The Process of Coping with Domestic Violence in Adult Survivors of Childhood Sexual Abuse

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ABSTRACT. Research suggests that the use of disengaged or avoidant strategies to cope with interpersonal violence contributes to the development of depressive symptoms and other psychological difficulties. Survivors of childhood sexual abuse (CSA) who are exposed to subsequent episodes of abuse may be more likely to rely on disengaged coping strategies, placing them at elevated risk of psychological symptomatology. In this study, we explored the interrelationships

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between coping, depression, and self-esteem in an ethnically diverse sample of domestic violence survivors (N = 219) with and without a history of CSA. As predicted, CSA survivors (n = 86) reported significantly greater use of disengaged coping strategies (wishful thinking, self-criticism, and social withdrawal) than non-CSA survivors (n = 133). As hypothesized, both a CSA history and the use of disengaged coping significantly predicted higher levels of depression and lower self- esteem. Clinical implications of the findings are discussed.

KEYWORDS. Coping, domestic violence, childhood sexual abuse, interpersonal violence

The decision to leave an abusive relationship involves a complex process that is influenced by both environmental and psychological factors (Foa, Cascardi, Zoellner, & Feeny, 2000; Griffing et al., 2002). Environmental factors that abused women may face involve economic dependence, legal issues, pressure from significant others, and child custody concerns. Potential psychological and social issues include an emotional commitment to the relationship, attachment to the batterer, cognitive factors (e.g., learned helplessness and low self-esteem), and psychological symptomatology (e.g., depression and trauma-related symptomatology). The ways in which the abused woman copes with these situations and feelings is likely to affect her ability to establish emotional and financial independence, as well as her general psychological well-being (Anderson & Saunders, 2003).

Relatively few studies have examined the relationship between the coping process and psychological well-being among domestic violence (DV) survivors who have recently left abusive relationships. This is an important area for research because coping appears to mediate the effects of exposure to interpersonal violence (Arias & Pape, 1999; Clements & Sawhney, 2000; Coffey, Leitenberg, Henning, Turner, & Bennett, 1996a; Dempsey, 2002; Leitenberg, Greenwald, & Cado, 1992; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Valentiner, Foa, Riggs, & Gershuny, 1996). Most conceptualizations of the coping process distinguish between problem-focused and emotion-focused coping (e.g., Lazarus & Folkman, 1984), and/or between engaged and disengaged forms of coping (e.g., Tobin, Holroyd, Reynolds, & Wigal, 1989). Tobin et al.

(1989) conceptualize coping as a tertiary level process that encompasses both approach-avoidance dimensions, and problem- and emotion-focused dimensions.

According to Tobin et al.'s (1989) model of coping, there are three distinct levels of coping (primary, secondary, and tertiary). Primary level strategies reflect the specific cognitive, affective, and behavioral strategies that people use in order to negotiate a stressful situation. There are eight primary level strategies: (1) problem solving (active cognitive and behavioral strategies focused on directly affecting the source of the stressor), (2) cognitive restructuring (strategies designed to affect the meaning of the stressful transaction), (3) emotional expression (releasing one's emotions), (4) social support (seeking and accepting assistance from one's support network), (5) problem avoidance (avoiding thoughts or actions related to the event), (6) wishful thinking (hoping or wishing that things could be different), (7) self-criticism (blaming oneself for the stressor), and (8) social withdrawal (isolating from or avoiding one's social network).

These primary subscales are grouped into four secondary level factors: problem-focused engagement (problem solving and cognitive restructuring), problem-focused disengagement (problem avoidance and wishful thinking), emotion-focused engagement (emotional expression and social support), and emotion-focused disengagement (self-criticism and social withdrawal). These secondary factors are further grouped into the two tertiary level factors of engagement (problem- and emotion-focused engagement) and disengagement (problem- and emotion-focused disengagement). The engagement dimension reflects efforts to engage in an active and ongoing negotiation with the stressor, whereas the disengagement dimension consists of strategies focused on avoiding thoughts and feelings about the situation.

