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Childhood Trauma, Poverty, and Adult Victimization

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Trauma exposure and revictimization have many serious personal and public health consequences. Both individual-level and community-level factors impact a person's risk of being victimized, and there are currently few studies examining both individual and community levels of analysis in the same study. The current study employs multilevel modeling to examine how community-level poverty interacts with individuals' trauma histories and dissociative symptoms to predict later victimization. In this study, a cross-level interaction was observed such that the relationship between childhood and adult victimization is stronger in communities with higher poverty rates. The importance of examining revictimization as a multifactorial process is discussed.

Keywords: betrayal trauma, revictimization, poverty, dissociation

Exposure to traumatic stressors is common in the general population, and often leads to long-term and quite serious consequences. People with histories of trauma, particularly interpersonal victimization traumas, also have higher risk of revictimization (i.e., experiencing another interpersonal trauma, Nelson et al., 2002). Women with a childhood abuse history are around 1.4 to 3.7 times more likely to be sexually assaulted in adulthood, and a majority (around 59%) of women with either childhood sexual assaults (CSA) or adult assaults have experienced both (Cloitre & Rosenberg, 2006). Many posttraumatic symptoms have been implicated as moderators of this relationship. For example, it appears that dissociative tendencies (disrupted integration of one's experience into conscious awareness) may increase a person's likelihood of exposure to further trauma (Hetzel & McCanne, 2005).

Several studies have found an association between dissociation and revictimization (Hetzel & McCanne, 2005; Sandberg, Lynn, & Green, 1994). Zurbriggen and Freyd (2004) described a social information processing model linking dissociation to risky sexual decision-making, and potential sexual revictimization. These authors suggest that lack of awareness of risk may be a contributing factor to revictimization, and may be particularly prevalent among individuals who have a tendency to dissociate when faced with trauma-relevant cues. Individuals who have been victimized in the past are more likely to dissociate, and this tendency may be activated by trauma-relevant social information. In an environment with more trauma-related cues and greater potential for victimization, dissociative tendencies may place a person at increased risk (Zurbriggen & Freyd, 2004).

Experiencing multiple victimizations increases a person's risk for developing disabling posttraumatic symptoms. Gill and Page (2006) report that multiple traumatic events increase PTSD risk, and large-scale studies of adverse childhood experiences have found a dose-response relationship between number of types of trauma experienced and likelihood of experiencing a variety of adverse outcomes (Edwards, Holden, Felitti, & Anda, 2003; Edwards, Anda, Felitti, & Dube, 2004). Preventing future victimization among individuals who have already experienced trauma would likely reduce this risk. Trauma-focused intervention, aimed at reducing posttraumatic symptoms including dissociation, might serve as a strategy for such prevention, given the links between symptoms and revictimization.

Zielinski (2009) found that childhood maltreatment was significantly associated with adult socioeconomic status, such that individuals maltreated in childhood were more likely than nonmaltreated individuals to be living in poverty and to be unemployed as adults. Living in urban communities with higher poverty rates has been shown to contribute to likelihood of exposure to trauma (Gill & Page, 2006). Additionally, trauma exposure not only increases risk for future victimization, but also for future perpetration of violence (Simons, Wurtele, & Heil, 2002). Thus living in a context where more people have been victimized, may mean living within a higher-than-average concentration of potential perpetrators. Traumatized individuals living in the context of poverty may be particularly vulnerable to revictimization.

