IPV (Murrell et al., 2005), have also been linked with increased adult perpetration.

Child Maltreatment Outcomes

There are many devastating consequences of child maltreatment, including death. CPA has been most strongly linked with both injury and death, as well as illness and disability into adulthood (e.g., lung disease, poor nutrition; Widom et al., 2012). Numerous cognitive and executive functioning deficits have been related to maltreatment, including lower academic performance and IQ, along with language, memory, and attention problems that may be tied to decreased long-term occupational success (for a review, see Hart & Rubia, 2012). Child maltreatment has also been associated with neurological changes in one’s brain structure and function (i.e., hippocampus, amygdala, prefrontal cortex, and cerebellum; Hart & Rubia, 2012). Reduced hippocampal volumes may be being particularly important due to their critical role in the body’s stress response through the hypothalamic pituitary adrenal (HPA) axis, which regulates stress reactions and other important processes (Holliday et al., 2014).
Beyond biological outcomes of maltreatment, serious psychological ramifications are often present, and they can be detrimental to one’s short- and long-term functioning (Pratchett & Yehuda, 2011). PTSD is one possible consequence of maltreatment. Yet, despite high rates of trauma, only a small proportion of trauma-exposed individuals develop PTSD in their lifetime (8.7%; APA, 2013). In general, maltreatment is associated with elevated levels of PTSS across the lifespan (30.9%; for a review, see Messman-Moore & Bhuptani, 2017). However, CSA has specifically been linked with a greater conditional risk for PTSD (37.5% lifetime, 22.5% current; Messman-Moore & Bhuptani, 2017), along with more severe PTSS (Wilson & Scarpa, 2014), compared with other forms of maltreatment (Ehring & Quack, 2010; Kisiel et al., 2014). Behavioral problems in children are commonly linked with maltreatment, including aggression, particularly if the exposure is chronic (Jonson-Reid et al., 2012; Widom, 2014). Witnessing IPV has specifically been linked with aggressive and violent behavior (Howell et al., 2016), along with peer victimization (Knous-Westfall et al., 2012).

The distress that PTSS cause has also been tied to difficulties regulating emotion (Lee, 2015; Messman-Moore & Bhuptani, 2017). Emotion regulation encompasses several processes related to affect, including how one experiences and identifies emotion, the intensity of the emotion, and how their emotions are expressed (Dvir et al., 2014). Emotion regulation skills are developed during early childhood, and trauma exposure may interrupt the development of emotion regulation skills, particularly if the caregiver is the perpetrator (Kim & Cicchetti, 2010; Shields & Cicchetti, 1998). Emotion regulation deficits have been observed in maltreatment survivors as the trauma may strain parent–child interactions, which reduces opportunities for development of socialization and emotion regulation skills (Ehring & Quack, 2010). Maltreated children may struggle to identify and express their emotions, along with having difficulties with modulating emotional experiences when they are upset, compared to children with no history of abuse or neglect (Charak et al., 2018; Kim & Cicchetti, 2010; Messman-Moore et al., 2015).

Maltreated children are more likely than non-maltreated peers to develop traits that may be considered maladaptive, such as impulsivity, which increases one’s engagement in risk-taking behaviors (e.g., substance misuse; Rogosch & Cicchetti, 2004; Lown et al., 2011). Negative reinforcement models of substance use provide an explanation for the underlying motivations for substance misuse, as individuals are aiming to reduce aversive states (Carpenter et al., 2019). In fact, the avoidance of negative emotion following trauma exposure may be a motivating factor for substance users (Baker et al., 2004). Unfortunately, prior work has suggested that individuals who are at higher risk for substance misuse experience less of a reduction in negative emotionality compared to lower risk individuals (Carpenter et al., 2019).

