Violence, revictimization and trauma-related shame and guilt

An investigation of event characteristics and mental health correlates among violence-exposed men and women from the general population and among young survivors of a terrorist attack.

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Summary

Background and aim: Violence is not uncommon and may have a range of negative consequences for victims. While mental health has received much research attention, other consequences are increasingly recognized, including victims' increased risk of subsequent violence exposure and shame and guilt related to their violent experiences. These latter consequences are adverse for the individual, and may relate to long-term health and well-being. Therefore, it is important to be able to identify those victims of violence who are particularly vulnerable for new violent experiences, shame and guilt. Certain characteristics of the event, including a close relationship to the perpetrator and the type of violence, and multivictimization can impact mental health after violence. However, less is known about how these characteristics relate to other negative consequences. This thesis investigates how the characteristics of violence in childhood relate to violence exposure in adulthood. Further, the thesis examines how various violent experiences are related to emotional responses to violence, namely trauma-related shame and guilt, in male and female violence survivors. Mental health correlates of shame and guilt are examined.

Methods: Two different study samples were used. First, a comprehensive telephone interview study (the prevalence study) was conducted to map exposure to violence in the Norwegian population (n=4,529). The study measured child sexual abuse (CSA), childhood physical violence from or between parents, psychological violence and childhood neglect, as well as adult physical violence from partners or others and lifetime rape. The employed mental health measures included a short scale that assessed anxiety/depression symptoms (HSCL-10). For this study, a new shame and guilt after trauma scale (SGATS) was developed.

The second study was conducted after the terrorist attack in Norway on 22nd of July, 2011. A sample of 325 survivors, who were primarily adolescents and young adults, were interviewed. This study focused on evaluating the survivors' experiences and reactions to the event, including posttraumatic stress reactions (PTSR; measured using the UCLA PTSD-RI) and trauma-related shame and guilt.

The statistical methods applied in this thesis include multiple regression analyses, logistic regression analyses, chi-square statistics, linear hypothesis testing, and confirmatory factor analysis.

Results: Violent experiences were highly overlapping for both women and men. Different types of childhood violence overlapped, and childhood experiences of violence were associated with violence in adulthood. Women who experienced CSA often experienced other violence types in childhood. CSA from a parent almost always co-occurred with other types of violence. The total number of childhood violence experiences (multivictimization) was strongly associated with intimate partner violence or rape in adulthood.

Women and men who experienced violence reported more anxiety/depression symptoms, and those symptoms increased with the number of violence categories experienced. All types of violence, including the terrorist attack, were associated with trauma-related shame and guilt. Women reported more shame and guilt than men in the prevalence study, but this gender difference was not found after the terrorist attack. Both emotions were independently associated with mental health problems in both samples. In the prevalence study, shame was more important for mental health. The total number of violence types in childhood and adulthood showed a graded relationship with trauma-related shame and guilt.

Conclusions: Violence is associated with various negative consequences, regardless of whether the violence happens in a close relationship, whether the violence happens in childhood or adulthood, and whether the violence is of a sexual nature. Childhood victims of violence have an increased likelihood of adult violent exposure that is not restricted to the same violence type. Both trauma-related shame and guilt contribute to mental health problems after violence, although shame may be more clinically relevant than guilt. Shame and guilt were fairly common among young survivors of a terrorist attack. It is not clear if women have more shame and guilt than men, but violence exposure was highly important for shame and guilt, for both men and women.

These findings imply that researchers and clinicians could benefit from a broad assessment of violence, in order to uncover the full scope of respondents and patients' violent experiences. Clinicians may find it helpful to address shame and guilt after a variety of violent experiences, with both men and women. Future research could investigate the hypothesis that shame and guilt might be a mechanism by which revictimization occurs.

List of papers

1. Thoresen, S., Myhre, M., Wentzel-Larsen, T., Aakvaag, H. F., & Hjemdal, O. K. (2015). Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population. *European Journal of Psychotraumatology, 6*. doi:10.3402/ejpt.v6.26259

2. Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., & Dyb, G. Adult victimization in female survivors of childhood violence and abuse: The contribution of multiple types of violence (resubmitted to *Violence Against Women*)

3. Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Dyb, G., Røysamb, E., & Olff, M. Broken and guilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse (manuscript submitted for publication)

4. Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Røysamb, E., & Dyb, G. (2014). Shame and guilt in the aftermath of terror: The Utøya Island Study. *Journal of Traumatic Stress, 27*(5), 618-621. doi:10.1002/jts.21957

Tables and figures

List of abbreviations

CDC – Center for Disease Control and Prevention

CSA – Child sexual abuse

DSM IV - Diagnostic and Statistical Manual of Mental Disorders, fourth edition

DSM-5- Diagnostic and Statistical Manual of Mental Disorders, fifth edition

HSCL – The Hopkins Symptom Check List

ICD-10 – International Classification of Diseases, 10th edition

IPV – Intimate partner violence

NKVTS – The Norwegian Center for Violence and Traumatic Stress Studies

PTE – Potentially traumatic event

PTSD – Posttraumatic stress disorder

SGATS – Shame and guilt after trauma scale

PTSD-RI – University of California, Los Angeles Posttraumatic Stress Disorder Reaction Index

UN – United Nations

WHO – The World Health Organization

1. Introduction

1.1. Rationale

Population studies of violence have increased our knowledge about how often violence occurs and about the negative consequences of these experiences for children and adults. In line with the important contributions of such studies, The Norwegian Center for Violence and Traumatic Stress Studies (NKVTS) conducted a large population study that aimed to estimate the prevalence of violence in the Norwegian population. An explicit goal of the study was to gain more in-depth knowledge about exposure to different violent events across the lifespan and to evaluate the possible impacts of violence on people's lives and well-being. More specifically, the study aimed to address knowledge gaps related to two areas: the overlap between exposure to different violence types and how these violence types relate to mental health. The study therefore employed a comprehensive operationalization of violence that encompassed events in childhood and adulthood that were of a physical, sexual and psychological nature and perpetrated by a range of potential perpetrators. The main hypotheses were (1) that violent events are highly overlapping and (2) that violence is linked to mental health problems. I investigated these two areas of interest more in-depth in my thesis in the following ways.

First, previous findings indicate that violent events overlap not only concurrently but also across the lifespan, and reporting events in childhood implies a likelihood of reporting events in adulthood. Victims of childhood violence may thus be vulnerable to new violent experiences. Previous research has identified potential mechanisms that may link childhood victimization and revictimization; however, little is known about how characteristics of childhood victimization may relate to vulnerability to new violence exposure. Specifically, I was interested to learn more about how childhood violence with different characteristics may influence vulnerability to violence exposure later in life.

Second, previous findings that violence is related to mental health problems, such as posttraumatic stress, anxiety and depression, spurred me to explore the possible link between such problems and affective responses to violence. In particular, I was interested in investigating emotions that relate to the interactions between individuals and their social surroundings; therefore, I aimed to investigate the social emotions shame and guilt. I wanted to explore how the characteristics of a violent event(s) may affect the levels of trauma-related shame and guilt and how these emotions associate with mental health problems.

As we were preparing for the data collection phase of the prevalence study, Norway was hit by a terrorist attack. NKVTS initiated a study program shortly after the attack, including a study of survivors of a shooting massacre at a youth summer camp on Utøya, which is a small island

outside of Oslo. This study provided me with the opportunity to explore the role of trauma-related shame and guilt in a different population of victims of violence.

The two goals of the current thesis thus relate to different violence exposures in relation to revictimization and to trauma-related shame and guilt. I will include a gender perspective under both goals.

1.2. Violence

1.2.1. Background. Violent and aggressive acts have always been a part of human history, although the way such experiences are viewed has changed. The notion that an event can cause mental wounds in the same way that it causes physical wounds is embedded in our use of the word 'trauma' to describe such events (Brewin, 2003). The great wars of the last century saw their veterans suffer from their war experiences beyond the physical injuries they sustained (Myers, 1940, as described in Herman, 1992). With the women's liberation movement, testimonies of women's experiences with sexual abuse and domestic violence emerged. Victims of such acts were studied by researchers, who described victims' reactions as 'rape trauma syndrome,' 'the battered woman syndrome,' and as violence against children became recognized, 'the battered-child syndrome' (Burgess & Holmstrom, 1974; Kempe, Silverman, Droegemueller, & Silver, 1962; Walker, 1977). There was emerging recognition of the similarities between the reactions of victims of civilian violence and the reactions of combat veterans, and in 1980, the DSM-III included posttraumatic stress disorder (PTSD) as a diagnosis (American Psychiatric Association, 1980).

The Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948 (UN, 1948), asserted that humans had rights that were contingent not on status or power but simply on being human; these rights included the right to protection from certain acts of violence, including slavery and torture. In 1989, the UN adopted the Convention of the Rights of the Child, which recognized children's particular need for protection (UN, 1989).

Although the last century saw considerable effort to regulate violence through legislation and although research has established the potentially detrimental consequences of violence for health and functioning, violence continues to be a major problem in society. Physical assault is reported by approximately 12% of men and 7% of women in American and Australian samples (Creamer, Burgess, & McFarlane, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Estimates of rape are approximately 10% for women (Kessler et al., 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). A large study of women from ten different countries around the world found that across cultures, intimate partner violence (IPV) was reported by 15 to 71% of

women who had ever had a partner (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). A British study found that 16% of young adults reported maltreatment before the age of 16 years, while serious physical abuse was reported by 7%, serious emotional abuse was reported by 6%, and contact sexual abuse was reported by 11% (May-Chahal & Cawson, 2005). Norwegian studies have reported comparable estimates (Haaland, Clausen, & Schei, 2005; Mossige & Stefansen, 2007; Steine et al., 2012), although no studies have investigated violence in a representative Norwegian population sample.

The above prevalence estimates suggest that violence is not uncommon. The consequences are dire for society and for the individual (WHO, 2002), and violence constitutes a major public health problem. To monitor violence and its consequences over time, repeated prevalence studies are needed. It is increasingly recognized that to know more about which individuals are at risk for violence, the kinds of violence they experience, from whom, and the kinds of consequences they are likely to suffer, we need prevalence studies that are inclusive in terms of the measurement of violence and its consequences.

1.2.2. What is violence?

1.2.2.1. Definitions and typology. There is considerable disagreement concerning what constitutes violence. Norwegian law prohibits all types of physical violence, even less severe corporal punishment, such as spanking. This situation stands in contrast to many other countries, including many European countries and the U.S., where corporal punishment in its less severe forms is allowed and quite common (Straus, 2001). Despite cultural differences, there appears to be agreement across many cultures that some types of violence, including very harsh disciplinary practices and sexual abuse, should not be allowed (WHO, 2002).

The current thesis will use the definition and typology provided by the World Health Organization (WHO, 2002) as a basis for the conceptualization of violence, supplemented by other sources. The WHO proposes that violence can be defined as the 'intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in, or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation' (WHO, 2002, p. 5). According to this definition, violence must be intentional and must be likely to have negative consequences; however, intentionality refers to the violent act and not its consequences. The definition sets the use of physical force or power, threatened or actual, as a criterion, but in this context, 'power' is not synonymous with 'physical force' but can also mean the power of being adult and in charge of a child. The definition does not specify that the occurrence of an injury is a defining feature;

instead, the definition takes a broad health perspective on potential consequences, including physiological and psychological health, as well as healthy development. The definition is comprehensive and includes a multitude of acts of violence. From this overall definition, violence is sub-categorized based on the type of act (physical, sexual or psychological violence or deprivation) and on the context in which it happens (Fig. 1).

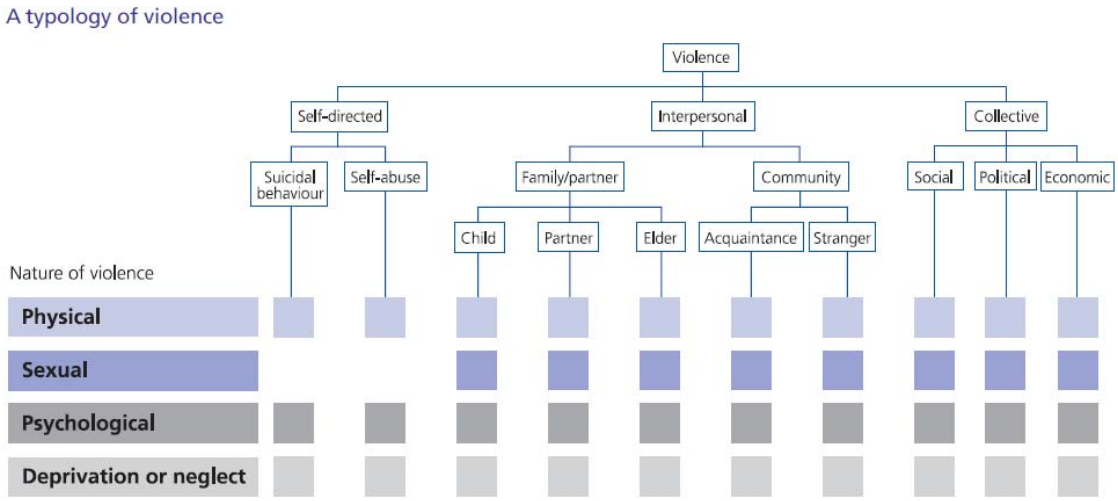

Figure 1: A typology of violence (WHO, 2002)

The focus of this thesis is interpersonal violence, which can be subdivided into family/partner violence and community violence. In family/partner violence, the perpetrator is a person with whom the victim has significant social and emotional ties. According to this typology, in community violence, the victim and perpetrator do not have close family ties and may know each other or be strangers.

Physical interpersonal violence includes various forms of physical force that can be used by one person against another, including hitting, kicking, punching, stabbing, biting, pushing, dropping, shaking, choking, scolding and poisoning (Centre for Disease Control and Prevention, CDC, 2008). Sexual violence may represent any sexual act that is obtained by coercion (WHO, 2002), as well as certain non-coercive acts, including an adult luring a child into sexual acts.

According to the above typology, violence may be perpetrated by partners, family members, acquaintances or strangers; however, some claim that psychological violence in childhood should be defined within the caregiver relationship (Glaser, 2002). Psychological violence from caregivers can be defined as 'intentional caregiver behavior (i.e., act of commission) that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs' (CDC, 2008). According to the WHO typology, other events, such as

school or workplace bullying, might also be considered to be psychological violence. In adulthood, psychological violence is typically studied in intimate relationships (for example Coker, Smith, Bethea, King, & McKeown, 2000). Neglect is a condition of deprivation and is most commonly used to refer to conditions in a child-caregiver relationship (but it may also occur in other situations that involve dependency, such as with disabled individuals who depend on care). Childhood neglect can be defined as occurring when 'a basic need of a child is not met, regardless of the cause(s)' (Dubowitz, Black, Starr, & Zuravin, 1993).

Witnessing one parent being violent towards the other parent in childhood may be considered to be a type of childhood violence (Øverlien, 2012). This type of situation is not explicitly included in the WHO typology, although it can be considered to be a form of psychological violence or neglect (CDC, 2008; Øverlien, 2012).

Defining violence is difficult, and some aspects of the above-mentioned definitions can be problematic. In the overall definition of violence, intentionality is a criterion; however, many definitions consider childhood neglect as a condition of deprivation regardless of whether it is intentional, as in the definition above (Dubowitz et al., 1993). Another source of difficulty is assessing the degree of closeness in the victim-perpetrator relationship. In the current definition, interpersonal violence is subdivided into family/partner violence (which includes child, partner and elder violence) and community violence. The definition of family is not straightforward; it is not clear whether we should consider only violence between close family members, such as parents and children or violence between intimate partners, or whether we should also include violence from extended family, such as grandparents, aunts or uncles. Further, perpetrators with whom the victim is not directly related but who are nonetheless members of the household, such as step-parents, are usually included in family violence (World Health Organization, 1992), but it is less clear whether we should include violence from a parent's short-term partner who does not live in the household or violence from a stepsibling who lives elsewhere.

Violence is a complex phenomenon, and providing a single unified definition is therefore challenging. Despite its difficulties, I consider the WHO conceptualization to be the best definition available.

1.2.2.2. Other terminology. In this thesis, the term 'childhood violence' will be used to describe all forms of violence against a person under the age of 18 years. Violence towards children from caregivers is often referred to as 'child abuse' or 'child maltreatment.' However, in the interest of using a consistent terminology in the thesis, parental/caregiver violence will be considered to be a part of childhood violence. In concordance with the WHO definition, the term

violence will be used to encompass many forms of violent acts, including sexual violence, which is otherwise often called sexual abuse. Consistent with the prevailing terminology, the term child sexual abuse (CSA) will be used to describe all sexual violence that is experienced by a child, regardless of the identity of the perpetrator. When describing the number of different types of violence, I will use the term 'multivictimization.' For the phenomenon in which a victim of childhood violence also becomes victim of violence in adulthood, I will use the term 'revictimization.' While victimization is often used to describe events that fall under the current definition of violence (e.g. Classen, Palesh, & Aggarwal, 2005), the term victimization is sometimes defined broadly, including being victim to theft or having one's belongings destroyed (Finkelhor, Ormrod, & Turner, 2007). In this thesis, 'victimization,' as in multi- or revictimization, is used solely to describe experiences with violence.

1.2.2.3. Violence versus trauma. The term 'traumatic event' is commonly used to describe events that have the potential to elicit a traumatic stress response in exposed individuals. However, not all individuals who experience events with the potential to be traumatic exhibit peri- or post-traumatic stress reactions. The term 'potentially traumatic event (PTE)' was introduced to establish a term that describes strictly the event, without assuming any particular response on the part of the individual.

To be considered a PTE, an event must have certain characteristics. According to the PTSD diagnostic criteria outlined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), a PTE must entail "exposure to actual or threatened death, serious injury, or sexual violence" because the individual directly experiences it, witnesses it as it occurs to others, or learns that it occurred to loved ones in an accidental or violent way (American Psychiatric Association, 2013). This definition includes a broad spectrum of events, including child abuse, sexual assault, physical violence, car accidents, natural disasters, war experiences, and terrorism, as well as witnessing violence or being a first responder at a disaster site or violent crime scene. PTEs include disasters and accidents and can be interpersonal, as is the case with experiences with violence and abuse.

All PTEs are not considered to be experiences of violence; a natural disaster can be a PTE but is not an act of violence. Similarly, violence includes events that typically do not qualify as PTEs, such as childhood neglect and some forms of low-intensity physical violence. However, many events can be defined as both traumatic and violent. Therefore, much of the literature that is relevant for this thesis will have a trauma perspective. Where this is the case, I will use the terminology used in the original source.

1.2.3. Consequences of violence.

Violence may have widespread consequences, including problems with health and everyday functioning. Exposure to violence has been associated with a variety of mental health problems, including anxiety, depression, PTSD, and substance abuse (Danielson, Moffitt, Caspi, & Silva, 1998; R. Gilbert et al., 2009; Kilpatrick et al., 2003; Kuo, Goldin, Werner, Heimberg, & Gross, 2011). Childhood exposure to violence is associated with a range of adult somatic health problems, such as obesity, ischemic heart disease, cancer, and chronic lung disease (Felitti et al., 1998; R. Gilbert et al., 2009). Victims of violence also appear to be at high risk for various life difficulties, including relationship problems, low work participation and subsequent exposure to violence (Colman & Widom, 2004; Strøm et al., 2013; Widom, Czaja, & Dutton, 2008). Exposure to violence may also result in experiences of shame and guilt (Beck et al., 2011; Feiring, Taska, & Chen, 2002, and see page 21.).

While the abovementioned adverse outcomes are hypothesized to be consequences of violence, a competing hypothesis is that individuals with health problems are more prone to experience violence, a perspective that has received some support (Ford et al., 1999). Alternatively, both violence and its proposed consequences can be hypothesized to occur due to background factors, such as socio-economic or family factors. Individuals who grow up in disadvantaged families have an increased risk of experiencing health problems, life difficulties, and violence (Melchior, Moffitt, Milne, Poulton, & Caspi, 2007). Many of these problems may be explained by the same background factors that initially placed the victims at risk of violence (Fergusson, Horwood, & Lynskey, 1997). However, compelling evidence implies that exposure to violence predicts health problems and other negative outcomes, even after adjustment for background factors, such as socioeconomic status and parental mental health (Fergusson et al., 1997; Font & Maguire-Jack, 2016; R. Gilbert et al., 2009; Melchior et al., 2007). This finding strengthens the hypothesis that negative outcomes are at least in part consequences of violence.

A diathesis-stress model of health assumes that pathology results from an individual's genetic predispositions, in interaction with environmental or psychosocial stressors (Schore, 2001). In concordance with such models, researchers tend to view health problems that occur after violence and trauma as the result of multiple factors, including individual factors, contextual factors, and the characteristics of the traumatic or violent event. Of the many potential consequences of violence, mental health problems have been subject to the most research and will be considered in more detail.

1.2.3.1. Mental health. The association between exposure to violence and trauma and mental health outcomes is well-established (WHO, 2002). PTSD is the most commonly described mental health problem after PTEs and violence. For PTSD to be diagnosed, a traumatic event must have preceded the symptoms (American Psychiatric Association, 2013). In addition to the event, PTSD consists of a constellation of event-related intrusions, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity, which persist for more than one month. PTSD is considered to be a response to extreme stress. PTSD may be seen as a form of pathological fear (Tolin & Foa, 2002) that involves physiological responses to fear, such as sympathetic-adrenomedullary (SAM) and hypothalamic-pituitary-adrenocortical (HPA) system activation, and brain structures, such as the amygdala (Gunnar & Quevedo, 2007; LeDoux & Phelps, 2008). It is increasingly recognized that other emotions besides fear may impact PTSD symptomatology (Lee, Scragg, & Turner, 2001; Rizvi, Kaysen, Gutner, Griffin, & Resick, 2008).

In the U.S., the life-time prevalence of PTSD has been estimated to be 7.8% (Kessler et al., 1995), and in Sweden, it has been estimated to be 5.6% (Frans, Rimmö, Åberg, & Fredrikson, 2005). Most studies find that women have an increased risk of PTSD following trauma exposure in comparison to men (Breslau, 2009; Olff, Langeland, Draijer, & Gersons, 2007; Tolin & Foa, 2006). PTSD has frequently been found to be comorbid with other mental health problems, most commonly depression, as well as substance abuse problems and anxiety disorders (Kilpatrick et al., 2003; Perkonigg, Kessler, Storz, & Wittchen, 2000).

Depression is characterized by marked and consistent decreased mood, followed by a variety of symptoms, including fatigue, loss of positive affect, loss of appetite, sleep disorder, and suicidal thoughts and acts (American Psychiatric Association, 2013; World Health Organization, 1992). Depressive symptoms, including the diagnosis of depressive disorders, are a leading global cause of disability (Ferrari et al., 2013) and are consistently found to be associated with experiences of violence (Campbell, 2002; Kilpatrick et al., 2003).

It has been suggested that repeated or prolonged trauma, particularly in childhood, may lead to symptoms that are not fully encompassed by the PTSD diagnosis or other diagnoses; therefore, scholars have suggested a particular form of posttrauma diagnosis, which is termed complex PTSD (Cloitre et al., 2009; Herman, 1992) or developmental trauma (van der Kolk & Courtois, 2005). Complex PTSD is currently not recognized as a diagnosis in DSM-5 or in the International Classification of Diseases' 10th edition (1CD-19; World Health Organization, 1992) but has been suggested for inclusion in ICD-11 (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013).

Although violent events are presumably aversive to most people, there is great variation in individual responses to violence. This variation probably results from a range of factors, including

characteristics of the violent event, such as severity and violence type, and the experience of multivictimization.

1.2.4. Characteristics of violence related to negative consequences.

In the trauma literature, meta-analyses find trauma severity to be a consistent predictor of PTSD (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2008; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). However, there is no standard definition that outlines how severity should be operationalized. The frequently used indicators include sustained physical injury and how likely the act was to result in a physical injury (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Brewin et al., 2000), as well as the amount of combat experience and atrocities (in veteran samples; King, King, Foy, Keane, & Fairbank, 1999). However, other characteristics may also indicate high severity. For example, in many cases, continuous sexual abuse of a child by a caregiver may have more detrimental effects on health and development than a single incident of physical violence from an acquaintance against an adult, even if the latter incident may be more likely to result in a physical injury. Other potential event characteristics that may indicate high severity are presented in the following sections.

1.2.4.1. Threat. Perceived life threat is closely linked to fear. Fear is a part of the conceptualization of PTSD (Ehlers & Clark, 2000). According to one model, fear after trauma may result from the generalization of conditioned fear responses (Foa, Steketee, & Rothbaum, 1989). For example, a woman who was raped while crossing a park at night may afterwards fear not only that particular park but also any park or public lawn, that particular time of night, and all men with characteristics that resemble those of the rapist. According to Foa and colleagues, emotional processing after a traumatic event involves fear structures that consist of information about fear stimuli, the individual's responses, and the meaning that is prescribed to the stimuli and the response elements of the structure (Foa et al., 1989; Tolin & Foa, 2002). High fear and stress may impact memory of the trauma, specifically the manner in which traumatic memories are stored and retrieved. Dual representation theory explains how traumatic memories are encoded in two different memory systems: one system that is verbally accessible and can be retrieved deliberately or automatically and one system that is situationally accessible, retrieved in the form of involuntary flashbacks, often highly emotional, and difficult to control (Brewin, Dalgleish, & Joseph, 1996; Brewin & Holmes, 2003). One model of PTSD claims that individuals may experience fear in the aftermath of trauma when the appraisal of the event and its sequelae represents a serious, current threat for the individual (Ehlers & Clark, 2000). Like Foa et al.

(1989), Ehlers and Clark identify that individuals may feel threatened because they overgeneralize the threat from the event. In addition, appraisals of the ways in which individuals felt or acted during or after the event may have implications that constitute and maintain current threats (for example, if the fact that the event happened is taken as proof that the individual attracts danger or is unable to cope or if PTSD symptoms are interpreted as permanent and irreversible damage; Ehlers & Clark, 2000).

1.2.4.2. Violence in a close relationship. The impact of trauma may depend not only on whether an event is frightening but also on whether the event involves betrayal. Betrayal trauma involves the violation of trust or well-being by people or institutions upon which a person depends (Freyd, 2008). Betrayal trauma theory states that the closer the relationship is and the more necessary the relationship is for the victim, the higher is the betrayal (Freyd, 1996). According to betrayal trauma theory, traumatic events can be high or low with respect to both fear and betrayal (see Figure 2). An event may be high on both fear and betrayal, which may be the case when a person experiences potentially lethal violence from a partner, low on fear but high on betrayal, which may happen in certain cases of CSA from a parent, or high on fear but low on betrayal, which may be the case for an earthquake survivor. According to Freyd, an event that is low on both fear and betrayal is not generally traumatic (Freyd, 1996), although there may be exceptions (for example, experiences with being a first responder to an accident or disaster site). Both fear and betrayal can be seen as continuums; most interpersonal violence will involve some degree of betrayal, as such violence betrays underlying assumptions concerning how people behave against each other (as opposed to many disasters and accidents, in which there is no intention to harm). However, even events that are presumably impersonal, such as natural disasters, may involve a sense of betrayal if consequences result from improper prevention strategies or if bystanders or the community fail to help survivors.

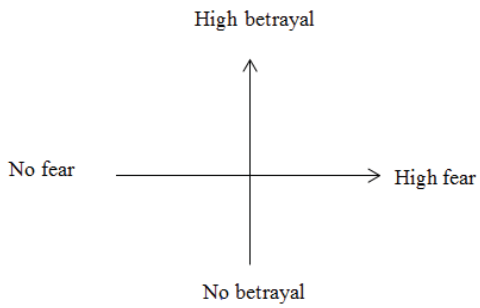

Figure 2: Betrayal and fear in trauma (adapted from Freyd, 1996, as described in Freyd, 2014)

Thus, betrayal may be a part of all forms of violence; however, betrayal is more pronounced in close relationships. Dependency is crucial to betrayal, and Freyd argues that the most devastating consequences should therefore result from child abuse from a parent (Freyd, 1996). Children may also experience the non-abusive parent as betraying if that parent did not notice what happened or was unable or unwilling to stop the abuse.

Attachment theory emphasize children's predisposition to form emotional bonds with their caregivers and the behaviors that go along with that predisposition (Bowlby, 1958; Cassidy, 2008). Attachment behavior includes the infant's attempts to create proximity between itself and the attachment figure (i.e., the caregiver), for example, when the fear system is activated. Children will seek attachment with caregivers at nearly any cost, including when the caregivers are abusive (Bowlby, 1956, as described in Cassidy, 2008). Violence and abuse within the child-caregiver bond thus presents children with a profound dilemma, as their attachment figures are also a source of danger (Kobak & Madsen, 2008). Herman (1992) describes how children who experience caregiver abuse may choose to blame themselves rather than the perpetrator as a solution to this dilemma. Abuse from caregivers therefore carries some additional challenges, including the disruption of attachment bonds, betrayal, and a heightened potential for self-blame.

The bulk of attachment research has focused on childhood experiences with caregivers; however, attachment is also seen as integral to bonds between intimate partners in adulthood (Zeifman & Hazan, 2008). As it is described in betrayal trauma theory, dependency may sometimes also apply to intimate relationships.

1.2.4.3. Sexual violence. Sexual violence may consist of a variety of different acts, and the definition presented on page 4 encompasses acts such as sexual harassment, indecent exposure, and forced touching, as well as the most severe sexually violent events, which are probably child sexual abuse (CSA) and rape.

According to Finkelhor and Browne (1985), CSA is unique when compared to other forms of childhood violence due to four co-occurring dynamics: traumatic sexualization, betrayal, powerlessness, and stigmatization. The authors claim that not all of these dynamics are unique to CSA but that their conjunction is. For the individual, these dynamics may result in a variety of problems, including confusion about sex and affection, isolation, shame, guilt, grief reactions, disillusion, fear, and anxiety (Finkelhor & Browne, 1985). Among the things that make CSA particularly stigmatizing may be the social transgression it represents and the secretive context in which it often occurs (Feiring, Simon, & Cleland, 2009). The secretive nature of CSA is described

by Freyd (1996) as involving the perpetrator's frequent denial that it has taken place, as well as the child's potential motivation to believe this denial if the perpetrator is a caregiver upon whom the child depends. The secrecy associated with CSA, along with the blaming responses of others and the child's sense that he or she is 'damaged goods' after what happened, may result in feelings of shame (B. Andrews, 1998; Feiring et al., 2009).

The dynamics described in the model of Finkelhor and Browne (1985) may also have pertinence for reactions to sexual violence in adulthood, particularly to rape (Kilpatrick et al., 1989). Stigmatizing responses from social surroundings may impact victims, for example by making them feel as if they have been permanently changed by the event (Ullman & Filipas, 2001). Negative responses from others, as well as personal feelings of shame, guilt, and self-blame, may be particularly likely after sexual assaults, as perpetrators may claim that the event was consensual and wanted by the victim, and the social surroundings may question the victim's contribution to the event. Expressions of doubt concerning whether or not the event was wanted by the victim are presumably less common with other forms of violence; after all, while sexual contact is often consensual, physical violence is typically not consensual. Rape myth acceptance and victim-blaming by surroundings may contribute to the negative consequences of sexual violence for its victims (Grubb & Turner, 2012). Another aspect of rape that may make it particularly severe is the personally intrusive nature of this act in comparison to many other violent events and crimes (Kilpatrick et al., 1989; Ullman & Filipas, 2001).

These aspects of sexual violence are likely damaging to victims; however, not all of the aspects mentioned above are necessarily unique to sexual violence. Other forms of violence, such as intimate partner violence, may also be stigmatized and may also be likely to lead to feelings of shame and self-blame (Beck et al., 2011; Street & Arias, 2001) . Finkelhor recently promoted the idea that the total number of different types of victimization is more important than any one specific type of victimization (Finkelhor et al., 2007). The hypothesis that sexual violence is particularly severe and damaging may be challenged by recent theory and findings.

1.2.4.4. Violence against a child. Exposure to violence may be particularly detrimental when it happens to a developing child. In addition to exposing the child to something highly negative, violence may disrupt development and deprive the child of something positive and necessary, including secure attachment figures, as well as positive interaction experiences.

Prolonged stress has been found to impact the developing brain, particularly in areas involved in emotion and learning, such as the amygdala, the hippocampus, and the prefrontal cortex (Pollak, 2008). In addition, hypothalamic-pituitary-adrenal axis (HPA-axis) activity may

be impacted by trauma in childhood (Pynoos, Steinberg, Ornitz, & Goenjian, 1997). Thus, children who experience violence, particularly from caregivers, may experience a range of problems in emotional expression and regulation, stress regulation, and cognitive abilities.

The developmental process from infancy to adolescence and beyond presents the child with various developmental tasks, including establishing security, differentiating between imagination and reality, and mastering social skills, which may be disrupted by exposure to trauma and violence (Punamäki, 2002). Depending on the age and developmental stage of the child, difficulties may arise in a variety of domains, including social, cognitive, behavioral and emotional areas. Childhood violence may therefore have particularly serious consequences for individuals.

1.2.4.5. Research findings concerning event characteristics and consequences. As may be seen from the theoretical foundation outlined above, several characteristics of violent events may have pertinence for health and functioning later in life. Empirical investigations of this foundation will be discussed in the following section.

Perceived life threat has repeatedly been found to be a predictor of PTSD, as have peri-traumatic emotional responses, including fear (see meta-analysis by Ozer et al., 2008).

Whether or not a close relationship with the perpetrator is associated with adverse outcomes has been subject to much investigation, yielding somewhat mixed results. While many studies find indications that violence perpetrated by someone with whom the victim has a close relationship is more detrimental in terms of health outcomes (Edwards, Freyd, Dube, Anda, & Felitti, 2012; Ketring & Feinauer, 1999; Lawyer, Ruggiero, Resnick, Kilpatrick, & Saunders, 2006; Martin, Cromer, DePrince, & Freyd, 2013; Molnar, Buka, & Kessler, 2001), some studies do not find support for this hypothesis (Bal, De Bourdeaudhuij, Crombez, & Van Oost, 2004; Lange et al., 1999). This discrepancy may be rooted in methodological differences. Several of the studies mentioned above investigated CSA without controlling for other forms of parental violence (Ketring & Feinauer, 1999; Lawyer et al., 2006), which may represent a comparable level of betrayal to the child. In one study where high-betrayal CSA (i.e., CSA perpetrated by a household member) was associated with worse mental health in adulthood, the inclusion of other adverse childhood experiences (including other types of violence and adversity in the family) fully mediated the association between betrayal and adult mental health (Edwards et al., 2012). Similarly, the two studies mentioned above that did not find support for an association between high-betrayal CSA and worse outcomes both found that other family factors (low family cohesion and emotional atmosphere in the family) were associated with mental health problems (Bal et al.,

2004; Lange et al., 1999). However, closeness to the perpetrator may not always be inferred from the relationship. For example, step-parents may have a parental relation to children in some families but not in other families.

One large study, which included more than eight thousand participants, found that high-betrayal CSA was associated with more PTSD, after controlling for other adverse childhood experiences and chronicity of abuse (Molnar et al., 2001). As many factors related to abuse may influence health outcomes after abuse and as the overlap with other types of childhood violence is high, a large sample may be necessary to detect small differences in health that are associated with the victim-perpetrator relationship and controlled for relevant background factors.

Sexual violence, including rape and CSA, has received much research attention, and there is some evidence that this type of violence is more strongly associated with mental health problems than other types of violence. In a national comorbidity study in the U.S., rape was found to be the PTE that is most strongly associated with PTSD (Kessler et al., 1995). Kilpatrick and colleagues found that victims of completed rape were more likely to meet criteria for PTSD than other crime victims (Kilpatrick et al., 1989), and Norris found sexual assault to have the strongest association with PTSD out of ten different events (Norris, 1992). One population study also found rape to be the crime that women, both victims and non-victims, fear the most (Walby & Allen, 2004) p. 54).

CSA has been the subject of much research in previous decades, and a range of associated outcomes, including mental health problems, such as depression, borderline personality disorder, substance abuse, PTSD, dissociative disorders, suicide attempts, and eating disorders, have been identified in literature reviews (G. Andrews, Corry, Slade, Issakidis, & Swanston, 2004; Putnam, 2003). However, much of the research on CSA does not take into account other types of childhood violence, which may co-occur with CSA. The hypothesis that sexual violence is more detrimental than other forms of violence may be challenged when a broad range of violent events, including events that often go un-assessed, such as psychological violence and childhood neglect, are taken into account. Thus, while sexual violence is found to be detrimental to health, whether or not such violence is more detrimental than other types of violence is not clear.

Findings show that both childhood and adulthood violence are associated with adverse health outcomes (Campbell, 2002; Kilpatrick et al., 2003; WHO, 2002). Whether childhood violence is more detrimental for health than violence in adulthood is not clear. One study found that cumulative violence in childhood was associated with a more complex symptom constellation than cumulative violence in adulthood in a clinical sample (Cloitre et al., 2009). One study found no differences in comorbid axis I disorders in PTSD patients with childhood trauma versus PTSD patients with adulthood trauma, although the childhood trauma patients did exhibit more anger

and dissociation (Hagenaars, Fisch, & van Minnen, 2011). However, this study was small and did not control childhood and adulthood violence for each other.

There is some evidence that age at childhood trauma exposure is associated with adverse outcomes; however, this association may not be straightforward (i.e., the younger the child, the worse the outcome). Rather, some findings lend support to the hypothesis that there are sensitive periods for particular developmental tasks. Yehuda and colleagues found that the nature of PTSD symptoms in adults who experienced the Holocaust as children was related to their developmental stage during the Holocaust; those who were younger had fewer intrusive symptoms but more amnesia, emotional detachment and hypervigilance than those who were older. The authors suggest that certain intrusions, such as disturbing thoughts, may require more developed capacities for mental representation and language (Yehuda, Schmeidler, Siever, Binder-Brynes, & Elkin, 1997). The impact of trauma on the developing brain may also differ according to sensitive periods. One study found associations between CSA at ages 3-5 years and 11-13 years and reduced hippocampal volume, CSA at age 9-10 years and reduced corpus callossum volume, and CSA at age 14-16 years and reduced frontal cortex grey matter volume (Andersen et al., 2008).

The consequences of childhood violence may thus persist long into adulthood; however, such consequences are not likely to be independent from what happens between violence exposure and the measurement of symptoms in adulthood (Pratchett & Yehuda, 2011). A child who is removed from an abusive environment, receives treatment, and is placed in an environment with good caregivers, where he or she can thrive, may display less (but not necessarily no) symptoms in adulthood than a child who grows up in an abusive family, does not receive treatment, and remains in an adverse environment into adulthood. Childhood violence may impact adult health through various mechanisms, including neurobiological alterations, behavioral problems, and revictimization (Pratchett & Yehuda, 2011).

1.2.5. Multivictimization.

Victims of violence often experience more than one type of violence (Herrenkohl & Herrenkohl, 2009; Kessler et al., 2010). The phenomenon of overlapping violence experiences is not easily categorized. Researchers have coined and investigated concepts such as revictimization (Classen et al., 2005; Widom et al., 2008), polyvictimization (Finkelhor et al., 2007), polytraumatization (Gustafsson, Nilsson, & Svedin, 2009), multivictimization (Kennedy, Tripodi, & Pettus-Davis, 2013) and the total number of adverse childhood experiences (Felitti et al., 1998), often referring to somewhat different but overlapping phenomena. In addition, studies of a particular traumatic experience often include prior trauma (Ozer et al., 2008). This lack of clarity

and consensus probably stems in part from the complex natures of the phenomena in question. One violent event can have elements of different violence types, such as an assaultive rape that also involves physical violence. Within one category of violence, an event can be single and discrete or a pattern of repeated acts. The same perpetrator can be violent in different ways; severe physical violence from parents against a child repeated over time will often involve some element of psychological violence as well. Certain violent intimate relationships may involve a pattern of control, incidents of severe physical violence, and threats, which may form a 'coercive bond' (Herman, 1992), in which different types of violence may be indistinguishable for the victim.

When health is the outcome, there is evidence that the number of different categories of violent experiences may be of particular importance (Edwards, Holden, Felitti, & Anda, 2003; Higgins & McCabe, 2000). Such multivictimization is not the same as repeated violent experiences of the same type. Multivictimized individuals have by definition experienced more than one violent event, but the notion that the violence they experience is directed at separate areas of their lives, often from different perpetrators, or at multiple stages in their development, may have additional negative impact. Finkelhor and colleagues hypothesize that negative self-attributions may be harder to resist when an individual is multivictimized (Finkelhor et al., 2007). Victimization in different arenas, such as at home and at school, may deprive the individual of 'safe places' and reinforce a feeling that there is no escape. Victimization from different perpetrators or at different times in life, such as when victims of childhood violence are revictimized, may make attributions that 'it will never stop' or 'there is something wrong with me because this happens again' more likely.

Multivictimization in childhood is found to be associated with health problems in a graded relationship. The more adverse childhood experiences are reported, the more likely the individual is to have experienced mental health problems, including anxiety and depression, somatic health problems, obesity, substance abuse problems, and reduced levels of functioning, including sexual dissatisfaction and high levels of stress (Anda et al., 2006). Previous experiences of trauma, particularly trauma that involves assaultive violence, have been found to be associated with PTSD after an index trauma in adulthood (Breslau, Chilcoat, Kessler, & Davis, 1999). The odds of PTSD, depression and substance abuse have been found to increase with the number of different categories of violent events (Hedtke et al., 2008). Two large meta-studies of risk factors for PTSD have found that having experienced a previous traumatic event (before the index trauma) was associated with PTSD (Brewin et al., 2000; Ozer et al., 2008).

1.2.5.1. Revictimization. Exposure to violence in childhood is a risk factor for violence exposure in adulthood, a phenomenon that is often called revictimization (Classen et al., 2005; Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007). Revictimization research has traditionally tended to focus on CSA and subsequent sexual assault, finding these two types of violence to be strongly associated (Classen et al., 2005). The suggested mechanisms by which this association occurs include sexual risk behaviors, perhaps due to emotion regulation problems or low perceived sexual control (Messman-Moore, Walsh, & DiLillo, 2010; Walsh et al., 2013). Such behaviors may make individuals vulnerable to new incidents of violence. The characteristics of the violent event that are pertinent for health problems may influence vulnerability to later victimization, although this potential link has been subject to less investigation than the link between event characteristics and health.

DePrince (2005) hypothesizes that the learning of betrayal detection in social contracts may be compromised in individuals who experience childhood abuse, which might make such individuals vulnerable to new experiences with violence. One study of an undergraduate sample found that survivors of high-betrayal trauma in childhood (violence from someone with whom they were very close) were more likely to have been victimized in adulthood (Gobin & Freyd, 2009), but little is known about how differences in the perpetrator relationship relate to revictimization in large community samples.

Increasingly, revictimization research broadens the scope from sexual violence, finding that other types of violence, alone or in combination, may be associated with subsequent victimization (Whitfield, Anda, Dube, & Felitti, 2003; Widom et al., 2008). However, there is a need for more research, particularly studies that encompass many types of violence.

1.2.6. A gender perspective on violence.

Violence is gendered in the sense that exposure to violence differs systematically between men and women. While men experience more physical violence from non-partners, women experience more sexual violence and more severe IPV (Haaland et al., 2005; Kessler et al., 1995; Norris, 1992; Walby & Allen, 2004). Thus, some of the violence characteristics that have been outlined as potentially particularly adverse (that is, sexual violence and violence in close relationships) may befall women disproportionally. Certain types of violence, such as IPV, entail a high likelihood of being repeated (Garcia-Moreno et al., 2006), which may imply that women experience repeated incidents more often (Walby & Allen, 2004).

Women have a higher conditional risk of PTSD, a notion that may be partially (but probably not completely) explained by the kind of violence to which women are exposed (Breslau,

2009; Olff et al., 2007; Tolin & Foa, 2006). Other factors that may contribute to the observed gender difference include neuroendocrine differences and coping styles (Olff et al., 2007), as well as emotional reactions, such as shame and guilt. Women are also found to have a higher prevalence of depression and anxiety (Kessler, Chiu, Demler, & Walters, 2005), mental health problems that are associated with violence (see page 8). The 'gendered' nature of violence has led to claims that violence exposure may at least partly explain gender-based differences in depression (Campbell, 2002).

Feministic approaches in violence research have contributed tremendously to the recognition of the violence women experience and the detrimental effects that such violence may have on their lives (Heise, 1998; Herman, 1992). However, such approaches fail to explain certain aspects of violence, such as individual variability in violence perpetration among men who are presumably exposed to the same patriarchal traditions (Heise, 1998), women's violence against children, and the notion that women may be violent towards their male partners in ways that are not consistent with self-defense (Winstok, 2011). Gender symmetry or asymmetry in IPV victimization and perpetration is not straightforward and has been subject to much debate and partially contradicting findings (Archer, 2000; Dobash, Dobash, Wilson, & Daly, 1992; Johnson, 1995; Johnson, 2008; Straus & Gelles, 1987).