The majority of psychological research on the consequences of trauma has been conducted at the level of the individual. That is, research typically surveys participants' trauma histories, and correlates trauma exposure with their symptom reports and their individual demographic characteristics. A few studies have employed multilevel research designs in trying to understand these processes, but so far the literature is scarce. One study, looking at the interplay between individual-level and contextual-level effects on resilience in the face of trauma, found that neighborhood

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advantage (based on income, home ownership status, and education of residents), in conjunction with household stability and other individual factors, contributed to resilience (DuMont, Widom, & Czaja, 2007). Another, assessing factors associated with emergency department visits for violence-related injuries, found that the concentration of vacant housing units and of poverty was related to the incidence of injury related to violence, including family violence (Boyle & Hassett-Walker, 2008). Some authors have suggested models of trauma and coping that include the erosion of family processes (e.g., structure, relations, coping) in the context of community violence and urban poverty, which might partially explain the higher likelihood of family violence in these contexts (Aisenberg & Ell, 2005; Kiser & Black, 2005). Simultaneously examining characteristics of both individuals and the communities in which they reside may prove useful for understanding the broad causes and consequences of interpersonal trauma, and for developing better prevention strategies.

This study employed multilevel modeling to examine whether a community-level factor previously shown to relate to trauma exposure—poverty rate—impacts individual-level relationships between childhood trauma, dissociation, and adult victimization. It was hypothesized that poverty, childhood trauma exposure, and dissociation would each predict victimization in adulthood, and that the relationships between childhood trauma, dissociation, and adult victimization would be stronger in higher-poverty communities.

Method

Participants

Research participants in this study were members of the Eugene-Springfield Community Sample (ESCS), a longitudinally studied sample originally recruited in 1993 through mail solicitation of local homeowners. Participants in this sample are homogeneous in racial/ethnic identity (over 96% identify as Caucasian), but are heterogeneous in age (ranging from 18 to 85 in 1993), educational attainment (with an average of approximately two years postsecondary education), and other demographic factors. Since 1993, participants in this sample have completed mailed surveys approximately twice per year. Surveys have asked about a variety of self-report information, such as various personality factors and physical and mental health variables. One primary purpose of ESCS studies has been to assess personality characteristics over time, and to associate personality with a variety of other psychological factors. A more detailed description of the ESCS is available elsewhere (e.g., Goldberg, 1999).

Participants in the current study were selected from this sample based on residence within one of eight target zip codes, which included all zip codes within Eugene and Springfield city limits. Other zip codes, with only one or two study participants living in each, were excluded. All participants residing in the target areas who also had complete data on all variables of interest were included in the current analyses. In all, 421 participants (185 men and 236 women) ranging in age from 18 to 83 at the time of first data collection in 1993, were included in the current study.

Measures

The Curious Experiences Survey (CES, Goldberg, 1999), is a 31-item scale measuring dissociation. The CES is a revision of the Dissociative Experiences Scale (DES, Bernstein & Putnam, 1986; Carlson & Putnam, 1993). Each item on the CES presents a dissociation-relevant experience (e.g., "Felt like I was disconnected from my body") and participants respond on a 5-point Likert scale indicating the frequency with which they have the experience. High scores on the CES indicate more frequent dissociative experiences. The CES demonstrates high reliability (α = .90), and preliminary validity in that it correlates with measures of behavior and personality in expected directions (e.g., positive correlations with neuroticism, fantasy, depression, and anxiety; Goldberg, 1999).

The Brief Betrayal Trauma Survey (BBTS, Goldberg & Freyd, 2006) asks participants whether they have experienced each of 14 types of traumatic events, both before and after age 18. The questions avoid using labels for the events and instead describe them behaviorally. Events on the survey range in level of betrayal from natural disasters (no betrayal) to sexual abuse by someone close (high betrayal). Because victimization by a close other is most predictive of future victimization, only the five high betrayal items on the survey were used in the current study. Example items include "you were made to have some form of sexual contact, such as touching or penetration, by someone with whom you were very close (such as a parent or lover)," and "you were deliberately attacked so severely as to result in marks, bruises, blood, broken bones, or broken teeth by someone with whom you were very close." For the purposes of this study, the variable "child victimization" refers to number of different types of high-betrayal interpersonal victimizations reported prior to age 18, and "adult victimization" refers to number of types of high-betrayal interpersonal victimizations reported after age 18. Reported rates of exposure to traumatic events using the BBTS are similar to those obtained with other measures of trauma exposure, and test–retest reliability for the BBTS is comparable to other trauma measures (percent agreement of 72–83, over a period of three years, which is adequate considering the possibility that participants may have been exposed to new traumas between administrations). See Goldberg and Freyd (2006) for further description of the properties of this measure.