Similar to the negative reinforcement models of substance use, trauma researchers have focused on tension-reduction hypotheses, such as the self-medication theory (Stewart & Israeli, 2002), which asserts that survivors are at greater risk for substance-related difficulties, possibly to self-medicate their trauma-related distress (Stewart & Israeli, 2002). Notably, maltreated children begin misusing substances at an earlier age than their non-abused peers (Lansford et al., 2010). Maltreatment is highly prevalent among individuals seeking treatment for alcohol dependence (CSA = 21.1%, CPA = 38.9%), potentially due to the high levels of negative affect that are present (Schwandt et al., 2013). Unfortunately, by using substances to cope with distress, maltreatment survivors may be at risk for additional difficulties, including revictimization (Ullman, 2016).

Another risk-taking behavior that may follow child maltreatment is risky sexual behavior. Finkelhor and Browne (1985) proposed a traumatic sexualization framework which asserts that CSA may contribute to one’s development of their sexuality and be related to inappropriate sexual behaviors and maladaptive cognitions regarding sex (e.g., “if I have sex, I will be loved”). CSA survivors may also struggle to form trusting relationships with adults, which may increase the likelihood of entrusting riskier partners, due to a lack of experience with safe relationships (Finkelhor & Browne, 1985; Littleton et al., 2014). Prior work has supported this theory, as CSA survivors are more likely to engage in risky sexual behaviors, potentially as a way of feeling power and control in their sexual encounters or to avoid dangerous or violent outcomes, which may elevate the risk for subsequent assault (Littleton et al., 2014; Messman-Moore et al., 2010).

**Revictimization**

As noted, children who experience maltreatment are at greater risk for revictimization across subsequent developmental time periods (Finkelhor et al., 2007; Walker et al., 2019). Revictimization has primarily been studied in the context of sexual trauma, and one recent meta-analysis determined that 47.9% of CSA survivors also experience ASA (Walker et al., 2019). The dearth of information on other forms of revictimization is rather surprising, as relations between victimization across the lifespan have been identified (Desai et al., 2002; Widom, 2014). For example, CPA and CSA have been linked with ASA and IPV for both men and women in a nationally representative sample (Desai et al., 2002), suggesting that maltreated individuals, beyond CSA survivors, are at risk for revictimization. Yet, to our knowledge, witnessing IPV has only been explored in relation to ASA (Werner et al., 2016). Maltreatment is also linked with greater incidence of adult IPV (McIntyre & Spatz Widom, 2011); thus, ASA is not the only trauma in adulthood that requires investigation. Few studies have examined the link between maltreatment and adult IPV; however, one study found that CSA survivors were at a greater risk for IPV compared to...
those with no abuse history (Noll et al., 2003). Given that rates of sexual revictimization are high (Walker et al., 2019), it is essential to determine the rates of non-sexual revictimization and expand the types of traumatic events examined.

There are a host of other challenges that have been identified in the revictimization literature. In addition to the skewed research focus on sexual revictimization, there is notable variability in its conceptualization, as the distinct types of revictimization have not been defined consistently. Sexual revictimization is commonly operationalized as occurring across separate developmental periods (e.g., childhood and adulthood), whereas studies on IPV revictimization often include instances of victimization within the same time point, such as two occurrences with distinct perpetrators (Iverson et al., 2013; Kuijpers et al., 2012). There are also differences regarding the age cut-offs used to define victimization across time periods. For example, some may refer to those under 18 as children (Brenner & Ben-Amitay, 2015), whereas others may distinguish between children (i.e., below 14) and adolescents (i.e., between 14 and 18; Balsam et al., 2011; Hequembourg et al., 2013; Miron & Orcutt, 2014). In prior work, restrictions have occasionally been placed on the perpetrator’s characteristics as well (e.g., at least 5 years older than the victim), which may limit our understanding of one’s actual exposure to victimization (Balsam et al., 2011). Given limitations in how data may be collected, it may also be unclear whether maltreatment occurred chronically across time points, possibly even by the same perpetrator, which further contributes to ambiguity regarding the prevalence of revictimization.