Coping appears to be situation specific, and whether a particular strategy will be adaptive depends on the type of stressor that is encountered (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Generally, however, disengaged strategies have been associated with greater psychological difficulties. Studies of survivors of CSA (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996b; Leitenberg et al., 1992; Merrill et al., 2001), DV (Arias & Pape, 1999; Clements & Sawhney, 2000), and adult sexual assault (Valentiner et al., 1996) all suggest that the use of disengaged coping to negotiate episodes of interpersonal victimization is associated with greater levels of general, depressive, and/or trauma-focused symptomatology. This relationship between disengaged coping and increased symptomatology is particularly

concerning because disengaged coping appears to be a common response to interpersonal victimization (Coffey et al., 1996b; Spaccarelli, 1994). Relationships between the use of engaged coping and psychological symptomatology have been less consistent in abuse survivors; most studies have not identified a relationship between the use of engaged coping and improved psychological functioning in CSA survivors (Kocot & Goodman, 2003; Merrill et al., 2001).

An important empirical question is whether DV survivors who have a prior history of CSA may cope differently with the relational violence than DV survivors without a CSA history. Our previous research suggests that CSA survivors differ from non-CSA survivors in patterns of separating from abusive partners in adulthood. Although many DV survivors return to the abusive partner multiple times before making a permanent separation (Griffing et al., 2002), CSA survivors appear to be at greater risk of returning, particularly because of internal/intrapsychic factors (i.e., because of their continued emotional commitment to the abuser, the abuser's expressions of remorse or the sense that he had suffered enough; Griffing et al., in press). Studies of the leave-taking process suggest that each separation may help the abused woman to develop coping skills and a greater sense of self-efficacy that will ultimately empower her to permanently separate (Anderson & Saunders, 2003). CSA survivors may require more frequent separations to work through this process and permanently terminate the abusive relationship, possibly because they are more likely to be affected by emotional and psychological factors in addition to the external obstacles that most DV survivors face.

Research using standardized measures of coping further supports the idea that CSA survivors may cope differently with episodes of interpersonal victimization in adulthood than non-CSA survivors. Gibson and Leitenberg (2001) found that a CSA history was associated with a significantly greater reliance on disengaged forms of coping (as measured by the Coping Strategies Inventory) to negotiate a subsequent episode of sexual assault in adulthood. In addition, the use of disengaged coping with the additional abuse episode was associated with higher levels of trauma symptomatology and general psychological distress. The authors suggested that disengaged coping may be a problematic way to cope with interpersonal violence because it interferes with the processing needed in order to work through the emotional aspects of suffering the trauma (Gibson & Leitenberg, 2001).

The use of disengaged coping has also been associated with depression and with low self-esteem. Numerous studies have reported a relationship

between avoidant coping and increased levels of depressive symptomatology (Folkman & Lazarus, 1986; Herman-Stahl & Peterson, 1996; Sherbourne, Hays, & Wells, 1995). Fewer studies have explored the relationship between disengaged coping and self-esteem, but emotion-focused coping does appear to mediate levels of self-worth in CSA survivors (Guelzow, Cornett, & Dougherty, 2002). DV and severe child abuse are both significant risk factors for depression (Carlson, McNutt, & Choi, 2003), and low self-esteem appears to be a common consequence of DV (Dutton & Painter, 1993; Sackett & Saunders, 1999). In addition, recent research indicates that disengaged coping strategies, such as denial and self-blame, appear to contribute to both dysphoria and low self-esteem in abused women (Clements, Sabourin, & Spiby, 2004). Additional studies are needed that explore whether disengaged coping is associated with depression and self-esteem in battered women, and also whether these relationships vary as a function of prior abuse status.