The social responses to survivors of trauma and violence may differ according to gender. Men and women may also differ in how they perceive the responses of those around them; one study found that women received more negative feedback from others after trauma than did men and were more adversely affected by that feedback (B. Andrews, Brewin, & Rose, 2003). This finding could imply that women would experience more shame and guilt after violence, a hypothesis which will be discussed further on page 24.

1.3. Shame and guilt after violence

1.3.1. Emotion theory. Emotion is a complex phenomenon that has neurophysiological, motor-expressive, and experiential components (Izard, 1977). The main purpose of emotion is thought to be connected to motivation, representing humans' most pervasive motivational system (Izard, 1977, 2011). While some emotion theorists view emotional activation as general and claim that the distinction between different emotions is contingent on cognitive appraisal processes (Barrett, 2006; Clore & Ortony, 2008; Schachter & Singer, 1962), other theorists distinguish between several discrete emotions that are evolved and shared by all humans (Izard, 1977, 2011; Panksepp, 2007; Tomkins, 1963b). According to Izard, each of these discrete first-order emotions has unique motivational properties that allow the individual to respond adaptively to the eliciting

situation without a component of cognitive processing (Izard, 1977, 2011). Tomkins (1963b) recognizes nine basic emotions, which include shame but not guilt. For Ekman and Cordaro, neither shame nor guilt is included among the seven basic emotions, although those authors note that both emotions have nearly all of the qualities that distinguish basic emotions[1] (Ekman & Cordaro, 2011). Lewis claims that while primary emotions emerge within the first six months of human development, self-conscious emotions, including shame and guilt, depend upon more sophisticated cognitive mechanisms, which do not develop before the second year of life (M. Lewis, 2008a). First-order or basic emotions are thought to occur in their pure form less often with development. As individuals develop and have experiences with various emotion-eliciting situations, cognition-emotion interactions become more important in emotional experiences (Izard, 2007, 2011).

Tomkins holds that affects refer to distinct physiological activations, while emotions refer to the combination of a physiological component with the memory of previous experiences the individual has had with that affect; the feeling component refers to the component of the emotion that is consciously available (as described by Kelly, 2009; Nathanson, 2008). The neurobiological component of emotion involves brain structures, such as the amygdala, the hippocampus and the sensory cortex (LeDoux & Phelps, 2008). In the following section, the emotions of shame and guilt will be considered in depth.

1.3.2. Theoretical perspectives on shame and guilt. Shame and guilt are seen as social emotions (P. Gilbert, 1997). From an evolutionary perspective, the purpose of these emotions may be related to smoothing relations in social groups in different ways; while shame typically elicits hiding or submissive strategies, guilt more often elicits reparation and care (P. Gilbert, 1997). These emotions may be studied as underlying traits, that is, the individual's proneness to respond with either emotion (Tangney, Dearing, Wagner, & Gramzow, 1997). Alternatively, shame and guilt can be studied in relation to certain features of the individual, such as body-shame (B. Andrews, 1995; P. Gilbert & Miles, 2002), or in relation to specific situations, such as shame and guilt after trauma. In the following sections, shame and guilt proneness will be discussed briefly before considering trauma-related shame and guilt.

Shame may be defined as "a painful affect, often associated with perceptions that one has personal attributes (e.g. body shape, size or textures), personality characteristics (e.g. boring, unintelligent or dishonest) or has engaged in behaviors (e.g. lying, stealing) that others will find

[1] According to Ekman and Cordaro, it is uncertain whether shame and guilt have distinctive signals that separate them from sadness signals.

unattractive and that will result in rejection or some kind of put-down" (P. Gilbert, 2000). Shame, then, functions to warn the individual that his or her social position is under threat and may trigger hiding behavior (P. Gilbert, 1997). The emotional display of shame is recognized by multiple authors as involving eye-averting, blushing, and a slumping of muscles in the neck and shoulders that involves looking away and appearing smaller (Darwin, 1872; Izard, 1977; Nathanson, 1992). According to Nathanson, the behaviors that are elicited to defend the individual from shame typically fall into four major patterns: attacking another person, attacking the self, withdrawal, and avoidance (Nathanson, 1992). Thus, while Gilbert defines shame as being rooted in submissive behavior, Nathanson also includes attacks on the self and on others. Many theorists have noticed that shame is closely linked to anger; for example, the term 'humiliated fury' describes an anger reaction to the experience of shame (H. B. Lewis, 1990). Alternative definitions emphasize other aspects of shame, for example that it is a global devaluation of the self (M. Lewis, 2008b; Tangney & Dearing, 2002a).

Guilt can be defined as "an unpleasant feeling with an accompanying belief that one should have felt, thought or acted differently" (Kubany & Manke, 1995). Guilt is often thought to be related to the devaluation of specific behaviors rather than to the devaluation of the self as a whole, as found in shame (Tangney & Dearing, 2002a; Tangney, Wagner, & Gramzow, 1992; Wilson, Droždek, & Turkovic, 2006). Guilt is also a painful feeling, although perhaps less intensely painful than shame. The behaviors elicited by guilt typically relate to reparations of the harm that is caused (P. Gilbert, 1997; M. Lewis, 2008b; Tangney & Dearing, 2002c), a task that is presumably easier than the task required to alleviate shame, which would mean changing the global self. For this reason, many authors have claimed that guilt is more adaptive than shame (M. Lewis, 2008b; Tangney & Dearing, 2002b). This claim has been debated and is still not resolved, leading some to separate guilt theorists into two different schools (Tilghman-Osborne, Cole, & Felton, 2010). The debate centers around findings that while shame is consistently associated with adverse outcomes, including mental health problems, guilt is often found to be unrelated to such outcomes or to be inversely associated with such outcomes (Street & Arias, 2001; Tangney & Dearing, 2002b; Tangney et al., 1992). Findings that guilt is neutral or positive often result from studies that measure shame and guilt using the Test of Self-Conscious Affect (TOSCA, as cited in Tangney & Dearing, 2002), a scale that presents respondents with vignettes of social situations and then instructs them to choose how they would respond from a set of possible responses. The TOSCA has been used extensively but has also been criticized, among other things for its tendency to measure only maladaptive aspects of shame and only adaptive or prosocial aspects of guilt (Luyten, Fontaine, & Corveleyn, 2002; Silfver, 2007). The idea that emotions are either

adaptive or maladaptive does not fall easily into the prevailing research tradition focused on emotion, which tends to view all emotions as bearing the potential for being both adaptive and maladaptive, depending on the cognitions and actions that are triggered by the emotions (Izard, 1977; Nathanson, 1992; Tomkins, 1963b). The debate about the adaptiveness of guilt may be transferred to the study of guilt after trauma, although the findings are somewhat distinct from those reported concerning general guilt-proneness. Trauma-related guilt may serve purposes for an individual; however, categorizing trauma-related guilt as an adaptive (and hence, adequate and welcome) response to trauma seems unfit for many traumatic experiences[2]. When guilt is studied in a trauma or violence context, it is generally found to be associated with negative outcomes. However, many studies do not control for the co-occurring effects of shame, and it is therefore not certain whether trauma-related guilt is associated with negative consequences independently of shame (see Pugh, Taylor, & Berry, 2015, for a meta-analysis on guilt and PTSD).

1.3.3. Trauma-related shame and guilt. The notion that victims may blame themselves for the violence they have suffered has been noted frequently. Janoff-Bulman found that the blame attributions of women who had experienced rape could be categorized into blaming themselves for something they did or did not do in the situation (behavioral self-blame) or blaming the event that had befallen them on some aspect of the self (characterological self-blame; Janoff-Bulman, 1979). Janoff-Bulman's two types of self-blame may resemble guilt and shame, respectively, in some aspects (e.g., in that guilt is described as more behavior-oriented, whereas shame involves a global judgement of the self; Wilson et al., 2006) but not in others. Both emotions have been studied after various violent events, including sexual violence (Feiring, Taska, & Lewis, 2002), IPV (Beck et al., 2011; Street & Arias, 2001), extra-familial violent attacks (shame; B. Andrews, Brewin, Rose, & Kirk, 2000), and combat experiences (Kubany, 1994). Shame and guilt after trauma have been found to be associated with mental health problems, including PTSD (B. Andrews et al., 2000; Pugh et al., 2015) and depression (Kim, Thibodeau, & Jorgensen, 2011). Some mechanisms by which this association may occur are outlined below. In the fifth edition of the DSM (American Psychiatric Association, 2013), shame and guilt are part of one symptom criterion for the PTSD diagnosis.

It may seem unreasonable that victims of violence experience shame and guilt. The last two decades have seen an increase in attempts to explain these phenomena. Lee, Scragg & Turner

[2] Whether or not it is adequate in certain situations (e.g., with combat veterans who have participated in atrocities) can be debated. See Kubany (1994) for a discussion of this issue, which concludes that the question of whether or not certain patients (combat veterans) should feel guilt it is mostly not relevant in the clinical setting.

(2001) postulate a clinical model for shame- and guilt-based PTSD. According to this model, shame and guilt arise after trauma because of the meaning the individual prescribes to the event.

Shame-related trauma meanings are often associated with a loss of status in the eyes of others, the experience that the self is under attack, or the loss of social attractiveness (Lee et al., 2001). The experience of shame may be more profound if the trauma-meaning is congruent with the underlying schema than if it is incongruent. Budden (2009) similarly emphasizes the social nature of shame. In his model, shame may be a defensive peri-traumatic response to threats to the social self (as opposed to fear-based PTSD, in which the physical self is under threat) due to the experience of acute domination and subjugation or an acute violation of norms, values and world expectations (Budden, 2009). Building on these models, shame may arise from trauma when the trauma threatens an individual's sense of self (peri-traumatic shame) and may be maintained as the individual prescribes trauma-meanings that relate to self-attack or to the loss of status or social attractiveness. This view is in concordance with Gilbert's descriptions of shame in an evolutionary psychological perspective, wherein shame may serve as a warning to the individual that his or her social position is threatened. In line with this conceptualization, one study found that crime victims with high trauma-related shame reported shame for not having been able to prevent the crime, for looking bad to others and for humiliation and emotional responses to the event (B. Andrews et al., 2000).

The loss of status or social attractiveness after violence should be related to how the individual imagines that other people relate to the event and to the individual after the event has happened. It is well-established that social support is negatively associated with mental health problems after trauma (Brewin et al., 2000; Ozer et al., 2008). Negative social reactions after trauma have been found to be strongly associated with mental health after trauma (B. Andrews et al., 2003; Ullman, Townsend, Filipas, & Starzynski, 2007), underscoring the negative effect social rejection may have after trauma. It is not uncommon for people to blame victims of violence for their victimization. For example, the acceptance of rape myths, relating, among other things, to the victims' responsibility and behavioral responses, may influence both the immediate and more distant social surroundings of the individual, including the legal system (Grubb & Turner, 2012).

According to the model of Lee and colleagues (2001), guilt-related trauma meanings tend to involve violations of or departures from standards or behavior or a feeling of responsibility for causing harm to others. Kubany et al. (1995) and Kubany & Watson (2003) claim that the magnitude of guilt after a trauma depends upon distress about the outcome and upon four interrelated beliefs about the individual's role in the event: perceived responsibility for causing a negative outcome, perceived insufficient justification for actions taken, perceived violation of

values, and beliefs about foreseeability and the preventability of the negative outcome of the event. One important mechanism by which this process occurs is hindsight bias, in which an individual's knowledge of the outcome of an event biases the recollection of what he or she thought was going to happen before the outcome was known (Kubany & Watson, 2003). Another mechanism may be counterfactual thinking, in which the individual employs post-hoc mental constructions or mental simulations of alternative outcomes that might have come to pass had he or she acted differently (C. G. Davis, Lehman, Silver, Wortman, & Ellard, 1996). The act of imagining alternative actions and outcomes may become repetitive rumination (Lee et al., 2001).

Overall, the cognitions specified by Kubany and Watson are similar to the guilty trauma-meanings suggested by Lee et al. (2001); however, while the model proposed by Lee et al. specifies that guilt relates to harm caused to others, Kubany and Watson do not specify to whom the wrongdoing is done. This distinction has important consequences.

The causing of harm to others may seem unlikely with many victims of civilian violence, but may nonetheless occur. Herman (1992) gives a clinical example of a woman who was a victim of IPV and felt guilty that she had not been able to protect her children from witnessing the violent events. Victims of violent events with multiple victims may feel guilty that they survived when others died or that they were not physically injured when others were (Wilson et al., 2006). However, many violent events do not involve harm to anyone but the victim. For example, after an assaultive rape, it is unlikely that the victim should feel guilty about having caused harm to others[3]. Kubany and Watson's definition encompasses the experiences of individuals who feel guilty that they did not manage to prevent the harm they themselves suffered. In the example of the assaultive rape, the victim may feel that she is to blame for having been in the place where the rape happened at that particular time, for having been alone, or for not having been able to run away or fight off the perpetrator. This aspect of guilt corresponds to what is sometimes referred to as self-blame (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). Studies find that individuals may blame themselves when the event is perceived as foreseeable and when the self is seen as having some responsibility (C. G. Davis et al., 1996).

1.3.4. Shame and guilt and characteristics of the event. The characteristics of a violent event may be pertinent to the likelihood of shame and guilt after violence. A Japanese study found that among sexually victimized university students, a close relationship with the perpetrator was associated with a stronger association between shame and PTSD (Uji, Shikai, Shono, & Kitamura,

[3] However, she may feel guilty if her trauma experience influences others; for example, she may feel bad for how her PTS symptoms may influence those close to her.

2007). Sexual behaviors and feelings are thought to be closely linked to shame (Izard, 1977; Nathanson, 1992), which may have pertinence for sexual violence. CSA often involves stigma (Finkelhor & Browne, 1985), which has led to the hypothesis that CSA is particularly likely to result in shame. One study found that in comparison to victims of non-sexual traumas, sexual assault victims experienced more shame and guilt (Amstadter & Vernon, 2008). Violence during childhood may have a particular impact on an individual's likelihood of shame and guilt; the schemas formed in early childhood may mean that an individual experiences more profound shame and guilt in adulthood, particularly if he/she has been revictimized (Lee et al., 2001). When abused by their parents, children may choose to blame themselves as a survival strategy (Herman, 1992). Shame has been found to be associated with childhood abuse after a violent extra-familial crime in adulthood (B. Andrews et al., 2000).

According to the model of Lee et al. (2001), the total burden of violence (i.e., the number of different violent events) may impact shame and guilt after violence, a notion that was supported by two recent small studies: one of psychology undergraduates (La Bash & Papa, 2014) and one of male minor refugees (Stotz, Elbert, Müller, & Schauer, 2015).

Little is known about trauma-related shame and guilt after mass traumas, such as school shootings or terrorist attacks. The characteristics of such events may imply that they should be less shame- and guilt-inducing; they often evoke public attention and sympathy (Thoresen, Aakvaag, Wentzel-Larsen, Dyb, & Hjemdal, 2012), and they are considered to be unpredictable, as they befall victims who are typically not particularly vulnerable in terms of previous violence exposure and are perpetrated by non-close perpetrators who are often little known or unknown to the victims. The presence of these emotions in a population exposed to a mass shooting might indicate that shame and may be related to trauma and violence exposure beyond event characteristics, such as high betrayal and sexual violence.

1.3.5. A gender perspective on shame and guilt. Previous research has found that women receive more negative feedback after violence than men (B. Andrews et al., 2003), which suggests a possible gender difference in trauma-related shame and guilt. However, while a small gender difference in proneness to shame and guilt has been found (see meta-study by Else-Quest, Higgins, Allison, & Morton, 2012), studies comparing men and women's reports of shame and guilt after trauma find no or few gender differences (B. Andrews et al., 2000; Byers & Glenn, 2011; Kubany et al., 1995).

Thus, there are few studies that have investigated systematically and comparatively how different event characteristics are associated with shame and guilt. In addition, those studies that

have done so have tended to use small samples. Whether or not there are gender differences in trauma-related shame and guilt is not well understood.

1.4. Aims

In the current thesis, I aimed to investigate how characteristics of violence are associated with mental health, revictimization, and trauma-related shame and guilt. To achieve this aim, the first paper examined how specific constellations types of violence were associated with anxiety/depression symptoms in violence-exposed men and women (paper 1). I further investigated the interplay between characteristics by examining whether the relationship with the perpetrator was related to revictimization in women exposed to CSA and whether the type of violence and multivictimization were more strongly associated with the likelihood of subsequent violence (paper 2).

I investigated the characteristics of the violent event in association with trauma-related shame and guilt and examined the strength of the associations between types of violence and multivictimization and shame and guilt in comparison to associations between gender and trauma-related shame and guilt (paper 3). I investigated shame and guilt after mass violence, which has event characteristics that are presumably different from those of more private violence experiences (paper 4). The interplay between gender, shame and guilt, and mental health was examined after violent events in a general population, which are typically gendered, and after a specific violent event in which the exposure presumably did not differ systematically between genders (papers 3 & 4).

The specific aims and the research questions were as follows:

Paper 1:

The aims of the study were to:

1. Estimate the association between childhood violence exposure and adult violence exposure in the general Norwegian population.

2. Investigate the association between both childhood and adult violence exposure and adult mental health.

3. Investigate the importance of the various combinations of childhood violence.

Paper 2

1. What characterizes child sexual abuse (CSA) perpetrated by a parent compared to CSA perpetrated by other known or uknown persons in terms of event severity, overlap with other categories of childhood violence, and adult victimization?

2. Is childhood violence associated with adult rape and IPV, and if so, is CSA of particular importance?

3. How is the combined burden of multiple categories of childhood violence associated with adult victimization?

Paper 3

The research questions were as follows

1. Does our scale measure trauma-related shame and guilt as separate constructs, and do women report more of both these emotions than men do?

2. Are shame and guilt associated with different types of violence and with the number of violence types?

3. Are trauma-related shame and guilt independently associated with anxiety/depression symptoms?

Paper 4

In this study, we aimed to examine the extent to which trauma-related shame and guilt were associated with posttraumatic stress (PTS) reactions in a sample of survivors of a terrorist attack. We hypothesized that both trauma-related shame and trauma-related guilt would be associated with PTS in this sample of mass trauma survivors.

2. Methods

2.1. About the studies in this thesis. This thesis utilizes two samples: the prevalence study of violence and health in the Norwegian population and the Utøya Island study, in which a group of terror survivors were interviewed about their experiences and responses.

The prevalence study was part of the Norwegian government's action plan against family violence and was funded by the Norwegian Ministry of Justice and Public Security. The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) started preparing for the study in 2009, and data collection took place in the spring of 2013. Throughout the process, Professor Dean Kilpatrick was a collaborating partner and contributed to the project group, which otherwise consisted of researchers from NKVTS. I was invited to join the project group in August 2010, and I worked on the preparation and implementation of the study through data collection.

During this period, I contributed to discussions, selection, and the preparation of measurements, and together with Siri Thoresen, I made and tested the Shame and Guilt After Trauma Scale (SGATS). I also contributed to planning the strategy for data collection. When a collaboration with the data collection agency Ipsos MMI was established, I participated in the preparation for data collection, including the evaluation of cognitive testing and the piloting of the manual. I also participated in the training and follow-up of interviewers throughout the data collection process, and I listened in on interviews as they were conducted.

The Utøya Island study was founded by the Norwegian Directorate of Health and commenced shortly after the Utøya Island terrorist attack in July 2011. I contributed to the discussion, the selection of instruments and the practical planning and implementation of the study, including the instruction and follow-up of interviewers. I also worked as an interviewer on the study and interviewed young survivors and their parents.

Both the prevalence study and the Utøya Island study consist of multiple data collection waves. In this thesis, I will only use the first waves; hence, as they appear here, both studies are cross-sectional.

2.2. Participants and procedures

2.2.1. The prevalence study. A random sample representative of the Norwegian population was drawn from the Norwegian Population Registry, which contains birth date, sex and municipality of residence data for all citizens of Norway. The names were then matched with phone numbers by Ipsos MMI, which is a measurement institute that specializes in population surveys. All potential participants received an invitation letter, which provided a brief description of the study. A week or more later, the participants were called by interviewers from Ipsos MMI, unless they had contacted us and asked not to be contacted (899 people did this). Of the 40,000 people drawn from the Population Registry, 31,971 were matched with phone numbers. We attempted to make contact with 23,441 individuals and reached 9,647 individuals. A total of 4,527 individuals agreed to participate, resulting in a response rate of 42.9% when calculating based on the number of potential participants we managed to reach (comparable to a random digit dialing procedure, used by similar studies; Kilpatrick et al., 2003; Resnick et al., 1993). When calculating based on the sample of 40,000 people who were drawn from the population registry, the final sample constitutes a response rate of 11.7%. A flowchart is presented in Figure 3.

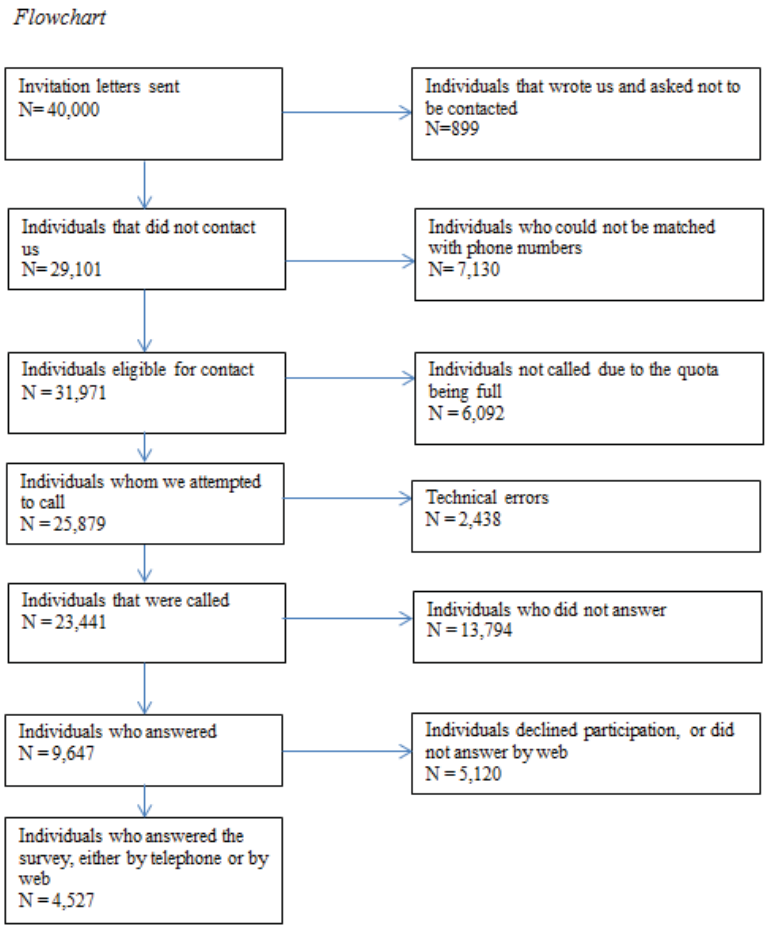

Figure 3: Flowchart

We used a computer-assisted telephone interview (CATI) approach in this study. Those who agreed to participate were interviewed by telephone. The interview included questions about experiences with violence and abuse, other stressful experiences, mental health, shame and guilt, social support, and contact with health services and the legal system. The computer program used by the interviewers was arranged to ensure that if the respondent answered affirmatively to the target questions about violence and abuse, follow-up questions about the experience appeared. The interview lasted for 24.5 minutes on average. When the respondents answered affirmatively to many target questions, the interviews were longer; in contrast, the interview was shorter for non-exposed individuals. The interview manual was pre-tested on exposed and non-exposed individuals. Cognitive interviews with those with whom we pre-tested the manual led to feedback that was used to adjust the interview manual.

Ipsos MMI selected among their interviewers those that they deemed fit for this study. Due to the sensitivity of the questions, the most experienced interviewers were chosen. All interviewers received special training for this study.

2.2.2. The Utøya Island study. On the 22nd of July, 2011, Norway was hit by a terrorist attack at two different locations. First, a bomb was exploded in the Governmental Quarter of Oslo, the capital of Norway, killing 8 people and wounding many more. A few hours later, the terrorist boarded a boat to Utøya Island, a small island in a lake that is 38 kilometers from Oslo, where the youth organization of the Norwegian Labour party held their annual summer camp. For 1 hour and 20 minutes, the terrorist walked the island, shooting at the 564 campers, killing 69 and injuring many more. The island is quite small (26 acres; it takes approximately ten minutes to cross the island by foot), so all of those present on the island were exposed to strong sensory impressions from the event, in addition to being in mortal danger for the duration of the attack. Many survivors lost close friends during the Utøya Island attack.

The research group received lists from the police with contact information for all those who were present on Utøya Island during the shooting. All survivors received an invitation letter from the present study and were subsequently called by an interviewer. A total of 165 survivors declined participation or were not reached by telephone. A total of 325 survivors were interviewed face-to-face, giving the study a response rate of 66.3%. The interviewers were selected carefully and were for the most part health personnel, primarily psychologists and medical doctors.

Table 1 below gives an overview of the main focus, participants and analytical method of each of the four papers included in the thesis.

Table 1: Main focus, sample and analytical method of each paper

	Main focus	Participants	Statistical analyses
Paper 1	Associations between child and adult victimization and their associations with mental health in adulthood	2,435 women and 2,092 men between 18 and 75 years, population sample	Chi square statistics Logistic regression and multiple regression analyses
Paper 2	CSA from parental vs. other perpetrators in terms of event characteristics Associations between CSA and non-sexual parental violence and adult victimization	2,435 women, population sample	Chi square statistics Logistic regression analyses
Paper 3	Shame and guilt after various types of violence; gender differences and associations with anxiety/depression symptoms	2,435 women and 2,092 men between 18 and 75 years, population sample	Confirmatory factor analysis T-tests Linear regression analyses Bootstrap BC_a CIs[1]

Paper 4	Associations between shame and guilt and PTS Gender differences in shame and guilt	325 survivors of a terrorist attack (mostly adolescents and young adults)	Chi square statistics Linear regression analyses

[1]Bootstrap bias corrected and accelerated confidence intervals

2.3 Measures

2.3.1. The prevalence study. Respondents were asked questions about their experiences with violence and abuse in childhood and adulthood, about different health and functional outcomes, and about health service utilization and the use of legal services. This section will describe those measures that were used in the studies included in this thesis. For the full questionnaire, see appendix 3.

Violence in childhood:

Child sexual abuse (CSA) was measured with one item selected from a web survey by Kilpatrick and colleagues (Kilpatrick, Resnick, Baber, Guille, & Gros, 2011), which included a small introduction adapted by the researchers for this study and read as follows: 'Sometimes children can be tricked, rewarded or threatened to engage in sexual acts they don't understand or are unable stop,' followed by the question, 'Before you were 13 years of age, did anyone who was at least 5 years older than you have any form of sexual contact with you?' Affirmative answers led to a series of follow-up questions, including whether or not the sexual contact involved penetration, the relationship to the perpetrator, if the respondent experienced one or more incidents, the respondent's age when the incident happened, and in the case of multiple incidents, the ages when the first and last incident happened. The respondents were also asked about whether or not they were afraid they would die or be severely injured, if they were physically injured, and several other questions. *Severe physical violence from parents* was measured by four items from the National Survey of Young Adults in the United States (Kilpatrick et al., 2003). The respondents were asked if they experienced any of the following from their parents before the age of 18: '1) hit with a fist or a hard object, 2) kicked, 3) beaten up, or 4) physically attacked in other ways?' Follow-up questions asked for information about the incident, such as age and injuries. *Psychological abuse from parents* was measured using one item from the Stressful Life-Events Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998), which reads 'Did your parent(s) repeatedly ridicule you, put you down, ignore you, or tell you that you were no good?' *Childhood neglect* was measured by two items from the Adverse Childhood Experiences study, which were slightly adjusted for the purpose of this study (Felitti et al., 1998): 'In your childhood, how often did you feel loved?' and 'In your childhood, how often did you feel that someone could

take care of you and protect you?' The answers were given on a 5-point Likert scale from 'never' to 'very often or always,' and for the purposes of this study, the answers 'never,' 'seldom' or 'sometimes' were defined as indicators of neglect. *Parental intimate partner violence (IPV)* was measured with four items from the National Survey of Young Adults (Kilpatrick et al., 2003), which asked if the respondents had seen or heard one parent slapping, hitting with a fist or an object, kicking, strangulating, or otherwise physically attacking the other parent. All questions about parental violence asked for behaviors from 'parents or other caregivers.'

Violence in adulthood/lifetime:

Forcible rape was measured using four separate items from the National Survey of Young Adults (Kilpatrick et al., 2003). The questions read as follows: 'Has anyone ever forced you into 1) intercourse, 2) oral sex, or 3) anal sex, or 4) put fingers or objects in your vagina or anus by use of physical force or by threatening to hurt you or someone close to you?' Forcible rape was defined as an affirmative answer to any one of these items. The follow-up questions asked for information about age, the perpetrator relationship, whether or not the respondent was injured, and several other characteristics of the incident. These questions measured forcible rape at any time during the respondent's life, including childhood. *Severe physical violence* was measured using 6 items from the National Survey of Young Adults (Kilpatrick et al., 2003). The respondents were asked if they had experienced the following violent acts after the age of 18 years: 1) hit with a fist or a hard object, 2) kicked, 3) strangulated, 4) beaten up, 5) threatened with a weapon, and/or 6) physically attacked in other ways. Affirmative answers to any one of these items led to a series of follow-up questions, in which, among other things, the respondents were asked about their relationship to the perpetrator of these violent acts. If the perpetrator was a partner or ex-partner, the experience was categorized as *intimate partner violence (IPV).* For those who experienced violence from other perpetrators (non-partners), a follow-up question about fear of sustaining injury was used as a criterion for categorizing the violent event(s) as severe physical violence. This restriction was implemented to ensure that minor events were not included. The respondents could report several violent episodes from different perpetrators and could thus report experiences with both IPV and severe physical violence from other perpetrators.

Violence characteristics:

Perpetrator relationship was recorded on a comprehensive list of possible relations, including family members, acquaintances, and strangers. For paper 2, we categorized CSA perpetrators into the following categories: parents (biological parents, step-parents or mother's or

father's girlfriend or boyfriend), other known perpetrators (other family members or people the respondent knew, such as teachers, leaders of activities, friends and neighbors), or strangers (both children and adults). *Early onset of CSA* was defined as onset before the age of ten years (Kliegman, Nelson, & Behrman, 2011). *Other CSA characteristics* used in the analyses included whether the respondent experienced a single event or multiple incidents; whether the abuse involved penetration; whether the respondent feared for her life or feared serious injury during the abuse; and whether she sustained physical injuries.

Shame and guilt:

We searched the literature for measurements of shame and guilt after trauma. While we did find one instrument for trauma-related guilt (Kubany et al., 1996) and one instrument for trauma-related shame (Øktedalen, Hagtvet, Hoffart, Langkaas, & Smucker, 2014), those instruments were not deemed fit for this study, as, among other things, they were adapted for use in settings where there is agreement that a trauma has taken place[4], such as in a clinical setting, rather than in a population study. We therefore decided to design our own questionnaire based on the strategy of the Trauma-Related Guilt Inventory by Kubany and colleagues (1996), a measure of the social side of shame (Other As Shamers; Goss, Gilbert, & Allan, 1994), and a measure of shame associated with specific features, such as body shame or behavior shame (the Experience of Shame Scale; B. Andrews, Qian, & Valentine, 2002). The resulting scale was tested on a college sample and adjusted accordingly. The scale was tested for the underlying factor structure and psychometric properties. We found support for the hypothesis that the scale measured two underlying factors, and the psychometric properties were acceptable (see paper 3). The scale also showed good psychometric properties when tested in two American samples: one student sample and one military veteran sample (Cunningham, 2015a, 2015b). In the current study, the Cronbach's alpha values were 0.84 for shame and 0.87 for guilt.

Anxiety/depression symptoms:

We measured anxiety and depression symptoms using an abbreviated 10-item version of the Hopkins Symptom Checklist-25 (HSCL-25; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), with five items measuring depressive symptoms in the previous week (feeling hopeless about the future; feeling blue; blaming yourself for things; feeling everything is an effort; and

[4] Questions such as 'as a result of my traumatic experience, I have lost respect for myself' have been found to work well with inpatients participating in a treatment program for trauma-related problems, such as PTSD (Øktedalen, Hoffart, & Langkaas, 2015); however, we decided that these questions were less appropriate when asking people about events that they may not consider to be traumatic or violent themselves.

feeling of worthlessness) and five items measuring anxiety symptoms in the previous week (suddenly scared for no reason; faintness, dizziness or weakness; feeling fearful; feeling tense or keyed up; and difficulties falling asleep, staying asleep). The responses were given on a 0-3 scale (not bothered – bothered a great deal), and the mean scores were calculated. Short forms of the HSCL have shown good psychometric properties in previous studies (Myhre, Thoresen, Grøgaard, & Dyb, 2012; Strand, Dalgard, Tambs, & Rognerud, 2003; Tambs & Moum, 1993). The Cronbach's alpha in the current study was 0.89.

2.3.2. The Utøya Island study

Posttraumatic stress (PTS) reactions were measured using the University of California, Los Angeles Posttraumatic Stress Disorder Reaction Index (PTSD-RI; Steinberg, Brymer, Decker, & Pynoos, 2004), which is a 17-item scale that measures symptoms of PTSD. The respondents reported how often in the last month they had experienced symptoms of PTS on a 5-point scale, from 'never' to 'almost all the time.' To ensure that the respondents had the same understanding of the frequency scale, the interviewers presented the respondents with a frequency sheet, which was marked with how many times during the previous month a symptom should have been present in order for it to be, for example, 'almost all the time.' The PTSD-RI measures PTS according to the DSM-IV-definition of PTSD (American Psychiatric Association, 1994).

Shame and guilt was measured by two items: 'I feel ashamed over something that happened during the terrorist attack' and 'I think that some part of what happened during the terrorist attack is my fault.' The items were taken from the extended PTSD-RI, which was added by the authors with the intention of measuring the new symptom clusters in the DSM-5 PTSD diagnosis ('Negative alterations in cognitions and mood'; American Psychiatric Association, 2013). At the time of the interviews, the DSM-5 was not yet in use, and consequently, these items were not included in the PTS score, in accordance with the instructions of the authors (Steinberg et al., 2004). As with PTS reactions, the respondents indicated how often in the past month they had experienced trauma-related shame and guilt on a 5-point Likert scale from 'never' to 'almost all the time,' which was standardized using a frequency sheet.

2.4. Statistical analyses.

Paper 1: We employed chi square statistics, logistic regression, and multiple regression analyses.

Paper 2: We employed chi square statistics and logistic regression analyses.

Paper 3: Chi square statistics and multiple regression analyses were employed. To investigate the properties of the scale used to measure trauma-related shame and guilt (the SGATS), we performed a confirmatory factor analysis. To estimate differences between odds ratios, we employed linear hypothesis testing and performed Bootstrap BC_a confidence intervals.

Paper 4: We used chi square statistics and multiple regression analyses.

The amount of missing data was generally low in both studies (percentages ranging from 0.1-5), and the data were consequently handled with complete case analysis. In paper 3, we performed multiple imputation to test if our results were affected by missing data. In all papers, we took great care to make conceptual decisions about the analytical strategy and which variables to include before performing any analyses, to ensure theoretically founded rather than empirical variable selection.

Chi square statistics, logistic and multiple linear regression analyses, and t-tests were performed in SPSS Statistics 20 for Windows (all papers). Bootstrapping and multiple imputation (paper 3) were performed using the R version 3.0.3 package. The confirmatory factor analysis (paper 3) was performed in Mplus.

2.5. Ethical considerations

Research on human subjects is regulated by the Helsinki Declaration, as well as national legislation (Act on medical and health research; Nylenna & Simonsen, 2009). However, considerations are often more complex than can be covered by legislation. Norwegian health research is required by law to gain approval from the Regional Ethical Committee, which obliges researchers to take extra care concerning the ethical considerations in their studies.

Research on violence and traumatic stress encounters some particular ethical challenges, as it requires people to report on experiences that are often painful to even think about. Trauma researchers may consider ethical issues in the following areas: Can talking about traumatic experiences be distressing or burdensome? Can talking about their experiences be dangerous for respondents? Can repeated exposure to stories about violence, abuse and other terrible events experienced by respondents be burdensome for the interviewer?

2.5.1. The prevalence study. Several ethical considerations were made when planning and conducting the prevalence study. First, as noted above, the participants might feel distress when being asked about experiences with violence. Costs, such as the potential for participants to feel stress, should be weighed against the benefits of the study, including the gathering of knowledge that is useful for policy makers and society. While some temporary distress during the study is

considered acceptable, given the benefits, strong and long-lasting discomfort should be avoided. A review found that across studies, the majority of those who experience distress still report that they benefitted from participation and that distress that interferes with functioning is rare (Newman, Risch, & Kassam-Adams, 2006). Nevertheless, researchers should do their best to minimize any distress that participants might feel. It is also important to make it clear that participation is voluntary and to have a safety net ready for the few participants who do feel an unacceptable amount of discomfort and distress.

Several steps were taken to prevent unnecessary stress for the participants in the prevalence study; for example, the interview was designed so that the respondent only had to report about a specific incident once. The behaviorally specific questions ensured that we did not have to use distressing words, such as 'rape.' After the interview, all participants were asked whether they felt that the interview had been distressing, and if they did, whether they needed to speak to someone about it. A total of 7.9% felt that some questions in the interview had been distressing, and of those that were distressed, 18.5% felt the need to speak to someone (1.5% of the full sample). Those who reported a need to speak to someone about their distress were asked whether they felt that they had someone to talk to or whether they needed a follow-up conversation. A collaboration was established with the Centre for Trauma Psychology, and for those who needed follow-up, a clinical psychologist independent of the research group was available to call participants for a one-hour telephone consultation, in which the need for further referral to health services was assessed. A total of 37 participants (0.8%) wanted this consultation.

Another consideration was whether participating in the study, or even being asked to participate, could put the respondents in danger. A particular concern was individuals who were living with violent and controlling partners. When crafting the invitation letter, care was taken to underscore that the respondent was randomly selected, in case someone else read the respondent's mail. The interviewers were instructed to ensure that the respondent was alone and in a private setting before commencing the interview. The interview was designed to ensure that most of the information that the respondent needed to provide was given with neutral words, such as 'yes' or 'no,' to ensure that if someone did overhear the conversation, they would not be able to infer its subject.

Participation in a telephone survey is generally not considered to be particularly invasive in respondents' lives, compared with other research (e.g., experimental testing of new medical procedures). Similarly, telephone surveys are not considered to entail many personal benefits for respondents (such as access to treatment, as might be the case in medical experimental research). Respondents may find that their contribution serves an important function that may benefit society,

and among those who reported experiences with violence and trauma, some may experience a benefit from being able to discuss their experiences with another person. Those who were put in contact with a psychologist might consider that to be a benefit. However, most participants probably had little or no particular benefit from the study. As the costs of participation were not high, we consider this situation to be acceptable.

Working closely with other people's traumatic and terrible experiences may impact professionals, a phenomenon that is described by terms such as compassion fatigue (Figley, 1995), secondary traumatization (Kassam-Adams, 1995) and vicarious trauma (Schauben & Frazier, 1995). These terms are most commonly used for therapists working with trauma victims; however, as our interviewers were instructed to ask people repeatedly about traumatic experiences, it was a concern that repeated exposure to stories of violence might influence the interviewers negatively. To prevent this outcome, self-care was part of the training for interviewers before the study started. The structural settings were adapted to meet this challenge (for example, by ensuring that interviewers could switch from this project to other, more neutral projects without losing work hours and by facilitating colleague support). Many respondents disclosed information to the interviewers that they had never before shared with anyone; for example, one third of women who had been raped had not told anyone about their experiences prior to the call from the interviewers. Feedback from the interviewers informed us that the project was not easy to work on due to these issues, but at the same time, the project was considered interesting, important and meaningful.

The prevalence study was approved by the Regional Committee for Medical and Health Research Ethics in South-East Norway.

2.5.2. The Utøya Island study. The ethical considerations taken during the planning and conduction of the Utøya Island study shared some of the features of those taken when conducting the prevalence study, but involved some additional challenges as well. The subjects of this study were adolescents and young adults who had recently experienced a life threatening trauma; many had lost friends, and all were the subject of massive attention, including attention from the media. The aim of the study was two-fold; in addition to gathering information, the study served a safeguarding function by aiming to put participants in need of help in contact with adequate services. For this reason, the interviewers were primarily trained clinicians, and they were instructed to assess whether or not the participants had unmet needs for help.

The young age of the respondents presented the research group with various dilemmas. In terms of which respondents should be included, it was decided that only participants over 13 years of age should be included, as this was the age limit for participation at the camp. There were a few

younger children who were present on the island that day, primarily children of adults who were working at the camp, and these children were excluded from the study[5]. Norwegian legislation obliges us to ask for parental consent for respondents under the age of 16 years. In cases where a child was in need of help, the parents were consulted, as obliged by legislation. Young respondents were informed about this possibility before the interview started, and such consultations were always discussed with the youth before they were implemented.

In the months following the attack, the survivors were the subject of attention and exposure in the media, a notion which made privacy issues particularly important in this research project. This issue needed to be handled during all stages of the project, including the contacts made from the research group to potential informants, data handling and storage, and the publication and communication of results.

As in the prevalence study, care for the interviewers was a concern. In the Utøya Island study, this concern had some additional challenges, as the interviewers were numerous, did not belong to a single organization, and were geographically located all over the country. In addition, the terrorist attack was a national tragedy that impacted not only those who were directly affected but also the general Norwegian population (Thoresen et al., 2012). Thus, the interviewers might feel personally affected by the event. To support the interviewers, we invited them to meetings in Oslo both before and after data collection, where they received training, learned about preliminary results, and were encouraged to share their interview experiences. During data collection, we provided helplines through which health personnel in the project group were available for interviewers, and we arranged a webinar about secondary traumatization and compassion fatigue with Dean Kilpatrick, who is an international expert, for the interviewers. The interviewers were also encouraged to share their experiences with colleagues and were organized in teams to promote colleague support.

The Utøya Island study was approved by the Regional Committee for Medical and Health Research Ethics in South-East Norway.

3. Results

3.1. Paper 1: Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population

[5] This was done in part to protect the youngest survivors. However, respondents who are excluded may feel that their contributions are less interesting or valuable. These issues should be considered before excluding participants and must be weighed against protection from the potential stress of participation in the study.

In the first paper, we found considerable overlap between different types of childhood violence. For both men and women, strong and significant relationships were observed between childhood violence and adulthood violence that was not restricted to violence within a similar category.

Both childhood violence and adulthood violence exposure were significantly associated with adult anxiety/depression. Anxiety/depression symptoms increased with the number of childhood and adult violence types experienced. Some differences were observed between different types of childhood violence and the association with anxiety/depression; those who were exposed to neglect and/or psychological violence reported more anxiety/depression than those who were exposed to sexual abuse alone or family violence. The combination of all three types of childhood violence (neglect/psychological violence, sexual abuse and family violence) yielded the highest association with anxiety/depression symptoms.

3.2. Paper 2: Adult victimization in female survivors of childhood violence and abuse: The contribution of multiple types of violence

The second paper examined the association between childhood sexual abuse and adult victimization in women. Women who were sexually abused by their parents experienced more severe CSA than those who were abused by other perpetrators with respect to some event characteristics but not others. Victims of CSA often experienced other childhood violence, particularly if the perpetrator was a parent.

CSA was associated with adult rape and intimate partner violence (IPV). When adjusted for background factors and other types of childhood violence, CSA was only associated with adult rape. All other types of childhood violence were associated with adult victimization in unadjusted models. In adjusted models, only parental psychological violence and witnessing parental IPV were associated with both types of adult victimization. Experiences of multiple types of childhood violence were significantly associated with both adult rape and IPV. The association was consistent with a hypothesized graded relationship between childhood and adult victimization, although not all contrasts were significant.

3.3. Paper 3: Broken and guilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse

The third paper investigated trauma-related shame and guilt after violence using the new shame and guilt after trauma scale (the SGATS). Our hypothesis that shame and guilt were

separate constructs was supported. Women reported significantly more trauma-related shame and guilt than men.