Poverty rates for each of the communities represented in this study were obtained from the American FactFinder website (http://factfinder.census.gov), which reports data from the U.S. census. Community-level data used in this study were collected in the 2000 U.S. Census, and were reported by the Census Bureau by 5-digit zip code. The data used in these analyses included percent of individuals within each zip code with incomes below the federal poverty level in 2000.

Procedures

Individual-level data were obtained from previously collected Eugene-Springfield community sample surveys conducted in 1997 and 2003. Dissociation data from the CES were collected in a 1997 mailed survey, and childhood trauma and adult trauma data from the BBTS were collected in a 2003 mailed survey.

Analyses and Results

Initial descriptive characteristics of the data are reported here at both at the individual person level and the community level. Table 1 reports means and standard deviations for each of the person-level variables. Table 2 reports means and standard deviations for the community-level variable (poverty rate).

To determine whether gender should be included in this model, *t* tests and correlations were run to examine mean gender differences as well as gender differences in associations among these variables. Women reported more exposure to childhood betrayal trauma ($M = .75$, $SD = 1.08$) than did men ($M = .44$, $SD = .89$; $t(419) = 3.23$, $p < .01$), and more exposure to betrayal trauma in adulthood ($M = .81$, $SD = 1.12$) than men ($M = .34$, $SD = .75$; $t(419) = 5.05$, $p < .01$). There were no gender differences in CES scores, $t(419) = .17$, $p = .86$. Correlations between childhood trauma and trauma experienced in adulthood were very similar for men ($r = .45$) and women ($r = .43$), and the same was true for correlations between CES scores and childhood trauma ($r = .22$ for men, $r = .19$ for women). Because there were no apparent gender differences in the associations among variables, to simplify interpretation of results, gender was not included in the model.

To determine the relative contribution of person-level and community-level effects to the overall variance in adult victimization, an unconditional random-coefficients model was run in the statistical program HLM (Raudenbush & Bryk, 2002). This and all other models in this study were run using restricted maximum likelihood estimation with freely estimated covariances. The outcome variable *adult victimization* was entered into the model uncentered (raw scores were used and the intercept corresponds with zero traumas reported). The model (Model 1) was specified using the equations below, where Y_{ij} refers to the predicted adult victimization score for an individual within a community, β_{0j} refers to the mean (intercept) for a particular community, r_{ij} refers to the individual's deviation from the mean of their group, γ_{00} refers to the grand mean adult victimization score for everyone in the study, and u_{0j} refers to a group mean's deviation from the grand mean. The level 1 equation was used to predict an individual's adult victimization score, and the level 2 equation was used to predict community mean adult victimization, which is then used in the level 1 equation.

Equations for Model 1

$$\text{Level 1: } Y_{ij} = \beta_{0j} + r_{ij}$$

$$\text{Level 2: } \beta_{0j} = \gamma_{00} + u_{0j}$$

The parameter estimates in this model suggest that a significant proportion of the variance in adult victimization is attributable to each level of analysis. The variance estimate at the person level was $\sigma^2 = 0.903$, variance at the community level was $\tau^2 = 0.095$, and the intraclass correlation was ICC = .095, indicating that nearly 10% of the variance in adult victimization is attributable to community-level variables, and around 90% of the variance is attributable to individual-level variables. A test for variation between groups was significant ($\chi^2(df = 7) = 50.45$, $p < .001$), indicating that the different communities vary significantly from one another in mean level of adult traumatic victimization.