There also appears to be a lack of cohesion regarding foci between the child and adult victimization literatures. The child literature has emphasized understanding polyvictimization, which while important, may be limiting as there may be nuanced outcomes associated with a singular trauma type (e.g., CSA). In contrast, the adult literature primarily centers on sexual revictimization, which may result in a lack of awareness regarding more cumulative effects of other trauma exposure. For instance, sexual victimization is associated with a greater conditional risk for PTSD compared with other traumas. Yet, cumulative trauma is related to higher PTSS (for a review, see Messman-Moore & Bhuptani, 2017). At present, the literature on adult revictimization is primarily examined following a single maltreatment type, even though polyvictimization is common and is tied to a greater risk for revictimization, including IPV revictimization (Brassard et al., 2020; Finkelhor et al., 2015). Growing up in an adverse environment may be tied to difficulties with selecting partners in adulthood due to difficulties accurately identifying risk or struggling with assertiveness (Brassard et al., 2020).

In line with prior research, the existing theories of revictimization have also centered on sexual revictimization. Messman-Moore and Long (2003) proposed an ecological theory of sexual revictimization where they posited that multiple factors are likely present, including psychological factors, perceptions about oneself, conflict with others, SES, risk-taking behaviors, and gender roles. This is the most comprehensive theory to date, as it acknowledges the complexities that exist within the revictimization framework, and it focuses on the interactions of various risk factors rather than fixating on the role of individual variables. However, given the concentration on sexual revictimization, additional theory should be developed to account for revictimization in general, along with specific types.

**Risk Factors for Revictimization**

A multitude of potential risk factors for revictimization have been examined, including PTSS, emotion dysregulation, anger/aggression, impaired risk perception, risk-taking behaviors, sexual assertiveness, and dissociation, (Bockers et al., 2014; Easton & Kong, 2017; Iverson et al., 2013; Jouriles et al., 2014; Lilly et al., 2014; Messman-Moore et al., 2009; Ullman, 2016; Walsh et al., 2011). Although several factors have been researched extensively (i.e., PTSS and substance misuse), they have predominantly been explored in studies of sexual revictimization. Thus, investigation of variables that may increase the likelihood of other revictimization types or revictimization in general is essential. Though some risk factors appear to be particularly relevant in the revictimization framework, such as PTSS, emotion dysregulation, and substance misuse, the relative strength of these mechanisms is still uncertain.

**Posttraumatic Stress Symptoms.** Though there are many factors that may elevate one’s risk for revictimization, PTSS appear to be particularly salient in this relationship. Like CSA, survivors of ASA are at higher risk for developing PTSD, and epidemiological studies have found that the rate of PTSD associated with sexual violence ranges from 30 to 50% (Walsh et al., 2012a, 2021b). Following maltreatment, elevated PTSS have been related to both sexual and IPV revictimization (Iverson et al., 2013; Kuijpers et al., 2012; Lilly et al., 2014; Messman-Moore et al., 2009). PTSS also likely interacts with other revictimization risk factors (Debell et al., 2014; Messman-Moore et al., 2009). As an example, PTSS may mediate the link between sexual victimization and substance misuse (Ullman et al., 2013). In a longitudinal study, PTSS were predictive of alcohol misuse following CSA, which in turn, predicted revictimization (Ullman et al., 2009).

The specific DSM-IV PTSS symptom clusters have also corresponded with both sexual and IPV revictimization, including re-experiencing symptoms being associated with a greater risk for IPV revictimization at a medium effect size ($d = .42$; Kuijpers et al., 2012). Additionally, numbing and hyperarousal symptoms have been linked with both sexual (Ullman et al., 2009) and IPV (Iverson et al., 2013) revictimization, as these symptoms may be interfering with one’s risk recognition and/or ability to appropriately react to threat. In fact, one prospective study indicated that survivors
were at a significantly greater risk of experiencing additional IPV over a 6-month period as their hyperarousal symptoms increased (Iverson et al., 2013). The distinct roles of the updated DSM-5 PTSD symptom clusters (i.e., intrusion, avoidance, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity) have yet to be explored in relation to revictimization.