Of seven types of violence (CSA, rape before and after 18 years of age, severe physical violence from and between parents, severe violence from a partner and from non-partners in adulthood), all were significantly and independently associated with trauma-related shame and guilt in comparison to other adverse events. All associations withstood adjustment for gender, age and ethnicity. We found that the more types of violence an individual had experienced, the stronger was the association with trauma-related shame and guilt. Gender was significantly associated with shame and guilt after adjusting for the type and number of categories of violence and was therefore not fully explained by violence exposure as measured in this study. However, the regression coefficients for gender were significantly reduced in most of the adjusted models, and those coefficients were significantly lower than most of the coefficients obtained for violent events.

Both shame and guilt were uniquely associated with anxiety/depression symptoms. The association withstood adjustment for the amount of violence exposure and gender. Shame and guilt yielded significantly stronger associations with anxiety/depression symptoms than did gender, and shame yielded a stronger association with mental health than did guilt. We found indications that shame was more clinically relevant for mental health than guilt.

3.4. Paper 4: Shame and guilt in the aftermath of terror: The Utøya Island Study

In the fourth paper, we found that 4-5 months after the attack, 44.1% of the participants had experienced at least some guilt, and 30.5% of the participants had experienced at least some shame for something that happened during the attack in the previous month. More men than women reported no shame, but among those who did report shame, more women than men reported infrequent (rather than frequent) shame. No significant gender difference was found for guilt.

Shame and guilt were both uniquely associated with PTS reactions after adjusting for terror exposure, gender, and other demographics.

4. Discussion

4.1. Violence type and multivictimization. We investigated characteristics of the violent event that may be related to consequences of violence, including the relationship to the perpetrator, whether or not the event was sexual, and whether or not the event occurred in childhood. We found that all types of violence, including violence in childhood and violence in adulthood, were

associated with anxiety/depression symptoms (paper 1). Various types of childhood violence were related to adult rape and adult IPV among women (paper 2). All types of severe violence were associated with trauma-related shame and guilt (paper 3). Overall, our findings did not point to one type of violence as consistently worse than the other; rather, any experience of violence appeared to be related to the investigated consequences, regardless of the specific characteristics of the event. Across all types of negative consequences, the total number of violence types appeared to give the highest contribution to negative consequences. Although not all contrasts were significant, our findings were consistent with a graded relationship between multivictimization and negative consequences.

Two important points must be made about these findings. First, when considering violence in childhood, CSA does not appear to be in a unique position with respect to negative consequences. The focus on CSA has had a long tradition in the child maltreatment research field, although increasingly, large studies, including the ACE-study, focus on multivictimization or polyvictimization (Anda et al., 2006; Felitti et al., 1998; Finkelhor et al., 2007). When studies have focused on negative outcomes of CSA in childhood, they have often not controlled for other forms of violence (e.g. Dinwiddie et al., 2000; Messman-Moore & Long, 2000; Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). In paper 2, we found that among women, parental CSA rarely occurred without other types of parental violence co-occurring. Even when the CSA perpetrator was not a parent, approximately half of the women experienced some form of non-sexual parental violence. Thus, an exclusive focus on CSA may lead to an over-estimation of the consequences of sexual violence. In addition, the potential consequences of other types of childhood violence may be under-recognized. This is not to say that CSA is not harmful to children, as our findings demonstrate that CSA is associated with negative consequences. However, other types of childhood violence may be comparably adverse.

Second, the large overlap between different types of violence and their combined contribution to negative consequences implies a particular vulnerability among those who are multivictimized. In our findings, multivictimization appeared to be most important for mental health after violence. Adult experiences were more strongly associated with anxiety/depression symptoms for those who experienced violence in childhood (revictimized individuals). Revictimization, shame, and guilt all increased with the number of violence types experienced. This outcome is in concordance with findings from the ACE-study, as well as other studies (Anda et al., 2006; La Bash & Papa, 2014; Whitfield et al., 2003). The papers included in the present thesis contribute to the existing literature by utilizing a comprehensive definition of violence and by investigating consequences beyond health.

If the number of violence types, rather than sexual abuse, is the best marker of the severity of consequences, a broader assessment may help recognize those victims of sexual abuse who are particularly at risk for adverse consequences (Finkelhor et al., 2007), including mental health problems, revictimization and shame and guilt after violence. The failure to employ a broad definition may lead not only to the underestimation of specific types of violence but also to an underestimation of the total burden of violent experiences that an individual carries.

Importantly, as this study is a cross-sectional study, we must be careful when we assume directionality. While childhood violence must necessarily occur before adult violence, bias may influence the reporting of violent experiences, and associations with mental health may be influenced by such bias (see page 48 for a discussion), although longitudinal studies indicate that revictimization is not observed as a result of bias alone (e.g. Barnes, Noll, Putnam, & Trickett, 2009).

4.2. High-betrayal childhood violence and revictimization. In paper 2, we hypothesized that women who experienced CSA from parents would have been revictimized more often than women who experienced CSA from other perpetrators, in concordance with betrayal trauma theory. However, this hypothesis turned out to be nearly impossible to test when taking other types of childhood violence into account, as parental CSA rarely occurred without the co-occurrence of other types of parental violence. This finding adds to the point made above concerning the inclusion of other types of childhood violence in addition to CSA. Revictimization appeared not to be specific to the type of violence; for example, while CSA was associated with adult rape, so were psychological violence in childhood and witnessing parental IPV.

Building on betrayal trauma theory, victimized children may have impaired threat detection, as the betrayal of violence perpetrated by someone upon whom a child is dependent interferes with threat detection skill learning (DePrince, 2005). Originally, Freyd focused primarily on CSA (Freyd, 1996; Freyd, Deprince, & Gleaves, 2007); however, the theory implies that other forms of parental violence, such as severe physical and psychological abuse, may also entail high betrayal (Freyd et al., 2007). Our findings suggest that various types of parental violence are associated with adult rape and IPV; hence, if betrayal and impaired threat detection is a mechanism by which revictimization occurs, it may also be relevant for non-sexual types of parental violence.

Our findings point to childhood multivictimization as particularly important for revictimization in adult life. This finding is in agreement with previous studies that showed that the co-occurrence of physical abuse increases revictimization risk after CSA (Classen et al., 2005)

or that the number of categories of childhood violence is associated with revictimization (Whitfield et al., 2003; Widom et al., 2008).

Thus, childhood violence exposure may create vulnerability to subsequent violence; however, a competing hypothesis is that the association between victimization in childhood and victimization in adulthood is explained by shared risk factors, including childhood social disadvantage or family instability. While this hypothesis probably explains some part of revictimization, previous research implies that childhood victimization places an individual at risk for adult violence beyond shared risk factors (Classen et al., 2005; Fergusson et al., 1997). The relative contributions of social disadvantage and maladaptive coping strategies or impairments that result from violence exposure are not clear and require further investigation.

4.3. Shame and guilt after violence: Conceptualization and measurement. A defining feature of shame is the belief that others would devalue or reject the individual should they learn about that for which the individual feels shame (P. Gilbert, 2000). In the setting of violence, individuals feel shameful when they think or fear that other people would reject or devalue them should they come to know about their violent experiences. This notion was reflected in the shame items of the new measure, the Shame and Guilt After Trauma Scale (SGATS; paper 3), which measured worries about what other people think of you after what happened, attempts to conceal what happened, feelings of shame about what happened, and looking down at yourself for what happened. As measured by the SGATS, the shame-response reflects to a large extent individuals' assessment of the potential or actual reactions to the violence experience from their social surroundings.

The social surroundings may include both close or personal relationships (family, friends, and acquaintances) and the more distant social context (cultural and social norms and attitudes, such as how violence survivors are generally portrayed, for example in the media). The assessment that the victim makes about his or her social relationships, including the reaction that the disclosure of violence is likely to be met with, may or may not be accurate. The costs of being met with devaluation or rejection after disclosing a painful experience may be high. Studies have found that victim blaming and negative social support are associated with mental health problems after exposure to violence (B. Andrews et al., 2003; R. C. Davis, Brickman, & Baker, 1991). According to one study, many child victims of CSA fear or feel ashamed of parental responses to their disclosure, and many parents respond by blaming the child or acting angry (Hershkowitz, Lanes, & Lamb, 2007). In addition, victims are often blamed by others for the violence they experience (Grubb & Turner, 2012). Thus, an individual may choose not to disclose when the

potential for rejection or devaluation is present, even if she does not estimate the likelihood to be high; to expect support and be met with rejection may be too high a price to pay.

Shame is a painful affect that is associated with adverse outcomes (Kim et al., 2011), but in this context, shame may nevertheless serve a purpose in the sense that it may motivate behavior that allows the violence survivor to avoid devaluation and rejection in her/his social group. However, shame may be costly for the individual. Non-disclosure prevents others from being supportive. A violence survivor who assesses that disclosure would result in rejection and therefore hides his experience from friends and family is effectively cut off from the possibility of having these views challenged, for example by experiencing that his family does support him after all and that his friends show concern for him rather than devalue or reject him. This potential corrective experience may promote mental health, in concordance with social support research (Thoits, 2011). Thus, in addition to being painful, shame is a lonely feeling.

Guilt is more behavior-oriented and specific than shame (e.g. Wilson et al., 2006). The SGATS measures bothersome thoughts about things that could have been done differently before or during the event, feelings of wrongdoing, self-blame, and feelings of guilt.

Beliefs about actions that should have been taken (or should not have been taken) can be linked to the cognitive phenomenon of hindsight bias, as described in the introduction (Kubany & Watson, 2003). An example can be a victim who in hindsight assumes that her ex-partner's violent tendencies were evident to her when she first met him. Brewin (2003) also describes how hindsight bias may affect onlookers when people defend their own sense of invulnerability when confronted with other people's traumatic experiences by blaming victims for not being able to foresee or prevent the violence they have experienced.

Trauma-related guilt may also serve purposes for an individual during a violent experience, although in a different way than shame. Guilty feelings imply that something could have been done differently by the individual to either prevent the violent event or make its outcome less detrimental. Janoff-Bulman (1979) has linked behavioral self-blame among rape victims to perceptions of control. To have been truly helpless during the event is likely very threatening for the victim; however, if she thinks that she could have done something differently, she has had some control. This belief may be preferable to being completely helpless, with no control over what happened or whether it will happen again. Guilt may thus be the price paid to avoid helplessness.

In this study, we introduced the SGATS (paper 3). The results from the confirmatory factor analysis supported our hypothesis that shame and guilt are different latent constructs, as assessed by this measure. Both the shame and guilt scales showed excellent internal consistency in this

study. The SGATS has also been included in other studies: both in follow-up data collection in the Utøya Island study and in an American study of trauma-related shame and guilt among students and military samples, where it showed good internal consistency (Cunningham, 2015a, 2015b).

4.4. Violence, shame and guilt, and mental health. We found that shame and guilt were independently related to anxiety/depression symptoms (paper 3) and PTS reactions (paper 4). Thus, both studies imply that both emotions are associated with mental health. This finding may indicate that the relation of these emotions to such symptomatology is at least partially dependent on different mechanisms. Lee et al. (2001) propose that shame and guilt may contribute to PTSD through specific mechanisms, including the trauma meaning's correspondence with previous schema. Guilt meanings concerning issues that include responsibility and hindsight bias may differ from shame meanings, which are concerned with the loss of status and social attractiveness, and attacks on the sense of self. Our findings in paper 3 indicate that shame contributes more to mental health problems than guilt. A recent study found that high levels of pre-treatment shame and guilt predicted PTSD symptomatology during the course of treatment in traumatized inpatients (Øktedalen et al., 2015).

Trauma-related shame and guilt are emotional reactions. The prevailing theory views emotions as evolutionarily evolved phenomena (Izard, 1977; Tomkins, 1963a); thus, all emotions should have the potential for being adaptive. Although both emotions may serve purposes for the individual, they are associated with mental health problems (Kim et al., 2011; Pugh et al., 2015). The directionality of this association is not given; it is possible that mental health problems lead to shame and guilt. Andrews and colleagues found that shame one month post-event predicted PTSD six months post-event, even after adjustment for PTSD symptoms one month post-event (B. Andrews et al., 2000), giving some support to the hypothesis that shame is a precursor of PTSD; however, additional longitudinal studies of different trauma- and violence-exposed populations are necessary to establish how these factors relate to each other over time. An alternative hypothesis may be that high violence exposure or particularly harmful event characteristics result in high shame and guilt, as well as high anxiety/depression scores (Pugh et al., 2015). The purposes that shame and guilt may serve for the individual, as discussed above, could imply that shame and guilt are efforts to cope with high exposure to violence. However, our findings show that these emotions are associated with anxiety/depression symptoms even after adjusting for exposure. Thus, while all single types of violence, as well as multivictimization, are associated with shame and guilt, the associations of these events with anxiety/depression symptoms are probably not fully explained by the amount of violence to which the individuals are exposed.

4.5. Shame and guilt after a terrorist attack. Our findings imply that violence is associated with shame and guilt. Previous studies have often focused exclusively on sexual violence or IPV (Beck et al., 2011; Feiring, Taska, & Lewis, 2002; Miller & Wright, 1995; Street & Arias, 2001; Uji et al., 2007), with some notable exceptions (Amstadter & Vernon, 2008; B. Andrews et al., 2000; La Bash & Papa, 2014). In this study, a broad range of violent experiences were associated with shame and guilt.

Findings from the Utøya Island study (paper 4) indicated that trauma-related shame and guilt were not uncommon after a specific violent event in which the perpetrator was unknown to all victims before the event and which did not entail sexual abuse. This finding may imply that shame and guilt after violence and trauma are not contingent on stigmatized aspects of the events. Instead, it is possible that these emotions are one part of a more general response to frightening or traumatic events. Shame after the Utøya Island shootings is unlikely to be associated with trying to hide the fact that the event has happened (the event received massive media attention, and for most victims, surroundings would know already that they were there). However, survivors may have experienced the event as humiliating or felt that some part of them was exposed to others as result of the event, in line with previous findings that the fear of looking bad to others is a commonly reported reason for shame after violence (B. Andrews et al., 2000). Guilt, in the sense of self-blame, is often linked to whether the event was considered predictable and whether the individual considers him/herself to be responsible (C. G. Davis et al., 1996), which may seem unlikely in this situation. However, when the consequences are grave and irreversible, individuals may be highly motivated to think about alternative actions, and hindsight bias may lead them to experience guilt (Kubany & Watson, 2003). Thinking counterfactually has been found to be associated with guilt (Mandel & Dhami, 2005). Counterfactual thinking involves constructing alternative outcomes of situations, such as "if only I had done something differently (e.g. insisted that we run the other way), a negative event (e.g. the death of my friend) would have been avoided." Additionally, even though the public overwhelmingly expressed their support for the victims, there were instances in which critical comments concerning the survivors' actions during the event were raised in the press, on TV and in social media. Such comments may have been particularly hurtful because they were raised publicly.

Our findings contribute to the existing literature by showing that the victims of a mass trauma experienced shame and guilt, which were associated with mental health problems. However, we did not investigate previous violent experiences, which may influence the

occurrence of shame and guilt after the Utøya Island attacks. Future research should investigate the role of previous violence exposure when investigating shame and guilt after mass trauma.

4.6. Shame, guilt and gender. We found no gender differences in guilt and a mixed gender difference in shame in the Utøya Island study. The few studies that have compared trauma-related shame and guilt among male and female trauma survivors of the same kind of event have reported similar findings; one study found no gender difference in shame after extra-familial violent crimes, and one study found no gender differences in shame and guilt among men and women who had experienced sexual coercion (B. Andrews et al., 2000; Byers & Glenn, 2011). In contrast, we found small but significant gender differences in both shame and guilt in the prevalence study, with women having more of both emotional responses. These gender differences were still significant after controlling for violence exposure. There may be several reasons for this inconsistency in findings.

First, there were gender differences in the types of violence that were not controlled for, including other types of sexual coercion and stalking (Thoresen & Hjemdal, 2014). An alternative explanation is that there really is a small gender difference in the amount of shame and guilt after violence. A recent meta-analysis of proneness to shame and guilt found that women have somewhat more of both emotions (Else-Quest et al., 2012). If this also holds true for trauma-related shame and guilt, a large sample may be necessary to find a small difference. The studies that found no or mixed gender differences in trauma-related shame and guilt all had substantially smaller samples than our prevalence study. An important issue to address is how large a gender difference must be in order for it to be relevant. The observed gender difference in shame and guilt was so small that it likely did not represent a noticeable difference for the individual. Thus, although we found a significant gender difference that was not fully explained by violence exposure, violence exposure appeared to be more important for shame and guilt than gender.

5. Methodological considerations

5.1. Response rate. One main problem in psychological research is selection bias, which refers to bias in how the respondents are entered into the study. If non-response is systematic according to one or more of the variables of interest, selection bias may influence the results. The prevalence study had an overall response rate of 42.9% when calculated based on the individuals we were able to reach, which is comparable to random digit dialing procedures (Kilpatrick et al., 2003; Resnick et al., 1993); however, the response rate was only 11.7% of the original sample drawn from the population registry (see the flowchart under point 2.2.1, page 28). The low

response rate is not a specific feature of this study; rather, there are indications of a trend of falling response rates (Atrostic, Bates, Burt, & Silberstein, 2001). When compared to the general Norwegian population, there were indications of a small positive bias among the respondents in terms of socio-demographic variables, including education, income and marital status. Compared to the original sample, the respondents were more often female and slightly older.

In an effort to achieve a sample representative of the Norwegian population, we drew 40,000 potential respondents from the Norwegian Population Registry, which is a registry of all citizens of Norway, and sent them invitation letters. As shown in the flowchart (Figure 3), the non-responders selected out of the study at different phases and included those we could not match with telephone numbers, those who contacted us and asked us not to call them, those who did not answer the phone, and those who did not wish to participate once we reached them.

The reasons for non-response are probably diverse. Victims of violence may be over-represented among those who could not be matched with phone numbers, for example due to an increased risk of living in institutions or living unstable lives (Dube et al., 2003; Flannery, Singer, & Wester, 2001). Previous victims of IPV may have unlisted phone numbers to avoid being contacted by the perpetrator, a phenomenon that is probably not common in a population sample, but which might none the less lead to an underestimation of severe IPV. Of those who were matched with phone numbers, many did not answer the phone. This may be due to busy lifestyles or attempts to avoid unwanted calls, such as calls from telemarketers. However, self-selection out of the study at this point may also have occurred due to the variables of interest. One hypothesis is that potential respondents who had experiences with violence perceived the survey (as described in the information letter) as more relevant to them and made themselves more available for interviewers. We tested for differences in the mean number of calls between exposed and un-exposed respondents on different types of violence under the assumption that the more calls that were necessary to reach an individual, the more similar that individual would be to those who never picked up the phone. Generally, the hypothesis that violence-exposed individuals made themselves more available was not supported (see Appendix 1, paper 1); however, fewer calls were necessary to reach women who were exposed to parental physical violence in childhood and men who were exposed to parental emotional violence in childhood. Thus, our results may overestimate the prevalence of these types of violence. The number of calls was not significantly associated with anxiety/depression symptoms.

While the study of associations between variables is presumably less affected by biased samples, prevalence estimates may be vulnerable (Gustavson, von Soest, Karevold, & Røysamb, 2012). Bias may affect our results in both directions (i.e., both higher and lower estimates than

what is true in the population), as discussed above. Thus, rather than speculating about how our results may have been influenced, the simpler notion is that our results may be inaccurate due to the low response rate; therefore, caution may be warranted when interpreting the results, especially for prevalence estimates.

In the Utøya Island study, all those who were over 13 years of age and were on the island were invited to participate in our study. Of the 490 individuals who were on the island according to police records and were 13 years or older, we were unable to reach 29 individuals, and 136 individuals declined participation. In a later data collection wave, 30 survivors who did not participate in the present study were interviewed. These 30 survivors reported more posttraumatic stress, more anxiety/depression, and more somatic symptoms than those who participated in both waves (Stene & Dyb, 2016). Thus, individuals with more health problems may be underrepresented in the current study.

5.2. Misclassification. Observational bias occurs when there is systematic misclassification in a study, for example through recall bias or interviewer bias. An example of how misclassification through recall bias may affect the results in the present study is that individuals who have experienced violence in adulthood may remember their childhood experiences with violence better than individuals who have not experienced violence in adulthood due to the recent relevance that the violence has had for them, leading to an overestimation of the association. Similarly, observational bias may affect the results if respondents who are shameful about their experiences with violence are unwilling to report their experiences or if a negative mood at time of the interview serves as an associative cue for stressful past events.

Misclassification in studies of violence may occur when a respondent is asked about exposure to an event and compares that event with his or her own experiences. Studies have found that prevalence estimates tend to be lower when asking so-called labeling questions, such as ‘have you ever been raped,’ than when asking behaviorally descriptive questions, such as ‘have you ever been forced to have sexual intercourse’ (Fisher, Cullen, & Turner, 2000). Clear descriptions of the kinds of events about which we are asking may help respondents, as labels like ‘rape’ and ‘abuse’ may mean different things to different people (e.g., how much force is necessary for an event to be a rape? how hard does someone have to shake you before it is violence?). The advantage of asking non-ambiguous questions is not specific to trauma and violence research; however, this issue may have particular importance, as terms like ‘rape’ or ‘violence’ may leave some participants unwilling to report, as they do not see themselves as victims or they are reluctant to label the perpetrator as violent (Thoresen & Øverlien, 2009).

Findings have shown that reports of violence and trauma are quite unstable over time (Fergusson, Horwood, & Woodward, 2000). This instability can be caused by under-reporting or over-reporting. In our study, we found that one-third of women who had experienced rape had not told anyone about their experience before our interviewers called. It is not unlikely that some women also chose not to disclose their experiences to our interviewers. Under-reporting can be associated with willingness to respond, for example due to stigma or shame. One way to encourage disclosure is to ensure privacy in the interviewer situation and to use experienced interviewers who appear trustworthy. A study that followed one birth cohort into adulthood found that while reports of violence were unstable, there was little evidence of over-reporting. Under-reporting appeared to be a bigger problem (Fergusson et al., 2000).

Methodological choices may influence misclassification. While personal interviews may be associated with lower disclosure of violent experiences (Mirrless-Black, 1999), this method may be more trustworthy in terms of health information. Telephone interviews may represent a middle path between these two options. Building on this possibility, the Utøya Island study methodology should decrease misclassification for the health variables, whereas the misclassification of violence in the prevalence study is presumably lower than it would have been had we used personal interviews but higher than it would have been had the respondents been able to report on a computer. However, the personal contact provided by phone interviews may increase motivation to complete the interview, thereby resulting in less missing data.

5.3. Validity. The validity of our study, including whether or not what we measure as violence is truly the violence that our respondents have experienced, rests in part on the study's sensitivity (the proportion of positives, e.g. violence exposed individuals, that are correctly identified) and specificity (the proportion of negatives, e.g. individuals not exposed to violence, that are correctly identified; Altman, 1991). In the preparation of the prevalence study, the balance between sensitivity and specificity was discussed at length. Violence is likely not a categorical phenomenon by nature; however, for the purpose of this study, we needed to differentiate between violent and non-violent events. We aimed to provide robust prevalence estimates of severe violence. Consequently, the operationalizations are strict, encompassing events that are most likely severe, and are hence more specific than sensitive. This approach helps to prevent overestimation and provides confidence that the estimates represent events that have been problematic for those who experienced them. The downside of strict definitions is that we probably lose some events that were serious for the individual, including intoxicated sexual exploitation, sexual coercion not defined as rape, less severe childhood physical violence, and

psychological violence not from parents (in childhood) or partners (in adulthood). For external validity, see paragraph 5.6 about generalizability.

We based our questions about shame and guilt on previous theoretical and empirical work (B. Andrews et al., 2002; P. Gilbert, 2000; Goss et al., 1994; Kubany et al., 1996; Kubany & Watson, 2003). The hypothesis that the scale (the SGATS) measured two underlying factors was supported by the confirmatory factor analysis, and the psychometric properties were excellent. The scale also showed good psychometric properties when tested in two American samples: one student sample and one military veteran sample (Cunningham, 2015b). The SGATS has not been validated through research, and the instrument has not been tested repeatedly. A well-established measure could have given more confidence with respect to validity issues. On the other hand, the development of a new measure where measures are scarce is one way to develop methodology in this area of study.

In the Utøya Island study, shame and guilt were each measured by a single item. This approach provides a crude measure but gives less information than a scale with multiple items. The items did not measure behavioral responses or various aspects of the emotions (such as hiding behavior, worry about what other people have thought about after the trauma, or thoughts about how the individual could have influenced the occurrence of the trauma). Rather, the items ask for shame and self-blame after the trauma and thus leave it up to the respondent to define the terms.

When measuring mental health problems, structured clinical interviews are considered to be the gold standard. However, as it was a concern to keep the interview relatively brief in both studies, shorter screening instruments for mental health problems were used (the HSCL-10 and the PTSD-RI; Derogatis et al., 1974; Steinberg et al., 2004).

5.4. Other methodological considerations. To avoid type I errors (i.e., concluding that there is a significant association between two variables that are in reality un-related) we ensured that the models were planned based on theoretically founded hypotheses before performing the analyses, rather than selecting the variables empirically. However, some explorative and descriptive data analysis is necessary before performing the main analyses to ensure that the different exposed and un-exposed groups are of appropriate size according to the analytical strategy. To avoid type II errors (i.e., the failure to find a true association), samples should be sufficiently large. In the prevalence study, we had a sample of 4,527 people; however, the end points (i.e., the number of individual cases in each cell) are more important than the number of people in the full sample. As an example, in paper 2, when investigating perpetrator relationships among women exposed to CSA, we could not control for other types of childhood violence, as

women who experienced parental CSA almost always experienced other types of parental CSA as well.

Confounding is a potential problem in all observational studies, and omitted variables should always be assessed. For example, when studying the relationship between childhood and adult victimization, we adjusted for parental mental health problems and education, which could have confounded our results. However, other potential confounders, such as household income or single-parent household, were not measured. We also do not want to over-adjust our analyses by adjusting for factors on the causal pathway (Schisterman, Cole, & Platt, 2009). An example could be if we adjust the association between shame and mental health for social support, which may be one mechanism by which shame is associated with mental health. Thus, we discussed carefully if and how a potential confounding variable was thought to influence both independent and dependent variables before we added that variable to the analyses.

5.5. Generalizability. In order to assess the generalizability of our results, we drew a random sample from the General Population Registry of Norway. The manner in which systematic non-response may have influenced the response is discussed in paragraph 5.1. It is probably not possible to obtain a thoroughly representative population sample with human subjects; therefore, generalizability to the general population will always be a question of judgement.

The prevalence of violence probably varies with cultural factors. A recent European study found prevalence estimates of sexual violence and IPV in the North of Europe that were comparable to those in the present prevalence study (FRA, 2014). The prevalence of rape in the current study is comparable to that found in an American study that used the same measure (Resnick et al., 1993).

Whether violence leads to the same negative consequences across cultures may be debated. As an example, shame and guilt after violent events may vary according to cultural factors. Violence victims in cultures with high rape myth acceptance and where prevailing attitudes tend to blame victims for the violence they suffer may experience more shame and guilt after violent events than victims in cultures with less rape myth acceptance and victim blaming. While only a few studies have examined the levels of shame and guilt after violence and there have been differences in measurement among those studies, studies from Japan, the U.S., and various European countries find that shame (and/or, to a lesser extent, guilt) is associated with mental health problems after violence (B. Andrews, 1995; La Bash & Papa, 2014; Uji et al., 2007; Øktedalen et al., 2015). The results of the Utøya Island study would ideally be generalizable to

other mass trauma-exposed populations (for example, to survivors of other terrorist attacks or of school shootings). As the survivors of this event were primarily adolescents and young adults, generalizability to an adult population may not be straightforward; for example, proneness to shame and guilt may vary across the lifespan.

6. Conclusions

Our results show that different types of violent events are highly overlapping. All types of violence were associated with negative consequences. This finding appeared not to be contingent on whether the violence was perpetrated by someone close to the victim, whether the events were of a sexual nature, or whether the events took place in childhood or adulthood. The more different types of victimizations individuals had experienced, the worse were the consequences, including revictimization, shame and guilt, or mental health problems. Therefore, multivictimization appears to be particularly important for the negative consequences of violence. Victims of childhood violence appear to have a risk of adult violence that is not specific to violence type; that is, revictimization was not restricted to adult violence of the same type.

The hypothesis that trauma-related shame and guilt are two separate constructs was supported. Both emotions independently contributed to mental health problems after violence. The contribution of shame to mental health was stronger and more robust than that of guilt. The finding that shame and guilt were not uncommon after the Utøya Island massacre implies that these emotional reactions does not occur solely due to stigmatizing events or due to event characteristics, such as closeness to the perpetrator or the degree to which the violence was sexual; rather, such reactions may be a part of more general posttrauma reactions.

We found mixed results for gender differences in shame and guilt after adjustment for exposure. Violence appears to be more important for shame and guilt after violence than gender. Violence was associated with shame and guilt, and shame and guilt was associated with mental health problems, for both men and women.

7. Implications

7.1. Implications for future research. The large overlap of violence types in our findings points to the importance of an inclusive definition and comprehensive measures of violence in future research. The inclusion of multiple types of violence has two primary advantages: it decreases the risk of overestimating the negative outcome associated with any single type of violence and the likelihood of overlooking other, potentially comparably serious violence types. In addition, this approach makes it possible to study multivictimization.

The occurrence of revictimization points to the potential for prevention; however, little is known about the efficiency of current therapeutic interventions, such as safety planning, for preventing subsequent violence exposure over time. Treatment approaches could benefit from explicitly including revictimization prevention as a therapeutic goal and specifying and testing potential interventions. Current treatment studies could benefit from including revictimization as a treatment outcome.

The relationship between multivictimization and shame and guilt could be investigated longitudinally in future studies. Specifically, one hypothesis that arises from the current findings is that shame and guilt after violence might predict revictimization and might even be a potential mechanism by which revictimization occurs. When investigating this hypothesis, our findings imply that that shame and guilt should be investigated as separate constructs, as these emotions might influence revictimization through different mechanisms and in different ways.

Given the social nature of shame and guilt and their importance for the regulation of social interaction, the study of how these emotions influence social interaction and relationships may expand our understanding. Most research on shame and guilt takes an individual approach. However, violence is interpersonal, and shame and guilt are social emotions. The behaviors and experiences that are stigmatized, blamed or shamed in a community may change over time and differ between cultures and subcultures. This area of research might benefit from including a societal, community, neighborhood, or subculture perspective to explore contextual factors that promote or inhibit shame and guilt in victims of violence and trauma.

7.2. Implications for clinicians and policy makers. Based on our findings, we may expect that a large proportion of children and adults who utilize mental health services have experiences with one or several types of violence. However, such experiences may not be apparent from the presented problem, and as violence exposure is associated with shame, it is likely that many patients do not spontaneously disclose their experiences. Clinicians may therefore find it useful to systematically screen for exposure to violence and trauma. One way to do so is to utilize short screening questionnaires for all patients in mental health clinics. Such screening instruments may include a variety of violent events. This approach will help clinicians to uncover as many victims as possible, to offer targeted treatment, and to identify multivictimized individuals.

As child victims of violence are at risk of being revictimized, contact with child victims represents a potential point for interventions aimed at preventing subsequent violent exposure. Such preventive work, along with the treatment of mental health problems following childhood violence, may make differences for individuals long into adulthood. The associations between

trauma-related shame and guilt and mental health imply that clinicians should be aware of these emotions when working with patients exposed to all types of violence, including violence that is presumably not particularly stigmatized. Clinicians could benefit from assessing shame and guilt after a variety of violent events, including mass traumas, among both male and female patients.

Shame is a lonely emotion, and when patients disclose shameful experiences, the clinician's response and attitude may be important for its alleviation. Clinicians who are knowledgeable on the subject of violence can provide their patients with psychoeducation that may de-shame their experiences. The notion that shame and guilt are painful emotions that are likely to elicit avoidance behavior and the notion that shame in particular is related to features of which the individual may expect others to disapprove can imply that patients will not spontaneously report their feelings of shame and guilt. Clinicians may therefore need to ask about these emotions.

Our results imply that violence exposure is a public health problem. Clinical interventions may be of great importance for the individual's health and well-being, but many victims never come into contact with mental health services, and it is unlikely that such interventions will reduce the prevalence of violence and negative consequences in society. As quite a large proportion of the population experiences some form of violence, policy makers may find it necessary to make violence prevention a priority.

At the individual level, in addition to the specialized treatment described above, screening procedures may help identify violence-exposed children and adults. General practitioners, occupational health services and school nurses could screen upon indication or in association with other interventions, such as vaccination or pregnancy care. Professionals who work with children could benefit from learning about violence and its consequences; for example, teachers who are aware that violence is common may be motivated to ask about such experiences when a child shows symptoms or to refer to school health services upon indication. At the family/relationship level, parental training programs and support interventions may help at-risk families. Prevention at the community and society levels may involve the implementation of prevention programs in high-risk or exposed communities, educational programs in schools, training police in preventive work, the allocation of resources for investigations of violent crime, and policies that target alcohol and drug abuse.

To prevent shame after violence, the social surroundings of victims, both close and distant, are important. While a less shame-inducing attitude in the population cannot be decided upon by policy makers, there are multiple ways in which helpful attitudes may be promoted. Examples include training that increases law enforcers' and health professionals' knowledge and understanding of violence and victims and the implementation of school programs that aim to

raise awareness for children and youth, providing them with understanding, which may promote adaptive responses should they or someone they know be victimized. As information about violence and its consequences for victims may help to de-stigmatize and de-shame such experiences, professionals with knowledge about violence may play a key role in informing the public. Role models who are open about their violence victimizations, be they politicians, artists or others, may ease the burden of shame for other survivors.

References

Acierno, R., Resnick, H., Kilpatrick, D. G., Saunders, B., & Best, C. L. (1999). Risk factors for rape, physical assault, and posttraumatic stress disorder in women: Examination of differential multivariate relationships. *Journal of Anxiety Disorders, 13*(6), 541-563. doi:http://dx.doi.org/10.1016/S0887-6185(99)00030-4

Altman, D. G. (1991). *Practical statistics for medical research*. London: Chapman & Hall.

Amstadter, A. B., & Vernon, L. L. (2008). Emotional reactions during and after trauma: A comparison of trauma types. *Journal of Aggression, Maltreatment & Trauma, 16*(4), 391-408. doi:10.1080/10926770801926492

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186. doi:10.1007/s00406-005-0624-4

Andersen, S. L., Tomada, A., Vincow, E. S., Valente, E., Polcari, A., & Teicher, M. H. (2008). Preliminary evidence for sensitive periods in the effect of childhood sexual abuse on regional brain development. *The Journal of Neuropsychiatry and Clinical Neurosciences, 20*(3), 292-301. doi:doi:10.1176/jnp.2008.20.3.292

Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression *Journal of Abnormal Psychology, 104* (2), 277-85.

Andrews, B. (1998). Shame and childhood abuse. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (176-190). New York: Oxford University Press.

Andrews, B., Brewin, C., & Rose, S. (2003). Gender, social support, and PTSD in victims of violent crime. *Journal of Traumatic Stress, 16*(4), 421-427. doi:10.1023/A:1024478305142

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology, 109*(1), 69-73. doi:10.1037/0021-843X.109.1.69

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41*(1), 29-42. doi:10.1348/014466502163778

Andrews, G., Corry, J., Slade, T., Issakidis, C., & Swanston, H. (2004). Child sexual abuse. In M. Ezzati, A. D. Lopez, A. Rodgers, & C. J. L. Murray (Eds.), *Comparative quantification of health risks* (Vol. 1). Geneva: World Health Organization.

Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin, 126*(5), 651-680. doi:10.1037/0033-2909.126.5.651

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders (3rd Ed)*. Arlington, VA: American Psychiatric Association.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th Ed)*. Washington, DC: American Psychiatric Association.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th Ed)*. London, England: American Psychiatric Association.

Atrostic, B. K., Bates, N., Burt, G., & Silberstein, A. (2001). Nonresponse in US government household surveys: consistent measures, recent trends, and new insights. *Journal of Official Statistics-Stockholm-, 17*(2), 209-226.

Bal, S., De Bourdeaudhuij, I., Crombez, G., & Van Oost, P. (2004). Differences in trauma symptoms and family functioning in intra- and extrafamilial sexually abused adolescents. *Journal of Interpersonal Violence, 19*(1), 108-123. doi:10.1177/0886260503259053

Barnes, J. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2009). Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child Abuse & Neglect, 33*(7), 412-420. doi:http://dx.doi.org/10.1016/j.chiabu.2008.09.013

Barrett, L. F. (2006). Are emotions natural kinds? *Perspectives on Psychological Science, 1*(1), 28-58. doi:10.1111/j.1745-6916.2006.00003.x

Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring negative emotion in women experiencing intimate partner violence: Shame, guilt, and PTSD. *Behavior Therapy, 42*(4), 740-750. doi:http://dx.doi.org/10.1016/j.beth.2011.04.001

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39*, 350-373.

Breslau, N. (2009). The epidemiology of trauma, PTSD, and other posttrauma disorders. *Trauma Violence Abuse, 10*, 198-210. doi:10.1177/1524838009334448

Breslau, N., Chilcoat, H. D., Kessler, R. C., & Davis, G. C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit area survey of trauma. *American Journal of Psychiatry, 156*(6), 902-907. doi:10.1176/ajp.156.6.902

Brewin, C. R. (2003). *Posttraumatic stress disorder: Malady or myth?* New Haven & London: Yale University Press.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748-766. doi:10.1037/0022-006X.68.5.748

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review, 103*(4), 670-686. doi:10.1037/0033-295X.103.4.670

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*(3), 339-376. doi:http://dx.doi.org/10.1016/S0272-7358(03)00033-3

Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V. *Social Science & Medicine, 69*(7), 1032-1039. doi:http://dx.doi.org/10.1016/j.socscimed.2009.07.032

Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry, 131*(9), 981-986. doi:doi:10.1176/ajp.131.9.981

Byers, E. S., & Glenn, S. A. (2011). Gender differences in cognitive and affective responses to sexual coercion. *Journal of Interpersonal Violence. XX*(X), 1-19, doi:10.1177/0886260511423250

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi:http://dx.doi.org/10.1016/S0140-6736(02)08336-8

Cassidy, J. (2008). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment* (pp. 3-22). New York: The Guilford Press.

CDC. (2008). *Child maltreatment surveillance - Uniform definitions for public health and recommended data elements*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/cm_surveillance-a.pdf

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse, 6*(2), 103-129. doi:10.1177/1524838005275087

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: a latent profile analysis. *European Journal of Psychotraumatology, 4*. doi:10.3402/ejpt.v4i0.20706

Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. v. d., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399-408. doi:10.1002/jts.20444

Clore, G. L., & Ortony, A. (2008). Appraisal theories: How cognition shapes affect into emotion. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions (3rd ed.)* (pp. 628-642). New York, NY, US: Guilford Press.

Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9*(5), 451-457.

Colman, R. A., & Widom, C. S. (2004). Childhood abuse and neglect and adult intimate relationships: a prospective study. *Child Abuse & Neglect, 28*(11), 1133-1151. doi:http://dx.doi.org/10.1016/j.chiabu.2004.02.005

Creamer, M., Burgess, P., & McFarlane, A. C. (2001). Post-traumatic stress disorder: findings from the Australian National Survey of Mental Health and Well-being. *Psychological Medicine, 31*(07), 1237-1247. doi:doi:10.1017/S0033291701004287

Cunningham, K., 2015a. Personal communication to Helene Flood Aakvaag.

Cunningham, K., 2015b. *Shame and post-traumatic stress disorder*. Dissertation for the degree of Doctor of Philosophy. University of Tulsa, The Graduate School.

Danielson, K. K., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbidity between abuse of an adult and DSM-III-R mental disorders: Evidence from an epidemiological study. *American Journal of Psychiatry, 155*(1), 131-133. doi:doi:10.1176/ajp.155.1.131

Darwin, C. (1872). Self-attention, shame, shyness, modesty; Blushing *The Expression of the Emotions in Man and Animals*. New York: Appleton & Company.

Davis, C. G., Lehman, D. R., Silver, R. C., Wortman, C. B., & Ellard, J. H. (1996). Self-blame following a traumatic event: The role of perceived avoidability. *Personality and Social Psychology Bulletin, 22*(6), 557-567.

Davis, R. C., Brickman, E., & Baker, T. (1991). Supportive and unsupportive responses of others to rape victims: effects on concurrent victim adjustment. *American Journal of Community Psychology, 19*(3), 443-451.

DePrince, A. P. (2005). Social cognition and revictimization risk. *Journal of Trauma & Dissociation, 6*(1), 125-141. doi:10.1300/J229v06n01_08

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science, 19*(1), 1-15. doi:10.1002/bs.3830190102

Dinwiddie, S., Heath, A. C., Dunne, M.P., Bucholz, K. K, Madden, P. A. F., Slutske, W.S…Martin, N. G. (2000). Early sexual abuse and lifetime psychopathology: a co-twin–control study. *Psychological Medicine, 30*(01), 41-52. doi:doi:null

Dobash, R. P., Dobash, R. E., Wilson, M., & Daly, M. (1992). The myth of sexual symmetry in marital violence. *Social Problems, 39*(1), 71-91. doi:10.2307/3096914

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and houshold dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences study. *Pediatrics, 111*(3).

Dubowitz, H., Black, M., Starr, R. H., & Zuravin, S. (1993). A conceptual definition of child neglect. *Criminal Justice and Behavior, 20*(1), 8-26. doi:10.1177/0093854893020001003

Edwards, V. J., Freyd, J. J., Dube, S. R., Anda, R. F., & Felitti, V. J. (2012). Health outcomes by closeness of sexual abuse perpetrator: A test of betrayal trauma theory. *Journal of Aggression, Maltreatment & Trauma, 21*(2), 133-148. doi:10.1080/10926771.2012.648100

Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the Adverse Childhood Experiences study. *American Journal of Psychiatry, 160*(8), 1453-1460. doi:doi:10.1176/appi.ajp.160.8.1453

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319-345.

Ekman, P., & Cordaro, D. (2011). What is meant by calling emotions basic. *Emotion Review, 3*(4), 364-370. doi:10.1177/1754073911410740

Else-Quest, N. M., Higgins, A., Allison, C., & Morton, L. C. (2012). Gender differences in self-conscious emotional experience: A meta-analysis. *Psychological Bulletin, 138*(5), 947-981. doi:10.1037/a0027930

Feiring, C., Simon, V. A., & Cleland, C. M. (2009). Childhood sexual abuse, stigmatization, internalizing symptoms, and the development of sexual difficulties and dating aggression. *Journal of Consulting and Clinical Psychology, 77*(1), 127-137. doi:10.1037/a0013475

Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development following sexual abuse. *Child Maltreatment, 7*(1), 25-39. doi:10.1177/1077559502007001003

Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology, 38*(1), 79-92.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4).

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse & Neglect, 21*(8), 789-803. doi:http://dx.doi.org/10.1016/S0145-2134(97)00039-2

Fergusson, D. M., Horwood, L. J., & Woodward, L. J. (2000). The stability of child abuse reports: A longitudinal study of the reporting behaviour of young adults. *Psychological Medicine, 30*, 529-544.

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J. L., . . . Whiteford, H. A. (2013). Burden of depressive disorders by country, sex, age, and year: Findings from the Global burden of disease study 2010. *PLoS Med, 10*(11), e1001547. doi:10.1371/journal.pmed.1001547

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. Baltimore, MD, US: The Sidran Press.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A Conceptualization. *American Journal of Orthopsychiatry, 55*(4), 530-541. doi:10.1111/j.1939-0025.1985.tb02703.x

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*(1), 7-26. doi:http://dx.doi.org/10.1016/j.chiabu.2006.06.008

Fisher, B. S., Cullen, F. T., & Turner, M. G. (2000). *The sexual victimization of college women*. Retrieved from Washington, U.S.: https://www.ncjrs.gov/pdffiles1/nij/182369.pdf

Flannery, D. J., Singer, M. I., & Wester, K. (2001). Violence exposure, psychological trauma, and suicide risk in a community sample of dangerously violent adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 435-442. doi:http://dx.doi.org/10.1097/00004583-200104000-00012

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment, 11*(3), 303-314. doi:10.1037/1040-3590.11.3.303

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior Therapy, 20*(2), 155-176. doi:http://dx.doi.org/10.1016/S0005-7894(89)80067-X

Font, S. A., & Maguire-Jack, K. (2016). Pathways from childhood abuse and other adversities to adult health risks: The role of adult socioeconomic conditions. *Child Abuse & Neglect, 51*, 390-399. doi:http://dx.doi.org/10.1016/j.chiabu.2015.05.013

Ford, J. D., Racusin, R., Daviss, W. B., Ellis, C. G., Thomas, J., Rogers, K., . . . Sengupta, A. (1999). Trauma exposure among children with oppositional defiant disorder and attention deficit-hyperactivity disorder. *Journal of Consulting and Clinical Psychology, 67*(5), 786-789.