In the present study, we explore the relationships between coping, depression, and self-esteem in a multiethnic sample of DV survivors with and without a CSA history. Few studies have examined the relationship between coping and violence exposure in women of color, despite the relevance and importance of this issue. High rates of partner abuse have been documented in samples of African American women (Huang & Gunn, 2001), and both CSA and partner violence are significantly associated with suicidal behavior in African American women (Kaslow, Thompson, Brooks, & Twomey, 2000). Researchers have also observed unique patterns of response to abuse among Latina women exposed to CSA, including a tendency toward nondisclosure (Romero & Wyatt, 1999). These findings illustrate the need for research that examines factors that mediate responses to victimization in culturally diverse samples of women.

We predict that CSA survivors will report a greater reliance on disengaged coping strategies (problem avoidance, wishful thinking, social withdrawal, and self-criticism) to negotiate their recent DV than non-CSA survivors. Given the mixed findings in the literature about whether engaged coping is inversely related to revictimization (Gibson & Leitenberg, 2001) or is associated with more positive outcome (Merrill et al., 2001), we explore whether there are between-group differences in engaged coping strategies between CSA survivors and non-CSA survivors. We also explore whether there are ethnic differences in rates of CSA, the use of particular forms of coping, and levels of depression and self-esteem. Finally, we hypothesize that both a CSA history and the use of disengaged coping strategies will uniquely predict levels of depression

and self-esteem among women who have recently left an abusive relationship.

METHODS

Participants

Participants were 219 female residents of the Urban Women's Retreat, a residential facility for DV victims. The mean age of participants was 26.77 years (SD = 6.23), and they were of African American (58.9%), Latina (32.9%), Caucasian (3.2%), or other (5%) ethnicity. Most participants (97.7%) came to the shelter with at least one child (M = 1.95, SD = 1.35). At the time of admission, 17.8% were married, 43.9% were living with a partner, 31.5% were involved in a dating relationship, and 6.8% were separated or divorced.

In terms of education, 53.9% had not completed high school, 25.1% had a high school diploma or its equivalent, 18.7% had attended technical school and/or completed college credits, and 2.3% had received a college degree. Regarding employment, 28.8% of participants were employed at the time of arrival to the facility.

Measures

Structured Interview. This measure, developed for use in this and other studies at the Urban Women's Retreat (Griffing et al., in press, 2002; Martin et al., 2000), consists of a combination of open-ended and structured questions addressing psychosocial variables, including CSA history. A participant was defined as a CSA survivor if she reported a positive response to one of five questions from the sexual abuse subscale of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1997). The Childhood Trauma Questionnaire is a 28-item measure of five different forms of abuse and neglect (physical, sexual, and emotional abuse, and physical and emotional neglect). Each item is based on a five-point Likert scale, ranging from never true to very often true. A sample CTQ items addressing sexual abuse is "Someone tried to touch me in a sexual way, or tried to make me touch him/her." The authors note that reliability coefficients for the sexual abuse subscale screening items ranged from .72 to .92 (median = .92) across several different types of samples that included ethnically diverse men and women. Scores for the sexual abuse subscale were also shown to corre-

late highly (.58) with a semi-structured trauma interview (the Childhood Trauma Interview) in a sample of substance abusers.

For the purposes of this study, the sexual abuse items from the CTQ were used as screening items, and additional data were collected about the abuse for those participants who provided a positive response to at least one of the screening items. Information was collected about the following descriptive features: (1) relationship to the perpetrator, (2) age at onset of abuse, (3) frequency of abuse, (4) duration of abuse, (5) whether the participant disclosed the abuse to anyone while it was occurring, and if so, their relationship to the person to whom they disclosed and the degree of support that they felt that they received (on a five-point scale, ranging from 0 = *not at all supportive*, to 4 = *extremely supportive*), and (6) whether the participant also reported CSA by additional perpetrators.

Coping Strategies Inventory–Short Form (CSI; Tobin, 1995). This 32-item, self-report measure of coping based on a five-point Likert scale (0 = *not at all*, 4 = *very much*) is a brief version of the full (72-item) scale (Tobin et al., 1989). The CSI measures the hierarchical structure of coping through two tertiary level subscales (engagement and disengagement), which subsume four secondary level subscales and eight primary level subscales. The four primary level strategies within the disengagement category are problem avoidance, wishful thinking, social withdrawal, and self-criticism. The four primary level strategies within the engagement category are as follows: problem solving, cognitive restructuring, social support, and emotional expression. Individual item scores were summed to produce the eight subscale scores. Each primary level subscale has a potential range of 0-16.