**Emotion Dysregulation.** Emotion dysregulation is another important psychological factor that has been frequently associated with both revictimization and PTSS. Early trauma exposure may disrupt the development of the emotion regulation skills, contributing to broader negative functioning (Shields & Cicchetti, 1998). Difficulties with emotion regulation may partially account for the link between maltreatment and revictimization (Berzenski & Yates, 2010; Lilly et al., 2014). Emotion regulation challenges have been related to higher levels of anger and impulsivity, which increased individuals’ risk for IPV revictimization (Berzenski & Yates, 2010). Moreover, emotion regulation deficits have also been associated with greater engagement in risk-taking behaviors, such as substance use and risky sexual behavior (Messman-Moore et al., 2010), thereby increasing the likelihood of additional trauma exposure. The relationship between emotion dysregulation and PTSS appears to be quite complex (Ehring & Quack, 2010), and given that much of the literature is cross-sectional, it is unclear whether emotion regulation deficits are developing concurrently, or as a cause or consequence of PTSS. However, it is likely that these constructs have several interactions. When a trauma survivor develops PTSS, their symptoms may heighten their emotional experiences and stress reactions in response to trauma-related stimuli (Lee, 2015). Notably, these constructs are highly correlated ($r = .57$, $p < .001$; Lilly et al., 2014), which is unsurprising, as PTSS severity has often been related to difficulties with various aspects of emotion regulation (e.g., reduced emotional awareness, impulse control, regulation of negative emotion, and experiential avoidance; Ehring & Quack, 2010; Messman-Moore et al., 2010). Emotion dysregulation may also contribute to elevated avoidance, thereby restricting one’s ability to habituate to and recover from trauma-related distress (Foa & Kozak, 1986). Distressing trauma symptoms may result in a greater need to regulate one’s emotions, and consequently, PTSS may make it more challenging to manage and modulate emotional responses (Seligowski et al., 2015).

**Anger.** Anger is a specific emotion that appears to be important within this framework. In fact, the updated DSM-5 conceptualization of PTSD now includes symptoms of anger and aggression within the fourth symptom cluster (i.e., marked alterations in arousal and reactivity; APA, 2013). Anger, aggression, and hostility have been related to sexual victimization in men (Easton & Kong, 2017), along with an increased risk for both sexual and IPV revictimization for men and women (Berzenski & Yates, 2010; Charak et al., 2019; Iverson et al., 2014; Lilly et al., 2014). Anger-specific dysregulation has also been identified as a partial mediator of the link between CPA and IPV, which aligns with the notion that maltreatment can disrupt the development of emotion regulation skills, particularly for anger (Iverson et al., 2014). Men who have experienced physical forms of revictimization are more likely to have anger and aggression difficulties (Iverson et al., 2014), possibly due to the dissonance between victimization and cultural views of masculinity (e.g., men are strong), which may increase trauma-related distress.

**Failure to Recognize Risk.** Beyond emotional outcomes, maltreatment survivors may have more difficulty assessing future risk. Sexual trauma exposure has specifically been associated with greater perceived risk for assault (Orchowski et al., 2012). Prior work suggests that survivors may feel less capable of resisting aggression from perpetrators compared to those with no abuse history (Untied et al., 2013). The inability to accurately assess risk in dangerous situations has been previously tied to both maltreatment and revictimization (Bockers et al., 2014); whereas an enhanced ability to detect threat may be protective against revictimization. It is possible that the cognitive deficits that have been linked with maltreatment affect one’s ability to recognize risk and may hinder one’s ability to utilize effective and assertive behavioral responses when they encounter a potentially threatening situation (DePrince & Gagnon, 2018). Further, dissociative and numbing symptoms of PTSD may decrease one’s overall awareness, which may also impair accurate risk assessment (Yeater et al., 2010), though these relations have largely been investigated in the context of sexual trauma. Notably, reductions in levels of PTSS have been linked with improvements in responding to danger cues from perpetrators (Iverson et al., 2011), suggesting that PTSS may be at least partially contributing to these deficits.