FRA. (2014). *Violence against women: an EU-wide survey*. FRA - European Agency for Fundamental Rights. Retrieved from Luxembourg: http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-at-a-glance-oct14_en.pdf

Frans, Ö., Rimmö, P. A., Åberg, L., & Fredrikson, M. (2005). Trauma exposure and post-traumatic stress disorder in the general population. *Acta Psychiatrica Scandinavica, 111*(4), 291-290. doi:10.1111/j.1600-0447.2004.00463.x

Freyd, J. J. (1996). *Betrayal Trauma: The logic of forgetting childhood abuse*. Cambridge, Massachusetts: Harvard University Press.

Freyd, J. J. (2008). Betrayal trauma. In G. Reyes, J. D. Elhai, & J. D. Ford (Eds.), *The encyclopedia of psychological trauma* (pp. 76). Hoboken, New Jersey: John Wiley & Sons.

Freyd, J. J. (2014). What is a betrayal trauma? What is betrayal trauma theory? Retrived from: http://dynamic.uoregon.edu/jjf/defineBT.html

Freyd, J. J., Deprince, A. P., & Gleaves, D. H. (2007). The state of betrayal trauma theory: Reply to McNally—Conceptual issues, and future directions. *Memory, 15*(3), 295-311. doi:10.1080/09658210701256514

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet, 368*(9543), 1260-1269. doi:http://dx.doi.org/10.1016/S0140-6736(06)69523-8

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology, 70*(2), 113-147. doi:10.1111/j.2044-8341.1997.tb01893.x

Gilbert, P. (2000). The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clinical Psychology an Psychotherapy, 7,* 174-189.

Gilbert, P., & Miles, J. (2002). *Body shame*. New York: Brunner-Routledge.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet, 373*(9657), 68-81. doi:http://dx.doi.org/10.1016/S0140-6736(08)61706-7

Glaser, D. (2002). Emotional abuse and neglect (psychological maltreatment): a conceptual framework. *Child Abuse & Neglect, 26*(6–7), 697-714. doi:http://dx.doi.org/10.1016/S0145-2134(02)00342-3

Gobin, R. L., & Freyd, J. J. (2009). Betrayal and revictimization: Preliminary findings. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(3), 242-257. doi:10.1037/a0017469

Goodman, L., Corcoran, C., Turner, K., Yuan, N., & Green, B. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. *Journal of Traumatic Stress, 11*(3), 521-542. doi:10.1023/A:1024456713321

Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures—I: The other as Shamer scale. *Personality and Individual Differences, 17*(5), 713-717. doi:http://dx.doi.org/10.1016/0191-8869(94)90149-X

Grubb, A., & Turner, E. (2012). Attribution of blame in rape cases: A review of the impact of rape myth acceptance, gender role conformity and substance use on victim blaming. *Aggression and Violent Behavior, 17*(5), 443-452. doi:http://dx.doi.org/10.1016/j.avb.2012.06.002

Gunnar, M., & Quevedo, K. (2007). The neurobiology of stress and development. *Annual review of psychology, 58*(1), 145-173. doi:doi:10.1146/annurev.psych.58.110405.085605

Gustafsson, P., Nilsson, D., & Svedin, C. (2009). Polytraumatization and psychological symptoms in children and adolescents. *European Child & Adolescent Psychiatry, 18*(5), 274-283. doi:10.1007/s00787-008-0728-2

Gustavson, K., von Soest, T., Karevold, E., & Røysamb, E. (2012). Attrition and generalizability in longitudinal studies: findings from a 15-year population-based study and a Monte Carlo simulation study. *BMC Public Health, 12*(1), 1-11. doi:10.1186/1471-2458-12-918

Haaland, T., Clausen, S.-E., & Schei, B. (2005). *Vold i parforhold - ulike perspektiver: Resultater fra den første landsdekkende undersøkelsen i Norge*. Retrieved from Oslo:

Hagenaars, M. A., Fisch, I., & van Minnen, A. (2011). The effect of trauma onset and frequency on PTSD-associated symptoms. *Journal of Affective Disorders, 132*(1–2), 192-199. doi:http://dx.doi.org/10.1016/j.jad.2011.02.017

Hedtke, K. A., Ruggiero, K. J., Fitzgerald, M. M., Zinzow, H. M., Saunders, B. E., Resnick, H. S., & Kilpatrick, D. G. (2008). A longitudinal investigation of interpersonal violence in relation to mental health and substance use. *Journal of Consulting and Clinical Psychology, 76*(4), 633-647. doi: 10.1037/0022-006X.76.4.633

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women, 4*(3), 262-290. doi:10.1177/1077801298004003002

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377-391. doi:10.1002/jts.2490050305

Herman, J. L. (1992). *Trauma and Recovery: From Domestic Abuse to Political Terror*: Basic Books.

Herrenkohl, R., & Herrenkohl, T. (2009). Assessing a child's experience of multiple Maltreatment types: Some unfinished business. *Journal of Family Violence, 24*(7), 485-496. doi:10.1007/s10896-009-9247-2

Hershkowitz, I., Lanes, O., & Lamb, M. E. (2007). Exploring the disclosure of child sexual abuse with alleged victims and their parents. *Child Abuse & Neglect, 31*(2), 111-123. doi:http://dx.doi.org/10.1016/j.chiabu.2006.09.004

Higgins, D. J., & McCabe, M. P. (2000). Multi-type maltreatment and the long-term adjustment of adults. *Child Abuse Review, 9*(1), 6-18. Retrieved from http://www.ingentaconnect.com/content/jws/car/2000/00000009/00000001/art00579

Izard, C. E. (1977). *Human emotions*. New York: Springer Science + business media.

Izard, C. E. (2007). Basic emotions, natural kinds, emotion schemas, and a new paradigm. *Perspectives on Psychological Science, 2*(3), 260-280. doi:10.1111/j.1745-6916.2007.00044.x

Izard, C. E. (2011). Forms and functions of emotions: Matters of emotion–cognition interactions. *Emotion Review, 3*(4), 371-378. doi:10.1177/1754073911410737

Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 37*(10), 1798-1809.

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and Family, 57*(2), 283-294. doi:10.2307/353683

Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Boston: Northeastern University Press.

Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 37-48). Baltimore, MD, US: The Sidran Press.

Kelly, V. C. (2009). A primer of affect psychology. Retrieved from http://www.tomkins.org/wp-content/uploads/2014/07/Primer_of_Affect_Psychology-Kelly.pdf

Kempe, C., Silverman, F. N., F., S. B., Droegemueller, W., & Silver, H. K. (1962). The battered-child syndrome. *JAMA, 181*(1), 17-24.

Kennedy, S., Tripodi, S., & Pettus-Davis, C. (2013). The relationship between childhood abuse and psychosis for women prisoners: Assessing the importance of frequency and type of victimization. *Psychiatric Quarterly, 84*(4), 439-453. doi:10.1007/s11126-013-9258-2

Kessler, R. C., Chiu, W., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month dsm-iv disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 617-627. doi:10.1001/archpsyc.62.6.617

Kessler, R. C., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., . . . Williams, D. R. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry, 197*(5), 378-385. doi:10.1192/bjp.bp.110.080499

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*(12), 1048-1060. doi:10.1001/archpsyc.1995.03950240066012

Ketring, S. A., & Feinauer, L. L. (1999). Perpetrator-victim relationship: Long-term effects of sexual abuse for men and women. *The American Journal of Family Therapy, 27*(2), 109-120. doi:10.1080/019261899262005

Kilpatrick, D. G., Resnick, H. S., Baber, B., Guille, C., & Gros, K. (2011). *The National Stressful Events Web Survey (NSES-W)*. Medical University of South Carolina; Charleston, South Carolina.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology, 71*(4), 692-700. doi:10.1037/0022-006X.71.4.692

Kilpatrick, D. G., Saunders, B. E., Amick-McMullan, A., Best, C. L., Veronen, L. J., & Resnick, H. S. (1989). Victim and crime factors associated with the development of crime-related post-traumatic stress disorder. *Behavior Therapy, 20*(2), 199-214. doi:http://dx.doi.org/10.1016/S0005-7894(89)80069-3

Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). Shame, guilt, and depressive symptoms: A meta-analytic review. *Psychological Bulletin, 137*(1), 68-96. doi:10.1037/a0021466

Kimerling, R., Alvarez, J., Pavao, J., Kaminski, A., & Baumrind, N. (2007). Epidemiology and consequences of women's revictimization. *Women's Health Issues, 17*(2), 101-106. doi:http://dx.doi.org/10.1016/j.whi.2006.12.002

King, D. W., King, L. A., Foy, D. W., Keane, T. M., & Fairbank, J. A. (1999). Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors,

war-zone stressors, and resilience-recovery variables. *Journal of Abnormal Psychology, 108*(1), 164-170. doi:10.1037/0021-843X.108.1.164

Kliegman, R. M., Nelson, W. E., & Behrman, R. E. (2011). *Nelson textbook of pediatrics*. Philadelphia: Saunders Elsevier.

Kobak, R., & Madsen, S. (2008). Disruptions in attachment bonds. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment* (pp. 23-47). New York: The Guilford Press.

Kubany, E. S. (1994). A cognitive model of guilt typology in combat-related PTSD. *Journal of Traumatic Stress, 7*(1), 3-19. doi:10.1002/jts.2490070103

Kubany, E. S., Abueg, F., Owens, J., Brennan, J., Kaplan, A., & Watson, S. (1995). Initial examination of a multidimensional model of trauma-related guilt: Applications to combat veterans and battered women. *Journal of Psychopathology and Behavioral Assessment, 17*(4), 353-376. doi:10.1007/BF02229056

Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment, 8*(4), 428-444. doi:10.1037/1040-3590.8.4.428

Kubany, E. S., & Manke, F. P. (1995). Cognitive therapy for trauma-related guilt: Conceptual bases and treatment outlines. *Cognitive and Behavioral Practice, 2*(1), 27-61. doi:http://dx.doi.org/10.1016/S1077-7229(05)80004-5

Kubany, E. S., & Watson, S. (2003). Guilt: Elaboration of a multidimensional model. *The Psychological record, 53*(1). doi:http://opensiuc.lib.siu.edu/tpr/vol53/iss1/4

Kuo, J. R., Goldin, P. R., Werner, K., Heimberg, R. G., & Gross, J. J. (2011). Childhood trauma and current psychological functioning in adults with social anxiety disorder. *Journal of Anxiety Disorders, 25*(4), 467-473. doi:http://dx.doi.org/10.1016/j.janxdis.2010.11.011

La Bash, H., & Papa, A. (2014). Shame and PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(2), 159-166. doi:10.1037/a0032637

Lange, A., De Beurs, E., Dolan, C., Lachnit, T., Sjollema, S., & Hanewald, G. (1999). Long-term effects of childhood sexual abuse: Objective and subjective characteristics of the abuse and psychopathology in later life. *The Journal of Nervous and Mental Disease, 187*(3), 150-158. Retrieved from http://journals.lww.com/jonmd/Fulltext/1999/03000/Long_ Term_Effects_of_Childhood_Sexual_Abuse_.4.aspx

Lawyer, S. R., Ruggiero, K. J., Resnick, H. S., Kilpatrick, D. G., & Saunders, B. E. (2006). Mental health correlates of the victim-perpetrator relationship among interpersonally victimized adolescents. *Journal of Interpersonal Violence, 21*(10), 1333-1353. doi:10.1177/0886260506291654

LeDoux, J. E., & Phelps, E. A. (2008). Emotional networks in the brain. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions* (pp. 159-179). New York: The Guilford Press.

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology, 74*(4), 451-466. doi:10.1348/000711201161109

Lewis, H. B. (1990). Shame, repression, field dependence, and psychopathology. In J. L. Singer (Ed.), *Repression and Dissociation: Implications for Personality Theory* (pp. 233-258). Chicago: The University of Chicago Press.

Lewis, M. (2008a). The emergence of human emotions. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions* (304-319). New York: The Guilford Press.

Lewis, M. (2008b). Self-conscious emotions. Embarrassment, pride, shame, and guilt. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions* (Third Edition ed.) (742-756). New York: The Guilford Press.

Luyten, P., Fontaine, J. R. J., & Corveleyn, J. (2002). Does the Test of Self-Conscious Affect (TOSCA) measure maladaptive aspects of guilt and adaptive aspects of shame? An empirical investigation. *Personality and Individual Differences, 33*(8), 1373-1387. doi:http://dx.doi.org/10.1016/S0191-8869(02)00197-6

Mandel, D. R., & Dhami, M. K. (2005). "What I did" versus "what I might have done": Effect of factual versus counterfactual thinking on blame, guilt, and shame in prisoners. *Journal of Experimental Social Psychology, 41*(6), 627-635. doi:http://dx.doi.org/10.1016/j.jesp.2004.08.009

Martin, C. G., Cromer, L. D., DePrince, A. P., & Freyd, J. J. (2013). The role of cumulative trauma, betrayal, and appraisals in understanding trauma symptomatology. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(2), 110-118. doi:10.1037/a0025686

May-Chahal, C., & Cawson, P. (2005). Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. *Child Abuse & Neglect, 29*(9), 969-984. doi:http://dx.doi.org/10.1016/j.chiabu.2004.05.009

Melchior, M., Moffitt, T. E., Milne, B. J., Poulton, R., & Caspi, A. (2007). Why do children from socioeconomically disadvantaged families suffer from poor health when they reach adulthood? A life-course study. *American Journal of Epidemiology, 166*(8), 966-974. doi:10.1093/aje/kwm155

Messman-Moore, T. L., & Long, P. J. (2000). Child sexual abuse and revictimization in the form of adult sexual abuse, adult physical abuse, and adult psychological maltreatment. *Journal of Interpersonal Violence, 15*(5), 489-502. doi:10.1177/088626000015005003

Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse & Neglect, 34*(12), 967-976. doi:http://dx.doi.org/10.1016/j.chiabu.2010.06.004

Miller, R. B., & Wright, D. W. (1995). Detecting and correcting attrition bias in longitudinal family research. *Journal of Marriage and Family, 57*. doi:10.2307/353412

Mirrless-Black, C. (1999). *Domestic violence: Findings from a new British Crime Survey self-completion questionnaire*. Retrieved from: http://webarchive.nationalarchives.gov.uk/20110218135832/http:/rds.homeoffice.gov.uk/rds/pdfs/hors191.pdf

Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health, 91*(5), 753-760. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446666/

Mossige, S., & Stefansen, K. (2007). *Vold og overgrep mot barn og unge - En selvrapporteringsstudie blant avgangselever i videregående skole* [Violence and abuse against children and youth – A self-report study of high school seniors]. Oslo: Norsk institutt for oppvekst, velferd og aldring.

Myhre, M. C., Thoresen, S., Grøgaard, J. B., & Dyb, G. (2012). Familial factors and child characteristics as predictors of injuries in toddlers: a prospective cohort study. *BMJ Open, 2*(2). doi:10.1136/bmjopen-2011-000740

Nathanson, D. L. (1992). *Shame and pride. Affect, sex, and the birth of the self*. New York: W. W. Norton & Company.

Nathanson, D. L. (2008). Prolouge. In S. S. Tomkins, *Affect Imagery Consciousness* (xi-xxvi). New York: Springer Publishing Company.

Newman, E., Risch, E., & Kassam-Adams, N. (2006). Ethical issues in trauma-related research: A review. *Journal of Empirical Research on Human Research Ethics: An International Journal, 1*(3), 29-46. doi:10.1525/jer.2006.1.3.29

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*(3), 409-418. doi:10.1037/0022-006X.60.3.409

Nylenna, M., & Simonsen, S. (2009). Helseforskningsloven [Health and medical research law]. *Tidsskr Nor Laegeforen, 129*(13), 1320. doi:10.4045/tidsskr.09.0521

Olff, M., Langeland, W., Draijer, N., & Gersons, B. P. R. (2007). Gender differences in posttraumatic stress disorder. *Psychological Bulletin, 133*(2), 183-204. doi:10.1037/0033-2909.133.2.183

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2008). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Trauma: Theory, Research, Practice, and Policy, S*(1), 3-36. doi:10.1037/1942-9681.S.1.3

Panksepp, J. (2007). Neurologizing the psychology of affects: How appraisal-based constructivism and basic emotion theory can coexist. *Perspectives on Psychological Science, 2*(3), 281-296. doi:10.1111/j.1745-6916.2007.00045.x

Perkonigg, A., Kessler, R. C., Storz, S., & Wittchen, H. U. (2000). Traumatic events and post-traumatic stress disorder in the community: prevalence,risk factors and comorbidity. *Acta Psychiatrica Scandinavica, 101*(1), 46-59. doi:10.1034/j.1600-0447.2000.101001046.x

Pollak, S. D. (2008). Mechanisms linking early experience and the emergence of emotions: Illustrations from the study of maltreated children. *Current Directions in Psychological Science, 17*(6), 370-375. doi:10.1111/j.1467-8721.2008.00608.x

Pratchett, L. C., & Yehuda, R. (2011). Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Development and Psychopathology, 23*(02), 477-491. doi:doi:10.1017/S0954579411000186

Pugh, L. R., Taylor, P. J., & Berry, K. (2015). The role of guilt in the development of post-traumatic stress disorder: A systematic review. *Journal of Affective Disorders, 182*, 138-150. doi:http://dx.doi.org/10.1016/j.jad.2015.04.026

Punamäki, R.-L. (2002). The uninvited guest of war enters childhood: Developmental and personality aspects of war and military violence. *Traumatology, 8*(3), 181-204. doi:10.1177/153476560200800305

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 269-278. doi:http://dx.doi.org/10.1097/00004583-200303000-00006

Pynoos, R. S., Steinberg, A. M., Ornitz, E. M., & Goenjian, A. K. (1997). Issues in the developmental neurobiology of traumatic stress. *Annals of the New York Academy of Sciences, 821*(1), 176-193. doi:10.1111/j.1749-6632.1997.tb48278.x

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61*(6), 984-91.doi:10.1037/0022-006X.61.6.984

Rizvi, S. L., Kaysen, D., Gutner, C. A., Griffin, M. G., & Resick, P. A. (2008). Beyond fear: The role of peritraumatic responses in posttraumatic stress and depressive symptoms among female crime victims. *Journal of Interpersonal Violence, 23*(6), 853-868. doi:10.1177/0886260508314851

Saunders, B. E., Villeponteaux, L. A., Lipovsky, J. A., Kilpatrick, D. G., & Veronen, L. J. (1992). Child sexual assault as a risk factor for mental disorders among women: A community survey. *Journal of Interpersonal Violence, 7*(2), 189-204. doi:10.1177/088626092007002005

Schachter, S., & Singer, J. (1962). Cognitive, social, and physiological determinants of emotional state. *Psychological Review, 69*(5), 379-399. doi:10.1037/h0046234

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*(1), 49-64. doi:10.1111/j.1471-6402.1995.tb00278.x

Schisterman, E. F., Cole, S. R., & Platt, R. W. (2009). Overadjustment bias and unnecessary adjustment in epidemiologic studies. *Epidemiology (Cambridge, Mass.), 20*(4), 488-495. doi:10.1097/EDE.0b013e3181a819a1

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 201-269.

Silfver, M. (2007). Coping with guilt and shame: a narrative approach. *Journal of Moral Education, 36*(2), 169-183. doi:10.1080/03057240701325274

Steinberg, A., Brymer, M., Decker, K., & Pynoos, R. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports, 6*(2), 96-100. doi:10.1007/s11920-004-0048-2

Steine, I., Milde, A. M., Bjorvatn, B., Grønli, J., Norhus, I. H., Mrdalj, J., & Pallesen, S. (2012). Forekomsten av seksuelle overgrep i et representativt befolkningsutvalg i Norge [The prevalence of sexual abuse in a representative Norwegian population sample]. *Tidsskrift for norsk psykologforening, 49*(10), 950-957.

Stene, L. E., & Dyb, G. (2016). Research participation after terrorism. An open cohort study of survivors and parents after the 2011 Utøya attack in Norway. *BMC Research Notes, 9*(1), 1-10. doi:10.1186/s13104-016-1873-1

Stotz, S. J., Elbert, T., Müller, V., & Schauer, M. (2015). The relationship between trauma, shame, and guilt: findings from a community-based study of refugee minors in Germany. *European Journal of Psychotraumatology, 6*, 10.3402/ejpt.v3406.25863. doi:10.3402/ejpt.v6.25863

Strand, B. H., Dalgard, O. S., Tambs, K., & Rognerud, M. (2003). Measuring the mental health status of the Norwegian population: A comparison of the instruments SCL-25, SCL-10, SCL-5 and MHI-5 (SF-36). *Nordic Journal of Psychiatry, 57*(2), 113-118. doi:doi:10.1080/08039480310000932

Straus, M. (2001). *Beating the devil out of them: Corporal punishment in American families and its effects on children*. New Brunswick, New Jersey: Transaction Publishers.

Straus, M., & Gelles, R. J. (1987). *How violent are American families? Estimates from the National family violence resurvey and other studies*. Retrieved from

Street, A. E., & Arias, I. (2001). Psychological abuse and posttraumatic stress disorder in battered women: Examining the roles of shame and guilt. *Violence and Victims, 16*(1), 65-78. Retrieved from http://www.ingentaconnect.com/content/springer/vav/2001/00000016/00000001/art00005

Strøm, I. F., Thoresen, S., Wentzel-Larsen, T., Hjemdal, O. K., Lien, L., & Dyb, G. (2013). Exposure to life adversity in high school and later work participation: A longitudinal population-based study. *Journal of Adolescence, 36*(6), 1143-1151. doi:http://dx.doi.org/10.1016/j.adolescence.2013.09.003

Tambs, K., & Moum, T. (1993). How well can a few questionnaire items indicate anxiety and depression? *Acta Psychiatrica Scandinavica, 87*(5), 364-367. doi:10.1111/j.1600-0447.1993.tb03388.x

Tangney, J. P., & Dearing, R. L. (2002a). *Shame and guilt*. New York: The Guilford Press.

Tangney, J. P., & Dearing, R. L. (2002b). Shame, Guilt, and Psychopathology *Shame and guilt*. New York: The Guilford Press.

Tangney, J. P., & Dearing, R. L. (2002c). What is the difference between shame and guilt? *Shame and guilt*. London: The Guilford Press.

Tangney, J. P., Dearing, R. L., Wagner, P. E., & Gramzow, R. (1997). *The Test of Self-Conscious Affect-3 (TOSCA-3)*. Fairfax, VA: George Mason University.

Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101*(3), 469-478. doi:10.1037/0021-843X.101.3.469

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior, 52*(2), 145-161. doi:10.1177/0022146510395592

Thoresen, S., Aakvaag, H. F., Wentzel-Larsen, T., Dyb, G., & Hjemdal, O. K. (2012). The day Norway cried: Proximity and distress in Norwegian citizens following the 22nd July

terrorist attacks in Oslo and on Utøya Island. *European Journal of Traumatic Stress, 3*. doi:10.3402/ejpt.v3i0.19709

Thoresen, S., & Hjemdal, O. K. (2014). *Vold og voldtekt i Norge. En nasjonal forekomststudie av vold i et livsløpsperspektiv* [Violence and abuse in Norway. A National prevalence study of violence across the lifespan]. Retrieved from: https://www.nkvts.no/content/uploads/2015/11/vold_og_voldtekt_i_norge.pdf

Thoresen, S., & Øverlien, C. (2009). Trauma victim: Yes or no?: Why it may be difficult to answer questions regarding violence, sexual abuse, and other traumatic events. *Violence Against Women, 15*(6), 699-719. doi:10.1177/1077801209332182

Tilghman-Osborne, C., Cole, D. A., & Felton, J. W. (2010). Definition and measurement of guilt: Implications for clinical research and practice. *Clinical Psychology Review, 30*(5), 536-546. doi:http://dx.doi.org/10.1016/j.cpr.2010.03.007

Tolin, D. F., & Foa, E. B. (2002). Gender and PTSD. A cognitive model. In R. Kimerling, P. Ouimette, & J. Wolfe (Eds.), *Gender and PTSD*. New York: The Guilford Press.

Tolin, D. F., & Foa, E. B. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin, 132*(6), 959-992. doi:10.1037/0033-2909.132.6.959

Tomkins, S. S. (1963a). *Affect Imagery Consciousness* (Vol. I, the positive affects). New York: Springer Publishing Company

Tomkins, S. S. (1963b). *Affect Imagery Consciousness (*Vol 2: The Negative Affects). New York: Springer.

Trickey, D., Siddaway, A. P., Meiser-Stedman, R., Serpell, L., & Field, A. P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review, 32*(2), 122-138. doi:http://dx.doi.org/10.1016/j.cpr.2011.12.001

Uji, M., Shikai, N., Shono, M., & Kitamura, T. (2007). Contribution of shame and attribution style in developing PTSD among Japanese University women with negative sexual experiences. *Archives of Women's Mental Health, 10*(3), 111-120. doi:10.1007/s00737-007-0177-9

Ullman, S., & Filipas, H. (2001). Predictors of PTSD symptom severity and social reactions in sexual assault victims. *Journal of Traumatic Stress, 14*(2), 369-389. doi:10.1023/A:1011125220522

Ullman, S. E., Townsend, S. M., Filipas, H. H., & Starzynski, L. L. (2007). Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD

among sexual assault survivors. *Psychology of Women Quarterly, 31*(1), 23-37. doi:10.1111/j.1471-6402.2007.00328.x

United Nations. (1948) *Universal Declaration of Human Rights*. Retrived from http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

United Nations. (1989). *Convention on the Rights of the Child*. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

van der Kolk, B. A., & Courtois, C. A. (2005). Editorial comments: Complex developmental trauma. *Journal of Traumatic Stress, 18*(5), 385-388. doi:10.1002/jts.20046

Walby, S., & Allen, J. (2004). *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Retrieved from http://www.avaproject.org.uk/media/28792/ hors276.pdf

Walker, L. E. (1977). Who are the battered women? *Frontiers: A Journal of Women Studies, 2*(1), 52-57. doi:10.2307/3346107

Walsh, K., Messman-Moore, T., Zerubavel, N., Chandley, R. B., DeNardi, K. A., & Walker, D. P. (2013). Perceived sexual control, sex-related alcohol expectancies and behavior predict substance-related sexual revictimization. *Child Abuse & Neglect, 37*(5), 353-359. doi:http://dx.doi.org/10.1016/j.chiabu.2012.11.009

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults: Assessment in a large health maintenance organization. *Journal of Interpersonal Violence, 18*(2), 166-185. doi:10.1177/0886260502238733

World Health Organization (2002). *World report on violence and health*. Retrieved from http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf.

World Health Organization (1992). *International Classification of Diseases (ICD)*. Geneva. WHO.

Widom, C. S., Czaja, S. J., & Dutton, M. A. (2008). Childhood victimization and lifetime revictimization. *Child Abuse & Neglect, 32*(8), 785-796. doi:http://dx.doi.org/10.1016/j.chiabu.2007.12.006

Wilson, J. P., Droždek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence, & Abuse, 7*(2), 122-141. doi:10.1177/1524838005285914

Winstok, Z. (2011). The paradigmatic cleavage on gender differences in partner violence perpetration and victimization. *Aggression and Violent Behavior, 16*(4), 303-311. doi:http://dx.doi.org/10.1016/j.avb.2011.04.004

Yehuda, R., Schmeidler, J., Siever, L. J., Binder-Brynes, K., & Elkin, A. (1997). Individual differences in posttraumatic stress disorder symptom profiles in Holocaust survivors in concentration camps or in hiding. *Journal of Traumatic Stress, 10*(3), 453-463. doi:10.1002/jts.2490100310

Zeifman, D., & Hazan, C. (2008). Pair bonds as attachtment: Reevaluationg the evidence. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment* (pp. 436-455). New York: The Guilford Press.

Øktedalen, T., Hagtvet, K., Hoffart, A., Langkaas, T., & Smucker, M. (2014). The Trauma Related Shame Inventory: Measuring trauma-related shame among patients with PTSD. *Journal of Psychopathology and Behavioral Assessment, 36*(4), 600-615. doi:10.1007/s10862-014-9422-5

Øktedalen, T., Hoffart, A., & Langkaas, T. F. (2015). Trauma-related shame and guilt as time-varying predictors of posttraumatic stress disorder symptoms during imagery exposure and imagery rescripting—A randomized controlled trial. *Psychotherapy Research, 25*(5), 518-532. doi:10.1080/10503307.2014.917217

Øverlien, C. (2012). *Vold i hjemmet - barns strategier*. Oslo: Universitetsforlaget.

I

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BASIC RESEARCH ARTICLE

Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population

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Background: Violence in childhood is associated with mental health problems and risk of revictimisation. Less is known about the relative importance of the various types of childhood and adult victimisation for adult mental health.

Objective: To estimate the associations between various types of childhood and adult violence exposure, and their combined associations to adult mental health.

Method: This study was a cross-sectional telephone survey of the Norwegian adult population; 2,435 women and 2,092 men aged 18–75 participated (19.3% of those we tried to call and 42.9% of those who answered the phone). The interview comprised a broad array of violence exposure in both childhood and adulthood. Anxiety/depression was measured by the Hopkins Symptom Check List (HSCL-10).

Results: Victimisation was commonly reported, for example, child sexual abuse (women: 10.2%, men: 3.5%), childhood–parental physical violence (women: 4.9%, men: 5.1%), and lifetime forcible rape (women: 9.4%, men: 1.1%). All categories of childhood violence were significantly associated with adult victimisation, with a 2.2–5.0 times higher occurrence in exposed children ($p < 0.05$ for all associations). Anxiety/depression (HSCL-10) associated with adult abuse increased with the number of childhood violence categories experienced ($p < 0.001$). All combinations of childhood violence were significantly associated with anxiety/depression ($p < 0.001$ for all associations). Individuals reporting psychological violence/neglect had the highest levels of anxiety/depression.

Conclusions: Results should be interpreted in light of the low response rate. Childhood violence in all its forms was a risk factor for victimisation in adulthood. Adult anxiety/depression was associated with both the number of violence categories and the type of childhood violence experienced. A broad assessment of childhood and adult violence exposure is necessary both for research and prevention purposes. Psychological violence and neglect should receive more research attention, especially in combination with other types of violence.

Keywords: *Violence*; *child abuse*; *child sexual abuse*; *rape*; *mental health*; *revictimisation*; *epidemiology*; *anxiety*; *depression*

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Childhood violence is related to mental health problems in adulthood, as demonstrated by both retrospective (Chen et al., 2010; Green et al., 2010) and prospective (Caspi et al., 2003; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003) studies. Unfortunately, violence against children is not uncommon in the general population (Briere & Elliott, 2003) and hence constitutes a public health problem. Although there is a strong relationship between childhood violence and adult mental health problems, the link is not necessarily simple or direct. Continued social deprivation, drug and alcohol use, genetic factors and changes in stress-response systems, and cognitions, resource loss, and emotions such as self-blame and shame are among factors that

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may represent potential mediators (Caspi et al., 2003; Fergusson, Horwood, & Lynskey, 1997; King & Liberzon, 2012; Schumm, Doane, & Hobfoll, 2012; Zayfert, 2012). Revictimisation is one factor that has received substantial empirical support as a potential pathway from childhood violence to adult psychological distress (Pratchett & Yehuda, 2011).

Research on revictimisation has traditionally been limited to child sexual abuse (CSA) and subsequent adult sexual victimisation. Some researchers even restrict their definition as such (Roodman & Clum, 2001). An increased and large revictimisation risk in CSA victims has been documented (Classen, Palesh, & Aggarwal, 2005; Messman & Long, 1996). In earlier studies, victimisation was often investigated separately for various types of violence, which resulted in parallel research on, for example, CSA and child physical maltreatment. During recent years, this research has become more integrated and has thus produced robust evidence that violence victims are often exposed to multiple types of victimisation (Finkelhor, Ormrod, & Turner, 2007). Adult health seems to be highly impacted by the cumulative burden of victimisation (Cloitre et al., 2009; Felitti et al., 1998; Zayfert, 2012). However, to date, there is no clear understanding of the relative importance of specific types of victimisation compared to the total burden of violence for adult revictimisation and mental health. Finkelhor and colleagues (2007) argue against a narrow definition that investigates only one type of victimisation at early and later time points, because one type of victimisation may also increase the later risk of other types of violence. Similarly, Teicher and colleagues (2006) note that some types of violence, such as psychological abuse, have been largely ignored. Several authors have called for a broad assessment of childhood exposure to violence to better identify young people at risk for later revictimisation and health problems (Miller et al., 2011).

To investigate the importance of various childhood and adult violence exposure for mental health, we conducted a large, cross-sectional study of violence exposure in the general Norwegian population. We used a broad assessment of childhood abuse that followed the World Health Organization's categorisation of violence into sexual, physical, psychological abuse and neglect (World Report on Violence and Health, 2002), and included adult sexual abuse, physical abuse, and intimate partner violence (IPV). We hypothesised that childhood violence exposure would increase the risk of adult violence exposure, and in addition that childhood violence exposure would increase the vulnerability for developing mental health problems following adult exposure.

The aims of the study were to: 1) estimate the association between childhood violence exposure and adult violence exposure in the general Norwegian population; 2) investigate the association between both childhood and adult violence exposure and adult mental health; and 3) investigate the importance of the various combinations of childhood violence.

Methods

Participants and procedure

A random sample of Norwegian citizens aged 18–75 was drawn from the General Population Registry of Norway, which contains records of all inhabitants' personal identification number, date of birth, sex, and address. All individuals first received a postal invitation letter with information about the study, and they were subsequently phoned and asked to consent to participation in the study. Those who consented were interviewed by telephone. The only exclusion criteria were inability to participate because of language problems, difficulties in hearing, intellectual disability, or intoxication, as evaluated by the interviewer.

Altogether, 40,000 invitation letters were distributed, although not all of these individuals were contacted, and 899 individuals called or mailed to inform that they did not want to be contacted by telephone. For 7,130 individuals, no telephone number could be identified. Of the remaining 31,971, 23,441 individuals were actually called. Individuals were called randomly from the population registry sample, and calling stopped when the prespecified sample size was achieved. The mean number of calls made to those who never answered the phone ranged from 1 to 18, with a mean of 5.6. Of these, 13,794 did not answer the phone, leaving 9,647 individuals who actually answered the phone and were asked to consent to participating. Of these, 5,120 declined participation, and 4,527 participated. Not including unidentified telephone numbers and unanswered phone calls, which is comparable to the random digit dialling procedures, the response rate was 42.9% (women: 45.0%, men: 40.8%). Compared to the rest of the sample of 40,000, responders were more often female (53.8% versus 48.9%, chi square $p < 0.001$) and were slightly older (mean age 43.9 versus 43.2, t-test $p = 0.004$). Compared to those who we reached by phone, but who rejected participation, responders were more often female (53.8% versus 49.6%, chi square $p < 0.001$) and were somewhat younger (mean age 43.9 versus 46.8, t-test $p < 0.001$).

As we did not have information on marital status, educational level, and household income for the drawn sample, we compared the respondents with corresponding population figures from Statistics Norway on these variables (http://www.ssb.no/en/statistikkbanken). Approximately equal proportions of the respondents and the population at large were married, 45.0% vs. 45.0% for women and 44.6% vs. 45.4% for men, but a significantly smaller proportion of our respondents compared to the population was divorced or separated, 11.0% vs. 14.7% for

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women and 8.9% vs. 10.9% for men (chi square $p < 0.001$). Almost two times the proportion of the respondents compared to the total population had a university or college education 47.7% vs. 26.0% for men (chi square $p < 0.001$) and 56.2% vs. 31.6% for women (chi square $p < 0.001$). The respondents were also economically better off than the population as a whole, 49% of the respondents vs. 37% of the population reported a household income of more than € 85,725 (chi square $p < 0.001$). These analyses of marital status, education, and household income suggest a positive selection of respondents.

However, these analyses of socio-demographic cannot tell us whether the sample is biased in the variables under investigation. It may be likely that violence-exposed individuals considered the study to be more relevant to them, and potentially made themselves more available via telephone. We performed analyses within responders of associations between number of calls required to get in touch and socio-demographic variables as well as violence exposure. Details are described in Appendix 1. These "hard to contact" analyses do not generally support the hypothesis that individuals with more exposure or more mental health problems were easier to contact. However, women who reported physical violence in childhood and men who reported emotional neglect seemed to be slightly more available. This might indicate a small over-representation of these types of violence.

Telephone interviews were conducted by the data collection agency Ipsos MMI from 23 April to 7 July 2013.

The structure of the telephone interview followed the design of three national studies in the USA (Kilpatrick, 2004; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), and was expanded to include a detailed assessment of childhood violence. The questions were direct and as behaviour-specific as possible. Each affirmative answer was followed by a series of supplementary questions. Interviewers were instructed to make sure that participants had the necessary privacy during the interview to ensure their safety. At the end of the interview, participants were asked if they were distressed by the questions and needed to talk to someone (1.5%, N = 66). They were subsequently referred to an external follow-up service if they so wished (0.8%, N = 37). The study was approved by the Regional Committee for Medical and Health Research Ethics in South-East Norway.

Measures

Childhood violence

Child sexual abuse

Child sexual abuse was introduced with the text "Sometimes children can be tricked, rewarded or threatened to engage in sexual acts they don't understand or are unable to stop," followed by the question: "Before you were 13 years of age, did anyone who was at least 5 years older than you have any form of sexual contact with you?" If the respondent answered affirmatively, follow-up questions asked if the sexual act included vaginal, oral or anal penetration (Kilpatrick et al., 2000,2003). *Forcible rape* was measured by four questions introduced in The National Women's Study (Kilpatrick, Edmunds, & Seymour, 1992) and later used by the National Violence Against Women Survey (Tjaden & Thoennes, 1998): "Has anyone ever forced you into 1) intercourse, 2) oral sex, or 3) anal sex, or 4) put fingers or objects in your vagina or anus by use of physical force or by threatening to hurt you or someone close to you?" Forcible rape was defined as an affirmative response to any one of these four questions. Participants indicated their age at the time of the rape (or their age at the first and last time of rape in cases with more than one incident); this information was used to create variables defining rape before the age of 18.

Parental physical violence

Parental physical violence included four questions: "Have you ever been 1) hit with a fist or a hard object, 2) kicked, 3) beaten up, or 4) physically attacked in other ways?" (Kilpatrick et al., 2003). *Parental IPV* included one parent slapping, hitting with a fist or an object, kicking, strangulating, or otherwise physically attacking the other parent. *Parental psychological violence* was measured by a slightly adapted single question from the Stressful Life Events Screening Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998): "Did your parent(s) repeatedly ridicule you, put you down, ignore you, or tell you that you were no good?" *Parental emotional neglect* was measured by the question: "In your childhood, how often did you feel loved?" *Parental physical neglect* was measured by the question: "In your childhood, how often did you feel that someone could take care of you and protect you?" Both neglect questions were drawn from the Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2014). Both neglect questions were measured on a five-point scale ranging from "never" to "very often or always." Responding "never," "seldom," or "sometimes" defined neglect. Parental violence included violence from biological parents or other caregivers in parental positions.

Adult violence

Forcible rape in adulthood was defined as at least one affirmative answer to any of the four rape questions described above, when the participant was 18 or older for one or more occurrences. *Physical violence* at 18 or older included six questions: "Have you ever been 1) hit with a fist or a hard object, 2) kicked, 3) strangulated, 4) beaten up, 5) threatened with a weapon, and/or 6) physically attacked in other ways?" (Kilpatrick et al., 2003).

Follow-up questions identified perpetrator relationships, and when the perpetrator was a partner or ex-partner, the violence was categorised as *intimate partner violence*. Participants who reported other perpetrators and in addition reported that they, during the incident, experienced fear of sustaining injury were categorised as *physical violence*. This restriction was made to ensure that minor incidents were not included. Individuals could report several perpetrators and hence could report both IPV and other physical violence.

Anxiety/depression

To reduce interview time, an abbreviated 10-item version of the Hopkins Symptom Checklist-25 (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) was used in this study. Five items intended to measure last week's symptoms of depression (feeling hopeless about the future; feeling blue; blaming yourself for things; feeling everything is an effort; and feeling of worthlessness) and five items intended to measure anxiety (suddenly scared for no reason; faintness, dizziness or weakness; feeling fearful; feeling tense or keyed up; difficulties falling asleep, staying asleep). Participants responded on a scale from 0 (not bothered) to 3 (bothered a great deal). This abbreviated version of the HSCL has shown good psychometric properties, and has previously been found to correlate highly ($r = 0.97$) with the HSCL-25 in a general population sample (Tambs & Moum, 1993). A cut-off value of >1.85 achieved the best combination of specificity, sensitivity, and predictive values (Strand, Dalgard, Tambs, & Rognerud, 1993) against the 5-items Mental Health Index (Ware, Snow, & Kosinski, 2000). In the current study, the Cronbach's alpha for the 10 items was 0.89.

Socio-demographic variables included gender, age (at the time of interview), marital status, occupational status, and education level.

Statistical procedures

Prevalence data were weighted for age and area of residence. The weights were constructed as inverse probability weights for the sample of responders based on population figures from Statistics, Norway. Table 1 presents unweighted and weighted data separately for women and men. Because only minor differences were found between weighted and unweighted prevalences, all tables and figures except Table 1 present unweighted data. Gender differences in violence exposure were tested with chi square statistics. In Tables 2–4 and Fig. 1, childhood violence was collapsed into broader categories: CSA and rape, before the age of 18 now represented "any childhood sexual abuse"; parental physical violence and parental IPV became "physical violence in the family"; and psychological violence, emotional neglect and physical neglect were collapsed into "psychological violence/neglect." The relationship between childhood violence and adult violence was estimated by logistic regression analyses. Furthermore, we conducted a multiple linear regression analysis using the HSCL mean score as the outcome variable, adjusted for age and gender. Figure 1b displays the regression coefficients for the increase of the mean HSCL-10 associated with an increase in adult violence categories within each group of childhood violence categories. We used multiple linear regression analyses

Table 1. Lifetime prevalence of sexual abuse, physical abuse, psychological abuse, and neglect by gender

	Women			Men			
Violence categories	N	Unweighted%	Weighted%	N	Unweighted%	Weighted%	χ^2 p value[b]
Childhood sexual abuse							
Sexual abuse before the age of 13[a]	248	10.2	10.7	74	3.5	3.6	<0.001
Forcible rape	113	4.7	4.6	19	0.9	0.9	<0.001
Childhood family violence							
Physical violence from caretaker	117	4.9	5.0	103	5.1	5.2	0.865
IPV between caretakers	240	9.9	9.6	208	10.0	9.8	0.904
Neglect/psychological violence							
Psychological violence from caretaker	374	15.4	14.6	233	11.2	11.0	<0.001
Emotional neglect	237	9.8	9.5	179	8.6	8.7	0.199
Physical neglect	133	5.5	5.2	98	4.7	4.7	0.245
Adult abuse							
Forcible rape	150	6.2	5.8	7	0.3	0.3	<0.001
Physical violence	147	6.1	5.6	285	13.7	13.5	<0.001
Intimate partner violence	224	9.2	9.1	40	1.9	1.9	<0.001

[a]With or without penetration.
[b]χ^2 tests performed with unweighted data.

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Table 2. Associations between childhood and adult violence exposure, odds ratios (OR), and 95% confidence intervals of OR

	Adult forcible rape		Adult physical violence		Adult IPV	
	Women	Men[a]	Women	Men	Women	Men
Childhood violence	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Sexual abuse[b]	5.95 (4.20–8.44)	–	3.57 (2.46–5.19)	5.46 (3.49–8.56)	2.55 (1.84–3.54)	3.51 (1.34–9.21)
Violence in the family[c]	3.76 (2.60–5.43)	–	2.40 (1.61–3.57)	2.99 (2.19–4.08)	3.57 (2.60–4.92)	4.24 (2.16–8.30)
Neglect/psychological violence[d]	4.46 (3.18–6.26)	–	2.54 (1.79–3.60)	2.66 (2.00–3.54)	3.98 (2.99–5.29)	2.43 (1.24–4.76)

[a]n = 19.
[b]Sexual abuse = CSA before the age of 13 and/or rape before the age of 18.
[c]Violence in the family = physical violence from parents and/or parental IPV.
[d]Neglect/psychological violence = emotional neglect, physical neglect and/or psychological violence. All these single items were significantly ($p \leq 0.011$) associated with all adult violence exposure variables, except the association between physical neglect and IPV for men and all associations with adult rape, which could not be tested due to low n.

to investigate the association between HSCL-10 and all possible combinations of the three childhood violence exposure categories. All analyses were conducted in SPSS for Windows version 20.