Reliability data for the short form of the CSI indicate that the average alpha coefficients are .70 for primary subscales, .80 for secondary subscales, and .90 for the tertiary subscales (Tobin, 1995). The average alpha coefficient for the primary subscales in the present study was .67. The authors note that the full scale discriminates well between depressed and non-depressed samples (Tobin et al., 1989).

Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977). The CES-D is a 20-item self-report measure of the severity of affective, behavioral, and cognitive symptoms of depression. Participants indicate the frequency with which they have experienced each symptom over the past week, based on a four-point Likert scale, ranging from 0 (*less than one day*) to 3 (*between five and seven days*). The total sum score (potential range: 0 to 60) is a measure of the current level of depressive symptomatology, and scores over 16 are considered

suggestive of depression (Radloff, 1991). Radloff (1977) notes that the scale has good reliability and validity across several demographic groups. The CES-D has been used frequently with community samples of low-income women (Kocot & Goodman, 2003), and correlated highly ($r = .58$) with the Beck Depression Inventory in an ethnically diverse sample of adolescent mothers (Wilcox, Field, Prodromidis, & Scafidi, 1998). Internal consistency in this sample was .73.

Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). The RSE is a widely used 10-item measure of self-esteem based on a 4-point Likert scale (0 = *strongly agree*, 3 = *strongly disagree*). The scale is reported to have high reliability (Rosenberg, 1986), and is considered to be a valid measure of self-esteem in African American samples (Rowley, Sellers, Chavous, & Smith, 1998). The alpha coefficient in this study was .89.

Procedure

Participants were recruited and interviewed by members of an independent evaluation unit. The evaluator explained that participation was voluntary, and that refusal to participate would not affect the services that the participant would receive at the facility. The evaluator also reviewed the fact that all information provided was confidential, unless the participant made statements indicating risk of self-harm or child abuse, in which case clinical intervention would be provided and/or mandated reporting procedures would be followed. Participants signed an informed consent form detailing this information.

The structured interview was completed privately with each participant. Participants were interviewed shortly after admission to the facility ($M = 7.61$ days, $SD = 5.68$). All interviewers held graduate research degrees, received ongoing training in the use of the instrument, and participated in monthly project meetings. Following the interview, participants were informed that counselors were available to speak with them further if they wished, given the sensitive nature of the topics addressed.

RESULTS

History of CSA

Participants were categorized into two groups: history of CSA ($n = 86$, 39.3%) or no history of CSA ($n = 133$, 60.7%). Data regarding the

descriptive features of the first/primary episode of abuse are presented in Table 1. Most (55.8%) participants suffered intrafamilial abuse, with 15.1% reporting abuse by a parent or step-parent, and an additional 40.7% reporting abuse by another relative (e.g., grandfather, uncle). The mean age at which the abuse began was 8.47 (*SD* = 3.12). The majority of participants (72.1%) suffered repeated abuse, and the average duration of abuse for these participants was 2.56 years (*SD* = 3.13). Over half the sample (53.5%) had not disclosed the abuse to anyone at the time that it was occurring; those participants who disclosed generally reported receiving a moderate degree of support (*M*=2.52, potential

TABLE 1. Descriptive Features of Episodes of Childhood Sexual Abuse (*N* = 86)