**Substance Misuse.** As mentioned, tension-reduction hypotheses have been proposed based on heightened trauma-related distress (self-medication theory; Stewart & Israeli, 2002). The data on these hypotheses have been somewhat mixed, and thus, additional factors are likely important to consider, such as how survivors are attempting to reduce distress or in what context. Substance misuse has been identified as a key mechanism of revictimization due to the added impairment of self-protective behaviors, being viewed as vulnerable due to intoxication, and an increased likelihood of being in risky or potentially dangerous situations (Messman-Moore et al., 2009; Messman-Moore & Long, 2003; Ullman, 2016). Prior work on sexual violence has suggested that the link between ASA and using substances to cope with distress may be reciprocal, where sexual assault increases the likelihood of drinking alcohol to cope with trauma-related distress, which elevates the risk for additional victimization (Messman-Moore et al., 2015).
The onset of substance misuse typically occurs after the development of PTSS, as opposed to before or concurrently (Ullman, 2016). Indeed, PTSS may help to explain high rates of substance misuse among adult maltreatment survivors, as PTSS has been identified as a mediator between maltreatment and substance misuse (Ullman, 2016). Further, there is support for a dose–response relationship between PTSS and substance misuse, suggesting that greater severity of PTSS is predictive of substance misuse severity (Debell et al., 2014). CSA severity has also been related to PTSS severity in adulthood, which has been predictive of increased substance misuse as a coping mechanism over a 1-year period (Ullman et al., 2013). Ullman and colleagues (2009) also observed distinct relations between substance misuse and sexual revictimization through all three of the DSM-IV PTSD symptom clusters.

**Risky Sexual Behavior.** In addition to a greater propensity for misusing substances, maltreatment is related to increased likelihood of engaging in risky sexual behaviors, which elevates revictimization risk (Walsh et al., 2013). Per the traumatic sexualization framework, CSA survivors may be more likely to learn developmentally inappropriate views about sex and their own sexuality (Finkelhor & Browne, 1985). CSA may be associated with attention, affection, and gifts, which may result in a greater use of inappropriate sexual behavior and distorted views of one’s own sexuality as one enters adulthood (Finkelhor & Browne, 2010). Therefore, the framework also puts forth that engaging in risky sexual behavior may be another way for individuals to regain feelings of power and control in sexual situations following a history of CSA. Like substance use, researchers have considered sexual risk-taking behaviors to be maladaptive coping strategies that may temporarily numb psychological distress, such as PTSS and other negative affectivity (e.g., emotion dysregulation; Littleton et al., 2014; Messman-Moore et al., 2010; Miron & Orcutt, 2014; Orcutt et al., 2005). CSA has been related to an elevated risk for using sex to manage feelings of sadness and loneliness (Orcutt et al., 2005). CSA is also linked with more sexual risk-taking behaviors between high school graduation and first year of college, a time of high rates of sexual assault (Testa et al., 2010). Consistent with studies of PTSS and substance misuse, psychological distress may act as a mediator of the relationship between sexual victimization and using sex to cope with and regulate negative emotionality (Littleton et al., 2013). These findings aid in our understanding of the complex pathway between sexual violence and risky sexual behaviors that may be, at least partially, driven by trauma-related distress.

**Lack of Sexual Assertiveness.** Children who have been sexually abused are often socialized into a victim role from an early age (Finkelhor & Browne, 1985). Thus, when CSA survivors are faced with potentially dangerous situations, they may be more likely to shut down as opposed to reacting assertively. These individuals may be particularly sensitive to adverse social outcomes (e.g., loss of affection or relationship status and fear of violence) if they reject a sexual advance, which may result in even fewer assertive behaviors in response to risk (Porter, 2015). In a study of Spanish women, the tendency to shut down in dangerous situations was tied to a greater risk for revictimization due to a lack of reactivity or forceful action (Santos-Iglesias & Sierra, 2012). In line with the traumatic sexualization framework, CSA survivors have been less likely to express anger when confronted with an unwanted sexual advance compared to women without an abuse history (Jouriles et al., 2014). A lack of assertiveness may be a result of impaired risk recognition or difficulties with emotional processing following CSA (Noll & Grych, 2011). Given that assertiveness can be quite valuable in diminishing one’s risk for assault, additional work is needed to explore why these challenges are present and whether certain aspects of abuse (e.g., severity) contribute to greater difficulties responding assertively.