Results

The sample comprised 2,437 women (53.8%) and 2,091 men (46.2%) and the mean age was 44.4 years (range = 18–74). The majority of participants were currently married or cohabitating (64.5%), were working or studying (76.9%), and had a college or university education (52.3%).

Prevalences of childhood and adult violence exposures are displayed in Table 1. CSA reported in Table 1 included vaginal, oral or anal penetration or attempted penetration for 4.0% of the total sample of women and 1.5% of the total sample of men. Table 1 displays rape separately for childhood and adulthood. The lifetime prevalence of forcible rape was 9.4% for women and 1.1% for men.

There were significant associations between the various violence categories reported during childhood. Participants who confirmed any CSA more often reported physical violence from caretaker (exposed: 16.7%, non-exposed: 3.8%), parental IPV (exposed: 25.2%, non-exposed: 8.3%), psychological violence (exposed: 38.4%, non-exposed 10.8%), emotional neglect (exposed: 25.3%, non-exposed: 7.3%), and physical neglect (exposed: 15.9%, non-exposed: 3.9%). Those who confirmed physical violence from caretaker more often reported any CSA (exposed: 28.8%, non-exposed: 7.4%), parental IPV (exposed: 46.5%, non-exposed: 7.2%), psychological violence (exposed: 64.8%, non-exposed: 9.9%), emotional neglect (exposed: 49.1%, non-exposed: 6.6%), and physical neglect (exposed: 32.1%, non-exposed: 3.3%). Among those who had experienced psychological violence and/or neglect, 22.9% reported any CSA (5.9% in non-exposed), 20.7% reported physical violence from caretakers (1.6% in non-exposed), and 29.7% reported parental IPV (5.5% in non-exposed). For all these associations, χ^2 p-values were < 0.001.

For both men and women, there were strong and significant relationships between childhood violence and adulthood violence that was not restricted to violence within a similar category (Table 2). Childhood exposure was associated with a 2.2–5.0 times higher occurrence of adult violence. The highest overlap was observed for women reporting CSA and adult rape (20.3% adult rape

Table 3. Psychological distress (HSCL-10) in various exposure groups

	Adult violence categories (0–2)					
	0 Adult abuse (n = 3783)		1 adult abuse (n = 645)		2 or more adult abuse (n = 100)	
Childhood violence categories (0–3)	Mean HSCL	% above cut-off HSCL	Mean HSCL	% above cut-off HSCL	Mean HSCL	% above cut-off HSCL
0 (n = 3270)	1.20	5.0	1.33	9.6	1.73	28.1
1 (n = 670)	1.35	12.1	1.63	29.3	1.86	35.3
2 (n = 306)	1.48	19.7	1.70	32.5	1.83	47.1
3 (n = 282)	1.77	38.2	1.95	50.5	2.32	64.7

Table 4. Associations between various combinations of childhood violence and HSCL-10 adjusted for adult violence, gender and age

Independent variables	Regression coefficient	95% CI
Childhood violence		
1 Sexual abuse alone (n = 167)	0.117	0.054–0.181
1 Violence in the family alone (n = 201)	0.128	0.071–0.186
1 Neglect/psychological violence alone (n = 384)	0.261	0.218–0.304
2 Sexual abuse and violence in the family (n = 42)	0.171	0.045–0.297
2 Sexual abuse and neglect/psychological violence (n = 87)	0.450	0.362–0.537
2 Violence in the family and neglect/psychological violence (n = 225)	0.370	0.314–0.425
3 Sexual abuse, violence in the family and neglect/psychological violence (n = 92)	0.637	0.550–0.724
Adult violence		
Forcible rape	0.241	0.170–0.312
Physical violence	0.188	0.146–0.230
IPV	0.188	0.133–0.243
Demographics		
Gender	0.070	0.045–0.095
Age	−0.001	−0.002–0.001

Univariate regression coefficient for child sexual abuse: 0.366, 95% CI = 0.322–0.411; for physical violence in childhood family: 0.325, 95% CI = 0.286–0.363; for neglect/psychological violence: 0.399, 95% CI = 0.367–0.431; for adult forcible rape: 0.529, 95% CI = 0.459–0.599; for adult physical violence: 0.265, 95% CI = 0.221–0.309; for adult IPV: 0.380, 95% CI = 0.325–0.435; for gender: 0.109, 95% CI = 0.083–0.135; and for age: –0.001, 95% CI = –0.002–0.000; $p < 0.001$ for all associations except age ($p = 0.014$).

in exposed versus 4.1% in non-exposed), followed by women reporting parental psychological violence/neglect and adult rape (15.3% in exposed versus 3.9% in non-exposed) and men reporting CSA and adult physical violence (43.5% in exposed versus 12.4% in non-exposed).

Anxiety/depression increased with the number of childhood and adult violence categories experienced (Table 3). Figure 1a illustrates the observed mean HSCL scores associated with adult exposure in individuals exposed to zero, one and two or more childhood violence categories. Anxiety/depression scores associated with adult abuse increased with the number of childhood violence categories. Figure 1b displays the results of a multiple regression analysis for the HSCL mean scores of adulthood abuse and childhood abuse and shows that anxiety/depression scores increased with both adult and childhood violence. Adult exposure was significantly associated with a higher HSCL mean score for all levels of childhood violence ($p < 0.001$). There was a significant interaction effect between childhood violence and adult violence ($p = 0.012$), which was due to a smaller increase in HSCL from zero to one adult violence category for those exposed to zero childhood violence (the green line in Fig. 1b).

Childhood violence exposure was significantly associated with adult anxiety/depression, even when adjusted for violence in adulthood (overall p-value < 0.001, Table 4). Among participants exposed to one childhood violence category, those exposed to neglect and/or psychological violence reported more anxiety/depression than those exposed to sexual abuse alone ($p < 0.001$) or family violence alone ($p < 0.001$). Of those who were exposed to two childhood violence categories, those exposed to neglect/psychological violence in combination with sexual abuse and/or family violence reported more anxiety/depression compared to individuals reporting the combination of sexual abuse and family physical violence ($p < 0.001$ for both comparisons). Individuals experiencing three childhood violence categories had the highest anxiety/depression scores ($p \leq 0.007$ for all comparisons). Adult violence was also uniquely associated with anxiety/depression.

Discussion

A substantial proportion of the Norwegian population reported exposure to violence. Among women, for example, 9.4% reported that they had been victims of forcible rape at least once. This is higher than the 5% rape prevalence reported in a recent study of violence in 28 European countries (Violence against women: an EU-wide survey. Main results, 2014). However, that study used an unusually strict rape definition, and used face-to-face interviews, which is known to reduce the willingness to disclose sensitive information (Jansson, 2007). The rape prevalence found in the current study is in agreement with a newly published Swedish study (Nationellt Centrum för Kvinnofrid, 2014), which found that 11% of women older than 18 years experienced rape/attempted rape. It is also in agreement with a previous study from Denmark that reported a 9% lifetime rape in women (Balvig & Kyvsgaard, 2006), but somewhat lower than the 13% rape

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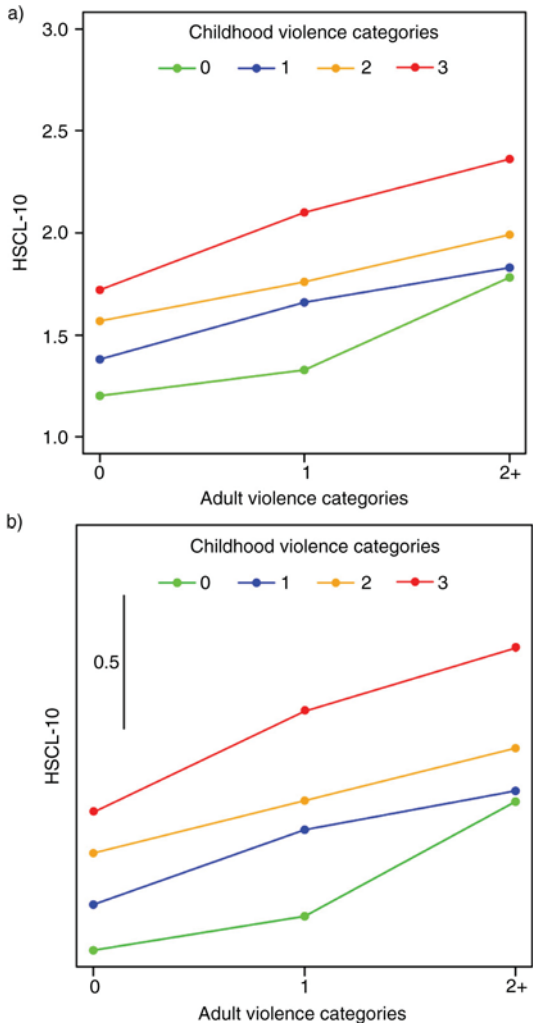

Fig. 1. Unadjusted (a) and gender- and age-adjusted (b) associations between adult violence categories and psychological distress (HSCL-10) in groups exposed to zero, one, two, or three childhood violence categories.

prevalence for women reported in the United States (Resnick et al., 1993). In our study, women carried a higher total burden of violence because they were more often exposed to sexual abuse and IPV than men.

Childhood victimisation was strongly associated with adult victimisation. This indicates a substantial risk of revictimisation in violence-exposed children, which is in accordance with previous retrospective and prospective studies (Koenen & Widom, 2009; Trickett, Noll, & Putnam, 2011). The current study expanded on previous knowledge by showing that the overlap between childhood and adult victimisation seemed to be unspecific; that is, any childhood victimisation was associated with any adult violence exposure. The associations were substantial, ranging from a two to five times higher occurrence of adult violence in exposed children. This finding contrasts with the previous main focus on CSA and sexual revictimisation (Classen et al., 2005) and concurs with recent calls for a broad research and prevention approach that targets all forms of violence against children (Finkelhor et al., 2007).

In line with previous research (Chapman et al., 2004; Dube et al., 2001; Gilbert et al., 2009), mental health problems showed a substantial and graded relationship to the number of childhood victimisation categories. Few studies have investigated both childhood and adult victimisation in detail, and our study adds to existing knowledge by showing that anxiety/depression associated with adult violence exposure increased systematically with increased childhood victimisation. All potential combinations of childhood violence were associated with anxiety/depression; however, psychological violence/neglect seemed to be particularly important. Although some studies have found CSA to be more damaging to mental health than other forms of violence (Widom, 1989), other studies have noted the importance of psychological violence and neglect (Gilbert et al., 2009; Norman et al., 2012; Teicher et al., 2006). Neglect and psychological violence may have a prominent impact on health because they are inherently long-lasting; in contrast, sexual and physical abuse are distinct events, although they may occur repeatedly. The combination of psychological violence/neglect and CSA or physical abuse seemed to be of particular importance for adult mental health. Our results concur with the increasingly large amount of literature finding that the burden of childhood violence may last a lifetime and underscore the long-term public health problems associated with violence against children.

Previous research has shown that revictimisation may be an important explanation for why violence-exposed children have increased mental health problems later in life (Koenen & Widom, 2009). This finding may not be due only to the increased risk of violence in adult life. Our study indicates that childhood violence makes individuals more vulnerable to suffering negative health consequences of the violence they experience in adulthood. Similar results have been found in a previous study (Koopman et al., 2005). Revictimisation and mental health are most likely interrelated, and previous research has also found mental health problems to be a risk factor for revictimisation—for example, through symptoms of PTSD (Arata, 2000; Ullman, Najdowski, & Filipas, 2009). Furthermore, complex relationships that include genetic factors, changes in stress-response systems, attachment, social support, and other environmental and individual conditions are also likely to play a role in revictimisation and mental health development (Pratchett & Yehuda, 2011). Prospective studies that investigate potential mediators and moderators are necessary to understand why, and for who, such negative development occurs, which will help to target prevention measures and improve care for victims.

Limitations

The current study was cross-sectional; therefore we cannot make causal inferences. Memory for past events may be influenced by current states, such as an ongoing depression. Current depressed mood may lead individuals to interpret past events more negatively, which may have resulted in an overestimation of the associations between past violence exposure and current anxiety/depression. This may have been particularly the case for emotional neglect and psychological violence, as these measures are more subjective in nature, compared to the more behaviourally specific forms of physical and sexual abuse. Although the measures of neglect and psychological violence in this study resembles those used in several other studies (Centers for Disease Control and Prevention, 2014; Christoffersen, Armour, Lasgaard, & Elklit, 2013; Green et al., 2010; Kilpatrick et al., 2003), the questions were simple, and would not be expected to capture the full variety of these phenomena. Lack of sufficient parental care and psychological abuse can happen in many different ways, in various time periods in childhood, and may have differential effects depending on the developmental stage of the child. There is currently no common agreement on how these phenomena are best measured. Hence, psychological violence and neglect has received less research attention than physical violence and sexual abuse (Gilbert et al., 2009).

The majority of the sample from the General Population Registry for who we were able to identify a telephone number, never answered the phone, and 57% of people who we were able to contact rejected participation. The comparisons of participants to general population data suggested a positive selection of respondents in terms of education and income, which may indicate that our prevalence estimates of violence and abuse are somewhat conservative.

Individuals with abuse histories may have found the study more relevant for them, and may have been more willing to participate in the study. It is also possible that violence-exposed individuals may find it hard to talk about their experiences, which would result in an underestimation of abuse prevalences. Analyses within responders of number of calls necessary to get in contact did not support the hypothesis that exposed individuals made themselves more available (see Appendix 1). However, women with a history of parental physical violence and men with a history of emotional neglect were both slightly easier to contact, which might imply a small overrepresentation of some exposure groups. On the other hand, forgetfulness, denial, misunderstanding, and embarrassment may result in false-negative reports (Gilbert et al., 2009), which may lead to under-reporting rather than over-reporting of childhood abuse (Fergusson et al., 1997). We conclude that the presented prevalence rates should be interpreted with caution.

The relationships between variables would, presumably, suffer less from a biased sample. Childhood victimisation may be related to a range of mental and somatic health consequences, but this study included only symptoms of depression and anxiety. Strengths of the study include the large sample size, the remarkably low level of missing information among respondents, and the broad assessment of childhood and adult victimisation.

Our results suggest that more effort is needed to identify and assist victimized children and follow them over time, and are in support of the newly published NICE guidelines that recommend routine screening for violence (National Institute for Health and Care Excellence, 2014). Such efforts have the potential to substantially improve mental health and quality of life of the general population. Child clinicians should be aware that child victims of violence carry an increased risk for future victimisation. It is important to note that the increased revictimisation risk seems not to be restricted to the same type of violence. The combination of both childhood victimisation and adult revictimisation is associated with particularly severe levels of psychological distress in adulthood.

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There is no conflict of interest in the present study for any of the authors.

References

Arata, C. M. (2000). From child victim to adult victim: A model for predicting sexual revictimization. *Child Maltreat*, *5*, 28–38.

Balvig, F., & Kyvsgaard, B. (2006). Volden i Danmark 1995 og 2005 [Violence in Denmark 1995 and 2005]. Denmark: University of Copenhagen.

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse Neglect*, *27*(10), 1205–1222.

Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H., et al. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, *301*(5631), 386–389. doi: 10.1126/science.1083968

Centers for Disease Control and Prevention. (2014). Family health history and health appraisal questionnaires. Retrieved December 1, 2014, from http://www.cdc.gov/violenceprevention/acestudy/pdf/fhhflorna.pdf

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217–225. doi: 10.1016/j.jad.2003.12.013

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings*, *85*(7), 618–629. doi: 10.4065/mcp.2009.0583

Christoffersen, M. N., Armour, C., Lasgaard, T. E., & Elklit, A. (2013). The prevalence of four types of childhood maltreatment in Denmark. *Clinical Practice and Epidemiology in Mental Health*, *9*, 149–156. doi: 10.2174/1745017901309010149

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma Violence Abuse*, *6*(2), 103–129. doi: 10.1177/1524838005275087

Cloitre, M., Stolback, B. C., Herman, J. L., van der Kolk, B., Pynoos R., Wang, J., et al. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408. doi: 10.1002/jts.20444

Danice, N., Jackson, D., & White, I. R. (2012). Can the repeated attempts model help til fit MNAR selection models?. Bergen, Norway: Poster presented at the 33rd Annual Conference of the International Society for Clinical Biostatistics.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science*, *19*(1), 1–15.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *JAMA*, *286*(24), 3089–3096.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse Neglect*, *21*(8), 789–803.

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Polyvictimization: A neglected component in child victimization. *Child Abuse Neglect*, *31*(1), 7–26. doi: 10.1016/j.chiabu.2006.06.008

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet*, *373*(9657), 68–81.

Goodman, L. A., Corcoran, C., Turner, K., Yuan, N., & Green, B. L. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. *Journal of Traumatic Stress*, *11*(3), 521–542. doi: 10.1023/A:1024456713321

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., et al. (2010). Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: Associations with first onset of DSM-IV disorders. *Archives of General Psychiatry*, *67*(2), 113–123. doi: 10.1001/archgenpsychiatry.2009.186

Jansson, K. (2007). *British crime survey: Measuring crime for 25 years*. London: Home Office.

Kilpatrick, D., Edmunds, C., & Seymour, A. (1992). Rape in America: A report to the nation. Arlington, VA: National Victim Center and Crime Victims Research and Treatment Center.

Kilpatrick, D. G. (2004). What is violence against women: Defining and measuring the problem. *Journal of Interpersonal Violence*, *19*(11), 1209–1234. doi: 10.1177/0886260504269679

Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology*, *68*(1), 19–30.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*, *71*(4), 692–700.

King, A. P., & Liberzon, I. (2012). Neurobiology of retraumatization. In M. P. Duckworth & V. M. Follette (Eds.), *Retraumatization: Assessment, treatment, and prevention* (pp. 61–110). New York: Routledge.

Koenen, K. C., & Widom, C. S. (2009). A prospective study of sex differences in the lifetime risk of posttraumatic stress disorder among abused and neglected children grown up. *Journal of Traumatic Stress*, *22*(6), 566–574. doi: 10.1002/jts.20478

Koopman, C., Palesh, O., Marten, B., Thompson, B., Ismailji, T., Holmes, D., et al. (2005). Child abuse and adult interpersonal trauma as predictors of posttraumatic stress disorder symptoms among women seeking treatment for intimate partner violence. In T. A. Corales (Ed.), *Focus on post-traumatic stress disorder research*. (pp. 1–16). Hauppauge, NY: Nova Science.

Messman, T. L., & Long, P. J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical Psychology Review*, *16*(5), 397–420. doi: http://dx.doi.org/10.1016/0272-7358(96)00019-0

Miller, E., Breslau, J., Chung, W. J., Green, J. G., McLaughlin, K. A., & Kessler, R. C. (2011). Adverse childhood experiences and risk of physical violence in adolescent dating relationships. *Journal of Epidemiology & Community Health*, *65*(11), 1006–1013. doi: 10.1136/jech.2009.105429

National Institute for Health and Care Excellence. (2014). *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*. NICE Public Health Guidance. London and Manchester, UK: NICE.

Nationellt Centrum för Kvinnofrid (2014). Våld och Hälsa. En befolkningsundersökning om kvinnors og mäns våldsutsatthet samt kopplingen til hälsa [National prevalence study: Violence and health]. Sweden: Uppsala Universitet, Nationellt Centrum för Kvinnofrid (NCK).

Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003). Revictimization and self-harm in females who experienced childhood sexual abuse: Results from a prospective study. *Journal of Interpersonal Violence*, *18*(*12*), 1452–1471. doi: 10.1177/0886260503258035

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Med*, *9*(11), e1001349. doi: 10.1371/journal.pmed.1001349

Pratchett, L. C., & Yehuda, R. (2011). Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Development and Psychopathology*, *23*(2), 477–491. doi: 10.1017/S0954579411000186

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology*, *61*(6), 984–991.

Roodman, A. A., & Clum, G. A. (2001). Revictimization rates and method variance: A meta-analysis. *Clinical Psychology Review*, *21*(2), 183–204.

Schumm, J. A., Doane, L. S., & Hobfoll, S. E. (2012). Conservation of resources theory. The central role of resource loss and gain in understanding retraumatization. In M. P. Duckworth & V. M. Follette (Eds.), *Retraumatization. Assessment, treatment, and prevention* (pp. 111–128). New York: Routledge.

Strand, B. H., Dalgard, O. S., Tambs, K., & Rognerud, M. (1993). Measuring the mental health status of the Norwegian population: A comparison of the instruments SCL-25, SCL-10, SCL-5 and MHI-5 (SF-36). *Nordic Journal of Psychiatry*, *57*(2), 113–118.

Tambs, K., & Moum, T. (1993). How well can a few questionnaire items indicate anxiety and depression? *Acta Psychiatrica Scandinavica*, *87*(5), 364–367.

Teicher, M. H., Samson, J. A., Polcari, A., & McGreenery, C. E. (2006). Sticks, stones, and hurtful words: Relative effects of various forms of childhood maltreatment. *American Journal of Psychiatry*, *163*(6), 993–1000. doi: 10.1176/appi.ajp.163.6.993

Thoresen, S., Aakvaag, H. F., Wentzel-Larsen, T., Dyb, G., & Hjemdal, O. K. (2012). The day Norway cried: Proximity and distress in Norwegian citizens following the 22nd July 2011 terrorist attacks in Oslo and on Utøya Island. *European Journal of Psychotraumatology*, *3*, 19709, doi: http://dx.doi.org/10.3402/ejpt.v3i0.19709

Tjaden, P. G., & Thoennes, N. (1998). Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. Washington, DC: U.S: Department of Justice, Office of Justice Programs, National Institute of Justice.

Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, *23*(2), 453–476. doi: 10.1017/S0954579411000174

Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse*, 18(4), 367–385. doi: 10.1080/10538710903035263

Violence against women: an EU-wide survey. Main results. (2014). Vienna, Austria: European Agency for Fundamental Rights (FRA).

Ware, J. E., Snow, K. K., & Kosinski, M. (2000). *SF-36® health survey: Manual and interpretation guide*: Lincoln, RI: Quality Metric Incorporated.

Widom, C. S. (1989). The cycle of violence. *Science*, *244*(4901), 160–166.

World Health Organization. (2002). *World report on violence and health*. Washington, DC: World Health Organization.

Zayfert, C. (2012). Cognitive behavioral conceptualization of retraumatization. In M. P. C Duckworth & V. M. Follette (Eds.), *Retraumatization: Assessment, treatment, and prevention* (pp. 9–32). New York: Routledge.

Appendix 1

Analyses of associations between number of calls to get in touch and socio-demographic variables, exposure variables, and mental health.

Analyses of socio-demographic differences between responders and non-responders cannot tell us whether the sample is biased in the variables under investigation. It may be likely that individuals who were especially affected by the terrorist attacks considered the study to be more relevant to them, potentially resulting in an over-representation of affected individuals. We hypothesized that those individuals who were most interested in the study would, after receiving the invitation letter, make themselves more available by telephone, resulting in fewer calls necessary to get in touch, and that those who were "hard to contact" and required many calls, would look more like non-responders. Similar procedures have been used previously, as non-responders are believed to behave more like late responders (Danice, Jackson, & White, 2012; Thoresen, Aakvaag, Wentzel-Larsen, Dyb, & Hjemdal, 2012). We investigated the number of calls required to make contact and socio-demographic variables and violence exposure. We used Mann–Whitney U tests to analyse differences between groups in number of calls, and Pearson's correlation for the association between age and number of calls.

Socio-demographic variables: Somewhat fewer calls were necessary to make contact with women (mean number of calls = 3.0, SD = 2.0) compared to men (mean = 3.1, SD = 2.1), $p = 0.015$. This gender difference was small, but statistically significant, and this is in agreement with the higher participation rate in females. Number of calls was also significantly correlated with age ($r = -0.17$, $p < 0.001$), implying that fewer calls were necessary to reach older individuals. Marital status ($p = 0.714$) and level of education ($p = 0.224$) were not significantly associated with number of calls required. Individuals who were currently unemployed, retired, or for other reasons not working or studying however, needed fewer calls (mean = 2.6, SD = 1.7) compared to those who were currently working or studying (mean = 3.2, SD = 2.1), $p < 0.001$. This finding may reflect higher availability in non-working groups.

Violence exposure and mental health: These analyses were conducted separately for women and men (Table 5). We found no significant differences in the number of calls necessary to reach those exposed versus not exposed for sexual contact before the age of 13; lifetime forcible rape; other sexual assaults; psychological violence; parental physical neglect; parental IPV; severe physical violence in adulthood or adult IPV. Fewer calls were necessary to reach women exposed to parental physical violence in childhood and men exposed to parental emotional

Table 5. Number of calls to reach respondent in relation to violence exposure

		Women			Men		
Violence exposure		Mean no of calls	SD	p	Mean no of calls	SD	p
Lifetime forcible rape	Exposed	3.0	2.1	0.875	3.7	2.6	0.348
	Not exposed	3.0	2.0		3.1	2.1	
Sexual contact before age 13	Exposed	3.0	2.0	0.896	3.1	1.7	0.579
	Not exposed	3.0	2.0		3.1	2.1	
Other sexual assaults lifetime	Exposed	3.1	2.1	0.308	3.2	2.0	0.391
	Not exposed	3.0	2.0		3.1	2.1	
Severe parental physical violence	Exposed	2.6	1.8	0.020	2.9	2.0	0.175
	Not exposed	3.0	2.1		3.2	2.1	
Parental psychological violence	Exposed	2.9	2.0	0.792	3.1	2.0	0.853
	Not exposed	3.0	2.1		3.2	2.1	
Parental IPV	Exposed	2.7	1.8	0.072	3.2	2.2	0.631
	Not exposed	3.0	2.1		3.1	2.1	
Parental emotional neglect	Exposed	2.8	1.9	0.055	3.2	2.1	0.029
	Not exposed	3.0	2.1		2.9	2.0	
Parental physical neglect	Exposed	2.8	1.9	0.396	3.0	2.0	0.657
	Not exposed	3.0	2.0		3.2	2.1	
Severe physical violence in adulthood	Exposed	3.0	2.1	0.708	3.2	2.1	0.130
	Not exposed	3.0	2.0		3.1	2.1	
Adult IPV	Exposed	3.1	1.9	0.158	3.1	2.0	0.860
	Not exposed	3.0	2.1		3.1	2.1	

Mann–Whitney U tests.

neglect. These differences were small, but statistically significant. Number of calls was not significantly associated with anxiety/depression (HSCL-10; $r = -0.085$, $p = 0.494$) or with posttraumatic stress symptoms (PCL-6; $r = -0.01$, $p = 0.494$). To conclude, these "hard to contact" analyses do not generally support the hypothesis that individuals with more exposure or more mental health problems were easier to contact. However, women who reported physical violence in childhood and men who reported emotional neglect seemed to be slightly more available. This might indicate a small overrepresentation of these types of violence.

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II

Adult victimization in female survivors of childhood violence and abuse: The contribution of multiple types of violence

Abstract

Childhood sexual abuse (CSA) is a well-established risk factor for adult victimization in women, but little is known about the importance of relationship to perpetrator and exposure to other violence types. This study interviewed 2437 Norwegian women (response rate=45.0%) about their experiences with violence. Logistic regression analyses were employed to estimate associations of multiple categories of childhood violence with adult victimization. Women exposed to CSA often experienced other childhood violence, and the total burden of violence was associated with adult rape and intimate partner violence (IPV). Research and clinicians need to take into account the full spectrum of violence exposure.

Keywords: Child sexual abuse, violence, revictimization, polyvictimization, perpetrator relationship.

Introduction

Childhood violence and abuse have been linked to a wide range of adverse outcomes in adulthood, such as adult mental health problems (Clark, Caldwell, Power, & Stansfeld, 2010; Cohen, Brown, & Smailes, 2001; Kessler et al., 2010), suicide attempts (Dube et al., 2005), somatic problems (Dong et al., 2004; Felitti et al., 1998), and various adverse functioning issues, including intimate relationship problems (Colman & Widom, 2004; Dennerstein, Guthrie, & Alford, 2004), work participation (Strøm et al., 2013), and exposure to new adverse experiences (Widom, Czaja, & Dutton, 2008). Specifically, there is ample evidence that exposure to childhood violence is a risk factor for adult violent victimization (Barnes et al., 2009; Classen, Palesh, & Aggarwal, 2005; Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007). This phenomenon is known as revictimization, and it is associated with mental health problems in adult life (Jonas et al., 2011; Kimerling et al, 2007). The results from the robust research tradition on revictimization imply that childhood experiences with violence make an individual vulnerable to new experiences of violence and abuse. Thus, it seems that childhood experiences are carried into adulthood, leading to an increased likelihood of re-exposure to violence. It is uncertain, however, which pathways are involved and which aspects of violence are most important for adult victimization.

Traditionally, child sexual abuse (CSA) has been the most studied childhood event, and its association with adult sexual violence has been repeatedly identified (Classen et al., 2005). CSA is quite prevalent in the general population, particularly in girls. Prevalence estimates from different countries suggest that CSA occurs in 7 to 36% of girls (Finkelhor, 1994). Studies from Norway show comparable results, indicating 9 to 11% CSA in girls (Mossige & Stefansen, 2007; Steine et al., 2012). Factors that may represent pathways between CSA and adult victimization

include risk behavior (Walsh et al., 2013), posttraumatic stress symptoms (Ullman, Najdowski, & Filipas, 2009), and learning processes, such as learned helplessness (see review by Messman & Long, 1996). Characteristics of the CSA experience may influence the risk of revictimization. For example, betrayal trauma theory states that the impact of trauma can depend not only on fear but also on betrayal. Dependency is crucial to betrayal; thus, the most devastating psychological effects of CSA will occur when a child is abused by a caregiver upon whom she is dependent (Freyd, 1996). Other trauma theorists concur that sexual abuse has particularly damaging effects when perpetrated by parents. For instance, Herman (1992) compares child abuse by parents to political captivity and describes children as captives due to their dependency. It may also be that CSA perpetrated by parents is more severe in terms of early onset (Trickett, Noll, & Putnam, 2011). Evidence diverges on whether health consequences are more severe when the perpetrator of CSA is a parent (Bal, De Bourdeaudhuij, Crombez, & Van Oost, 2004; Edwards, Freyd, Dube, Anda, & Felitti, 2012; Ketring & Feinauer, 1999; Lange et al., 1999; Lawyer, Ruggiero, Resnick, Kilpatrick, & Saunders, 2006). There is some empirical support for the suggestion that the experience of parental trauma may result in a compromised capacity to detect social betrayal, possibly increasing the risk of later revictimization (DePrince, 2005). Gobin and Freyd (2009) found that individuals who experienced high-betrayal trauma were more likely to experience a subsequent high-betrayal trauma, such as intimate partner violence (IPV), in adulthood. Thus, there is some indication that the perpetrator relationship in CSA is important for the revictimization risk, though the literature remains scarce. In particular, there is a lack of studies investigating the victim's relationship to the perpetrator and revictimization in light of exposure to other categories of childhood violence, such as physical or psychological violence, or childhood neglect.

Violence and abuse are currently conceptualized in a variety of ways, and concepts may differ between those researchers focusing on children and those focusing on adults, as well as between various academic and clinical fields. The World Health Organization (WHO) defines violence against children as encompassing physical and psychological violence and childhood neglect, as well as CSA (WHO, 2002), thereby employing a comprehensive definition of violence. This definition was used in the current study, and we use the term 'violence' as an overarching concept including physical violence, witnessing parental intimate partner violence (IPV), psychological violence, sexual abuse, and neglect. The focus on CSA in revictimization literature has recently been expanded, and researchers have investigated revictimization in relation to a broader range of childhood violence (Whitfield, Anda, Dube, & Felitti, 2003; Widom et al., 2008). Several studies have found that other forms of childhood abuse are associated with adult victimization, such as child physical abuse (Fiorillo, Papa, & Follette, 2013; Messman-Moore, Walsh, & DiLillo, 2010), childhood neglect (Villodas et al., 2012), and emotional abuse (Obasaju, Palin, Jacobs, Anderson, & Kaslow, 2009). One prospective study found that although all forms of childhood abuse were associated with adult victimization, individuals exposed solely to childhood neglect had significantly more revictimization than those exposed solely to physical abuse or sexual abuse (Widom et al., 2008). In addition, exposure to various categories of child abuse and neglect tend to overlap (Herrenkohl & Herrenkohl, 2009; Kessler et al., 2010); that is, the experience of one form of childhood abuse increases the likelihood of experiencing another. CSA may be only one part of the violence a child experiences.

Several studies have found an additive effect of multiple forms of abuse on adult health outcomes; for example, the Adverse Childhood Experiences study (ACE study) found

associations between number of adverse experiences in childhood (including sexual, physical and psychological abuse, and parental IPV) and diseases such as depression, alcoholism, ischemic heart disease, cancer, and liver disease in adulthood (Anda et al., 2006; Felitti et al., 1998). This underscores the importance of studying not only various categories of childhood violence but also their co-occurrence when adult health is the focus. Little is known about the way in which the combined burden of various categories of childhood violence relates to adult victimization. However, there is some support for the hypothesis that individuals who experience multiple forms of abuse are at a heightened risk for revictimization (Whitfield et al., 2003; Widom et al., 2008).

Given what we know about the overlap between different forms of childhood adversity their additive effect and the potential importance of the relationship with the perpetrator, there is a need for revictimization research that encompasses a comprehensive assessment of childhood experiences of violence. We investigated adult victimization and its association with CSA, relationship to the perpetrator, and other forms of parental childhood violence in a recent cross-sectional general population study of Norwegian women's experiences with violence. The study thus focuses on the overlap between various childhood and adult victimization, and does not aim to investigate mechanisms by which such overlap occurs. We examined the following research questions:

1. What characterizes child sexual abuse (CSA) perpetrated by a parent compared to CSA perpetrated by other known or uknown persons in terms of event severity, overlap with other categories of childhood violence, and adult victimization?

2. Is childhood violence associated with adult rape and IPV, and if so, is CSA of particular importance?
3. How is the combined burden of multiple categories of childhood violence associated with adult victimization?

Methods

Study and response rate

The current sample comprised 2437 women between the ages of 18 and 75 (mean age 45.2, SD 15.8). This sample is part of a larger study that assessed violence and sexual abuse in a sample of 6500 Norwegian men, women, and youths. The response rate among those reached by telephone, which is comparable to random digit dialing procedures, was 45.0% for women and 40.8% for men. In a previous publication, we investigated selection bias by analyzing whether our sample differed from the general Norwegian population, and if responders differed from non-responders, in characteristics such as marital status, education and income. We found indications of a moderate positive bias in terms of marital status and income compared to the general population. Once we had established contact, women were more likely to be willing to participate than men, and responders were slightly older than non-responders. We also investigated whether our study variables correlated with the number of calls necessary to obtain contact with participants, under the hypothesis that the more calls needed to reach an individual, the more similar that individual would be to non-responders. There were few significant differences in the number of calls necessary to contact those that had been exposed to violence compared to those that had not been exposed, though women who had experienced physical violence in childhood seemed to be slightly more available than women who did not report such experiences (Thoresen, Myhre,

Wentzel-Larsen, Aakvaag & Hjemdal, 2015). Most participants (65.4%) were either married or cohabited with a partner. Only a few participants (3.9%) had a non-Nordic cultural background, defined as having two parents born outside the Nordic countries (of these, most parents were born in Europe). Approximately half (52.6%) had completed higher education after high school (university or university college), and most (90.6%) perceived their financial situation as average or above. Further, 247 women (10.1%) had experienced CSA before the age of 13, 150 (6.2%) women had experienced at least one forcible rape in adulthood, and 224 (9.2%) had experienced IPV (Thoresen et al., 2015).

We used a computer-assisted telephone interview (CATI), a method that allows for flexibility in the interview. Our manual was designed after a strategy developed by Kilpatrick and colleagues (Kilpatrick et al., 2003; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), where endorsement of items asking about experiences leads the respondent to a series of supplementary questions about events. Questions about experiences with violence were, as much as possible, behaviorally specific (Kilpatrick et al., 2003). Although the telephone interview was designed according to the second wave of the National Adolescent Study (Kilpatrick et al., 2003), questions were adapted to fit the Norwegian context. In addition, the interview was expanded with a broad assessment of childhood violence. Interviewers were instructed to make sure that participants had sufficient privacy when answering questions, by asking if the participant was alone and could answer the survey without being overheard by others. If the participant did not have sufficient privacy, the interviewers offered to call back at a more suitable time. In addition, questions were designed so that answers were neutral (e.g., “yes” or “no”), ensuring further privacy for the respondents. At the end of the interview, all participants were asked a series of follow-up questions designed to assess their need for assistance. Those who

were in need of assistance were offered referrals to mental health services. The study was approved by the Regional Committee for Medical and Health Ethics in Norway.

Measures

Child sexual abuse was measured using the following question: "We will now ask you a few questions about sexual acts that may take place during childhood. Sometimes children can be tricked, rewarded or threatened into sexual acts that they do not understand or are not able to stop. Before you were age 13, did anyone who was five or more years older than you ever have sexual contact with you?" This question was taken from The National Stressful Events Web Survey (Kilpatrick, Resnick, Baber, Guille, & Gros, 2011). All women who answered this item affirmatively were defined as having been exposed to CSA. Those who were exposed to CSA were asked follow-up questions. These questions included relationship to the perpetrator, age when the event happened, and whether it was a single event or an event that occurred multiple times. *Relationship with the perpetrator* was recorded on a comprehensive list of potential relationships and, for the purpose of this article, categorized into parental relation (biological parents, step-parents or mother's or father's girlfriend or boyfriend), other known perpetrators (other family members or people the respondent knew, such as teachers, leaders of activities, friends and neighbors), or strangers (both children and adults). In the category "other known perpetrators", the most common groups were adult relatives (other than parents) and acquaintances. C*haracteristics of abuse* included age of onset, for the purposes of this study dichotomized as before the age of ten or older (Kliegman, Nelson, & Behrman, 2011); whether it was a single event or multiple incidents; whether abuse involved penetration; whether the respondent feared for her life or feared serious injury during the abuse; and whether she

sustained physical injuries. We considered early onset, multiple incidents, penetration, fear for life or serious injury, and sustaining physical injury as indicators of the severity of abuse.

Parental physical violence was defined by the following four items: having been beaten with a fist or hard object, kicked, beaten up or otherwise physically attacked by a caregiver (Kilpatrick et al., 2003). Endorsement of at least one item was defined as having experienced parental physical violence. *Psychological violence* was measured by one item from the Stressful Life Event Screening Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998), asking whether a caregiver repeatedly ridiculed, put down, ignored the respondent or told the respondent that she was no good; this item was scored according to a yes/no format. *Emotional neglect* was measured by one item asking respondents how often in their childhood they felt loved. Responses were given on a 5-point Likert scale ranging from "never" to "very often or always" and were coded as emotional neglect if "never", "rarely" or "sometimes" was endorsed. *Parental IPV* was defined by endorsement of at least one of the following five items: having seen or heard one parent or caregiver slapping the other, beating the other with a fist or hard object, kicking the other, choking the other or otherwise physically attacking the other (Kilpatrick et al., 2003).

Adult victimization

Adult rape: Respondents were asked questions about four forms of rape: "Has anyone ever forced you into a) intercourse, b) oral sex, c) anal sex or d) put fingers or objects in your vagina or anus by use of physical force or by threatening to hurt you or someone close to you?" If a respondent had experienced at least one of these items when she was 18 years or older, the event was defined as adult rape. *Adult IPV:* Respondents were asked six questions about violent acts

they might have experienced: having been beaten with a fist or object, kicked, choked, beaten up, threatened with a weapon or otherwise physically assaulted after they had turned 18. All items had yes/no response categories. Relationship to the perpetrator was asked in supplementary questions, and respondents who identified a partner or ex-partner as the perpetrator were categorized as endorsing adult IPV. Measures of adult rape and adult IPV were adapted from the National Adolescent Study (Kilpatrick et al., 2003).

Adjustment variables were age, ethnicity (having a Non-Nordic background, i.e. having two parents born outside of Norway and the Nordic countries), parental mental health problems (as measured by Felitti et al., 1998), and education (high school completion).

Statistical analyses

In tables 1 and 2, groups of CSA perpetrator relationships were compared. Some respondents experienced CSA both from parents and from other people they knew or from known and unknown perpetrators. To ensure that each respondent was only represented in one category, we represented the relationship with the perpetrator in a hierarchical variable in which the closeness of the relationship determined where a respondent was placed in cases of overlap. Parental relationships were defined as the closest, whereas other known perpetrators were defined as less close than parents but closer than strangers. Thus, a respondent with both a parental perpetrator and another known perpetrator was placed in the parental perpetrator category, whereas a person with both another known perpetrator and an unknown perpetrator was placed in the known perpetrator category. Overall, 17 women reported such an overlap (8 had an overlap between parents and other known perpetrators, and 9 had an overlap between other known perpetrators

and strangers). In the multivariable models (table 4), relationship with the perpetrator was not defined according to this hierarchy. Instead, CSA perpetrated by someone who was not a parent was included as a separate dichotomous variable, whereas CSA from a parent was included in the parental violence variable. Thus, a respondent with both parental and other CSA was scored as exposed on both variables. One person did not report her relationship with the perpetrator and was excluded from the analyses.

We adjusted for sociodemographic variables (age and ethnicity), and for variables that may indicate social disadvantage in childhood (parental mental health and high school completion).

Chi-square tests were employed to test differences in event characteristics between different groups of perpetrator relationships (tables 1 and 2). Where small cells occurred, exact tests were employed, using a Monte Carlo procedure with 100000 replications if necessary. Logistic regression analyses were employed to test associations between various forms of childhood violence and perpetrator relationships with two dichotomous outcome variables: adult rape and adult IPV (tables 3 and 4). Because the amount of missing information was very low in this sample (out of 2437 respondents, 13 did not answer questions about adult rape, and 3 did not answer questions about adult IPV), complete case analyses were implemented. All regressions within the same table were run on the same selection of individuals.

All analyses in the tables were performed using SPSS Statistics 20 for Windows.

Results

Characteristics of abuse

Among the women with CSA experiences, most had experienced CSA from a non-parental known perpetrator. When CSA was committed by a parental perpetrator, it was more often severe in some characteristics of the event (more than one incident and injury sustained) than if it was committed by another known or unkown perpetrator. However, CSA was not more severe in terms of other characteristics (early onset, fear for life or severe injury and penetration).

Relationship to the perpetrator and other parental violence

Women who had experienced CSA had been victims of other forms of childhood violence more often than women without such experiences (all χ^2 p-values <.001). As shown in table 1, women who were sexually abused by their parents experienced all of these forms of parental violence to a greater extent than those who were sexually abused by other perpetrators. Table 2 presents the occurrence of non-sexual parental violence in the three perpetrator groups. Those who experienced CSA from a parental perpetrator experienced a high number of other categories of parental violence, with 85.7% experiencing at least one other category of parental violence and 34.3% experiencing three or more other categories. Children who were sexually abused by perpetrators other than parents also reported high levels of exposure to parental violence: 47.6% of those sexually abused by other known perpetrators, and 57.5% of those abused only by strangers experienced at least one category of parental violence. Thus, all women who were exposed to CSA were highly burdened by other forms of parental violence, but none as much as the respondents who were sexually abused by their parents.

Adult victimization

CSA was significantly associated with adult rape and IPV, which occurred 2-3 times more often in exposed respondents than in non-exposed respondents (adult rape: 18.4% in those exposed to CSA, 4.8% in those not exposed to CSA; adult IPV: 18.3% in those exposed to CSA, 8.2% in those not exposed; both χ^2 p-values <.001). The increased occurrence of adult rape and IPV was observed for all CSA perpetrator groups. There were no significant differences between the different groups of perpetrators in the occurrence of adult rape and IPV (χ^2 p-values .829 and .285, respectively).

Associations between childhood violence and adult victimization

To compare different forms of childhood violence, we examined the association between CSA, non-sexual parental violence and adult victimization (table 3). CSA by different perpetrators was collapsed into "any CSA". Before adjusting for each other, all measured forms of childhood violence were associated with both outcomes. CSA was associated with adult rape, as expected. Parental psychological violence and witnessing parental IPV were also significantly associated with adult rape after adjusting for the other categories of violence and age. CSA was also associated with adult IPV; however, after adjusting for the other categories of childhood violence and adjustment variables, the association was no longer significant. Parental psychological violence, parental emotional neglect, and witnessing parental IPV remained significantly associated with adult IPV.