	Mean Score (*SD*)	*n* (% of Participants)
Perpetrator of the abuse		
Parent		13 (15.1)
Other relative		35 (40.7)
Acquaintance		23 (26.7)
Stranger		7 (8.1)
Friend/family friend		6 (6.9)
Foster parent		1 (1.2)
Relationship not reported		1 (1.2)
Age at the time of the abuse	8.47 years (3.12)	
Frequency of abuse		
Single episode		24 (27.9)
Occasionally		28 (32.6)
Sometimes		12 (13.9)
Often/frequently		22 (25.6)
Duration of abuse	2.56 years (3.13)	
Disclosure at the time of the abuse		
No disclosure		46 (53.5)
Disclosed to caregiver		25 (29.1)
Disclosed to other relative		11 (12.8)
Disclosed to peer		2 (2.3)
Disclosed to unspecified person		2 (2.3)
Perceived supportiveness (for those who disclosed)	2.52 (1.83)	
Reported CSA by additional perpetrators		31 (36.0)

range: 0-4). About one-third (36%) reported having suffered at least one additional episode of CSA by another perpetrator.

Ethnicity, CSA, Coping, and Psychological Functioning

A series of analyses were computed to explore whether ethnicity was related to CSA, coping, depression, and self-esteem. These analyses were restricted to African American and Latina women (n = 201) due to the low representation of other ethnic groups. African American women were significantly more likely to report a history of CSA than Latina women; 48.8% of African American participants compared with 26.4% of Latina participants had been sexually abused, $\chi^2(1, N = 201) = 9.64$, $p < .01$. Comparisons between those African American and Latina women with a CSA history indicated no significant differences in descriptive features of the abuse (intra vs. extrafamilial, age of onset, duration, frequency, and tendency toward disclosure, all p's n.s.).

An examination of the relationship between ethnicity and coping was completed at the tertiary level of coping (engaged vs. disengaged) rather than the primary level, in order to reduce the likelihood of a Type II error. The results of independent sample t-tests indicated no significant ethnic differences in coping or in psychological functioning. There were similar levels of disengaged coping for African American (M = 34.16, SD = 12.22) and Latina (M = 36.74, SD = 12.02) participants, $t(199) = -1.44$, $p = .15$, and engaged coping between African American (M = 32.60, SD = 11.20) and Latina (M = 33.86, SD = 12.00) participants, $t(199) = -.75$, $p = .46$. There were also no significant differences in levels of depression for African American (M = 26.64, SD = 13.97) and Latina (M = 28.70, SD = 14.56) participants, $t(199) = -.99$, $p = .33$, or in levels of self-esteem for African American (M = 19.53= 5.50) and Latina (M = 18.14, SD = 5.64) participants, $t(199) = 1.70$, $p = .09$. Ethnicity was not included in the regression equations predicting self-esteem or depression because of the lack of a significant association with any of the predictor or outcome variables.

Coping and Psychological Functioning in CSA Survivors and Non-CSA Survivors

As hypothesized, there were significant differences between CSA survivors and non-CSA survivors in the extent to which they employed disengaged forms of coping; the results of these analyses are presented in Table 2. CSA survivors reported significantly higher levels of wish-

ful thinking, self-criticism, and social withdrawal than non-CSA survivors. There were no significant differences between CSA survivors and non-CSA survivors in problem avoidance. There was a non-significant trend ($p = .06$) for CSA survivors to report slightly higher levels of cognitive restructuring, and no significant differences in any of the other engaged coping strategies.

Table 2 also shows that there are significant differences between CSA survivors and non-CSA survivors in both depression and self-esteem. As hypothesized, CSA survivors reported significantly higher levels of depression than non-CSA survivors, and CSA survivors reported significantly lower levels of self-esteem than non-CSA survivors.