Table 1
Person-Level Descriptive Statistics (N = 421)

Variable	Mean	*SD*	Minimum	Maximum
Child betrayal trauma	0.61	1.00	0.00	5.00
Adult betrayal trauma	0.60	0.99	0.00	5.00
Dissociation—CES total	45.65	10.04	31.00	109.00

Table 2
Community-Level Descriptive Statistics (N = 8)

Variable	Mean	*SD*	Minimum	Maximum
Community poverty rate	0.15	0.07	0.04	0.27

The level 1 predictors (childhood traumatic victimization and dissociation) were entered into the model uncentered. This model (Model 2) was specified using the equations below. The level 1 equation was used to predict an individual's adult victimization score. The new components of this equation, $\beta_1(X_1)$ and $\beta_2(X_2)$, refer to the regression weights used to predict adult victimization based on childhood victimization and dissociation. These components were added to the group mean to predict the adult victimization score. Each person's predicted score was calculated using a group (community-level) intercept for adult victimization plus a weighted score for childhood victimization representing the effect of childhood victimization on adult victimization within the person's community, plus a weighted score for dissociation representing the effect of dissociation on adult victimization within the person's community. In this analysis, a person's predicted score takes into account not only how adult victimization scores differ for each community, but also how the relationships between adult victimization and the other variables differ for each community.

Equations for Model 2

$$\text{Level 1: } Y_{ij} = \beta_{0j} + \beta_{1j}(X_{1ij}) + \beta_{2j}(X_{2ij}) + r_{ij}$$

$$\text{Level 2: } \beta_{0j} = \gamma_{00} + u_{0j}$$

$$\beta_{1j} = \gamma_{10} + u_{1j}$$

$$\beta_{2j} = \gamma_{20} + u_{2j}$$

Using deviance testing in HLM, it was determined that Model 2 had significantly better fit than Model 1, ($\chi^2(df = 5) = 138.77$, $p < .001$). This indicates that the predictors (childhood victimization and dissociation) explained a significant proportion of the variance in adult victimization. The statistical tests for each of the model components are summarized in Table 3.

Childhood victimization was a significant positive predictor of adult victimization, such that a 1 point higher childhood victimization score corresponded to a 0.442 point higher adult victimization score, $t(7) = 5.361$, $p < .01$. Putting this in context, on average for every 2–3 types of childhood victimization a person reported, they experienced one additional type of victimization as an adult. Dissociation was also a significant predictor of adult victimization, such that a 10-point higher dissociation score corresponds to a 0.25 point higher adult victimization score, $t(7) =$

Table 3
Two-Level Model Predicting Traumatic Victimization in Adulthood

Fixed effect	Coefficient	*SE*	*t*
Mean adulthood trauma γ_{00}	−0.759	0.318	−2.385*
Childhood trauma γ_{10}	0.442	0.082	5.361**
Dissociation γ_{20}	0.025	0.008	3.183*
Random effect	**Variance component**	***df***	**χ^2**
Adulthood trauma u_0	0.469	7	16.048*
Childhood trauma u_1	0.033	7	22.038**
Dissociation u_2	0.001	7	23.783**
Level-1 error, r	0.620		

Note. Results based on data from 421 individuals from 8 communities.
* $p < .05$. ** $p < .01$.

3.183, $p < .05$. There are no available norms for the measure of dissociation used, but in general this means that a person who reported on average having dissociative experiences "sometimes" or "frequently" also reported 1–2 more types of adult victimization than people who reported having dissociative experiences "never" or "occasionally." These results are displayed in the fixed effects portion of Table 3.

Table 3 also displays results for the random effects, or variability in regression coefficients among communities. The random effects for all of these components is significant, indicating that there is significant variability from community to community in mean level of adult victimization ($\chi^2(df = 7) = 16.048$, $p < .05$), and there is also variability among communities in how childhood trauma ($\chi^2(df = 7) = 22.038$, $p < .01$) and dissociation predict adult victimization ($\chi^2(df = 7) = 23.783$, $p < .01$).