The total burden of childhood violence and adult victimization

Table 4 presents the associations of the number of categories of parental violence and extra-parental CSA with adult victimization. Our results show that having experienced one category of

parental violence in childhood, as opposed to no categories, was significantly associated with rape and IPV in adulthood. Further, our findings suggest a graded relationship between the number of categories of childhood parental violence and both adult rape and IPV, where the odds of adult victimization increase with the number of childhood violence categories. Thus, in our data, the more categories of childhood abuse a woman experienced, the more likely she was to have been a victim of sexual or physical violence in adulthood. After adjusting for parental violence, extra-parental sexual abuse was significantly and uniquely associated with adult rape, though no longer significantly associated with adult IPV. Our findings are consistent with a graded relationship, although not all contrasts were significant.

Education may be on a causal pathway between childhood violence and adult victimization, for example, mental health problems and substance abuse resulting from childhood violence may make it more difficult for an individual to complete high school. Therefore, adjusting for education may represent overadjustment. We performed supplementary analyses without adjusting for education. These analyses yielded results that were almost identical to the full models, with highly overlapping confidence intervals.

Discussion

Revictimization is one of the main concerns facing women who have experienced violence. In the present study, we found that not only sexual abuse, but also other types of violence in childhood, were associated with adult victimization. The strongest association with revictimization was found for those who experienced multiple types of childhood violence.

We found that CSA from parents was associated with some, but not all, indicators of abuse severity. Thus, our findings were inconclusive regarding whether parental CSA is more severe than CSA perpetrated by other known or unknown persons. However, when we considered the co-occurrence of other categories of violence experienced in childhood, clear differences emerged between those abused by parents and those abused by others. It is important to note that in comparison with non-exposed women, all groups of CSA-exposed women, regardless of their relationship to the perpetrator, had an increased occurrence of additional childhood violence. However, women who had experienced parental CSA were particularly prone to report other types of parental violence, namely emotional neglect, physical and psychological violence, and witnessing parental IPV. In fact, parental CSA rarely occurred alone. Rather, parental CSA seems to fit into a pattern of violence from parents. These results emphasize the particular vulnerability to other types of violence exposure in girls exposed to parental CSA.

Contrary to our hypothesis, revictimization in adulthood was not significantly more common among individuals who were sexually abused by parents. Betrayal trauma theory states that traumas high in betrayal, such as parental sexual abuse, might result in a reduced capacity to detect betrayal in interpersonal relationships, leading to revictimization in adulthood (DePrince, 2005; Freyd, 1996). However, children might experience a high degree of betrayal even when the perpetrator is not a parent. Perpetrators of CSA are typically persons the child trusts, depends upon or cares for, such as other relatives or acquaintances.

Importantly, we found relatively high levels of exposure to other categories of parental violence among all CSA survivors. Perhaps non-sexual violence from parents is just as likely to create a sense of betrayal as parental CSA.

Our findings imply that both sexual and non-sexual violence in childhood are associated with adult rape and adult IPV. Childhood violence entails an increase in adult victimization that appears largely unspecific; for example, witnessing parental IPV in childhood is associated with adult rape, and childhood psychological violence is associated with adult IPV. However, not all categories of childhood violence were significantly associated with adult victimization in the adjusted model. The more categories of childhood violence a respondent had experienced, the more likely she was to have also experienced adult physical or sexual victimization. It seems that not only are categories of violence other than CSA comparably associated with adult victimization, but tthat he combination of various types of parental violence is particularly potent when adult victimization is the outcome. Thus, the additive effect of multiple categories of childhood adversity and violence that has been found on mental and somatic health outcomes (Anda et al., 2006; Felitti et al., 1998) seems apply to various categories of victimization in adulthood as well.

Our findings underscore the need to assess childhood violence in a broad, comprehensive fashion, in line with the recommendations from Finkelhor, Ormrod, and Turner (2007). To better understand the impact of the violence children experience, a range of violent acts should be taken into account. In our study, the total burden of childhood violence was the most important factor for adult victimization. Thus, the adverse effect of multiple categories of childhood violence seems to be present in the general population as well as in more severely exposed populations, as shown by other authors (Widom et al., 2008).

A potentially causal relationship between childhood and adult violence is likely not simple and direct (Pratchett & Yehuda, 2011); many factors influence an individual's vulnerability. The strong association between childhood violence and adult victimization, and

their combined effect on health, nevertheless points to an opportunity for intervention. Clinicians working with children who have experienced one type of violence, such as CSA, can benefit from assessing experiences of parental violence in a comprehensive manner. Our findings imply that such assessment will be of particular importance when CSA was committed by a parent, although it is still recommended with non-parental perpetrators. Screening for violent experiences is not always done in child mental health clinics, and clinicians may experience ambivalence towards asking about such experiences (Hultmann, Möller, Ormhaug, & Broberg, 2014). The systematic use of a screening tool may help clinicians to assess these experiences in help-seeking children.

Understanding that childhood violence entails an increased risk of adult violence provides clinicians and others who work with exposed children with an opportunity to prevent subsequent violence and abuse. Our results emphasize children's need for protection from further violence after experiencing a variety of violent events. In particular, children who experience multiple forms of violence are in need of intervention in order to prevent revictimization.

When working with adult victims of rape and IPV, clinicians could also benefit from a comprehensive assessment of experiences of childhood violence, so that they can select the appropriate interventions. In addition, being aware of the full range of childhood violence experienced by their adult patients may help therapists to better understand their patients' current problems. Our findings imply that childhood experiences with violence should be a part of the screening of violence-exposed adults.

Revictimization in adulthood constitutes one of many negative outcomes in the study of the consequences of childhood violence and abuse. In our opinion, studies of treatment

approaches to trauma-related problems in children could benefit from including subsequent violence as an outcome, in addition to health.

This study focuses on the association between childhood and adult experiences with violence. Future prospective studies should identify mediators that may lie on the path between first exposure to violence or abuse and later victimization. with a focus on individual coping ability, risk and protective factors in close relationships, and community factors and social or educational deprivation. Identifying these mechanisms will help target interventions to prevent negative long-term development in high-risk children.

This study has several important limitations. Because it is a cross-sectional study, we cannot imply causality. Individuals with experiences of violence in adulthood may recall their experiences of violence in childhood more easily, possibly affecting our estimates of association. The response rate of the study was such that more than half of those we reached by telephone declined to participate, which may have introduced selection bias to our sample. Unfortunately, lower response rates in telephone surveys seems to be a trend (Atrostic, Bates, Burt, & Silberstein, 2001). In studies of violence and abuse, it is hard to evaluate the validity of self-report, as there is no gold standard with which to compare. Nevertheless, there is no accepted alternative to self-report in these studies. The respondents' lack of willingness to disclose highly sensitive information is perceived by some authors as a greater challenge than false positive reports (Fergusson, Horwood, & Woodward, 2000). We used behaviorally specific questions in this study, and previous studies have demonstrated that this strategy greatly increases participants' disclosure (Fisher, Cullen, & Turner, 2000). Some studies have investigated test-retest reliability on self-reports of experiences with violence. The results from these studies indicate that people are just as likely to be inconsistent when answering questions about violence

and abuse as when they are answering questions about subjects such as lifetime drug use or age of first alcohol use (see Thoresen & Øverlien, 2009 for a discussion). Nevertheless, retrospective report may be biased, as memories of past events may be influenced by current emotional states.

The hierarchical variable we used for tables 1 and 2 to perform chi-square analyses might introduce a bias by shifting more serious violence (e.g., with multiple perpetrators) in the direction of parental perpetrators or other relatives or known perpetrators (tables 1 and 2). When we performed the analyses for tables 1 and 2 with the individuals who had experienced CSA with overlapping categories of perpetrators excluded, the results remained largely the same; thus, it is unlikely that our results can be attributed to the hierarchical variable. We lacked information about non-parental violence other than CSA, such as community violence or bullying. Our analyses show that the overlap between childhood and adult violence withstood adjustment for age, ethnicity, education, and parental mental health problems during childhood (tables 3 and 4). Other indicators of childhood social disadvantage that we were not able to control for may also have influenced revictimization risk (e.g. parental income, parental education, financial situation in childhood). Current social disadvantage, such as low income or unemployment, could not be used for adjustment, as they may be an outcome of violence exposure, rather than a confounding variable. Participants in this study are Norwegian women, and our results are not necessarily transferable to women from other countries and cultures.

The strengths of this study include the thorough assessment of childhood violence with questions about a variety of events and detailed information about experiences of violence, including the perpetrator relationship.

References

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186. doi: 10.1007/s00406-005-0624-4

Andrews, G., Corry, J., Slade, T., Issakidis, C., & Swanston, H. (2004). Child sexual abuse. In WHO (Ed.), *Comparative quantification of health risks,* 1851-1940. Geneva: WHO.

Atrostic, B. K., Bates, N., Burt, G., & Silberstein, A. (2001). Nonresponse in US government household surveys: Consistent measures, recent trends, and new insights. *Journal of Official Statistics, 17*(2), 209-226.

Bal, S., De Bourdeaudhuij, I., Crombez, G., & Van Oost, P. (2004). Differences in trauma symptoms and family functioning in intra-and extrafamilial sexually abused adolescents. *Journal of Interpersonal Violence, 19*(1), 108-123. doi: 10.1177/0886260503259053

Barnes, J. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2009). Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child Abuse & Neglect, 33*(7), 412-420. doi: http://dx.doi.org/10.1016/j.chiabu.2008.09.013

Clark, C., Caldwell, T., Power, C., & Stansfeld, S. A. (2010). Does the influence of childhood adversity on psychopathology persist across the lifecourse? A 45-year prospective epidemiologic study. *Annals of Epidemiology, 20*(5), 385-394. doi: http://dx.doi.org/10.1016/j.annepidem.2010.02.008

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse, 6*(2), 103-129. doi: 10.1177/1524838005275087

Cohen, P., Brown, J., & Smailes, E. (2001). Child abuse and neglect and the development of mental disorders in the general population. *Development and Psychopathology, 13*(04), 981-999. doi: http://dx.doi.org/10.1017/S0954579401004126

Colman, R. A., & Widom, C. S. (2004). Childhood abuse and neglect and adult intimate relationships: A prospective study. *Child Abuse & Neglect, 28*(11), 1133-1151. doi: http://dx.doi.org/10.1016/j.chiabu.2004.02.005

Dennerstein, L., Guthrie, J. R., & Alford, S. (2004). Childhood abuse and its association with mid-aged women's sexual functioning. *Journal of Sex & Marital Therapy, 30*(4), 225-234. doi: 10.1080/00926230490422331

DePrince, A. P. (2005). Social cognition and revictimization risk. *Journal of Trauma & Dissociation, 6*(1), 125-141. doi: 10.1300/J229v06n01_08

Dong, M., Giles, W. H., Felitti, V. J., Dube, S. R., Williams, J. E., Chapman, D. P., & Anda, R. F. (2004). Insights into causal pathways for ischemic heart disease: Adverse Childhood Experiences Study. *Circulation, 110*(13), 1761-1766. doi: 10.1161/01.cir.0000143074.54995.7f

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28*(5), 430-438. doi: http://dx.doi.org/10.1016/j.amepre.2005.01.015

Edwards, V. J., Freyd, J. J., Dube, S. R., Anda, R. F., & Felitti, V. J. (2012). Health outcomes by closeness of sexual abuse perpetrator: A test of betrayal trauma theory. *Journal of Aggression, Maltreatment & Trauma, 21*(2), 133-148. doi: 10.1080/10926771.2012.648100

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258. doi: 0.1016/S0749-3797(98)00017-8

Fergusson, D. M., Horwood, L. J., & Woodward, L. J. (2000). The stability of child abuse reports: A longitudinal study of the reporting behaviour of young adults. *Psychological Medicine, 30*, 529-544.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse & Neglect, 18*(5), 409-417. doi: http://dx.doi.org/10.1016/0145-2134(94)90026-4

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*(1), 7-26. doi: http://dx.doi.org/10.1016/j.chiabu.2006.06.008

Fiorillo, D., Papa, A., & Follette, V. M. (2013). The relationship between child physical abuse and victimization in dating relationships: The role of experiential avoidance. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(6), 562-569. doi: 10.1037/a0030968

Fisher, B. S., Cullen, F. T., & Turner, M. G. (2000). *The sexual victimization of college women*. Washington, U.S.: U.S. Department of Justice.

Freyd, J. J. (1996). *Betrayal Trauma: The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet, 373*(9657), 68-81. doi: http://dx.doi.org/10.1016/S0140-6736(08)61706-7

Gobin, R. L., & Freyd, J. J. (2009). Betrayal and revictimization: Preliminary findings. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(3), 242-257. doi: 10.1037/a0017469

Goodman, L., Corcoran, C., Turner, K., Yuan, N., & Green, B. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. *Journal of Traumatic Stress, 11*(3), 521-542. doi: 10.1023/A:1024456713321

Herman, J. L. (1992). *Trauma and Recovery. The aftermath of violence—From domestic abuse to political terror.* New York, NY: Basic Books.

Herrenkohl, R., & Herrenkohl, T. (2009). Assessing a child's experience of multiple maltreatment types: Some unfinished business. *Journal of Family Violence, 24*(7), 485-496. doi: 10.1007/s10896-009-9247-2

Hultmann, O., Möller, J., Ormhaug, S., & Broberg, A. (2014). Asking routinely about intimate partner violence in a child and adolescent psychiatric clinic: A qualitative study. *Journal of Family Violence, 29*(1), 67-78. doi: 10.1007/s10896-013-9554-5

Jonas, S., Bebbington, P., McManus, S., Meltzer, H., Jenkins, R., Kuipers, E., . . . Brugha, T. (2011). Sexual abuse and psychiatric disorder in England: Results from the 2007 Adult Psychiatric Morbidity Survey. *Psychological Medicine, 41*(4), 709-719. doi: 10.1017/S003329171000111X

Kessler, R. C., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., . . . Williams, D. R. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry, 197*(5), 378-385. doi: 10.1192/bjp.bp.110.080499

Ketring, S. A., & Feinauer, L. L. (1999). Perpetrator-victim relationship: Long-term effects of sexual abuse for men and women. *The American Journal of Family Therapy, 27*(2), 109-120. doi: 10.1080/019261899262005

Kilpatrick, D. G., Resnick, H. S., Baber, B., Guille, C., & Gros, K. (2011). *The National Stressful Events Web Survey (NSES-W)*. Charleston, SC: Medical University of South Carolina.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology, 71*(4), 692-700. doi: 10.1037/0022-006X.71.4.692

Kimerling, R., Alvarez, J., Pavao, J., Kaminski, A., & Baumrind, N. (2007). Epidemiology and consequences of women's revictimization. *Women's Health Issues, 17*(2), 101-106. doi: http://dx.doi.org/10.1016/j.whi.2006.12.002

Kliegman, R. M., Nelson, W. E., & Behrman, R. E. (2011). *Nelson textbook of pediatrics*. Philadelphia, PA: Saunders Elsevier.

Lange, A., De Beurs, E., Dolan, C., Lachnit, T., Sjollema, S., & Hanewald, G. (1999). Long-term effects of childhood sexual abuse: Objective and subjective characteristics of the abuse and psychopathology in later life. *The Journal of Nervous and Mental Disease, 187*(3), 150-158. doi: 10.1097/00005053-199903000-00004

Lawyer, S. R., Ruggiero, K. J., Resnick, H. S., Kilpatrick, D. G., & Saunders, B. E. (2006). Mental health correlates of the victim-perpetrator relationship among interpersonally victimized adolescents. *Journal of Interpersonal Violence, 21*(10), 1333-1353. doi: 10.1177/0886260506291654

Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse & Neglect, 34*(12), 967-976. doi: http://dx.doi.org/10.1016/j.chiabu.2010.06.004

Messman, T. L., & Long, P. J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical Psychology Review, 16*(5), 397-420. doi: http://dx.doi.org/10.1016/0272-7358(96)00019-0

Mossige, S., & Stefansen, K. (2007). Vold og overgrep mot barn og unge - En selvrapporteringsstudie blant avgangselever i videregående skole [Violence and sexual abuse against children and youth – A self-report study of students in the last year of high school]. *Rapporter 20/2007*.

Obasaju, M. A., Palin, F. L., Jacobs, C., Anderson, P., & Kaslow, N. J. (2009). Won't you be my neighbor? Using an ecological approach to examine the impact of community on revictimization. *Journal of Interpersonal Violence, 24*(1), 38-53. doi: 10.1177/0886260508314933

Pratchett, L. C., & Yehuda, R. (2011). Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Development and Psychopathology, 23*(02), 477-491. doi: doi:10.1017/S0954579411000186

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative

national sample of women. *Journal of Consulting and Clinical Psychology, 61*(6), 984-991. doi: 10.1037/0022-006X.61.6.984

Steine, I., Milde, A. M., Bjorvatn, B., Grønli, J., Norhus, I. H., Mrdalj, J., & Pallesen, S. (2012). Forekomsten av seksuelle overgrep i et representativt befolkningsutvalg i Norge [The prevalence of sexual abuse in a population-based Norwegian sample]. *Tidsskrift for norsk psykologforening, 49*(10), 950-957.

Strøm, I. F., Thoresen, S., Wentzel-Larsen, T., Hjemdal, O. K., Lien, L., & Dyb, G. (2013). Exposure to life adversity in high school and later work participation: A longitudinal population-based study. *Journal of Adolescence, 36*(6), 1143-1151. doi: http://dx.doi.org/10.1016/j.adolescence.2013.09.003

Thoresen, S., Myhre, M., Wentzel-Larsen, T., Aakvaag, H. F., & Hjemdal, O. K. (2015). Violence against children, later victimisation, and mental health: A cross-sectional study of the general Norwegian population. *European Journal of Psychotraumatology, 6*. doi: 10.3402/ejpt.v6.26259

Thoresen, S., & Øverlien, C. (2009). Trauma victim: Yes or no?: Why it may be difficult to answer questions regarding violence, sexual abuse, and other traumatic events. *Violence Against Women, 15*(6), 699-719. doi: 10.1177/1077801209332182

Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology, 23*(02), 453-476. doi: doi:10.1017/S0954579411000174

Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault

survivors. *Journal of Child Sexual Abuse, 18*(4), 367-385. doi: 10.1080/10538710903035263

Villodas, M. T., Litrownik, A. J., Thompson, R., Roesch, S. C., English, D. J., Dubowitz, H., . . . Runyan, D. K. (2012). Changes in youth's experiences of child maltreatment across developmental periods in the LONGSCAN consortium. *Psychology of Violence, 2*(4), 325-338. doi: 10.1037/a0029829

Walsh, K., Messman-Moore, T., Zerubavel, N., Chandley, R. B., DeNardi, K. A., & Walker, D. P. (2013). Perceived sexual control, sex-related alcohol expectancies and behavior predict substance-related sexual revictimization. *Child Abuse & Neglect, 37*(5), 353-359. doi: http://dx.doi.org/10.1016/j.chiabu.2012.11.009

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults: Assessment in a large health maintenance organization. *Journal of Interpersonal Violence, 18*(2), 166-185. doi: 10.1177/0886260502238733

WHO. (2002). World report on violence and health. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *Public Helath Report* (pp. 3-21). Geneva: World Health Organization.

Widom, C. S., Czaja, S. J., & Dutton, M. A. (2008). Childhood victimization and lifetime revictimization. *Child Abuse & Neglect, 32*(8), 785-796. doi: http://dx.doi.org/10.1016/j.chiabu.2007.12.006

Table 1: Characteristics of child sexual abuse according to relationship to the perpetrator of CSA, n=247 (total N=2437)

	CSA, yes or no (N=2437)		CSA (n=247), relationship to perpetrator			
	N (%)	N (%)	N (%)	N (%)	N (%)	χ^2 p-value[d]
	No CSA	CSA	Parental perpetrator[a]	Other known perpetrator[b]	Only stranger as perpetrator[c]	
	2177 (89.8)	247 (10.2)	35 (1.4)	181 (7.5)	31 (1.3)	
Characteristics of abuse						
Onset before age 10		143 (59.8)	16 (48.5)	111 (63.4)	16 (51.6)	.165
More than one incident		148 (59.9)	29 (82.9)	112 (61.9)	7 (22.6)	<.001
Fear for life/severe injury		36 (14.9)	8 (24.2)	19 (10.7)	9 (29)	.008
Sustained injury		22 (9.1)	10 (30.3)	9 (5.1)	3 (9.7)	<.001
Involved penetration		98(40.2)	12 (36.4)	74 (41.1)	12 (38.7)	.888
Other parental violence						
Parental physical violence	78 (3.7)	36 (16.1)	8 (36.4)	21 (12.3)	7 (22.6)	.009
Parental psychological violence	279 (12.8)	90 (36.4)	23 (65.7)	54 (29.8)	13(41.9)	<.001
Childhood emotional neglect	166 (7.7)	60 (24.4)	14 (41.2)	37 (20.4)	9 (29.0)	.028
Witnessing parental IPV	175 (8.0)	60 (24.6)	15 (44.1)	40 (22.2)	5 (16.7)	.014

[a] Any woman who reported that CSA was committed by a parent. [b]Women who reported that CSA was committed by someone they knew that was not a parent; if two categories were endorsed and one was a parent, the respondent was categorized in the parental perpetrator category. [c] Only stranger(s) as perpetrator(s); if two categories were endorsed and one was a parent or other known perpetrator, the respondent was categorized in the parental perpetrator category (if any CSA by parent) or other known perpetrator (if no CSA from parent but any from other known). [d] χ^2 analyses between the three groups of perpetrator relationships.

Table 2: Number of other categories of parental violence, by perpetrator of CSA

Other parental violence	No CSA	CSA, by perpetrator			
	N (%)	Parental N (%)	Other known N (%)	Only stranger N (%)	χ^2 p-value[a]
No kind	1723 (79.1)	5 (14.3)	97 (53.6)	13 (41.9)	
One kind	287 (13.2)	13 (37.1)	44 (24.3)	9 (29.0)	
Two kinds	104 (4.8)	5 (14.3)	17 (9.4)	4 (12.9)	
Three or more kinds	63 (2.9)	12 (34.3)	23 (12.7)	5 (16.1)	<.001

[a] χ^2 p-value for difference between the three perpetrator groups

Table 3: Logistic regression analysis displaying associations between different forms of childhood victimization and adult rape and IPV

	Adult rape						Adult IPV					
	Unadjusted			Adjusted[a]			Unadjusted			Adjusted[a]		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Any childhood sexual abuse	4.37	2.93-6.53	<.001	2.93	1.90-4.50	<.001	2.24	1.51-3.32	<.001	1.32	.86-2.04	.204
Parental physical violence	4.26	2.55-7.10	<.001	1.18	.63-2.22	.626	4.30	2.74-6.75	<.001	1.12	.65-2.00	.680
Parental psychological violence	4.41	3.06-6.37	<.001	2.38	1.48-3.82	<.001	4.11	2.99-5.66	<.001	2.22	1.47-3.37	<.001
Parental emotional neglect	3.88	2.54-5.92	<.001	1.61	.95-2.72	.077	4.33	3.01-6.22	<.001	1.94	1.24-3.03	.004
Witnessing parental IPV	3.58	2.34-5.49	<.001	1.77	1.07-2.91	.025	3.51	2.42-5.09	<.001	1.82	1.18-2.79	.006

n=2323 [a] Additionally adjusted for age, ethnicity, parental mental health, education, and each other.

Table 4: Logistic regression analysis displaying associations between number of categories of parental violence (CSA, physical violence, psychological violence, emotional neglect, and parental IPV), extra-parental CSA, and adult rape and IPV

	Adult rape						Adult IPV					
	Unadjusted			Adjusted[a]			Unadjusted			Adjusted[a]		
	OR	CI	p-value	OR	CI	p-value	OR	CI	p-value	OR	CI	p-value
Parental violence[b]			<.001			<.001			<.001			<.001
One kind	2.89	1.86-4.48	<.001	2.37	1.49-3.78	<.001	2.61	1.79-3.81	<.001	2.26	1.51-3.37	<.001
Two kinds	4.14	2.32-7.41	<.001	3.35	1.79-6.27	.001	4.05	2.46-6.67	<.001	3.28	1.92-5.58	<.001
Three or more kinds	9.27	5.64-15.22	<.001	6.45	3.52-11.80	<.001	8.00	5.10-12.55	<.001	5.47	3.23-9.26	<.001
Extra-parental CSA	4.30	2.87-6.43	<.001	2.81	1.82-4.33	<.001	2.26	1.52-3.37	<.001	1.36	.88-2.10	.161

n=2345 [a] Additionally adjusted for age, ethnicity, parental mental health, education, and each other. [b] Reference category: No parental violence.

III

Broken and guilty since it happened: a population study of trauma-related shame and guilt after violence and sexual abuse

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Abstract

Background There is increasing interest in trauma-related shame and guilt. However, much remains unknown in terms of how these emotions relate to the type of event, gender and mental health. We investigated shame and guilt in men and women following various types of severe violence and their relation to mental health.

Methods Telephone interviews were conducted with a Norwegian general population sample (n=4,529; age=18-75; response rate=42.9%). Measures included child sexual abuse, child and adult rape, severe physical violence from/between parents, severe violence from a partner and non-partners, less severe violence and non-violent trauma, the new Shame and Guilt After Trauma Scale, and the Hopkins Symptom Checklist. Analyses included t-tests and linear regressions.

Results All types of severe violence were significantly associated with trauma-related shame and guilt (coefficients from .11 to .38, p-values <0.001). The number of violence types showed a graded relationship with both emotions. Women had significantly more shame and guilt than men did (p-values <0.001 for both emotions), which was partially explained by violence exposure. Both emotions were independently associated with mental health problems (p-values <0.001).

Limitations The study is cross-sectional. The shame and guilt measure requires further validation.

Conclusions The more types of violence that were reported, the higher levels of shame and guilt were. Clinicians should be aware of shame and guilt after a variety of violent events,

including non-sexual violence, in both men and women and should particularly be aware of whether individuals have multiple violent experiences.

Keywords: Shame, guilt, trauma, violence, gender

Introduction

Victims of violence and trauma tend to feel shame and self-blame (Janoff-Bulman, 1979; Stone, 1992). Much remains unknown about how trauma-related shame and guilt relate to particular events and event constellations, whether they are more frequent among women than among men, and whether both have importance for mental health.

Shame can be defined as "a painful affect, often associated with perceptions that one has personal attributes, personality characteristics or has engaged in behaviors that others will find unattractive and that will result in rejection or some kind of put-down" (Gilbert, 2000), whereas guilt can be described as "an unpleasant feeling with an accompanying belief that one should have felt, thought or acted differently" (Kubany and Manke, 1995; Kubany and Watson, 2003). Though often discussed interchangeably, shame and guilt are considered separate constructs. Guilt is generally related to the devaluation of behaviors rather than the devaluation of the self, as is the case with shame (Tangney and Dearing, 2002; Wilson et al., 2006). Gilbert (1997) emphasizes that although the purpose of both emotions is to smooth group dynamics, they do so in different ways. Shame is linked to social positioning and typically elicits submissive or avoidance behavior, whereas guilt is linked to care strategies and elicits reparation behavior. In addition, the associations of shame and guilt with mental health have been debated. Whereas shame is found to be associated with mental health problems, such problems are less consistently associated with guilt (see Tilghman-Osborne et al., 2010, for a review). These findings lead some to conclude that whereas shame is maladaptive, guilt is not (Tangney et al., 2007; Tangney et al., 1992). This view has been met with criticism (Gilbert, 1997; Luyten et al., 2002). When researchers study guilt after trauma, they generally find that guilt is associated with mental health problems, although it remains debatable whether this is because of co-occurring shame (Pugh et al., 2015). Thus, although

trauma-related shame and guilt are presumably associated with mental health problems, it is less clear whether both emotions yield such associations independently of each other.

Interpersonal traumatic events, including violence, may have stronger associations with adverse outcomes than non-interpersonal events do (Green et al., 2000), possibly due to mediation by shame (La Bash and Papa, 2014). Shame and guilt have been identified after various types of violence (Andrews et al., 2000; Kubany et al., 1996; Street and Arias, 2001). Violent events may differ in ways that are pertinent to shame and guilt, including whether the event is stigmatized, as sexual abuse may be, whether the event is experienced early in life, and whether it occurs in close relationships. Theories on why these aspects have particular importance for shame and guilt include the internalization of stigma (Amstadter and Vernon, 2008; Finkelhor and Browne, 1985), the early development of schema (Lee et al., 2001), and threats to the social self (Budden, 2009). Two studies with university samples have found that sexual abuse entails more shame and guilt than other traumas do (Amstadter and Vernon, 2008) and that the age when sexual abuse begins may influence shame (Uji et al., 2007). In addition, exposure to various types of violence often overlaps (Classen et al., 2005; Herrenkohl and Herrenkohl, 2009). Thus, researchers increasingly focus on the total burden of violence in relation to adverse outcomes (Finkelhor et al., 2007). Recent small studies of undergraduates (La Bash and Papa, 2014), outpatients with PTSD (Hagenaars, Fisch, & van Minnen, 2011) and male refugee minors (Stotz et al., 2015) suggest that the number of traumatic events may be associated with shame and guilt. However, to our knowledge, no studies have investigated shame and guilt after different events in a large population sample.

When overall proneness to shame and guilt is considered, women have been found to have somewhat higher levels of both emotions (see Else-Quest et al., 2012, for a meta-analysis). However, less is known about gender differences when shame and guilt occur in relation to trauma and violence. In terms of exposure to violence, women more often

experience severe intimate partner violence (IPV) and sexual violence (Creamer et al., 2001; Fischer, 1992; Tolin and Foa, 2002), which may be relevant for shame and guilt. A potential gender difference in trauma-related shame and guilt may be due to some aspect of the difference between men and women (e.g., biology, coping style) or some aspect of the event (e.g., sexual abuse, perpetrator relationship).

One study found that women scored higher on some, but not other, subscales of trauma-related guilt (Kubany et al., 1996). In another study, women experienced more negative social feedback after trauma (Andrews et al., 2003), which could imply an increased risk; however, several studies have found no or mixed gender differences (Aakvaag et al., 2014; Andrews et al., 2000; Byers and Glenn, 2011). Many studies of trauma-related shame and guilt are restricted to one gender and target events that are gendered (Beck et al., 2011; Leskela et al., 2002; Street and Arias, 2001). Thus, whether women experience more trauma-related shame and guilt is not known, although existing evidence indicates that gender differences are small or non-existent after the same type of trauma.

Several instruments to measure shame and/or guilt exist (e.g. Harder and Zalma, 1990; Tangney et al., 1997), but few are adapted to measure these emotions after trauma. Those that exist are typically suitable for use with survivors of a particular trauma or for patient groups (Kubany et al., 1996; Øktedalen et al., 2014). Therefore, there is a need for a measure of trauma-related shame and guilt in general population samples.

This study aimed to investigate how gender and violence experiences relate to shame and guilt and how shame and guilt relate to mental health in a large, population-based study of violence and abuse.

The research questions were as follows:

1. Does our scale measure trauma-related shame and guilt as separate constructs, and do women report more of both these emotions than men do?

2. Are shame and guilt associated with different types of violence and with the number of violence types?
3. Are trauma-related shame and guilt independently associated with anxiety/depression symptoms?

Methods

Participants and procedure

The sample comprised 2,437 women and 2,092 men (age 18-75; mean age: 44.4 years). Potential participants were randomly selected from the General Population Registry, which contains all citizens of Norway. All potential participants received invitation letters and were later called by interviewers. The response rate was 42.9% (45.0% for women, 40.8% for men), calculated from those who were reached by telephone (comparable to response rate calculation for random digit dialing). For more information about the sampling procedure, see Thoresen, Myhre, Wentzel-Larsen, Aakvaag & Hjemdal (2015).

The majority of our sample were married or cohabiting (64.5%), educated at high school level or higher (91.%), and perceived their financial situation as average or above (90.9%). Education, household income and proportion married were slightly higher in our sample than in the general population (Thoresen et al., 2015). The majority (96.0%) of our participants were of Norwegian origin.

We used computer-assisted telephone interviews based on the strategy of Kilpatrick and colleagues (Kilpatrick et al., 2003; Resnick et al., 1993), in which each affirmative answer on violence leads to follow-up questions about event characteristics, including injury, fear of injury, and age when the event happened. Questions about experiences with violence were behaviorally specific. The interview was designed according to the National Adolescent

Study (Kilpatrick et al., 2003), and questions were adapted to fit a Norwegian context and expanded to include a broad assessment of childhood violence.

The study was approved by the Regional Committee for Medical and Health Ethics in Norway.

Measures

Child sexual abuse (CSA) was indicated by affirmative answers to the following: "Before you were age 13, did anyone who was five or more years older than you ever have sexual contact with you?" This question was adapted from The National Stressful Events Web Survey (Kilpatrick et al., 2011). *Rape before the age of 18* was indicated by responding positively to at least one of four separate questions before the age of 18: "Has anyone ever forced you into a) intercourse, b) oral sex, or c) anal sex or d) put fingers or objects in your vagina or anus by use of physical force or by threatening to hurt you or someone close to you?"

Parental physical violence was indicated by responding positively to one of the following events: having been beaten with a fist or hard object, kicked, beaten up or otherwise physically attacked by a caregiver before turning 18.

Parental intimate partner violence (IPV) was indicated by reporting at least one of the following before turning 18: having seen or heard one parent or caregiver slapping the other, beating the other with a fist or hard object, kicking, choking or otherwise physically attacking the other.

Adult rape: If one of the four types of rape measured (see above) was experienced at 18 years or older, the event was defined as adult rape. *Adult IPV:* Respondents who reported at least one of the following: having been beaten with a fist or object, kicked, choked, beaten up, threatened with a weapon or otherwise physically assaulted after they had turned 18 and who identified a partner or ex-partner as perpetrator were categorized as reporting adult IPV.

Severe physical violence from a non-partner in adulthood was indicated if at least one form of physical violence in adulthood (see above) was perpetrated by a non-partner. The category was qualified to only include events in which the respondent was afraid of sustaining an injury or was injured to exclude minor incidents. All measures except CSA were adapted from the National Adolescent Study (Kilpatrick et al., 2003).

Number of violence types was obtained by adding together the seven types of violence (CSA, rape before 18, severe physical violence from parents, severe parental IPV, adult rape, adult IPV and severe adult physical violence from a non-partner). We categorized the number of violence types as follows: not exposed to severe violence; exposed to one type; two; three; or four or more types of severe violence.

Other adverse events included experiences with stalking, sexual assault (including intoxicated sexual contact and forced touching), less severe physical violence (including slapping and pinching), and other stressful events (including life-threatening disease, witnessing violence, and non-specific deeply upsetting events; Goodman et al., 1998)

Trauma-related shame and guilt: For this study, we developed a brief instrument (Shame and Guilt After Trauma Scale, SGATS) that measures both trauma-related guilt and shame. The scale consists of 9 items: 4 items are about trauma-related shame, and 5 items are about trauma-related guilt (Table 1). Each item was rated on a 0-2 Likert scale, with the following options: no; yes, a little; and yes, a lot. The SGATS consists of items similar to elements of the Trauma-related Guilt Inventory (Kubany et al., 1996) and The Experience of Shame Scale (Andrews et al., 2002). Because it tests shame and guilt in relation to an event, only individuals who reported some adverse experience (one or more types of severe violence or other adverse events) were asked to answer these questions. People who reported multiple events were asked to report from the worst event, a strategy commonly used when measuring posttraumatic stress with individuals with multiple traumas (Norris and Hamblen, 2004).

Mean scores were calculated (range: 0-2). Individuals with half or less of the values missing on each subscale were included. Cronbach's alpha was 0.84 for shame and 0.87 for guilt.

Anxiety/depression symptoms were measured using a short-form of the Hopkins Symptom Checklist-25 (HSCL; Derogatis et al., 1974). This version includes ten items on symptoms of anxiety and depression (five items each), with a response scale from 0 (not bothered) to 3 (bothered a great deal). Short versions of the HSCL have shown good psychometric properties (Myhre et al., 2012; Strand et al., 2003; Tambs and Moum, 1993). The mean score was calculated (range: 0-3). Cronbach's alpha was 0.89.

Statistical analyses

Gender differences on mean shame and guilt were investigated using t-tests. Factor structures in the SGATS were investigated using confirmatory factor analysis (CFA). Associations of gender, violence, shame and guilt with anxiety/depression symptoms were investigated using hierarchical multiple regression. Interactions between the type of violence and gender were tested in all categories for which we had sufficient power. However, due to low numbers of men who had experienced rape before or after 18 (<20 for both), interactions were not investigated for these types of violence. The interaction between gender and the number of violence types was tested, although few men had experienced more than four types of violence; a less detailed variable would be less informative in the main analyses. This issue warrants caution in interpretation.

Differences between regression coefficients were assessed based on whether the confidence intervals overlapped. With marginally overlapping confidence intervals, we used linear hypothesis testing and bootstrapping to investigate whether differences were significant.

There were generally low levels of missing data. With the exception of 180 persons who did not receive the shame and guilt questions due to a technical error in the computer

program guiding the interviewers, there were practically no missing data on shame and guilt. Of 3,614 participants who answered the shame and guilt questions, missing information on violence or demographics led to 165-182 participants missing from different analyses. This means that 94.9% (n=3,431) of people who received shame and guilt questions were included in all regression analyses. Due to different constellations of variables in the regression analyses, N in each analysis varies between 3,432 and 3,440. We handled missing values using complete case analyses. To investigate whether missing values affected our analyses, we applied multiple imputation and performed our analyses on the imputed material. The results were presented when differences from complete case analyses were not negligible.

Multiple imputation, linear hypothesis testing and bootstrapping were run using the R (R3.1.2) packages car and boot, CFA was run in Mplus (version 7.11), and other analyses were conducted in SPSS Statistics (version 22) for Windows.

Results

The confirmatory factor analysis supported the hypothesis that shame and guilt as measured by the SGATS are two separate latent constructs (CFI: 0.986, TLI: 0.981, RMSEA: 0.076). The four shame items loaded on the shame factor in the 0.79 – 0.96 range, whereas the five guilt items loaded on the guilt factor in the 0.82 – 0.92 range. The model-based correlation between shame and guilt in the CFA was 0.87, whereas the empirical Pearson correlation between the corresponding scale scores in the data set was 0.71. Cronbach's alpha was .90.

Women reported more shame and guilt than men did (Table 1). The mean shame scores were .40 for women and .22 for men; the mean guilt scores were .39 (women) and .29 (men; t-test p-value for both differences <0.001). Table 2 gives the means and standard

deviations for men and women for different types of severe violence and for other adverse events.

All types of severe violence were significantly and independently associated with trauma-related shame and guilt (Table 3). All associations withstood adjustment for gender, age and ethnicity. There were some differences between types of violence; CSA, rape, IPV and physical violence from parents yielded stronger associations with shame than IPV between parents and physical violence from a non-partner in adulthood (non-overlapping confidence intervals). See table notes for information about interactions.

In Table 4, we investigated the number of violence types related to shame and guilt. All levels (one, two, three, or four or more types of violence) had significantly higher trauma-related shame and guilt compared to no types of violence. These differences withstood adjustment for gender, age, and ethnicity. Further, the more types of violence an individual had experienced, the higher the levels of trauma-related shame and guilt were. This finding is consistent with a graded relationship in which all contrasts were significant for shame (all p-values <0.001, except three versus four or more violent experiences, p-value 0.010) and all but one were significant for guilt (three versus four or more violent experiences, p-value 0.113, all other p-values <0.001). For information about interactions, see the table notes.

Gender was still significantly associated with shame and guilt after adjusting for the type of violence and for the number of types of violence. Thus, in this model, gender differences in shame and guilt were not fully explained by exposure to violence. However, the regression coefficient for gender was significantly reduced when violence exposure was entered into the model. All but one type of violence had significantly larger regression coefficients than gender had (non-overlapping confidence intervals and linear hypothesis testing parental IPV-gender, p-values 0.016 and 0.018). In Table 4, the regression coefficients for gender were significantly lower than the coefficients for all contrasts from no violence in

the violence variable. Thus, reporting one or more severe violent experiences was more strongly associated with both shame and guilt than being female was.

Both shame and guilt were independently associated with anxiety/depression symptoms (Table 5). The association withstood adjustment for the amount of violence exposure and gender. Shame was more strongly associated with anxiety/depression symptoms than guilt was (non-overlapping confidence intervals). Both shame and guilt were more strongly associated with anxiety/depression symptoms than gender was (shame and gender: non-overlapping confidence intervals; guilt and gender: p-value <0.001).

To assess whether the statistically significant differences between groups have relevance for practical purposes, we used a rule of thumb proposed by Fayers and Machin (2007), which states that a 10-point increase on a 0-100 scale is indicative of a difference that is clinically relevant in the sense that it can likely be felt by the individual. The regression coefficients of most types of violence with shame and guilt were of a size that made them clinically relevant for the outcomes. Exceptions were parental IPV and severe physical violence from non-partners in adulthood when shame is the outcome and parental IPV when guilt is the outcome. Having one or more violent experiences was associated with an increase in shame and guilt at a level that is deemed clinically relevant. In contrast, whereas gender was significantly associated with both shame and guilt after adjusting for violence, the coefficients were low and did not meet our criterion for relevance. An increase in the SGATS that was clinically relevant at the lowest level was associated with a relevant increase in anxiety/depression symptoms only for shame.

Discussion

All types of severe violence (CSA, rape before and after 18, severe physical violence from and between parents, severe violence from a partner and from non-partners in adulthood)

were significantly associated with both shame and guilt. In addition, most of these associations were deemed clinically relevant. The more types of violence respondents reported, the more trauma-related shame and guilt they experienced. Gender was significantly associated with both emotions after adjustment for violence exposure, but adjustment significantly reduced the associations. Associations between violence and shame and guilt were stronger than those between gender and shame and guilt. Both emotions were independently associated with anxiety/depression symptoms when adjusted for gender and number of violence types.

All types of severe violence were associated with trauma-related shame and guilt compared to other adverse events. There were some differences in the strength of associations; when shame was the outcome, witnessing parental IPV in childhood and being exposed to severe physical violence from non-partners in adulthood yielded lower regression coefficients than the other types of violence. Previous literature highlights aspects of violence that may be particularly pertinent for shame and guilt, including violence in childhood, sexual violence, and violence from close perpetrators (Budden, 2009; Finkelhor and Browne, 1985; Lee et al., 2001). The two types of violence that are lower in their association with shame in this sample include childhood and adult experiences from close and less close perpetrators. All types of violence that involved sexual abuse yielded high associations with shame; however, we cannot conclude that sexual abuse is more important for shame because the regression coefficients of other types of violence were comparable, with highly overlapping confidence intervals. Rather, our findings imply that severe violence is associated with shame and guilt regardless of whether it involves sexual abuse, is perpetrated by someone close or less close, or occurs in childhood or adulthood.

We found that the more violence types an individual reported, the higher were the levels of shame and guilt that the individual reported. Thus, shame and guilt after violence

depends not only on the type of violence an individual has experienced but also on how many types of violence have been experienced. It has repeatedly been found that there is considerable overlap between violence types (Herrenkohl and Herrenkohl, 2009; Kimerling et al., 2007; Resnick et al., 1993). Multi-victimization has been found to be associated with mental health (Finkelhor et al., 2007). One recent study found that the more adverse events an individual had experienced, the more shame and guilt was present (Stotz et al., 2015). Our study expands upon this finding by presenting similar results in a large sample from the general population.

The experience of multiple types includes some indication of the amount of violence (that is, the number of discrete events) and reflects the experience of violence on different aspects of life, often on different arenas, at different developmental stages, or from different perpetrators. Finkelhor, Ormrod and Turner (2007) suggest that when someone is victimized from multiple sources, it may become difficult to resist negative self-attributions. Lee et al. (2001) suggest that when trauma experiences are congruent with pre-existing shame- and guilt-relevant schema, the resulting feelings of shame and/or guilt are more profound.

Contrary to findings in populations of survivors of extra-familial crime (Andrews et al., 2000), sexual coercion (Byers and Glenn, 2011) and a terrorist attack (Aakvaag et al., 2014), women had more shame and guilt than men did, even when adjusting for the type and number of violence types. There may be several explanations for this finding.

Although we found no support for different violence types being more severe for women in terms of shame and guilt, aspects of other adverse events may vary systematically between the genders. Other adverse events included intoxicated sexual contact and stalking, which may occur more often for women than for men (Basile et al., 2006; Kaysen et al., 2006).

Alternatively, there may be differences between men and women beyond the violence they experience that are relevant for shame and guilt. Women may be somewhat more prone

to experience general shame and guilt than men are (Else-Quest et al., 2012). Proposed mechanisms for gender differences in PTSD include peri-traumatic dissociation, coping strategies, biological differences, and social support (Olff et al., 2007), all of which may also influence shame and guilt after trauma.