CSA History and Coping as Predictors of Self-Esteem and Depression

We used two hierarchical multiple regressions to examine the relative contribution of a CSA history and disengaged coping strategies to depression and self-esteem. Exploratory analyses indicated that the necessary assumptions for normality were met. In both analyses, the presence or absence of CSA was entered in Step 1, and the use of disengaged

TABLE 2. Differences Between CSA Survivors and Non-CSA Survivors in Types of Coping, Depression and Self-Esteem ($N = 219$)

Type of Coping	History of CSA ($n = 86$)	No History of CSA ($n = 133$)	t (217)
Engaged strategies			
Problem solving	9.52 (3.44)	9.45 (3.25)	0.14
Cognitive restructuring	9.13 (3.53)	8.20 (3.53)	1.91
Emotional expression	7.23 (4.52)	8.17 (4.41)	−1.52
Social support	7.06 (5.29)	7.43 (5.36)	−0.50
Disengaged strategies			
Problem avoidance	7.70 (3.80)	7.38 (4.22)	0.57
Wishful thinking	12.74 (2.68)	11.95 (3.40)	1.84*
Self-criticism	7.63 (5.24)	4.88 (4.99)	3.90***
Social withdrawal	9.80 (4.51)	8.13 (4.77)	2.59**
CES depression scale	30.52 (13.67)	24.05 (14.09)	3.33***
Rosenberg self-esteem scale	17.63 (5.60)	20.24 (5.28)	−3.49***

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

coping (at the tertiary level) was entered in Step 2. CSA history was entered into the equation first because it was presumed to increase the likelihood of disengaged coping. The results of these regression analyses are presented in Table 3. Model summaries indicate that a CSA history and the use of disengaged coping entered as highly significant predictors in both analyses.

When the presence of a CSA history was entered in the first step of the regression equation predicting depression, the overall R^2 was .05, $F(1, 217) = 11.29$, $p < .001$. When disengaged coping was added to the equation in Step 2, the overall R^2 increased to .21, $F(2, 216) = 29.33$, $p < .001$. This increment was highly significant ($p < .001$), and indicates that disengaged coping explains an additional 16% of the variance in depressive symptomatology. In predicting self-esteem, the presence of a CSA history in Step 1 resulted in an overall R^2 of .05, $F(1, 217) = 12.19$, $p < .001$. After disengaged coping was added in Step 2, the overall R^2 increased to .18, $F(2, 216) = 24.58$, $p < .001$. This increment was also highly significant ($p < .001$), and indicates that disengaged coping explained an additional 13% of the variance in self-esteem.

DISCUSSION

These findings are consistent with previous research which suggests that women who suffer multiple episodes of victimization are more likely to use avoidant coping strategies than women who suffer a single

TABLE 3. Stepwise Regression Analysis Summary for CSA Exposure and Disengaged Coping as Predictors of Psychological Functioning (N = 219)

Variable	B	SEB	β
Depression[a]			
Step 1: CSA history	3.81	1.80	.13*
Step 2: Disengaged coping	.48	.07	.42***
Self-esteem[b]			
Step 1: CSA history	−1.68	−.71	−.15**
Step 2: Disengaged coping	−.17	.03	−.37***

Note: [a]$R^2 = .21$, $p < .001$; $R^2 = .05$ for step 1 ($p < .001$), $\Delta R^2 = .16$ for step 2 ($p < .001$).
[b]$R^2 = .18$, $p < .001$; $R^2 = .05$ for step 1 ($p < .001$), $\Delta R^2 = .13$ for step 2 ($p < .001$).
*$p < .05$
**$p < .01$
***$p < .001$

episode of abuse (Gibson & Leitenberg, 2001). Disengaged strategies may be used to cope with CSA because of a need to avoid emotionally overwhelming feelings and stimuli associated with the current trauma (Spaccarelli, 1994). An interpersonal assault in adulthood may cause women who have previously been victimized to revert to strategies that they used to negotiate the initial episode of abuse (Gibson & Leitenberg, 2001). An analysis at the primary level of coping indicates that differences between CSA survivors and non-CSA survivors emerged in three areas: wishful thinking, self-criticism, and social withdrawal. These data are similar to findings of a study reported by Valentiner et al. (1996), in which victims of a sexual assault, compared with victims of a non-sexual assault (other than intimate partner violence), were significantly more likely to use wishful thinking, a construct which in their study reflected both "denial by fantasy" and self-blame. The similarities between their research and the present study suggest that this may reflect a common pattern of coping for survivors of interpersonal victimization.