**Dissociation.** It is also possible that when a maltreatment survivor can recognize a threat, they may detach themselves emotionally, as opposed to responding with anger or assertiveness (Messman-Moore et al., 2010; Walsh et al., 2011). Dissociation has been conceptualized as ranging from normal states (i.e., daydreaming) to maladaptive forms of dissociation that may include detachment, numbing, or “out of body” experiences. Following trauma exposure, dissociation may occur only shortly after the event (i.e., state) or it may become more pervasive across the lifespan (i.e., trait). Notably, many studies have focused on the relations between trait dissociation and revictimization, and very few have explored the role of state dissociation (Bockers et al., 2014). Dissociation as a subtype of PTSD has a prevalence between 14 and 35% (Armour et al., 2014; Blevins et al., 2014), with higher rates for women and after interpersonal trauma (Wolf et al., 2016). Dissociation has similar negative reinforcing properties to substance misuse and may hinder one’s ability to process information and respond assertively during potentially threatening situations (Iverson et al., 2013).

Dissociative symptoms have been previously examined for their role in the revictimization framework (Bockers et al., 2014; for a review, see; Messman-Moore & Long, 2003). Greater dissociation has been linked with an elevated risk for revictimization (Bockers et al., 2014; Iverson et al., 2013), possibly due to inhibited protective behaviors or difficulty with perceiving the risk for violence. The ties between state dissociation and revictimization may be due to numbing, possibly rendering one less vigilant to threat (Bockers et al., 2014). Although difficulties with risk perception and numbing may be the link between dissociation and revictimization (Bockers et al., 2014; Iverson et al., 2013), there remains a lack of longitudinal work.
examining these associations for both sexual and IPV revictimization.

Posttraumatic Stress Symptoms Model of Revictimization

Based largely on the sexual revictimization literature and several other studies incorporating other forms of revictimization, PTSS appear to explain, or partially explain, the roles of other factors that place maltreatment survivors at risk for revictimization. First, PTSS have been linked with greater difficulties with emotional functioning following maltreatment (Messman-Moore & Bhuptani, 2017). Specifically, PTSS appear to have a reciprocal relationship with emotion dysregulation, where PTSS exacerbate one’s emotional experiences, and emotion dysregulation serves to maintain an elevation in PTSS levels in both the short- and long-term (Lee, 2015). Unfortunately, emotion dysregulation has been associated with an increased risk for both sexual and IPV revictimization (Berzinski & Yates, 2010; Lilly et al., 2014). Consistent with these findings, anger and aggression, which are PTSD symptoms (APA, 2013), also are related to revictimization (Charak et al., 2019; Iverson et al., 2014; Lilly et al., 2014). Experiencing high levels of anger or aggression, may make it more difficult to identify and react to threatening situations. Further, CSA survivors specifically have exhibited deficits in risk recognition, as symptoms of PTSD, including numbing and dissociation, may limit one’s awareness and cognitive faculties, thereby increasing the likelihood of revictimization (Yeater et al., 2010).

As noted, PTSS are strongly associated with the development of maladaptive coping behaviors (e.g., substance misuse or sexual risk-taking behavior), which may further elevate one’s risk for danger (Littleton et al., 2014; Messman-Moore et al., 2009; Ullman et al., 2013). Substance misuse may result in cognitive impairment and compromised self-protective behaviors (Ullman, 2016). CSA survivors are particularly more apt to develop inappropriate views about sex and their sexuality from a young age, and though these distorted views may lead to risky sexual behavior (Littleton et al., 2014), they may also be related to difficulties with sexual assertiveness, elevating one’s risk for assault (Jouriles et al., 2014; Porter, 2015). PTSS have also been tied to an emotional detachment from reality (i.e., dissociation; Blevins et al., 2014; Walsh et al., 2011). Survivors may detach themselves from negative emotions and trauma-related distress, also rendering them more vulnerable (Bockers et al., 2014; Iverson et al., 2013).