In order to attempt to explain some of the community to community variation in adult victimization and the relationships between the predictors and adult victimization, community-level poverty rate was entered into the model. Poverty rate was grand-mean centered. Model 3 is an expansion of Model 2, in which community poverty rate (W_j in the equations below) is added as a predictor of variability in the intercept (β_{0j}, the community mean adult victimization), and the slopes (β_{1j}, the regression coefficient for childhood victimization and β_{2j}, the regression coefficient for dissociation). Using deviance testing in HLM, it was determined that Model 3 had significantly better fit than Model 2, ($\chi^2(df = 1) = 10.54$, $p < .01$). This indicates that the level 2 predictor (community poverty rate) explained a significant proportion of the variance in adult victimization, beyond what was predicted by childhood victimization and dissociation. The results of this analysis are presented in Table 4.

Equations for Model 3

$$\text{Level 1: } Y_{ij} = \beta_{0j} + \beta_{1j}(X_{1ij}) + \beta_{2j}(X_{2ij}) + r_{ij}$$

$$\text{Level 2: } \beta_{0j} = \gamma_{00} + \gamma_{01}(W_j) + u_{0j}$$

$$\beta_{1j} = \gamma_{10} + \gamma_{11}(W_j) + u_{1j}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21}(W_j) + u_{2j}$$

Poverty rate did not significantly predict the community means (intercepts) for adult victimization, $t(6) = 0.013$, $p > .50$, or variability between communities in the relationship between dissociation and adult victimization, $t(6) = -0.317$, $p > .50$. Poverty rate did significantly modify the relationship between childhood victimization and adult victimization, $t(6) = 3.164$, $p < .05$. The association between childhood victimization and adult victimization was significantly stronger for those residing in areas with higher poverty rates, indicating that there was a significant cross-level interaction between childhood victimization and community poverty rate in predicting adult victimization. Specifically, a 1% higher community poverty rate corresponded with a 2.78 point higher functional relationship (slope) between childhood victimization and adulthood victimization.

The results of the random effects tests indicated that there is still significant unexplained variability from community to community in mean level of adult victimization ($\chi^2(df = 6) = 15.825$, $p < .05$), and significant unexplained variability among communities in how dissociation predicts adult victimization ($\chi^2(df = 6) = 23.817$, $p < .01$), even when considering community poverty rate. However, the results indicated that after adding poverty rate to the model, there was no longer significant unexplained variability among communities in the relationship between childhood trauma and adult victimization ($\chi^2(df = 6) = 7.168$, $p > .30$). The implication is that adding community poverty rate to the model explained a significant proportion of the community-level variance in the association between childhood trauma and adult victimization.

To illustrate this interaction, a graph was created in which regression lines for the relationship between childhood victimization trauma and adult victimization trauma were plotted for communities in the upper 50% for poverty rate, and communities in the lower 50%. As displayed in Figure 1, the relationship between childhood and adult victimization was stronger in communities with higher poverty rates, and weaker in communities with lower poverty rates. This cross-level interaction indicates that community poverty rate moderated the relationship between childhood victimization and adult victimization in this study.

Table 4
Two-Level Model Predicting Traumatic Victimization in Adulthood (With Level 2 Predictor)

Fixed effect	Coefficient	*SE*	*t*
Mean adulthood trauma γ_{00}	−0.737	0.315	−2.341*
Percent below poverty γ_{01}	0.064	4.932	0.013
Childhood trauma γ_{10}	0.406	0.049	8.314**
Percent below poverty γ_{11}	2.782	0.879	3.164*
Dissociation γ_{20}	0.025	0.008	3.315*
Percent below poverty γ_{21}	−0.038	0.119	−0.317
Random effect	**Variance component**	***df***	**χ^2**
Adulthood trauma u_0	0.437	6	15.825*
Childhood trauma u_1	0.004	6	7.168
Dissociation u_2	0.001	6	23.817**
Level 1 error, r	0.619		

Note. Results based on data from 421 individuals from 8 communities.
* $p < .05$. ** $p < .01$.