The wishful thinking subscale of the CSI includes items such as, "I hoped that if I waited long enough that things would turn out OK," and "I hoped a miracle would happen." Valentiner et al. (1996) observed that the use of wishful thinking predicted symptoms of post-traumatic stress disorder; the authors suggested that emotion-focused coping may perpetuate trauma-related symptomatology because dissociative/avoidant responses interfere with the ability for emotional processing. It is important to note that in the present study, both CSA survivors and non-CSA survivors relied more on wishful thinking than any other coping strategy, and that the difference between these two groups, although statistically significant, is relatively small. The association between wishful thinking and PTSD symptoms in previous research suggests that wishful thinking may be a detrimental strategy. However, the frequency with which wishful thinking was used to cope with abuse by both CSA survivors and non-CSA survivors suggests that further exploration of this issue is warranted. It is possible that wishful thinking is particularly detrimental for survivors of previous abuse because it is more likely to be used in conjunction with other potentially maladaptive strategies such as social withdrawal and self-criticism.

CSA survivors displayed significantly higher levels of social withdrawal in response to the current DV than non-CSA survivors. The finding that they were less willing to seek social support than non-CSA survivors may be partially related to their previous experiences of disclosure about the CSA. An exploration of CSA-related variables

indicated that less than half of the participants with a CSA history had disclosed the abuse at the time that it was occurring, and a substantial proportion of those participants reported relatively low levels of support after having done so. It cannot be determined whether those women who did not disclose the CSA chose not to do so because they did not feel that they had supportive people to share this with, because they were struggling with feelings of shame and self-blame, or a combination of these factors. However, these powerful early experiences with support (or lack thereof) during a traumatic event are likely to have a lasting impact on one's ability/willingness to seek support during a similar trauma.

Research indicates that self-blame and shame are common responses to interpersonal victimization, and these findings are consistent with research suggesting that survivors of multiple episodes of abuse have a greater sense of shame and self-blame (Kellogg & Hoffman, 1997). The fact that women who have been revictimized suffer higher levels of self-blame is particularly concerning because shame and self-criticism may mediate long-term adjustment (Coffey et al., 1996a) as well as adult victimization (Kessler & Bieschke, 1999). A positive sign in this study is that both CSA survivors and non-CSA survivors used self-criticism less frequently than any other coping strategy. Nonetheless, the significant difference between these two groups suggests that focused intervention with revictimized women may be warranted.

In contrast to the between-group differences in disengaged coping strategies, there were no significant differences between CSA survivors and non-CSA survivors in the use of engaged coping strategies. Past studies of engaged coping have also been somewhat surprising in that they have not found associations with improved psychological functioning (Merrill et al., 2001) or that repeated abuse is associated with lower levels of engaged coping (Gibson & Leitenberg, 2001). It is possible that CSA survivors may be implementing adaptive, problem-focused strategies, but may also use disengaged strategies to cope with the overwhelming feelings brought up by their experience. The data also revealed a non-significant trend for CSA survivors to report higher levels of cognitive restructuring. This pattern is consistent with our previous research, which indicates that DV survivors use a blend of engaged and disengaged strategies (Lewis et al., in press), and further suggests that CSA survivors may be trying to reframe their experience in an adaptive manner. In interpreting these findings, it should be noted that the use of a shelter-seeking sample may have resulted in higher levels of engaged coping than in general samples of DV survivors. All participants had

engaged in significant steps to actively address the DV and change their own life situation by entering the facility. Studies of DV survivors in different stages of the leave-taking process would help to inform research on engaged coping.

Consistent with our hypotheses, both a CSA history and the use of disengaged coping strategies contributed uniquely toward predicting current psychological functioning. CSA survivors had significantly higher levels of depressive symptomatology than non-CSA survivors ($M = 30.52$ vs. $M = 24.05$). It should be noted that the mean scores for both groups were well above the cut-off score suggestive of depression ($M = 16$). The fact that both groups of participants appeared to meet the criteria for depression is concerning, but not surprising given that all participants were in an emergency crisis facility. Additional research is needed to determine whether these symptoms are primarily situational and remit over a short period of time after the DV is resolved, or whether more focused clinical intervention to address this issue is needed. The significant between-group differences further suggest that CSA is a particular risk factor for depression, and that DV survivors with a CSA history are likely to display more serious and clinically significant depressive symptoms.