Unanswered Questions in the Revictimization Literature

Despite the extensive work that has advanced our understanding of revictimization, there are still significant gaps in the literature that must be addressed. As mentioned, there are inconsistencies in definition of revictimization and discerning between the initial and subsequent victimization, which makes it difficult to determine whether the trauma exposure is chronic and/or if the perpetrator is the same across episodes of victimization. Additionally, much of the data are cross-sectional, which makes it challenging to make any temporal or casual conclusions about the mechanisms of revictimization. Retrospective, self-report measurement is often used, and though these tools are low-cost and easy to administer to large groups, it may be challenging to ask enough questions and ascertain all the desired information due to the length of the survey. The literature is also predominantly adult-focused, even though children are often revictimized between childhood and adolescence (Finkelhor et al., 2015). Thus, it is less clear whether there are distinct factors elevating the risk for revictimization between childhood and adolescence.

There are also notable discrepancies in sampling for revictimization studies. Notably, the bulk of the maltreatment and revictimization literature has been conducted in the U.S. and other Western countries, and much less is known about the prevalence of these traumas globally. The prior literature has also relied heavily on college (Hannan et al., 2017; Messman-Moore et al., 2013, 2015), or markedly high-risk samples (e.g., domestic violence shelters and HIV clinics; Iverson et al., 2013; Kuijpers et al., 2012; Pantalone et al., 2015), which makes it difficult to generalize findings to the larger population. Moreover, given the disproportional use of college samples, much of the results are based on educated, white, females. This is problematic as racial and gender minorities are at an increased risk for violence, and yet they appear to be grossly underrepresented in this literature (Balsam et al., 2011; Littleton & Ullman, 2013H. Littleton & Ullman, 2013; Orcutt et al., 2005; Pantalone et al., 2013). Men are also largely absent from the revictimization literature, and though they may be victimized less frequently than women, these experiences may be particularly devastating as they may not align with one’s cultural views of masculinity (Aosved et al., 2011).

While the research focus on sexual revictimization is merited due the severity of the potential consequences (Messman-Moore et al., 2013; Miron & Orcutt, 2014; Santos-Iglesias & Sierra, 2012; Ullman, 2016), it is unclear whether risk factors for more general revictimization may differ. Thus, there may be distinct clinical and research implications that are unknown. For example, specific factors that place CSA survivors at risk for ASA may differ in type and severity compared to those who have experienced CPA or poly-victimization. Furthermore, the cumulative impact of maltreatment may increase the likelihood of the presence of multiple risk factors (e.g., emotion dysregulation and dissociation), which certainly enhances the complexity of the pathway between maltreatment and revictimization and also introduces reciprocal pathways. PTSS clearly play a critical role in the revictimization framework given the distinct overlap with other, heavily researched risk factors that may be
exacerbated by a survivor’s levels of PTSS (Messman-Moore et al., 2009; Ullman et al., 2013). PTSS are strongly, and sometimes temporally, related to each of the factors that have been discussed in this review. Reductions in PTSS also appear to be linked with reductions in other maladaptive outcomes that may increase the risk for revictimization, including emotion dysregulation, substance misuse, and impaired risk perception (Debell et al., 2014; Iverson et al., 2011; Lee, 2015).