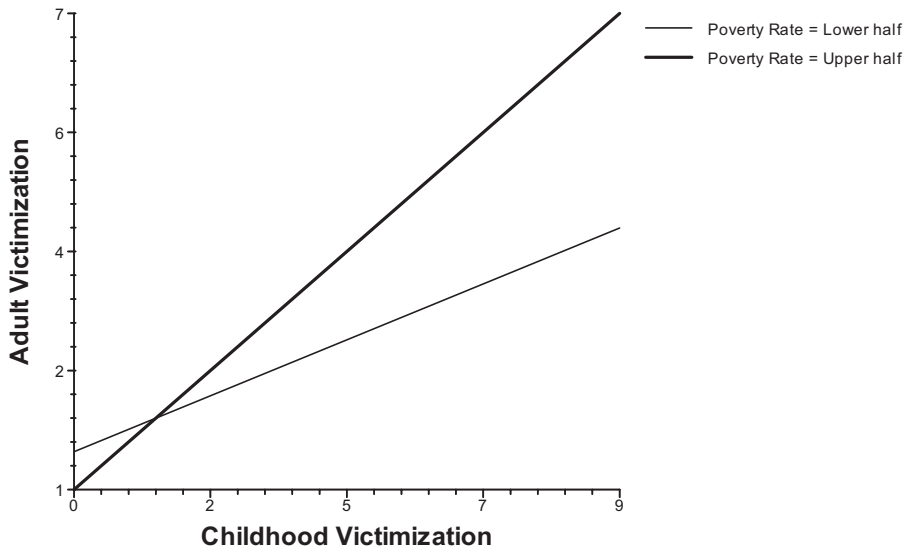

Figure 1. Relationship between childhood and adult victimization by community poverty rate.

Discussion

The results of these analyses provide evidence to support the previously observed relationships between childhood victimization, dissociation, and victimization in adulthood. Childhood victimization and dissociation each uniquely predicted variance in adult victimization. This study provides further description of these relationships, suggesting that some of the variance in adult victimization is attributable to community-level variables, and that the relationships between childhood victimization, dissociation, and adult victimization function differently within different social contexts. In particular, the relationship between childhood trauma and victimization in adulthood tends to be stronger among individuals in communities with higher poverty rates.

The implications of these results are still somewhat open to interpretation. It is difficult to make causal inferences about neighborhood effects with a research design that is inherently correlational. It is not immediately clear whether social context impacts revictimization risk, or whether prior victimization impacts both social context and later victimization. Childhood victimization may lead a person to experience personal poverty and thus live in a higher poverty neighborhood, and also lead to later revictimization as an adult. On the other hand, the individuals within a neighborhood create a part of the social context of the neighborhood, and thus person-level effects are not easily disentangled from community-level effects (Oakes, 2003; Roux, 2004).

There are a number of theoretical reasons why community poverty would be expected to have an effect on the relationship between childhood victimization and later revictimization in adulthood. It is possible that there are fewer resources available to people in communities with higher poverty rates, so that these individuals are less able to overcome the symptoms associated with childhood victimization, which in turn may lead to greater likelihood of revictimization in adulthood. It could also be that people with worse symptoms related to childhood victimization tend to live in poorer neighborhoods, and a greater concentration of victims and potential perpetrators leads to greater victimization in adulthood.

Many intertwined factors likely contribute to the findings observed in the current study. For example, level of educational attainment is a consistent predictor of exposure to violence, in that less education corresponds with greater violence exposure, (e.g., Breslau et al., 1998; Wilson, Rosenthal, & Battle, 2007), and higher poverty communities may have fewer resources to direct toward education. Relatedly, lower income individuals are at higher risk of exposure to assaultive violence (Perilla, Norris, & Levizzo, 2002), as income impacts ability to choose a safe neighborhood to live in. Research has also suggested that lack of access to financial resources predicts a wide variety of psychiatric and physical health symptoms following all types of traumatic events (Adler & Rehkopf, 2008; Dohrenwend, 2000). It is theorized that symptoms contribute to behaviors that increase likelihood of revictimization, and one example of this is choosing to live in unsafe environments. As a hypothetical example, a person may experience victimization, leading to symptoms, causing difficulty with employment and subsequent lack of financial resources. Both symptoms and lack of income may lead this person into an unsafe living arrangement, leading to further victimization. Leaving out any of these factors leads to oversimplification, and yet the complexity of these relationships makes it difficult to parcel out the unique impact of one factor over another.