Disengaged coping also entered the regression analysis as a highly significant predictor of depressive symptomatology. Similar findings were observed in the regression analysis predicting self-esteem. Both a CSA history and the use of disengaged coping emerged as highly significant predictors of lower levels of self-esteem. Overall, these findings suggest that the use of disengaged coping is associated with greater psychological difficulties, and that a history of CSA increases the likelihood that women will rely more heavily upon disengaged coping to deal with current interpersonal victimization. Research on revictimization suggests that exposure to episodes of violence throughout the lifetime may exert a cumulative impact, in which the distress experienced due to the current episode may be further compounded by an exacerbation of feelings about previous episodes of trauma (Nishith, Mechanic, & Resick, 2000; Terr, 1991). The results of the present study also suggest that the early traumatic experience of CSA may predispose survivors toward methods of coping that are likely to intensify psychological difficulties arising from subsequent traumas that they experience.

A noteworthy feature of this study is that it was conducted with a sample of primarily African American and Latina women, and there have been few explorations of coping with DV in ethnically diverse women. Our results with respect to coping were consistent with findings reported

by other researchers based on primarily Caucasian samples (Gibson & Leitenberg, 2001; Valentiner et al., 1996). We also found that African American participants were significantly more likely to report a CSA history than Latina participants. It is unclear whether this finding accurately reflects a significant relationship between ethnicity and abuse, or whether there was a difference in the frequency with which participants were willing to disclose prior abuse during the interview. Previous research suggests a tendency toward nondisclosure of abuse in Latina women (Romero & Wyatt, 1999), so firm conclusions about this finding cannot be drawn. Additional research on the relationships between abuse and coping in ethnically diverse samples is needed, given the role that ethnicity and culture play in the types of coping strategies used to negotiate stressful situations and in perceptions of what constitutes adaptive coping (Yoshihama, 2002).

Methodological limitations may affect the extent to which these findings can be generalized to other samples. The sample consisted exclusively of battered women in a shelter, and as such their coping strategies may not reflect those of most battered women. The retrospective nature of participants' responses regarding a CSA history may be subject to reporting biases and responses may also have been affected by social desirability factors. Furthermore, because of the cross-sectional design of the study, no conclusions about causality or about the directionality of the findings may be drawn.

Despite these limitations, the relationships between CSA, disengaged coping, and psychological functioning among DV survivors have important clinical implications. Clinicians who work with abused women should assess for whether they have suffered previous episodes of victimization, and should be attuned to ways in which this history may affect their patterns of coping and psychological functioning. It will be important to provide clinical interventions that target less adaptive coping strategies that may predispose DV survivors to psychological symptoms such as depression and low self-esteem. General psychoeducation about common ways of coping with interpersonal violence and the ways in which particular types of coping may increase the risk of revictimization are likely to be helpful. CSA survivors may also benefit from interventions focused on exploring and reframing perceptions of self-blame and on ways to identify and access positive social supports. In addition, some CSA survivors may benefit from more intensive therapeutic services than are ordinarily provided in DV shelters.

Additional research is needed to further elucidate the relationship between coping and psychological functioning in CSA and non-CSA

survivors. Longitudinal studies in particular are needed to clarify whether the differences between CSA survivors and non-CSA survivors are a long-term consequence of the early abuse, are related to their history of returning more frequently in the past, or are a more severe reaction to the current/recent violence that they have experienced. Research does suggest that coping may mediate PTSD in adult survivors of sexual assault (Valentiner et al., 1996) and of DV (Arias & Pape, 1999); further research is needed to explore whether specific forms of coping are predictive of PTSD in DV survivors.

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