**Clinical Implications and Barriers to Treatment**

The revictimization literature has important implications for how to ameliorate the risk for additional trauma exposure following maltreatment. The risk factors reviewed are notably not external (e.g., living with a perpetrator), and therefore, may be targeted clinically. Risk reduction prevention programs that focus on individuals who are at high-risk for victimization (e.g., college women, racial minorities, and LGBTQ) have been highly beneficial (Blackwell et al., 2004). Similarly, educating people on the threat of assault and revictimization may improve their ability to recognize threat (Blackwell et al., 2004). Early evidence-based interventions are also critical following maltreatment to reduce distress symptoms and build emotion regulation and interpersonal skills (Wolfsdorf & Zlotnick, 2001). Interventions that reduce one’s PTSS and engagement in risky behaviors may serve to mitigate the risk for revictimization (Messman-Moore et al., 2009). Clinicians working with this population should be sure to assess for risk-taking behaviors and identify the motivations for engaging in these behaviors (e.g., to cope with PTSS), as prior work has suggested that one’s motivations may make these pathways even more complex (Littleton et al., 2014; Smith et al., 2014).

Unfortunately, barriers to treatment may keep trauma survivors from accessing the treatment they may need to recover from their experiences. Not all individuals recognize that they were abused or assaulted (Bottoms et al., 2016), possibly due to knowing the perpetrator or self-blame and guilt (e.g., unacknowledged rape; Wilson & Miller, 2016). There is significant stigma associated with both maltreatment and adult victimization, particularly when it is sexual (Walsh et al., 2012a, 2012b). The stigma that is unique to sexual violence results in fewer treatment-seeking behaviors (Holliday & Mouteith, 2019). Notably, the stigma of maltreatment, as well as beliefs about mental health generally, may also be deeply engrained in one’s culture (Dean et al., 2018), resulting lower rates of treatment utilization. Relatedly, cultural mistrust may be a treatment barrier. This mistrust exists as a consequence of oppression upon marginalized groups that results in a mistrust of the majority people (Hanna et al., 2017). For example, Blacks have reported greater feelings of stigma, more negative perceptions of mental health treatment, and a greater fear of being discriminated against by their therapist than other racial groups (Dean et al., 2018). Unfortunately, one’s experiences of discrimination may even worsen their reactions to the trauma, thereby exacerbating their symptom severity (Williams et al., 2014). Challenges for seeking trauma-focused treatment for persons of color may include family disapproval, limited familiarity with how to access treatment, negative perceptions regarding therapy, or views that therapy is unimportant (Davis et al., 2008). Research on trauma-focused intervention with minority groups has supported the inclusivity of added treatment sessions for rapport building and assessment of race-related themes associated with the trauma (Williams et al., 2014).

**Conclusions and Future Directions**

Although the maltreatment and revictimization literature is vast, there are still significant gaps in this field that require further examination. Greater attention is needed regarding potential nuance within the revictimization framework, such as different types of initial traumas (e.g., CSA vs. CPA), different types of secondary traumas (e.g., ASA vs. IPV), or whether multiple victimization types are present. Moreover, longitudinal work is still needed to improve our understanding of the relationship between maltreatment and adult revictimization and any potential mechanisms driving this association. Though several variables have been extensively studied in relation to revictimization (e.g., PTSS and emotion dysregulation), the relative strength of these risk factors is still somewhat ambiguous. Furthermore, the temporality of risk factor development in the context of the revictimization framework is particularly important for informing prevention and intervention, as it may provide information as to when certain factors should be targeted clinically.

Survivors of maltreatment and adult victimization show markedly high levels of PTSS, particularly in circumstances of cumulative or chronic trauma (Messman-Moore & Bhuptani, 2017; Walsh et al., 2012a, 2012b). Prior findings have identified relations between PTSS and the development of other maladaptive outcomes that may serve to increase the risk for additional victimization (Iverson et al., 2013; Lilly et al., 2014; Messman-Moore et al., 2009). Examining PTSS more closely, and in tandem with other risk factors, is crucial, as PTSS appear to drive the existence and the severity of these other mechanisms. Given the devastating effects of maltreatment and revictimization, garnering a better understanding of the role of PTSS and other risk factors will serve to improve both the research and the development of prevention and clinical intervention moving forward.

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