Given that previous single-level research tends to support the hypothesis that both person-level and community-level factors influence revictimization (Gill & Page, 2006; Sabol, Coulton, & Korbin, 2004; Simons et al., 2002), we suggest that the current study lends support to the interpretation that the social context of poverty contributes to likelihood of revictimization. From a practical standpoint, the direction of causality may not be immediately important. The fact that we find relationships between childhood trauma, dissociation, poverty, and victimization in adulthood suggests the existence of a highly vulnerable population in need of

services and support. It seems that efforts targeting people who were victimized in childhood who are currently living in poorer communities might have potential for reducing revictimization. Similar future research in clinical populations may help with identification of individuals and communities most at risk for revictimization, and aid in the development of targeted prevention and intervention programs.

Additionally, the cross-level interaction observed in this study points to the importance of using multiple methods and multiple levels of analysis to study phenomena as complex as trauma and revictimization. When combined with data from other sources, such as case and qualitative studies, epidemiological studies, and more traditional single-level analyses, studies based on multilevel models can help researchers better understand complex social processes like victimization.

This study has several important limitations. First, the data were collected as part of a larger longitudinal study that did not initially set out to explore relationships between trauma, dissociation, poverty, and victimization. Because of this, there are time gaps between administration of the different measures. It is possible that these gaps may have impacted results; for example participants may have moved between zip codes during this time. Additionally, prior research has noted relationships between PTSD symptoms and revictimization, and a measure of PTSD symptoms was not available in the current study. Future research collecting data at one time point, and including other variables associated with revictimization would be useful to strengthen the current results.

The participants in the study were mostly Caucasian, middle-class, and relatively educated compared with the general U.S. population. Results from a medium-sized college community will not necessarily generalize to more diverse communities. Additionally, the poverty rates in this study may have been artificially inflated by the presence of large numbers of college students in several target zip codes. Although the participants in the study were all area homeowners, the poverty rates came from census data which included all residents in households (dormitories were excluded) in a particular area, and thus some zip codes include many low-income but otherwise high-SES individuals. It is arguable that neighborhoods with high rates of "student poverty" are substantially different from other high-poverty neighborhoods. We do not have data on the percentage of "impoverished" individuals in each neighborhood who were college students. We do know that the study participants, as homeowners, were not themselves typically students, and thus it is unlikely that the increased risk of assault associated with college life explains the findings in this study. However, it may be that neighborhood environments in which there is a high density of college students create risk factors for victimization that are not poverty related, but rather due to other factors. Due to this possibility, readers should be cautious in generalizing these results to different types of communities.

Relatedly, the majority of participants in this study, and the majority of individuals in the neighborhoods studied, were not poor. The context of poverty in a relatively wealthy or middle-class community likely has different effects than being poor in a poor community. Additionally, defining a community based on zip code is limiting, and there may be other ways of dividing people into communities that better reflect the groups of people that interact with one another on a regular basis. Future research will be necessary to determine whether these results generalize to other types of communities.

Future research on the impact of trauma should continue to consider poverty and other social context factors. It remains to be seen whether associations observed between trauma, symptoms, and revictimization are present in all social contexts, or whether these relationships may be strengthened or attenuated in some social contexts. It is currently also unclear whether community-level factors that predict victimization (e.g., concentrated poverty) have the same negative effects on all people, or whether some person-level factors (e.g., prior history of victimization, dissociative tendencies) might affect this relationship. The current study begins to address these questions, and it is hoped that the body of research on this topic will continue to grow.

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