Importantly, although a small gender difference was found in all the adjusted models, the regression coefficient for gender was consistently low. All but one type and all combinations of types of violence had regression coefficients with shame and guilt that were significantly higher than those of gender. Studies that did not find gender differences in shame and guilt after violence (Aakvaag et al., 2014; Andrews et al., 2000; Byers and Glenn, 2011) have used substantially smaller samples than the current study. If the gender difference that remains after adjusting for exposure is quite small, a large sample size may be necessary for it to be detected.

Shame and guilt were both uniquely associated with anxiety/depression symptoms in the adjusted model. Whereas shame is consistently found to be associated with mental health problems, the contribution of guilt remains debated (Pugh et al., 2015; Tilghman-Osborne et al., 2010). A recent review notes that most studies of trauma-related guilt do not control for shame, which may explain, partially or fully, the relationship between guilt and mental health problems (Pugh et al., 2015). In our study, shame and guilt were independently related to anxiety/depression symptoms. Thus, rather than being a single pathogenic factor, shame and guilt seem to be associated with anxiety/depression symptoms through different pathways. However, the association between guilt and anxiety/depression symptoms yielded a lower regression coefficient than shame did. The association between shame and anxiety/depression symptoms was deemed clinically relevant, whereas there was less support for the clinical relevance of the association between guilt and anxiety/depression symptoms. Because shame has a strong social component, it is possible that it relates to mental health through its effect

on social relationships. Shame-based avoidance and hiding behavior may prevent individuals from feeling at ease and accepted in their social groups and may lead to loneliness.

Øktedalen, Hoffart, and Langkaas (2015) found that pre-treatment trauma-related shame and guilt predicted post-treatment PTSD with inpatients, strengthening the assumption that shame and guilt may influence recovery from mental health problems.

Strengths and limitations

This study has several limitations. The response rate was relatively low. Comparisons with population data presented in a previous publication (Thoresen et al., 2015) indicate a modest positive bias in terms of education and income, which may imply an underestimation of violence. Associations are presumably less affected by low response rates than prevalence estimates are (Gustavson et al., 2012).

This study was cross-sectional, so we could not assess the directionality of the associations. Although we may hypothesize that shame and guilt precede mental health symptoms after trauma, it is entirely possible that mental health symptoms make individuals prone to feeling shameful or guilty or that the two co-occur. Recall bias may influence associations, such as when individuals with shame, guilt or mental health problems are more likely to recall violent events.

Individuals who reported multiple violent or adverse events were instructed to use the worst event as an index when answering shame and guilt questions. We therefore do not know the particular event to which the respondents related. This strategy is not uncommon when measuring other reactions after a trauma, such as PTSD. Shame and guilt after one event are presumably not independent of shame and guilt after another event.

A technical error in the computer system that provided questions to interviewers led to failure to ask shame and guilt questions to some respondents (180 persons, 4.8% of the 3,792

who should have received these questions). We tested whether this error was systematic according to violent experiences or gender and found no significant associations.

This study was the first to use this measure of shame and guilt. Therefore, it requires further validation. It has since been translated to English and tested in American college and military samples, which showed excellent internal consistency (Cronbach's alpha: shame: military sample: 0.88, student sample: 0.88; guilt: military sample: .90, student sample: 0.92; Cunningham, 2015a, 2015b).

We used a rough rule of thumb to assess clinical relevance that was originally intended for measuring clinical relevance of an unrelated measure (Fayers and Machin, 2007). Thus, the conclusions should be interpreted with caution.

The strengths of this study include the comprehensive behaviorally specific measures of violent experiences, the low missing values, and the large sample size.

Implications

Our findings imply that trauma-related shame and guilt occur more often after violence and occur more frequently with the more violence an individual has experienced. Because shame and guilt are related to mental health problems, our findings suggest that clinicians should be aware of their potential contribution to the problems of their clients. The recognition of shame and guilt in PTSD treatment and management is critical (Taylor, 2015). Delayed disclosure is a well-known problem after violence such as sexual trauma (Bicanic et al., 2015). Shame may make disclosure of violent experiences less likely (Bögner et al., 2007; Bonanno et al., 2002). Clinicians may therefore want to ask their patients explicitly about violent experiences and about shame and guilt related to these experiences. Our study implies that both male and female survivors of all types of violence should be asked about these experiences, especially if they are multi-victimized. Shame, in particular, may be important

for mental health after violence, such as through the effects of shame-based avoidance and hiding on social relationships. Further research should target the mechanisms by which shame and guilt, particularly shame, relate to mental health.

Conflict of interest

The authors have no conflicts of interest to declare.

References

Aakvaag, H.F., Thoresen, S., Wentzel-Larsen, T., Røysamb, E., Dyb, G., 2014. Shame and guilt in the aftermath of terror: the Utøya Island study. J. Trauma. Stress 27, 618-621.

Amstadter, A.B., Vernon, L.L., 2008. Emotional reactions during and after trauma: a comparison of trauma types. J. Aggress. Maltreat. Trauma 16, 391-408.

Andrews, B., Brewin, C., Rose, S., 2003. Gender, social support, and PTSD in victims of violent crime. J. Trauma. Stress 16, 421-427.

Andrews, B., Brewin, C.R., Rose, S., Kirk, M., 2000. Predicting PTSD symptoms in victims of violent crime: the role of shame, anger, and childhood abuse. J. Abnorm. Psychol. 109, 69-73.

Andrews, B., Qian, M., Valentine, J.D., 2002. Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. Br. J. Clin. Psychol. 41, 29-42.

Basile, K.C., Swahn, M.H., Chen, J., Saltzman, L.E., 2006. Stalking in the United States: recent national prevalence estimates. Am. J. Prev. Med. 31, 172-175.

Beck, J.G., McNiff, J., Clapp, J.D., Olsen, S.A., Avery, M.L., Hagewood, J.H., 2011. Exploring negative emotion in women experiencing intimate partner violence: shame, guilt, and PTSD. Behav. Ther. 42, 740-750.

Bicanic, I.A.E., Hehenkamp, L.M., van de Putte, E.M., van Wijk, A.J., de Jongh, A., 2015. Predictors of delayed disclosure of rape in female adolescents and young adults. Eur. J. Psychotraumatol. 6, 25883.

Bögner, D., Herlihy, J., Brewin, C.R., 2007. Impact of sexual violence on disclosure during Home Office interviews. Br. J. Psychiatry 191, 75-81.

Bonanno, G.A., Keltner, D., Noll, J.G., Putnam, F.W., Trickett, P.K., LeJeune, J., Anderson, C., 2002. When the face reveals what words do not: facial expressions of emotion,

smiling, and the willingness to disclose childhood sexual abuse. J. Pers. Soc. Psychol. 83, 94-110.

Budden, A., 2009. The role of shame in posttraumatic stress disorder: a proposal for a socio-emotional model for DSM-V. Soc. Sci. Med. 69, 1032-1039.

Byers, E.S., Glenn, S.A., 2011. Gender differences in cognitive and affective responses to sexual coercion. J. Interpers. Violence 27, 827-845.

Classen, C.C., Palesh, O.G., Aggarwal, R., 2005. Sexual revictimization: a review of the empirical literature. Trauma Violence Abuse 6, 103-129.

Creamer, M., Burgess, P., McFarlane, A.C., 2001. Post-traumatic stress disorder: findings from the Australian National Survey of Mental Health and Well-being. Psychol. Med. 31, 1237-1247.

Cunningham, K., 2015a. Personal communication to Helene Flood Aakvaag.

Cunningham, K., 2015b. Shame and post-traumatic stress disorder. Dissertation for the degree of Doctor of Philosophy. University of Tulsa, The Graduate School.

Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., Covi, L., 1974. The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. Behav. Sci. 19, 1-15.

Else-Quest, N.M., Higgins, A., Allison, C., Morton, L.C., 2012. Gender differences in self-conscious emotional experience: A meta-analysis. Psychol. Bull. 138, 947-981.

Fayers, P., Machin, D., 2007. Quality of Life: The Assessment, Analysis and Interpretation of Patient-reported Outcomes, second ed. Wiley, New York.

Finkelhor, D., Browne, A., 1985. The traumatic impact of child sexual abuse: a conceptualization. Am. J. Orthopsychiatry 55, 530-541.

Finkelhor, D., Ormrod, R.K., Turner, H.A., 2007. Poly-victimization: a neglected component in child victimization. Child Abuse Negl. 31, 7-26.

Fischer, G.J., 1992. Gender differences in college student sexual abuse victims and their offenders. Sex. Abuse 5, 215-226.

Gilbert, P., 1997. The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. Br. J. Med. Psychol. 70, 113-147.

Gilbert, P., 2000. The relationship of shame, social anxiety and depression: the role of the evaluation of social rank. Clin. Psychol. Psychother. 7, 174-189.

Goodman, L., Corcoran, C., Turner, K., Yuan, N., Green, B., 1998. Assessing traumatic event exposure: general issues and preliminary findings for the Stressful Life Events Screening Questionnaire. J. Trauma. Stress 11, 521-542.

Green, B., Goodman, L., Krupnick, J., Corcoran, C., Petty, R., Stockton, P., Stern, N., 2000. Outcomes of single versus multiple trauma exposure in a screening sample. J. Trauma. Stress 13, 271-286.

Gustavson, K., von Soest, T., Karevold, E., Roysamb, E., 2012. Attrition and generalizability in longitudinal studies: findings from a 15-year population-based study and a Monte Carlo simulation study. BMC Public Health 12, 918.

Hagenaars, M. A., Fisch, I., & van Minnen, A. (2011). The effect of trauma onset and frequency on PTSD-associated symptoms. Journal of Affective Disorders, 132(1–2), 192-199.

Harder, D.H., Zalma, A., 1990. Two promising shame and guilt scales: a construct validity comparison. J. Pers. Assess. 55, 729-745.

Herrenkohl, R., Herrenkohl, T., 2009. Assessing a child's experience of multiple maltreatment types: some unfinished business. J. Fam. Violence 24, 485-496.

Janoff-Bulman, R., 1979. Characterological versus behavioral self-blame: inquiries into depression and rape. J. Pers. Soc. Psychol. 37, 1798-1809.

Kaysen, D., Neighbors, C., Martell, J., Fossos, N., Larimer, M.E., 2006. Incapacitated rape and alcohol use: a prospective analysis. Addict. Behav. 31, 1820-1832.

Kilpatrick, D.G., Resnick, H.S., Baber, B., Guille, C., Gros, K., 2011. The National Stressful Events Web Survey (NSES-W). Medical University of South Carolina, Charleston, SC.

Kilpatrick, D.G., Ruggiero, K.J., Acierno, R., Saunders, B.E., Resnick, H.S., Best, C.L., 2003. Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results from the National Survey of Adolescents. J. Consult. Clin. Psychol. 71, 692-700.

Kimerling, R., Alvarez, J., Pavao, J., Kaminski, A., Baumrind, N., 2007. Epidemiology and consequences of women's revictimization. Women's Health Issues 17, 101-106.

Kubany, E.S., Haynes, S.N., Abueg, F.R., Manke, F.P., Brennan, J.M., Stahura, C., 1996. Development and validation of the Trauma-Related Guilt Inventory (TRGI). Psychological Assessment 8, 428-444.

Kubany, E.S., Manke, F.P., 1995. Cognitive therapy for trauma-related guilt: conceptual bases and treatment outlines. Cogn. Behav. Pract. 2, 27-61.

Kubany, E.S., Watson, S., 2003. Guilt: elaboration of a multidimensional model. Psychol. Rec. 53, 4.

La Bash, H., Papa, A., 2014. Shame and PTSD symptoms. Psychol. Trauma 6, 159-166.

Lee, D.A., Scragg, P., Turner, S., 2001. The role of shame and guilt in traumatic events: a clinical model of shame-based and guilt-based PTSD. Br. J. Med. Psychol. 74, 451-466.

Leskela, J., Dieperink, M., Thuras, P., 2002. Shame and posttraumatic stress disorder. J. Trauma. Stress 15, 223-226.

Luyten, P., Fontaine, J.R.J., Corveleyn, J., 2002. Does the Test of Self-Conscious Affect (TOSCA) measure maladaptive aspects of guilt and adaptive aspects of shame? An empirical investigation. Pers. Individ. Dif. 33, 1373-1387.

Myhre, M.C., Thoresen, S., Grøgaard, J.B., Dyb, G., 2012. Familial factors and child characteristics as predictors of injuries in toddlers: a prospective cohort study. BMJ Open 2, e000740.

Norris, F.H., Hamblen, J.H., 2004. Standardized self-report measures of civilian trauma and PTSD, in: Wilson, J.P., Keane, T.M. (Eds.), Assessing Psychological Trauma and PTSD. The Guilford Press, New York, pp. 63-102.

Øktedalen, T., Hagtvet, K., Hoffart, A., Langkaas, T., Smucker, M., 2014. The Trauma Related Shame Inventory: measuring trauma-related shame among patients with PTSD. J. Psychopathol. Behav. Assess. 36, 600-615.

Øktedalen, T., Hoffart, A., Langkaas, T.F., 2015. Trauma-related shame and guilt as time-varying predictors of posttraumatic stress disorder symptoms during imagery exposure and imagery rescripting—a randomized controlled trial. Psychother. Res. 25, 518-532.

Olff, M., Langeland, W., Draijer, N., Gersons, B.P.R., 2007. Gender differences in posttraumatic stress disorder. Psychol. Bull. 133, 183-204.

Pugh, L.R., Taylor, P.J., Berry, K., 2015. The role of guilt in the development of post-traumatic stress disorder: a systematic review. J. Affect. Disord. 182, 138-150.

Resnick, H.S., Kilpatrick, D.G., Dansky, B.S., Saunders, B.E., Best, C.L., 1993. Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. J. Consult. Clin. Psychol. 61, 984-991.

Stone, A.M., 1992. The role of shame in post-traumatic stress disorder. Am. J. Orthopsychiatry 62, 131-136.

Stotz, S.J., Elbert, T., Müller, V., Schauer, M., 2015. The relationship between trauma, shame, and guilt: findings from a community-based study of refugee minors in Germany. Eur. J. Psychotraumatol. 6, 25863.

Strand, B.H., Dalgard, O.S., Tambs, K., Rognerud, M., 2003. Measuring the mental health status of the Norwegian population: a comparison of the instruments SCL-25, SCL-10, SCL-5 and MHI-5 (SF-36). Nordic J. Psychiatry 57, 113-118.

Street, A.E., Arias, I., 2001. Psychological abuse and posttraumatic stress disorder in battered women: examining the roles of shame and guilt. Violence Vict. 16, 65-78.

Tambs, K., Moum, T., 1993. How well can a few questionnaire items indicate anxiety and depression? Acta Psychiatr. Scand. 87, 364-367.

Tangney, J.P., Dearing, R.L., 2002. Shame and Guilt. The Guilford Press, New York.

Tangney, J.P., Dearing, R.L., Wagner, P.E., Gramzow, R., 1997. The Test of Self-Conscious Affec-3 (TOSCA-3). George Mason University, Fairfax, VA.

Tangney, J.P., Stuewig, J., Mashek, D.J., 2007. Moral emotions and moral behavior. Annu. Rev. Psychol. 58, 345-372.

Tangney, J.P., Wagner, P., Gramzow, R., 1992. Proneness to shame, proneness to guilt, and psychopathology. J. Abnorm. Psychol. 101, 469-478.

Taylor, T.F., 2015. The influence of shame on posttrauma disorders: have we failed to see the obvious? Eur. J. Psychotraumatol. 6, 28847.

Thoresen, S., Myhre, M., Wentzel-Larsen, T., Aakvaag, H.F., Hjemdal, O.K., 2015. Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population. Eur. J. Psychotraumatol. 6, 26259.

Tilghman-Osborne, C., Cole, D.A., Felton, J.W., 2010. Definition and measurement of guilt: implications for clinical research and practice. Clin. Psychol. Rev. 30, 536-546.

Tolin, D.F., Foa, E.B., 2002. Gender and PTSD. A Cognitive Model, in: Kimerling, R., Ouimette, P., Wolfe, J. (Eds.), Gender and PTSD. The Guilford Press, New York, pp. 76-97.

Uji, M., Shikai, N., Shono, M., Kitamura, T., 2007. Contribution of shame and attribution style in developing PTSD among Japanese University women with negative sexual experiences. Arch. Womens Ment. Health 10, 111-120.

Wilson, J.P., Droždek, B., Turkovic, S., 2006. Posttraumatic shame and guilt. Trauma Violence Abuse 7, 122-141.

Table 1. Shame and guilt items among men and women, all adverse events (severe violence or other adverse events)

	Women (%)			Men (%)		
	No	Yes, a little	Yes, a lot	No	Yes, a little	Yes, a lot
Shame[1]						
Worried about what others might think	72.8	16.7	10.5	80.8	12.0	7.2
Tried to hide what happened, or some of it	70.4	13.8	15.8	83.9	9.5	6.6
Been ashamed of yourself after what happened	72.3	15.2	12.5	83.7	11.3	5.0
Belittled yourself after what happened	75.1	14.1	10.9	86.3	9.4	4.3
Guilt[2]						
Blamed yourself for what happened	68.0	20.8	11.2	75.5	18.4	6.1
Bothersome thoughts about something you could have done to prevent it from happening	63.1	24.4	12.5	72.4	20.3	7.3
Bothersome thoughts about something you could have done differently while it was happening	68.9	20.0	11.1	75.4	17.9	6.6
Felt like you did something wrong	80.0	13.2	6.9	80.6	14.6	4.8
Felt guilty about what happened	77.4	14.7	7.9	82.6	12.6	4.8

N = 3614. [1] Scale score mean: .32, s.d. .36 (women: .40, s. d. .58; men: .22 s. d. .43; p-value for t-test of gender difference: <0.001)
[2] Scale score mean: .34, s.d. .49 (women: .39, s. d. .53; men: .29, s d.: .44; p-value for t-test of gender difference: <0.001)

Table 2. Shame and guilt related to type of violence in men and women (mean scores)

	Shame				Guilt			
	Women		Men		Women		Men	
Violence type	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
No severe violence (only other adverse events) (n = 2300)	0.191	0.376	0.131	0.320	0.242	0.401	0.206	0.370
Any severe violence (n = 1149)	0.690	0.675	0.441	0.578	0.600	0.620	0.472	0.536
Childhood violence								
Child sexual abuse (CSA) (n = 306)	0.874	0.710	0.770	0.756	0.707	0.668	0.611	0.682
Rape before 18 (n = 128)	10.050	0.696	0.776	0.874	0.895	0.638	0.874	0.734
Parental physical violence (n = 214)	0.868	0.681	0.685	0.689	0.690	0.606	0.612	0.624
Parental IPV (n = 435)	0.716	0.682	0.507	0.593	0.624	0.617	0.514	0.531
Adult violence								
Adult rape (n = 150)	10.007	0.705	0.611	0.801	0.917	0.647	0.767	0.833
Adult IPV (n = 256)	0.844	0.688	0.581	0.598	0.707	0.636	0.446	0.480
Adult severe violence from non partners (n = 416)	0.557	0.659	0.452	0.571	0.603	0.617	0.530	0.553

Table 3. Multiple regression analyses displaying associations between gender and different categories of violence and trauma-related shame and guilt

	Shame						Guilt					
	Unadjusted			Adjusted[1]			Unadjusted			Adjusted[2]		
	Coeff	CI	p-value	Coeff	CI	p-value	Coeff	CI	p-value	Coeff	CI	p-value
Gender (female)	0.16	0.12-0.19	<0.001	0.08	0.05-0.11	<0.001	0.09	0.06-0.13	<0.001	0.04	0.01-0.07	0.007
Childhood violence												
CSA	0.56	0.50-0.62	<0.001	0.38	0.32-0.43	<0.001	0.36	0.30-0.42	<0.001	0.21	0.15-0.26	<0.001
Rape before 18	0.69	0.59-0.78	<0.001	0.34	0.25-0.43	<0.001	0.56	0.47-0.65	<0.001	0.31	0.220-0.40	<0.001
Severe physical violence from parents	0.45	0.38-0.51	<0.001	0.29	0.22-0.36	<0.001	0.34	0.27-0.41	<0.001	0.18	0.11-0.25	<0.001
Severe physical violence between parents	0.33	0.28-0.38	<0.001	0.15	0.10-0.20	<0.001	0.25	0.20-0.30	<0.001	0.11	0.06-17	<0.001
Adult violence												
Adult rape	0.70	0.62-0.78	<0.001	0.33	0.25-0.42	<0.001	0.59	0.51-0.67	<0.001	0.34	0.25-0.42	<0.001
Adult IPV	0.52	0.45-0.58	<0.001	0.33	0.27-0.40	<0.001	0.34	0.28-0.41	<0.001	0.20	0.14-0.24	<0.001
Severe physical violence from non-partners	0.19	0.14-0.25	<0.001	0.12	0.07-0.17	<0.001	0.25	0.20-0.30	<0.001	0.19	0.14-0.24	<0.001

N=3432. Coefficients are unstandardized. Interaction analyses yielded the following results: Shame: interaction gender and severe physical violence from non-partners in adulthood is significant (p-value for interaction =.007; adjusted difference for men: .17, CI: .11-.23, p-value: <0.001; for women: .03, CI: -.05-.11, p-value: .446). Guilt: interaction between gender and severe physical violence from non-partners in adulthood, is near-significant (p-value=.067). Other interactions were not significant (lowest other p-value was .101). Adjusted models adjust for age and ethnicity and all covariates. [1]Adjusted R squared: 0.248 [2]Adjusted R squared: 0.155.

Table 4. Multiple regression analyses displaying associations between gender and total number of violence types and trauma-related shame and guilt

	Shame						Guilt					
	Unadjusted			Adjusted[1]			Unadjusted			Adjusted[2]		
	Coeff	CI	p-value	Coeff	CI	p-value	Coeff	CI	p-value	Coeff	CI	p-value
Gender (female)	0.16	0.13-0.19	<0.001	0.11	0.08-0.14	<0.001	0.09	0.06-0.13	<0.001	0.06	0.03-0.09	<0.001
Types of violence (contrast: none)												
One (n = 751)	0.29	0.25-0.33	<0.001	0.28	0.24-0.32	<0.001	0.22	0.18-0.25	<0.001	0.21	0.18-0.25	<0.001
Two (n = 266)	0.56	0.50-0.61	<0.001	0.54	0.49-0.60	<0.001	0.39	0.33-0.44	<0.001	0.38	0.32-0.44	<0.001
Three (n = 77)	0.88	0.78-0.98	<0.001	0.87	0.77-0.97	<0.001	0.75	0.64-0.85	<0.001	0.74	0.64-0.85	<0.001
Four or more (n = 55)	1.09	0.97-1.22	<0.001	1.07	0.95-1.20	<0.001	0.88	0.76-1.00	<0.001	0.87	0.75-0.99	<0.001

N = 3440. Coefficients are unstandardized. Interaction analyses yielded the following results: Shame: interaction gender and number of violence types was significant (violence contrasts were slightly more pronounced for women than for men, p-value: <0.001); guilt: no significant interaction between gender and number of violence types (p-value: 0.317). Adjusted models are adjusted for age, ethnicity and all covariates (violence and gender) [1]Adjusted R squared: 0.245 [2] Adjusted R squared: 0.159

Table 5. Multiple regression analyses displaying associations between gender, violence, shame and guilt and mental health problems (HSCL)

	Unadjusted			Adjusted			Imputed model		
	Coeff	CI	p-value	Coeff	CI	p-value	Coeff	CI	p-value
Gender (female)	0.16	0.12-0.19	<0.001	0.05	0.02-0.08	<0.001	0.05	0.02-0.07	<0.001
Violence									
1 type	0.17	0.13-0.20	<0.001	0.07	0.03-0.11	<0.001	0.1	0.07-0.14	<0.001
2 types	0.4	0.34-0.45	<0.001	0.21	0.16-0.27	<0.001	0.26	0.21-0.32	<0.001
3 types	0.6	0.50-0.70	<0.001	0.3	0.20-0.40	<0.001	0.35	0.25-0.45	<0.001
4 or more types	0.94	0.83-.1.06	<0.001	0.57	0.45-0.68	<0.001	0.61	0.49-0.73	<0.001
Shame	0.41	0.39-0.44	<0.001	0.241	0.20-0.28	<0.001	0.22	0.18-0.26	<0.001
Guilt	0.38	0.35-0.41	<0.001	0.122	0.08-0.16	<0.001	0.11	0.07-0.15	<0.001

N = 3439. Coefficients are unstandardized. Interaction analyses yielded no significant results (shame and gender: p-values = 0.119; guilt and gender: p-value = 0.448).In adjusted models, adjustment variables are age and ethnicity, in addition, and all dependent variables adjusted for each other. Adjusted R Squared: 0.247. [1]Standardized regression coefficient .26. [2]Standardized regression coefficient 0.13

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BRIEF REPORT

Shame and Guilt in the Aftermath of Terror: The Utøya Island Study

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In recent years, there has been increased interest in trauma-related shame and guilt and their relationship to mental health. Little is known, however, about shame and guilt following mass traumas, such as terrorism. This study investigates the potential associations of trauma-related shame and guilt with posttraumatic stress (PTS) reactions after the terrorist attack of July 22, 2011 on Utøya Island in Norway. Interviews were conducted with 325 of the 490 survivors 4 to 5 months after the event. Multiple linear regression analyses were employed to investigate associations. In the month previous to the interview, 44.1% ($n = 143$) of participants had experienced at least some guilt for what happened during the attack, and 30.5% ($n = 99$) had experienced at least some shame. Shame and guilt were both uniquely associated with PTS reactions after adjusting for terror exposure, gender, and other potential confounders (frequent shame: $B = 0.54$, frequent guilt: $B = 0.33$). We concluded that trauma-related shame and guilt are related to mental health after mass trauma.

Shame and guilt have been found in survivors of a variety of potentially traumatic events (Andrews, Brewin, Rose, & Kirk, 2000; Kubany et al., 1996; Street & Arias, 2001). The two emotions differ in several ways, such as whether the focus of self-evaluation is the global self (shame) or a certain behavior (guilt; Tangney & Dearing, 2002), or whether hiding behavior (shame) or reparation behavior (guilt) is elicited (Gilbert, 1997). They are, however, both self-conscious emotions (Lewis, 2008; Tangney & Dearing 2002), typically experienced in an interpersonal context (Tangney & Dearing, 2002). Shame, and to a lesser extent, guilt, are associated with mental health problems such as depression (Kim, Thibodeau, & Jorgensen, 2011), social anxiety (Gilbert, 2000), and posttraumatic stress disorder (PTSD; Kubany, 1994; Lee, Scragg, & Turner, 2001; Leskela, Dieperink, & Thuras, 2002). Shame and guilt may contribute to PTSD through the individual's evaluation of meaning of the event (e.g., shame through loss of status or social attractiveness, and guilt through responsibility or hindsight bias; Lee et al., 2001). Other explanations may be negative guilt cognitions causing memories to be more painful and more resistant to extinction (Kubany & Manke, 1995) and shame interacting with fear and anger (Budden, 2009).

Explanations for the occurrence of shame and guilt after trauma include stigmatization and secrecy (Finkelhor & Browne, 1985), and victims taking the blame or being blamed by others for what happened (Brewin, 2003; Campbell & Lewandowski, 1997). To our knowledge, the occurrence of shame and guilt has not been studied with survivors of mass trauma. Mass trauma events, such as terrorist attacks, differ from more private traumas in ways that may be related to shame and guilt. These events are not secret. The massive public attention of mass traumas will often entail that the social groups of an individual know about the event. This omits the issue of disclosure, thought to be central to shame (Bögner, Herlihy, & Brewin, 2007). Further, the attention is often positive, with surrounding populations expressing their support for and sympathy with victims (Thoresen, Aakvaag, Wentzel-Larsen, Dyb, & Hjemdal, 2012). The experience is to a large degree acknowledged as a potentially traumatic event, which may provide the individual with social support. The public attention, however, may also entail aspects that can contribute to shame and guilt. Survivors may be publically exposed in a vulnerable situation, without having the option of keeping their experience private. Though the bulk of public attention may be positive and supportive, some people may voice criticism of actions or inactions

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during the event, which may be all the more difficult to handle when expressed publically. Survivors may also experience that the portrayal of them as a group in media or other contexts is overly heroic or positive, which may not correspond with their private experience of the trauma. Thus, it is not clear whether shame and guilt are important factors for mental health for terror survivors. In this study, we aimed to examine the extent to which trauma-related shame and guilt were associated with posttraumatic stress (PTS) reactions in a sample of survivors of a terrorist attack. We hypothesized that both trauma-related shame and trauma-related guilt would be associated with PTS in this sample of mass trauma survivors.

Method

Participants and Procedure

Face-to-face interviews were conducted with 325 survivors (of a total 490; response rate: 66.3%, Dyb et al., 2014) 4–5 months after the event. Interviews were conducted by trained health care professionals. Parents also participated, but this study only used parental reports to describe the family's financial situation.

The sample comprised 52.9% men. Though primarily consisting of youth, the sample included some adult personnel (92.5% were under 25 years of age; 97.0% were under 30), and had an age range of 13–57 years. The mean age of respondents was 19.37 ($SD = 4.61$) years at the time of terror exposure. The vast majority had a Norwegian ethnic background (87.7%), and 86.2% of respondents' parents reported that their financial situation was "about normal" or above. More details about the study are published elsewhere (Dyb et al., 2014).

Measures

PTS reactions were measured using the 17-item University of California, Los Angeles Posttraumatic Stress Disorder Reaction Index (PTSD-RI; Steinberg, Brymer, Decker, & Pynoos, 2004), designed to measure PTSD according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (4^{th} ed.; *DSM-IV*; American Psychiatric Association, 1994). Only items from the second part, which measures symptoms according to the *DSM-IV*, were used. Respondents reported how frequently they had experienced a variety of symptoms in the previous month on a 5-point Likert-like scale, ranging from $0 =$ *never* to $4 =$ *almost all the time*. The mean score was 1.56 ($SD = 0.72$) on the 0–4 scale. The PTSD-RI has previously shown good psychometric properties (Steinberg et al., 2004). In our study, Cronbach's α was .89. The variable had a close to normal distribution (Dyb et al., 2014).

Shame and guilt were measured using two items from the extended PTSD-RI: "I feel ashamed over something that happened during the terrorist attack" and "I think that some part of what happened during the terrorist attack is my fault." As with PTS symptoms, respondents reported the frequency of experiencing shame and guilt for something that happened during the massacre during the month prior to the interview. These items are not included in the PTS reactions score in accordance with the instructions for the instrument (Steinberg et al., 2004). Response categories were identical to those of PTS reactions. Because of the low number of respondents reporting trauma-related shame and guilt *often* or *almost always* in the month prior to the interview, these categories were collapsed with *sometimes or more,* giving the following three categories: (a) no shame/guilt, (b) infrequent shame/guilt, and (c) frequent shame/guilt.

Demographic variables included gender, age, and ethnicity. During the 75 minutes the shooting lasted, all participants in our study were exposed to life-threatening danger. Terror exposure was measured by the following three items: mortal danger (having been aimed at or shot at, 45.1%), physical injury (having been physically injured to an extent that medical aid was required, 18.2%), and having lost someone close in the terrorist attack (74.5%). The items were rated yes or no.

Data Analysis

Differences between genders were investigated using Pearson's χ^2 tests. Linear regression analyses were applied to investigate the relationships of shame and guilt with PTS reactions (mean score). As shame and guilt were two single items with three response categories each (no shame/guilt, infrequent shame/guilt, and frequent shame/guilt), and as there were sufficient degrees of freedom, the two variables were entered as categorical variables. To decide if differences between levels of shame and guilt were clinically significant, we used 5.0% difference in the dependent variable as threshold (Fayers & Machin, 2007). We adjusted for age, ethnicity, and three items measuring terror exposure.

Missing values in the regression analyses were handled with complete case analysis. Due to missing data, 11 of 325 respondents were omitted. We used SPSS Statistics 20 for Windows.

Results

Of respondents, 44.2% (49.7% women and 39.2% men) reported any trauma-related guilt in the month prior to the interview. Overall, 30.4% (36.0% women and 25.5% men) reported any trauma-related shame in the same period. More men than women reported no shame χ^2 $(1, N = 325) = 9.83$, $p = .007$, but among those who did report shame, more women than men reported infrequent shame (Table 1). No significant gender difference was found for guilt.

In the unadjusted analyses, both shame and guilt were significantly associated with PTS reactions (Table 2). These associations withstood adjustment for gender, age, ethnicity, and terror exposure. An individual who reported frequent shame compared with no shame in the month prior to the interview, would on average have a 0.54 higher PTS reaction score on a scale of 0–4 when adjusted for gender, age, ethnicity, and terror

Table 1
Levels of Trauma-Related Guilt and Shame in Survivors of the Utøya Island Massacre

	Total		Women		Men	
	n	%	*n*	%	*n*	%
Guilt						
None	181	55.9	77	50.3	104	60.8
Infrequent	79	24.4	39	25.5	40	23.4
Frequent	64	19.8	37	24.2	27	15.8
Shame						
None	226	69.5	98	64.1	128	74.4
Infrequent	56	17.2	37	24.2	19	11.0
Frequent	43	13.2	18	11.8	25	14.5

*$p < .05$.

exposure. Similarly, reported frequent trauma-related guilt represented the mean PTS reaction score being 0.33 higher.

Discussion

In our study, trauma-related shame and guilt were both uniquely associated with PTS reactions in mass-trauma survivors. The association between shame and guilt and PTS reactions appeared to be at a level that was clinically relevant according to the criteria we had set for this study (Fayers & Machin, 2007). The study showed that shame and guilt were not uncommon after this mass trauma, and that they may contribute to PTS reactions for those who experience a mass trauma, as they have been found to do in survivors of other traumas (Andrews et al., 2000; Kubany et al., 1996; Street & Arias, 2001).

Trauma-related shame has been found to be rooted in an experience of not having taken effective action to prevent the event, and of looking bad to others (Andrews et al., 2000). Although preventing the massacre from occurring would have been extremely difficult for our participants, they may have believed that they could have prevented aspects of the event. Shame may also have resulted from knowing that others witnessed their experience. Participants encountered numerous choices during the event, such as whether to run or to hide, stay in groups, or flee alone. Given the grave consequences, they may be highly motivated to imagine different courses of actions, which may result in regret for choices made. In addition, participants may have experienced survivor guilt.

Table 2
Linear Regression of Associations of Shame and Guilt With PTS Reactions

	Unadjusted		Adjusted[a]	
Variables	*B*	95% CI	*B*	95% CI
Shame[b]				
Infrequent	0.44***	[0.25, 0.64]	0.14	[–0.06, 0.34]
Frequent	0.84***	[0.63, 1.06]	0.54***	[0.32, 0.75]
Guilt[c]				
Infrequent	0.29**	[0.12, 0.47]	0.16	[– 0.01, 0.32]
Frequent	0.73***	[0.54, 0.92]	0.33**	[0.13, 0.53]

Note. $N = 314$. *Never* was used as the reference category. CI = confidence interval.
[a]The model is adjusted for gender, age, ethnicity, and terror exposure. [b]Overall unadjusted and adjusted model, $p < .001$. [c]Overall unadjusted model, $p < .001$; overall adjusted model, $p < .05$.
*$p < .05$. **$p < .01$. ***$p < .001$.

Shame is a painful emotion (Budden, 2009; Lewis, 2008), and may be linked with PTS reactions through intensifying pain from symptoms, or through avoidance of shameful trauma reminders. Guilt may be linked to PTS reactions through guilty rumination, or through an inappropriate attribution of responsibility (Kim et al., 2011). In addition, shame and guilt may affect PTS reactions; for example, intrusive memories involving shame or guilt may be more painful.

The study was cross-sectional; hence, the direction of associations cannot be assessed. The items measuring shame and guilt were brief, and did not differentiate between the two emotions by defining them. Thus, respondents' reports reflect their own understanding of these terms. To admit to shame and guilt may in itself be stigmatizing, leading to underreporting on these items. Individuals experiencing frequent shame or guilt may have been more prone to decline participation in the study. We did not have information about respondents' previous trauma exposure or peritraumatic shame and guilt. There is also a chance that individuals experiencing high levels of psychological pain are more prone to endorse shame, guilt, and PTS symptoms, as all may be painful. Shame and guilt items were a part of an extended version of the PTSD-RI. They were not included in the PTS reaction score. The strengths of this study include the high response rate, good psychometric properties of the measure of PTS reactions, and the use of face-to-face interviews with health professionals.

Although levels of trauma-related shame and guilt were not very high in this group, both shame and guilt were uniquely associated with PTS reactions. This indicates that they may have separate pathways to mental health problems, and clinicians may find it helpful to attend to both these emotions and the aspects of the trauma that have given rise to them. The inclusion of shame and self-blame in the revised diagnostic criteria for PTSD in *DSM-5* (American Psychiatric Association, 2013) will likely lead researchers and clinicians to more systematically map these emotions after trauma.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Amercican Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).Washington, DC: Author.

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger,

and childhood abuse. *Journal of Abnormal Psychology*, *109*, 69–73. doi:10.1037/0021-843X.109.1.69

Bögner, D., Herlihy, J., & Brewin, C. R. (2007). Impact of sexual violence on disclosure during home office interviews. *The British Journal of Psychiatry*, *191*, 75–81. doi:10.1192/bjp.bp.106.030262

Brewin, C. R. (2003). *Posttraumatic stress disorder malady or myth?* New Haven, CT: Yale University Press.

Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for *DSM-V*. *Social Science & Medicine*, *69*, 1032–1039. doi:http://dx.doi.org/10.1016/j.socscimed.2009.07.032

Campbell, J. C., & Lewandowski, L. A. (1997). Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America*, *20*, 353–374. doi:http://dx.doi.org/10.1016/S0193-953X(05)70317-8

Dyb, G., Jensen, T. K., Nygaard, E., Ekeberg, Ø., Diseth, T. H., Wentzel-Larsen, T., & Thoresen, S. (2014). Post-traumatic stress reactions in survivors of the 2011 massacre on Utøya Island, Norway. *The British Journal of Psychiatry*, *204*, 361–367. doi:10.1192/bjp.bp.113.133157

Fayers, P., & Machin, D. (2007). *Quality of life: The assessment, analysis and interpretation of patient-reported outcomes* (2nd ed.). Hoboken, NJ: Wiley.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55*, 530–541. doi:10.1111/j.1939-0025.1985.tb02703.x

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, *70*, 113–147. doi:10.1111/j.2044-8341.1997.tb01893.x

Gilbert, P. (2000). The relationship of shame, social anxiety and depression: The role of the evaluation of social rank. *Clinical Psychology and Psychotherapy*, *7*, 174–189. doi:10.1002/1099-0879(200007

Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). Shame, guilt, and depressive symptoms: A meta-analytic review. *Psychological Bulletin*, *137*, 68–96. doi:10.1037/a0021466

Kubany, E. S. (1994). A cognitive model of guilt typology in combat-related PTSD. *Journal of Traumatic Stress*, *7*, 3–19. doi:10.1002/jts.2490070103

Kubany, E. S., & Manke, F. P. (1995). Cognitive therapy for trauma-related guilt: Conceptual bases and treatment outlines. *Cognitive and Behavioral Practice*, *2*, 27–61. doi:http://dx.doi.org/10.1016/S1077-7229(05)80004-5

Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment*, *8*, 428–444. doi:10.1037/1040-3590.8.4.428

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, *74*, 451–466. doi:10.1348/000711201161109

Leskela, J., Dieperink, M., & Thuras, P. (2002). Shame and posttraumatic stress disorder. *Journal of Traumatic Stress*, *15*, 223–226. doi:10.1023/A:1015255311837

Lewis, M. (2008). Self-conscious emotions. Embarrassment, pride, shame, and guilt. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions* (3rd ed., pp. 742–756). New York, NY: Guilford Press.

Steinberg, A., Brymer, M., Decker, K., & Pynoos, R. (2004). The University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports*, *6*, 96–100. doi:10.1007/s11920-004-0048-2

Street, A. E., & Arias, I. (2001). Psychological abuse and posttraumatic stress disorder in battered women: Examining the roles of shame and guilt. *Violence and Victims*, *16*, 65–78.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York, NY: Guilford Press.

Thoresen, S., Aakvaag, H. F., Wentzel-Larsen, T., Dyb, G., & Hjemdal, O. K. (2012). The day Norway cried: Proximity and distress in Norwegian citizens following the 22nd July terrorist attacks in Oslo and on Utøya Island. *European Journal of Psychotraumatology*, *3*. doi:10.3402/ejpt.v3i0.19709

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APPENDICES

SGATS Shame and Guilt After Trauma Scale

You have now told me about an experience (experiences) that happened to you. I am now going to ask you some questions about possible reactions following such events. (Please base your answers on the event that has bothered you the most).

Response format: No – Yes, a little – Yes, a lot

1. (S) Have you been worried about what people might think of you after what happened?

2. (S) Have you tried to conceal what happened, or any part of it?

3. (S) Have you felt ashamed about any part of what happened?

4. (S) Have you looked down on yourself after what happened?

5. (G) Have you blamed yourself for any part of what happened?

6. (G) Have you been bothered by thoughts that you should have done something differently to prevent what happened?

7. (G) Have you been bothered by thoughts that you should have done something differently while it was happening?

8. (G) Have you felt that you did anything wrong?

9. (G) Have you experienced any feelings of guilt about any part of what happened?

G = Guilt
S = Shame

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SGATS Shame and Guilt After Trauma Scale

Du har nå fortalt meg om en hendelse (noen hendelser) du har opplevd, vi skal nå stille noen spørsmål om reaksjoner man kan ha etter slike hendelser. (Hvis du tar utgangspunkt i den hendelsen som du opplevde som den verste…)

Responsformat: Nei – Ja, litt – Ja, mye

1. (S) Har du bekymret deg over hva andre mennesker kan tenke om deg etter det som skjedde?

2. (S) Har du forsøkt å skjule det som skjedde, eller noe av det?

3. (S) Har du skammet deg over noe av det som skjedde?

4. (S) Har du sett ned på deg selv etter det som skjedde?

5. (G) Har du bebreidet deg selv for noe av det som skjedde?

6. (G) Har du hatt plagsomme tanker om noe du kunne ha gjort annerledes for å hindre at det skjedde?

7. (G) Har du hatt plagsomme tanker om at du skulle ha gjort noe annerledes da det skjedde?

8. (G) Har du følt at du gjorde noe galt?

9. (G) Har du hatt skyldfølelse for noe av det som skjedde?

G = Skyld
S = Skam

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NKVTS - VOLD I NÆRE RELASJONER WEB

Prosjekt	**1302521001**
Skjemanummer	

ID: cawi_start

START **Starttidspunkt**

A a: sys_timenowf c 1

STARTDATO **Startdato**

A a: sys_date c 1

UKE **Uke**

A a: sys_week c 1

UKEDAG **Ukedag**

A a: sys_dayofweek c 1

WEBID **Web id**

R: *

A a: sms_webid c 1

PROSJEKT **Prosjekt**

R: *

A a: sms_prosjekt c 1

LISTE **Listegrunnlag**

R: *
A: sms_liste c

Ordinært basetrekk (Ipsos MMIs Nettforum) ..... ☐ 1
Kundeliste ..... ☐ 2
Vervet på Cati ..... ☐ 3
Vervet fra E-base ..... ☐ 4

Velkommen til undersøkelsen

Vi gjennomfører for tiden en stor undersøkelse om personlig trygghet og livskvalitet blant menn og kvinner i Norge. Undersøkelsen utføres for Nasjonalt kunnskapssenter om vold og traumatisk stress på oppdrag fra Justisdepartementet , og vi vil blant annet spørre om utsatthet for vold.

For å få best mulige resultater er det viktig at flest mulig svarer på spørsmålene, uansett hva man har opplevd eller hvor trygg man føler seg. Dine svar er viktige, så vi håper du vil ta deg tid til å svare.

Undersøkelsen tar ca. 15 minutter. Svarene dine behandles konfidensielt og ingen resultater av undersøkelsen vil kunne knyttes til enkeltpersoner.

Noen av spørsmålene i undersøkelsen er ganske direkte, vi ønsker derfor at du besvarer undersøkelsen uten at andre personer kan se hva du krysser av for.

KJONN **Kjønn**

R: *

Mann 1
Kvinne 2

ALDER **Hva er din alder?**

R: 18:99

Noter antall år ____ 1

STILLING **Hva er din hovedbeskjeftigelse for tiden? Er du ...**

R: *

I arbeid 1
Skoleelev/student 2
Alderspensjonist 3
Trygdet/ uførepensjon 4
I militæret 5
Annet (arbeidsløs/ hjemmeværende etc.) 6
Vil ikke svare 7

Q_INTRO **Hvor fornøyd er du med din egen tilværelse? Er du ...?**

R: *

Meget fornøyd 1
Ganske fornøyd 2
Hverken fornøyd eller misfornøyd 3
Litt misfornøyd 4
Meget misfornøyd 5
Vet ikke/vil ikke svare 6

Q1 **Nå kommer noen spørsmål som handler om bekymring for vold og fysiske angrep fra andre mennesker.**

Har du den siste tiden vært urolig for å bli utsatt for vold eller trusler når du går ute alene på stedet der du bor?

R: *

Ja 1
Nei 2
Vet ikke/ønsker ikke å svare 3

Q2 **Har du – i løpet av det siste året – vært urolig for å bli utsatt for vold i forbindelse med arbeidet ditt eller skolen din?**

F: \stilling.a=1 :2
R: *

Ja 1
Nei 2
Vet ikke/ønsker ikke å svare 3

Q4 **Har det - i løpet av det siste året - hendt at du har avstått fra noen aktivitet, for eksempel å gå tur, gå på kino eller å møte noen, fordi du har vært urolig for å bli utsatt for overfall?**

R: *

Ja 1
Nei 2
Vet ikke 3
Vet ikke/ønsker ikke å svare 4

ID: eksp_barn

Q5 **Nå kommer noen spørsmål om hva du selv har opplevd i din egen BARNDOM. Det vil si frem til du fylte 18 år.**

I din barndom, var det sjelden eller ofte slik at...?

R: *

F: \startdato.a.1=20130101

	Aldri	Sjelden	Noen ganger	Ofte	Veldig ofte eller alltid	Ønsker ikke å svare	
	1	2	3	4	5	6	
Du hadde nok å spise	☐	☐	☐	☐	☐	☐	1
Du hadde for lite å spise	☐	☐	☐	☐	☐	☐	2
Du visste at det var noen som kunne ta vare på deg og beskytte deg	☐	☐	☐	☐	☐	☐	3
Du måtte gå med skitne klær	☐	☐	☐	☐	☐	☐	4
Det var noen i familien din som fikk deg til å føle at du betydde noe for dem	☐	☐	☐	☐	☐	☐	5
Du følte deg elsket	☐	☐	☐	☐	☐	☐	6

Q9 **Opplevde du at en av foreldrene dine eller andre voksne hjemme hadde psykiske problemer?**

R: *

Ja 1
Nei 2
Vet ikke/ønsker ikke å svare 3

Q5_2 **Skjedde det at foreldre eller foresatte gjentatte ganger gjorde narr av deg, ydmyket deg, ignorerte deg eller fortalte deg at du ikke fikk til noe ting?**

R: *

Ja 1
Nei 2
Vet ikke 3

Q6 **Skjedde det at en av foreldrene dine eller andre foresatte ...?**

R: *

Lugget eller kløp deg ..... ☐ 1,
Ristet eller dyttet deg voldsomt ..... ☐ 2,
Slo deg med flat hånd ..... ☐ 3,
Slo deg med knyttneven eller hard gjenstand ..... ☐ 4,
Sparket deg ..... ☐ 5,
Banket deg opp ..... ☐ 6,
Angrep deg fysisk på andre måter ..... ☐ 7,
Ingen av disse ..... (⇒ **Q7**) ☐ 8e,
Vet ikke/ønsker ikke å svare ..... (⇒ **Q7**) ☐ 9e.

ID: loop1

Q6A_NY **Du har nå krysset av for at det hendte at foreldre eller foresatte svar fra Q6.A**

Har (noe av) dette skjedd mer enn én gang, altså ved mer enn ett tidspunkt?

R: *

Kun én gang ..... ☐ 1
Minst én av hendelsene har skjedd mer enn én gang ..... ☐ 2

Q6B **Omtrent hvor gammel var du da det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q6A_ny=1

Oppgi alder ..... ☐☐, 1

Q6C **Omtrent hvor gammel var du første gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q6A_ny=2

Oppgi alder ..... ☐☐, 1

Q6D **Omtrent hvor gammel var du siste gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q6A_ny=2

Oppgi alder ..... ☐☐, 1

Q6E **Var det samme person som gjorde dette begge/alle gangene?**

F: \Q6A_ny=2
R: *

Samme person ..... ☐ 1
Mer enn en person ..... ☐ 2

Q6E2 **Var det en mann eller kvinne som utførte dette?**

F: \Q6A_ny=1:2| \Q6E=1:2
R: *

Mann ..... ☐ 1
Kvinne ..... ☐ 2
Både mann og kvinne ..... ☐ 3
Vet ikke/ønsker ikke å svare ..... ☐ 4

Nå kommer noen spørsmål om det som skjedde. Ikke alle spørsmålene vil passe for alle. Det er likevel viktige at vi kan stille alle spørsmålene.

Q6H **Var du noen gang redd for at du kom til å bli alvorlig skadet eller drept mens dette skjedde?**

F: \Q6A_ny=1:2
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q6J **Fikk du fysiske skader, enten små eller alvorlige, som følge av denne hendelsen?**

F: \Q6A_ny=1
R: *

Ja ..... ☐ 1
Nei ..... (⇒ **Q6M**) ☐ 2
Vet ikke/ ønsker ikke å svare ..... (⇒ **Q6M**) ☐ 3

Q6K **Fikk du fysiske skader, enten små eller alvorlige, som følge av noen av disse hendelsene?**

F: \Q6A_ny=2
R: *

Ja, en gang ..... ☐ 1
Ja, flere ganger ..... ☐ 2
Nei ..... (⇒ **Q6M**) ☐ 3
Vet ikke/ ønsker ikke å svare ..... (⇒ **Q6M**) ☐ 4

Q6L **Hva slags skader fikk du?**

F: \Q6=4:7
R: *

Skrammer eller blåmerke ..... ☐ 1,
Blått øye ..... ☐ 2,
Sår eller kutt ..... ☐ 3,
Indre skader eller brudd ..... ☐ 4,
Ødelagte tenner ..... ☐ 5,
Andre fysiske skader ..... ☐ 6,
Vet ikke/ ønsker ikke å svare ..... ☐ 7e.

Q6M **Var du til medisinsk undersøkelse eller behandling i forbindelse med det som skjedde?**

F: \Q6=4:7
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q6M2 **Tror du at den som undersøkte deg var klar over hva du hadde vært utsatt for?**

F: \Q6M=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q6O **Har du noen gang snakket med helsepersonell om denne/disse hendelsen(e) eller om helseproblemer eller bekymringer du kan ha hatt som følge av dette?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q6Q **Har du noen gang snakket om denne hendelsen med noen andre?**

F: \Q6A_ny=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q6R **Har du noen gang snakket om disse hendelsene med noen andre?**

F: \Q6A_ny=2
R: *

Ja om noe av det ..... ☐ 1
Ja om alt ..... ☐ 2
Nei ..... ☐ 3
Vet ikke/ ønsker ikke å svare ..... ☐ 4

Q7 **Så eller hørte du noen gang at en av dine foreldre eller foresatte ...?**

R: *

Slo den andre med flat hånd ..... ☐ 1,
Slo den andre med knyttneven eller hard gjenstand ..... ☐ 2,
Sparket den andre ..... ☐ 3,
Tok kvelertak på den andre ..... ☐ 4,
Angrep den andre fysisk på annen måte ..... ☐ 5,
Nei, ingen av disse ..... ☐ 6e,
Vet ikke/ ønsker ikke å svare ..... ☐ 7e.

Q8 **Visste du at noe av dette foregikk mellom foreldrene dine, uten at du så eller hørte det direkte?**

F: \Q7=6
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q10 **Vi vil nå stille deg noen spørsmål om seksuelle handlinger som kan skje i barndommen. Noen ganger kan barn bli lurt, belønnet eller truet til seksuelle handlinger som de ikke forstår eller ikke er i stand til å stoppe.**

Før du fylte 13 år: hadde noen som var minst 5 år eldre enn deg noen form for seksuell kontakt med deg?

R: *

Ja ..... ☐ 1
Nei ..... **(⇒ Q13)** ☐ 2
Vet ikke/ønsker ikke å svare ..... **(⇒ Q13)** ☐ 3

Q11 **Involverte dette forsøk på eller gjennomført...?**

F a: \kjonn.a=2
R: *

	Ja	Nei	Ønsker ikke å svare	
	1	2	3	
Inntrenging i skjeden	☐	☐	☐	1
Oralsex	☐	☐	☐	2
Analsex	☐	☐	☐	3

Q12 **Involverte dette at de befølte kjønnsorganene dine eller fikk deg til å beføle sine kjønnsorganer?**

F: (!\Q11.a.1=1) &(!\Q11.a.2=1) &(!\Q11.a.3=1)
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

ID: loop2

Q12A **Skjedde det en eller flere ganger?**

R: *

1 gang ..... ☐ 1
Flere ganger ..... ☐ 2

Q12A2 **Omtrent hvor gammel var du da det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q12A=1
R: -;0:130

Alder ..... ☐☐, ☐ 1

Q12B **Omtrent hvor mange ganger tror du at det skjedde før du fylte 13 år?**

F: \Q12A=2
R: *

2-3 ganger ..... ☐ 1
4-10 ganger ..... ☐ 2
Mer enn 10 ganger ..... ☐ 3

Q12C **Omtrent hvor gammel var du første gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q12A=2
R: -;0:250

Oppgi alder ..... ☐☐, ☐ 1

Q12D **Omtrent hvor gammel var du siste gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q12A=2
R: -;0:250

Oppgi alder ..... ☐☐, ☐ 1

Q12E **Var det samme person som gjorde dette begge/alle gangene?**

F: \Q12A=2
R: *

Samme person ..... ☐ 1
Mer enn en person ..... ☐ 2

Q12E2 **Var det en mann eller kvinne som utførte dette?**

F: \Q12A=1 :2|\Q12E=1 :2
R: *

Mann ..... ☐ 1
Kvinne ..... ☐ 2
Både mann og kvinne ..... ☐ 3
Vet ikke/ønsker ikke å svare ..... ☐ 4

Q12F **Hva var ditt forhold til denne/disse personen(e) da det skjedde?**

R: *

Ektefelle, samboer, partner ..... ☐ 01,
Tidligere ektefelle, samboer, partner ..... ☐ 02,
Kjæreste ..... ☐ 03,
Tidligere kjæreste ..... ☐ 04,
Far, stefar ..... ☐ 05,
Mor, stemor ..... ☐ 06,
Fars kjæreste ..... ☐ 07,
Mors kjæreste ..... ☐ 08,
Bror, stebror, adoptivbror ..... ☐ 09,
Søster, stesøster etc ..... ☐ 10,
Bestemor ..... ☐ 11,
Bestefar ..... ☐ 12,
Andre voksne slektninger ..... ☐ 13,
Egne barn ..... ☐ 14,
Stebarn ..... ☐ 15,
Andre slektninger som er barn ..... ☐ 16,
Venner ..... ☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk, ... ☐ 18,
Trener ..... ☐ 19,
Lærer, annet skolepersonale ..... ☐ 20,
Elever, andre kjente barn/ungdom ..... ☐ 21,
Lege, psykolog, helsepersonale ..... ☐ 22,
Religiøs leder, for eksempel prest, imam ..... ☐ 23,
Sosialarbeider ..... ☐ 24,
Nabo ..... ☐ 25,
Bekjente ..... ☐ 26,
Kollega ..... ☐ 27,
Leder ..... ☐ 28,
Kunde, klient, pasient ..... ☐ 29,
Andre, ukjente voksne ..... ☐ 30,
Andre, ukjente barn ..... ☐ 31,
Usikker ..... ☐ 32e,
Ønsker ikke å svare ..... ☐ 33e.

Q12H **Var du noen gang redd for at du kom til å bli alvorlig skadet eller drept?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q12J **Fikk du fysiske skader, enten små eller alvorlige, som følge av denne/disse hendelsen(e)?**

R: *

Ja ..... ☐ 1
Nei .....**(⇒ Q12M)** ☐ 2
Vet ikke/ ønsker ikke å svare .....**(⇒ Q12M)** ☐ 3

Q12L **Hva slags skader fikk du?**

R: 1:7;9;10 when \kjonn=1 else 1:10

Skrammer eller blåmerke ..... ☐ 01,
Blått øye ..... ☐ 02,
Sår eller kutt ..... ☐ 03,
Indre skader eller brudd ..... ☐ 04,
Ødelagte tenner ..... ☐ 05,
Genitale skader (skader på kjønnsorganer) ..... ☐ 06,
Kjønnssykdom ..... ☐ 07,
Uønsket graviditet ..... ☐ 08,
Andre fysiske skader ..... ☐ 09,
Vet ikke/ ønsker ikke å svare ..... ☐ 10e.

Q12M **Var du til medisinsk undersøkelse eller behandling i forbindelse med det skjedde?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q12N **Tror du at den som undersøkte deg var klar over hva du hadde vært utsatt for?**

F: \Q12M=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/husker ikke ..... ☐ 3

Q12O

(F: \Q12A.a=1) **Har du noen gang snakket med helsepersonell om denne hendelsen eller om helseproblemer eller bekymringer du kan ha hatt som følge av denne hendelsen?**

(F: \Q12A.a=2) **Har du noen gang snakket med helsepersonell om noen av disse hendelsene eller om helseproblemer eller bekymringer du kan ha hatt som følge av noen av dem?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q12Q **Har du noen gang snakket om denne hendelsen med noen andre?**

F: \Q12A=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q12R **Har du noen gang snakket om disse hendelsene med noen andre?**

F: \Q12A=2
R: *

Ja om noe av det ..... ☐ 1
Ja om alt ..... ☐ 2
Nei ..... ☐ 3
Vet ikke/ ønsker ikke å svare ..... ☐ 4

Q13 **De neste spørsmålene handler om uønskede seksuelle hendelser som du kan ha opplevd på noe tidspunkt i livet, enten som barn eller voksen. Personer som utfører slike handlinger kan være en fremmed, men kan også være en man kjenner godt. Spørsmålene er ganske direkte. Det er fordi det gir best informasjon. Hvis det er noen spørsmål du ikke vil svare på, så kan du gå videre til neste spørsmål**

Har noen noen gang tvunget deg til å ha samleie ved å bruke fysisk makt eller ved å true med å skade deg eller noen som står deg nær?

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q14 **Har noen – mann eller kvinne – noen gang tvunget deg til å ha oralsex ved å bruke fysisk makt eller ved å true med å skade deg eller noen som står deg nær?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q15 **Har noen – mann eller kvinne – noen gang tvunget deg til å ha analsex ved å bruke fysisk makt eller ved å true med å skade deg eller noen som står deg nær?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q16

(F: \kjonn.a=2) **Har noen – mann eller kvinne – mot din vilje noen gang puttet fingre eller objekter inn i din vagina eller anus ved å bruke fysisk makt eller ved å true med å skade deg?**

(F: \kjonn.a=1) **Har noen – mann eller kvinne – mot din vilje noen gang puttet fingre eller objekter inn i anus ved å bruke fysisk makt eller ved å true med å skade deg?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q16A

Nå har vi stilt noen spørsmål om tvang til seksuelle handlinger. Nå kommer noen oppfølgningsspørsmål.

Skjedde dette én eller flere ganger?

F: \Q13=1|\Q14=1|\Q15=1|\Q16=1
R: *

1 gang ..... ☐ 1
Flere ganger ..... ☐ 2

Q16A2

Omtrent hvor gammel var du da det skjedde?

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q16A=1

Oppgi alder ..... ☐☐, ☐ 1

Q16B

De hendelsene som du nå har beskrevet:

Var dette del av samme hendelse eller var det ulike hendelser som har skjedd på ulike tidspunkt?

F: \Q16A=2
R: *

Del av samme hendelse ..... ☐ 1
Ulike hendelser på ulike tidspunkt ..... ☐ 2

Q16BB

Hvor mange ganger til sammen har dette skjedd deg i løpet av livet?

F: \Q16B=2|\Q16A=2
R: *

2-3 ganger ..... ☐ 1
4-10 ganger ..... ☐ 2
Mer enn 10 ganger ..... ☐ 3

Q16C

Omtrent hvor gammel var du første gang det skjedde?

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q16A=2

Oppgi alder ..... ☐☐, ☐ 1

Q16D

Omtrent hvor gammel var du siste gang det skjedde?

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q16A=2

Oppgi alder ..... ☐☐, ☐ 1

Q16E

Var det samme person eller personer som gjorde dette begge/alle gangene?

F: \Q16A=2
R: *

Samme person ..... ☐ 1
Mer enn en person ..... ☐ 2

Q16E2

Var det en mann eller kvinne som utførte dette?

F: \Q16A=1:2|\Q16E=1:2
R: *

Mann ..... ☐ 1
Kvinne ..... ☐ 2
Både mann og kvinne ..... ☐ 3
Vet ikke/ønsker ikke å svare ..... ☐ 4

Q16F **Hva var ditt forhold til disse personene?**

F: \Q16E=2
R: *

Ektefelle, samboer, partner	☐ 01,
Tidligere ektefelle, samboer, partner	☐ 02,
Kjæreste	☐ 03,
Tidligere kjæreste	☐ 04,
Far, stefar	☐ 05,
Mor, stemor	☐ 06,
Fars kjæreste	☐ 07,
Mors kjæreste	☐ 08,
Bror, stebror, adoptivbror	☐ 09,
Søster, stesøster etc	☐ 10,
Bestemor	☐ 11,
Bestefar	☐ 12,
Andre voksne slektninger	☐ 13,
Egne barn	☐ 14,
Stebarn	☐ 15,
Andre slektninger som er barn	☐ 16,
Venner	☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk,	☐ 18,
Trener	☐ 19,
Lærer, annet skolepersonale	☐ 20,
Elever, andre kjente barn/ungdom	☐ 21,
Lege, psykolog, helsepersonale	☐ 22,
Religiøs leder, for eksempel prest, imam	☐ 23,
Sosialarbeider	☐ 24,
Nabo	☐ 25,
Bekjente	☐ 26,
Kollega	☐ 27,
Leder	☐ 28,
Kunde, klient, pasient	☐ 29,
Andre, ukjente voksne	☐ 30,
Andre, ukjente barn	☐ 31,
Usikker	☐ 32e,
Ønsker ikke å svare	☐ 33e.

Q16G **Hva var ditt forhold til denne personen?**

F: \Q16E=1|
\Q16A=1
R: *

Ektefelle, samboer, partner	☐ 01,
Tidligere ektefelle, samboer, partner	☐ 02,
Kjæreste	☐ 03,
Tidligere kjæreste	☐ 04,
Far, stefar	☐ 05,
Mor, stemor	☐ 06,
Fars kjæreste	☐ 07,
Mors kjæreste	☐ 08,
Bror, stebror, adoptivbror	☐ 09,
Søster, stesøster etc	☐ 10,
Bestemor	☐ 11,
Bestefar	☐ 12,
Andre voksne slektninger	☐ 13,
Egne barn	☐ 14,
Stebarn	☐ 15,
Andre slektninger som er barn	☐ 16,
Venner	☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk,	☐ 18,
Trener	☐ 19,
Lærer, annet skolepersonale	☐ 20,
Elever, andre kjente barn/ungdom	☐ 21,
Lege, psykolog, helsepersonale	☐ 22,
Religiøs leder, for eksempel prest, imam	☐ 23,
Sosialarbeider	☐ 24,
Nabo	☐ 25,
Bekjente	☐ 26,
Kollega	☐ 27,
Leder	☐ 28,
Kunde, klient, pasient	☐ 29,
Andre, ukjente voksne	☐ 30,
Andre, ukjente barn	☐ 31,
Usikker	☐ 32e,
Ønsker ikke å svare	☐ 33e.

Q16H **Var du noen gang redd for at du kom til å bli alvorlig skadet eller drept?**

F: \Q16A=1
:2
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke/ ønsker ikke å svare	☐ 3

Q16J **Fikk du fysiske skader, enten små eller alvorlige, som følge av denne hendelsen?**

F: \Q16A=1
R: *

Ja	☐ 1
Nei **(⇒ Q16M)**	☐ 2
Vet ikke/ ønsker ikke å svare **(⇒ Q16M)**	☐ 3

Q16K **Fikk du fysiske skader, enten små eller alvorlige, som følge av noen av disse hendelsene?**

F: \Q16A=2
R: *

Ja, en gang ..... ☐ 1
Ja, flere ganger ..... ☐ 2
Nei ..... **(⇒ Q16M)** ☐ 3
Vet ikke/ ønsker ikke å svare ..... **(⇒ Q16M)** ☐ 4

Q16L **Hva slags skader fikk du?**

F: \Q16J=1|\Q16K=1:2
R: 1:7;9;10 when \kjonn=1 else 1:10

Skrammer eller blåmerke ..... ☐ 01,
Blått øye ..... ☐ 02,
Sår eller kutt ..... ☐ 03,
Indre skader eller brudd ..... ☐ 04,
Ødelagte tenner ..... ☐ 05,
Genitale skader (skader på kjønnsorganer) ..... ☐ 06,
Kjønnssykdom ..... ☐ 07,
Uønsket graviditet ..... ☐ 08,
Andre fysiske skader ..... ☐ 09,
Vet ikke/ ønsker ikke å svare ..... ☐ 10e.

Q16M **Var du til medisinsk undersøkelse eller behandling i løpet av de første dagene eller ukene etter at det skjedde?**

F: \Q13=1|\Q14=1|\Q15=1|\Q16=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q16N **Var den som undersøkte deg klar over hva du hadde vært utsatt for?**

F: \Q16M=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/husker ikke ..... ☐ 3

Q16O **Har du noen gang snakket med helsepersonell om denne hendelsen eller om helseproblemer eller bekymringer du kan ha hatt som følge av denne hendelsen?**

F: \Q16A=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q16P **Har du noen gang snakket med helsepersonell om noen av disse hendelsene eller om helseproblemer eller bekymringer du kan ha hatt som følge av disse hendelsene?**

F: \Q16A=2
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q16Q **Har du noen gang snakket om denne hendelsen med noen andre?**

F: \Q16A=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q16R **Har du noen gang snakket om disse hendelsene med noen andre?**

F: \Q16A=2
R: *

Ja om noe av det ..... ☐ 1
Ja om alt ..... ☐ 2
Nei ..... ☐ 3
Vet ikke/ ønsker ikke å svare ..... ☐ 4

Q18 (F: \Q13=1|\Q14=1|\Q15=1|\Q16=1) **I tillegg til det du allerede har krysset av for:**

Har du noen gang opplevd uønsket seksuell kontakt mens du var så beruset at du ikke kunne samtykke eller ikke kunne stoppe det som skjedde?

Registreres ikke dersom dette er samme hendelse som tidligere

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q19 (F: \Q13=1|\Q14=1|\Q15=1|\Q16=1|\Q18=1) **I tillegg til det du allerede har krysset av for:**

Har noen – mann eller kvinne – noen gang berørt eller befølt kjønnsorganene dine eller fått deg til å berøre deres kjønnsorganer ved å bruke makt eller ved å true med å skade deg?

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q20 (F: \Q13=1|\Q14=1|\Q15=1|\Q16=1|\Q18=1|\Q19=1) **I tillegg til det du allerede har krysset av for:**

Har du noen gang opplevd å bli presset til seksuelle handlinger?

R: *

Ja ..... ☐ 1
Nei ..... **(⇒ Q22)** ☐ 2
Vet ikke/ønsker ikke å svare ..... **(⇒ Q22)** ☐ 3

Q21 (F: \kjonn.a=2) **Involverte dette inntrenging i skjeden, oralsex eller analsex?**

(F: \kjonn.a=1) **Involverte dette oralsex eller analsex?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q22 **Har du opplevd andre former for seksuelle krenkelser eller overgrep enn de vi har spurt om til nå?**

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ønsker ikke å svare ..... ☐ 3

Q22A **Du krysset av for at du hadde vært utsatt for seksuelle krenkelser eller overgrep.**

Har dette skjedd en eller flere ganger?

F: \Q18=1| \Q19=1| \Q20=1| \Q22=1
R: *

1 gang ..... ☐ 1
Flere ganger ..... ☐ 2

Q22A2 **Omtrent hvor gammel var du da det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q22A=1

Oppgi alder ..... ___, __ 1

Q22B **De hendelsene som du nå har krysset av for:**

Var dette del av samme hendelse eller var det ulike hendelser som har skjedd på ulike tidspunkt?

F: \Q22A=2
R: *

Del av samme hendelse ..... ☐ 1
Ulike hendelser på ulike tidspunkt ..... ☐ 2

Q22BB **Hvor mange ganger til sammen har dette skjedd deg i løpet av livet?**

F: \Q22B=2| \Q22A=2
R: *

2-3 ganger ..... ☐ 1
4-10 ganger ..... ☐ 2
Mer enn 10 ganger ..... ☐ 3

Q22C **Omtrent hvor gammel var du første gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q22A=2

Oppgi alder ..... ___, __ 1

Q22D **Omtrent hvor gammel var du siste gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q22A=2

Oppgi alder ..... ___, __ 1

Q22E **Var det samme person som gjorde dette begge/alle gangene?**

F: \Q22A=2
R: *

Samme person ..... ☐ 1
Mer enn en person ..... ☐ 2

Q22E2 **Var det en mann eller kvinne som utførte dette?**

F: \Q22A=1 :2| \Q22E=1 :2
R: *

Mann ..... ☐ 1
Kvinne ..... ☐ 2
Både mann og kvinne ..... ☐ 3
Vet ikke/ønsker ikke å svare ..... ☐ 4

Q22F **Hva var ditt forhold til disse personene?**

F: \Q22E=2
R: *

Ektefelle, samboer, partner	☐ 01,
Tidligere ektefelle, samboer, partner	☐ 02,
Kjæreste	☐ 03,
Tidligere kjæreste	☐ 04,
Far, stefar	☐ 05,
Mor, stemor	☐ 06,
Fars kjæreste	☐ 07,
Mors kjæreste	☐ 08,
Bror, stebror, adoptivbror	☐ 09,
Søster, stesøster etc	☐ 10,
Bestemor	☐ 11,
Bestefar	☐ 12,
Andre voksne slektninger	☐ 13,
Egne barn	☐ 14,
Stebarn	☐ 15,
Andre slektninger som er barn	☐ 16,
Venner	☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk,	☐ 18,
Trener	☐ 19,
Lærer, annet skolepersonale	☐ 20,
Elever, andre kjente barn/ungdom	☐ 21,
Lege, psykolog, helsepersonale	☐ 22,
Religiøs leder, for eksempel prest, imam	☐ 23,
Sosialarbeider	☐ 24,
Nabo	☐ 25,
Bekjente	☐ 26,
Kollega	☐ 27,
Leder	☐ 28,
Kunde, klient, pasient	☐ 29,
Andre, ukjente voksne	☐ 30,
Andre, ukjente barn	☐ 31,
Usikker	☐ 32e,
Ønsker ikke å svare	☐ 33e.

Q22G **Hva var ditt forhold til denne/disse personene?**

F: \Q22E=1|
\Q22A=1
R: *

Ektefelle, samboer, partner	☐ 01,
Tidligere ektefelle, samboer, partner	☐ 02,
Kjæreste	☐ 03,
Tidligere kjæreste	☐ 04,
Far, stefar	☐ 05,
Mor, stemor	☐ 06,
Fars kjæreste	☐ 07,
Mors kjæreste	☐ 08,
Bror, stebror, adoptivbror	☐ 09,
Søster, stesøster etc	☐ 10,
Bestemor	☐ 11,
Bestefar	☐ 12,
Andre voksne slektninger	☐ 13,
Egne barn	☐ 14,
Stebarn	☐ 15,
Andre slektninger som er barn	☐ 16,
Venner	☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk,	☐ 18,
Trener	☐ 19,
Lærer, annet skolepersonale	☐ 20,
Elever, andre kjente barn/ungdom	☐ 21,
Lege, psykolog, helsepersonale	☐ 22,
Religiøs leder, for eksempel prest, imam	☐ 23,
Sosialarbeider	☐ 24,
Nabo	☐ 25,
Bekjente	☐ 26,
Kollega	☐ 27,
Leder	☐ 28,
Kunde, klient, pasient	☐ 29,
Andre, ukjente voksne	☐ 30,
Andre, ukjente barn	☐ 31,
Usikker	☐ 32e,
Ønsker ikke å svare	☐ 33e.

Q22Q **Har du noen gang snakket om denne hendelsen med noen andre?**

F: \Q22A=1
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke/ ønsker ikke å svare	☐ 3

Q22R **Har du noen gang snakket om disse hendelsene med noen andre?**

F: \Q22A=2
R: *

Ja om noe av det	☐ 1
Ja om alt	☐ 2
Nei	☐ 3
Vet ikke/ ønsker ikke å svare	☐ 4

ID: eksp_vold

Q24 **De neste spørsmålene handler om fysiske angrep fra andre mennesker. Se bort fra utilsiktede angrep, for eksempel i forbindelse med lek eller sport.**

Har du, i løpet av det siste året - altså de 12 siste månedene - opplevd at noen har...

R: *

	Ja	Nei	Ønsker ikke å oppgi	
	1	2	3	
Slått deg med flat hånd	☐	☐	☐	1
Lugget deg	☐	☐	☐	2
Klort deg	☐	☐	☐	3
Kløpet deg hardt	☐	☐	☐	4

HJELPEBOKS **Fysiske angrep - hjelpeboks**

F: \Q24.1=1 |\Q24.2=1| \Q24.3=1| \Q24.4=1 R: 1 try \Q24.1=1 2 try \Q24.2=1 3 try \Q24.3=1 4 try \Q24.4=1 A: sys_range c

slo deg med flat hånd	☐ 1,
lugget deg	☐ 2,
klorte deg	☐ 3,
kløp deg hardt	☐ 4.

Q24A **Hvor mange ganger de siste 12 måneder har du opplevd at noen har ...?**

R: *

	1 gang	2 ganger	3-4 ganger	5 ganger eller mer	Vet ikke/ husker ikke	
F: \Q24.a.1=1						
slått deg med flat hånd	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	1
F: \Q24.a.2=1 lugget deg	☐	☐	☐	☐	☐	2
F: \Q24.a.3=1 klort deg	☐	☐	☐	☐	☐	3
F: \Q24.a.4=1 kløpet deg hardt	☐	☐	☐	☐	☐	4

Q24B **Var det en mann eller en kvinne som gjorde følgende?**

R: *

	Mann	Kvinne	Både mann og kvinne	Vet ikke/ husker ikke	
F: \Q24.a.1=1	1	2	3	4	
slo deg med flat hånd .	☐	☐	☐	☐	1
F: \Q24.a.2=1 lugget deg	☐	☐	☐	☐	2
F: \Q24.a.3=1 klorte deg	☐	☐	☐	☐	3
F: \Q24.a.4=1 kløp deg hardt	☐	☐	☐	☐	4

Q24C **De hendelsene som du nå har krysset av for:**

Var dette del av samme hendelse eller var det ulike hendelser som har skjedd på ulike tidspunkt?

F: \Q24.1=1 |\Q24.2=1| \Q24.3=1| \Q24.4=1 R: *

Del av samme hendelse	☐ 1
Ulike hendelser på ulike tidspunkt	☐ 2

Q24D **Hva var ditt forhold til den (de) som svar fra HJELPEBOKS.A ?**

F: \hjelpeboks=1:4
R: *

Ektefelle, samboer, partner	☐ 01,
Tidligere ektefelle, samboer, partner	☐ 02,
Kjæreste	☐ 03,
Tidligere kjæreste	☐ 04,
Far, stefar	☐ 05,
Mor, stemor	☐ 06,
Fars kjæreste	☐ 07,
Mors kjæreste	☐ 08,
Bror, stebror, adoptivbror	☐ 09,
Søster, stesøster etc	☐ 10,
Bestemor	☐ 11,
Bestefar	☐ 12,
Andre voksne slektninger	☐ 13,
Egne barn	☐ 14,
Stebarn	☐ 15,
Andre slektninger som er barn	☐ 16,
Venner	☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk,	☐ 18,
Trener	☐ 19,
Lærer, annet skolepersonale	☐ 20,
Elever, andre kjente barn/ungdom	☐ 21,
Lege, psykolog, helsepersonale	☐ 22,
Religiøs leder, for eksempel prest, imam	☐ 23,
Sosialarbeider	☐ 24,
Nabo	☐ 25,
Bekjente	☐ 26,
Kollega	☐ 27,
Leder	☐ 28,
Kunde, klient, pasient	☐ 29,
Andre, ukjente voksne	☐ 30,
Andre, ukjente barn	☐ 31,
Usikker	☐ 32e,
Ønsker ikke å svare	☐ 33e.

Q24E **Forekom dette samtidig med noe du har opplevd som vi allerede har snakket om?**

F: (\Q24.a.1=1| \Q24.a.2=1| \Q24.a.3=1| \Q24.a.4=1) &(\Q13=1| \Q14=1| \Q15=1| \Q16=1)
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke/ husker ikke	☐ 3

Q25 **Har du, NOEN GANG opplevd at en PARTNER eller TIDLIGERE PARTNER har kløpet, klort, lugget eller slått deg med flat hånd?**

R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke/ ønsker ikke å svare	☐ 3

Q25B **Hvor mange ganger til sammen har dette skjedd deg i løpet av livet?**

F: \Q25.a=1
R: *

1 gang	☐ 1
2 ganger	☐ 2
3-4 ganger	☐ 3
5 ganger eller mer	☐ 4
Vet ikke/ ønsker ikke å svare	☐ 5

Q25C **Omtrent hvor gammel var du da det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q25B=1

Oppgi alder ☐☐, ☐ 1

Q25C2 **Hvor gammel var du første gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q25B=2:4

Oppgi alder ☐☐, ☐ 1

Q25C3 **Hvor gammel var du siste gang det skjedde?**

Noter middelverdi - f.eks. hvis svar 4-5 år, noter 4,5

Vet ikke = ubesvart

F: \Q25B=2:4

Oppgi alder ☐☐, ☐ 1

Q25E **Var det samme person som gjorde dette begge/alle gangene?**

F: \Q25B=2:4
R: *

Samme person	☐ 1
Mer enn en person	☐ 2

Q25E2 **Var det en mann eller kvinne som utførte dette?**

F: \Q25B=1 :4|\Q25E=1 :2
R: *

Mann ..... ☐ 1
Kvinne ..... ☐ 2
Både mann og kvinne ..... ☐ 3
Vet ikke/ønsker ikke å svare ..... ☐ 4

Q25E3 **Har du noen gang snakket med noen om dette?**

F: \Q25=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke/ ønsker ikke å svare ..... ☐ 3

Q26 **Har du noen gang – etter fylte 18 år – opplevd at noen har angrepet deg fysisk på følgende måter?**

R: *

	Ja	Nei	Vet ikke/ ønsker ikke å svare	
	1	2	3	
Slått deg med knyttneven eller hard gjenstand	☐	☐	☐	1
Sparket deg	☐	☐	☐	2
Tatt kvelertak på deg	☐	☐	☐	3
Banket deg opp	☐	☐	☐	4
Truet deg med våpen	☐	☐	☐	5
Angrepet deg fysisk på andre måter	☐	☐	☐	6

HJELPEBOKS2 **Fysiske angrep 2 - hjelpeboks**

F: \Q26.1=1 |\Q26.2=1| \Q26.3=1| \Q26.4=1| \Q26.5=1| \Q26.6=1
R: 1 try \Q26.1=1 2 try \Q26.2= 1 3 try \Q26.3=1 4 try \Q26.4= 1 5 try \Q26.5=1 6 try \Q26.6= 1
A: sys_range c

slo deg med knyttneven eller hard gjenstand ..... ☐ 1,
sparket deg ..... ☐ 2,
tok kvelertak på deg ..... ☐ 3,
banket deg opp ..... ☐ 4,
truet deg med våpen ..... ☐ 5,
angrep deg fysisk på andre måter ..... ☐ 6.

Q26A **Hvor mange ganger har du opplevd at noen har ...?**

R: *

	1 gang	2 ganger	3-4 ganger	5 ganger eller mer	Vet ikke/ husker ikke	
	1	2	3	4	5	
F: \Q26.a.1=1 Slått deg med knyttneven eller hard gjenstand	☐	☐	☐	☐	☐	1
F: \Q26.a.2=1 Sparket deg ..	☐	☐	☐	☐	☐	2
F: \Q26.a.3=1 Tatt kvelertak på deg	☐	☐	☐	☐	☐	3
F: \Q26.a.4=1 Banket deg opp	☐	☐	☐	☐	☐	4
F: \Q26.a.5=1 Truet deg med våpen	☐	☐	☐	☐	☐	5
F: \Q26.a.6=1 Angrepet deg fysisk på andre måter	☐	☐	☐	☐	☐	6

Q26B **Hvor gammel var du da du ble...?**

Vet ikke = ubesvart

F: \Q26A.a.1=1 Slått med knyttneven eller hard gjenstand ___, ___ 1
F: \Q26A.a.2=1 Sparket ..... ___, ___ 2
F: \Q26A.a.3=1 Tatt kvelertak på ..... ___, ___ 3
F: \Q26A.a.4=1 Banket opp ..... ___, ___ 4
F: \Q26A.a.5=1 Truet med våpen ..... ___, ___ 5
F: \Q26A.a.6=1 Angrepet fysisk på andre måter ..... ___, ___ 6

Q26CA **Hvor gammel var du FØRSTE gang du ble...?**

Vet ikke = ubesvart

F: \Q26A.a.1=2:4 Slått med knyttneven eller hard gjenstand ___, ___ 1
F: \Q26A.a.2=2:4 Sparket ..... ___, ___ 2
F: \Q26A.a.3=2:4 Tatt kvelertak på ..... ___, ___ 3
F: \Q26A.a.4=2:4 Banket opp ..... ___, ___ 4
F: \Q26A.a.5=2:4 Truet med våpen ..... ___, ___ 5
F: \Q26A.a.6=2:4 Angrepet fysisk på andre måter ..... ___, ___ 6

Q26CB **Hvor gammel var du SISTE GANG du ble...?**

Vet ikke = ubesvart

F: \Q26A.a.1=2:4
Slått med knyttneven eller hard gjenstand ____, __ 1

F: \Q26A.a.2=2:4
Sparket ____, __ 2

F: \Q26A.a.3=2:4
Tatt kvelertak på ____, __ 3

F: \Q26A.a.4=2:4
Banket opp ____, __ 4

F: \Q26A.a.5=2:4
Truet med våpen ____, __ 5

F: \Q26A.a.6=2:4
Angrepet fysisk på andre måter ____, __ 6

Q26D **Var det en mann eller kvinne som ...?**

R: *

	Mann	Kvinne	Både mann og kvinne	Vet ikke/ ønsker ikke å svare	
	1	2	3	4	
F: \Q26.a.1=1 Slo med knyttneven eller hard gjenstand	☐	☐	☐	☐	1
F: \Q26.a.2=1 Sparket deg	☐	☐	☐	☐	2
F: \Q26.a.3=1 Tok kvelertak på deg	☐	☐	☐	☐	3
F: \Q26.a.4=1 Banket deg opp	☐	☐	☐	☐	4
F: \Q26.a.5=1 Truet deg med våpen	☐	☐	☐	☐	5
F: \Q26.a.6=1 Angrep deg fysisk på andre måter	☐	☐	☐	☐	6

Q26E **Hva var ditt forhold til den (de) som svar fra HJELPEBOKS2.A ?**

F: \hjelpeboks2=1:6
R: *

Ektefelle, samboer, partner	☐ 01,
Tidligere ektefelle, samboer, partner	☐ 02,
Kjæreste	☐ 03,
Tidligere kjæreste	☐ 04,
Far, stefar	☐ 05,
Mor, stemor	☐ 06,
Fars kjæreste	☐ 07,
Mors kjæreste	☐ 08,
Bror, stebror, adoptivbror	☐ 09,
Søster, stesøster etc	☐ 10,
Bestemor	☐ 11,
Bestefar	☐ 12,
Andre voksne slektninger	☐ 13,
Egne barn	☐ 14,
Stebarn	☐ 15,
Andre slektninger som er barn	☐ 16,
Venner	☐ 17,
Voksen leder i ungdomsaktivitet, for eksempel ungdomsklubb, kor, sjakk,	☐ 18,
Trener	☐ 19,
Lærer, annet skolepersonale	☐ 20,
Elever, andre kjente barn/ungdom	☐ 21,
Lege, psykolog, helsepersonale	☐ 22,
Religiøs leder, for eksempel prest, imam	☐ 23,
Sosialarbeider	☐ 24,
Nabo	☐ 25,
Bekjente	☐ 26,
Kollega	☐ 27,
Leder	☐ 28,
Kunde, klient, pasient	☐ 29,
Andre, ukjente voksne	☐ 30,
Andre, ukjente barn	☐ 31,
Usikker	☐ 32e,
Ønsker ikke å svare	☐ 33e.

Q26H **Var du noen gang redd for at du kom til å bli alvorlig skadet eller drept mens dette skjedde?**

F: \Q26.a.1=1| \Q26.a.2=1| \Q26.a.3=1| \Q26.a.4=1| \Q26.a.5=1| \Q26.a.6=1
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke/ønsker ikke å oppgi	☐ 3

Q26J **Fikk du fysiske skader, enten små eller alvorlige, som følge av denne hendelsen?**

F: \Q26A.a.1=1| \Q26A.a.2=1| \Q26A.a.3=1| \Q26A.a.4=1| \Q26A.a.5=1| \Q26A.a.6=1
R: *

Ja	☐ 1
Nei	**(⇒ Q26M)** ☐ 2
Vet ikke/ønsker ikke å oppgi	**(⇒ Q26M)** ☐ 3

Q26K **Fikk du fysiske skader, enten små eller alvorlige, som følge av noen av disse hendelsene?**

F: \Q26A.a.1=2:4| \Q26A.a.2=2:4| \Q26A.a.3=2:4| \Q26A.a.4=2:4| \Q26A.a.5=2:4| \Q26A.a.6=2:4 R: *

- Ja, en gang ☐ 1
- Ja, flere ganger ☐ 2
- Nei (⇒ **Q26M**) ☐ 3
- Vet ikke/ønsker ikke å oppgi (⇒ **Q26M**) ☐ 4

Q26L **Hva slags skader fikk du?**

F: \Q26J=1| \Q26K=1:2 R: *

- Skrammer eller blåmerke ☐ 1,
- Blått øye ☐ 2,
- Sår eller kutt ☐ 3,
- Indre skader eller brudd ☐ 4,
- Ødelagte tenner ☐ 5,
- Andre fysiske skader ☐ 6,
- Vet ikke/ønsker ikke å oppgi ☐ 7e.

Q26M **Var du til medisinsk undersøkelse eller behandling i løpet av de første dagene eller ukene etter at det skjedde?**

F: \Q26A.a.1=1| \Q26A.a.2=1| \Q26A.a.3=1| \Q26A.a.4=1| \Q26A.a.5=1| \Q26A.a.6=1 R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke/ønsker ikke å oppgi ☐ 3

Q26N **Var den som undersøkte deg klar over hva du hadde vært utsatt for?**

F: \Q26M=1 R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke/husker ikke ☐ 3

Q26O **Har du noen gang snakket med helsepersonell om denne hendelsen eller om helseproblemer eller bekymringer du kan ha hatt som følge av denne hendelsen?**

F: \Q26A.a.1=1| \Q26A.a.2=1| \Q26A.a.3=1| \Q26A.a.4=1| \Q26A.a.5=1| \Q26A.a.6=1 R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke/ønsker ikke å oppgi ☐ 3

Q26Q **Har du noen gang snakket om denne hendelsen med noen andre?**

F: \Q26A.a.1=1| \Q26A.a.2=1| \Q26A.a.3=1| \Q26A.a.4=1| \Q26A.a.5=1| \Q26A.a.6=1 R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke/ønsker ikke å oppgi ☐ 3

Q26P **Har du noen gang snakket med helsepersonell om noen av disse hendelsene eller om helseproblemer eller bekymringer du kan ha hatt som følge av disse hendelsene?**

F: \Q26A.a.1=2:4| \Q26A.a.2=2:4| \Q26A.a.3=2:4| \Q26A.a.4=2:4| \Q26A.a.5=2:4| \Q26A.a.6=2:4 R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke/ønsker ikke å oppgi ☐ 3

Q26R **Har du noen gang snakket om disse hendelsene med noen andre?**

F: \Q26A.a.1=2:4| \Q26A.a.2=2:4| \Q26A.a.3=2:4| \Q26A.a.4=2:4| \Q26A.a.5=2:4| \Q26A.a.6=2:4 R: *

- Ja om noe av det ☐ 1
- Ja om alt ☐ 2
- Nei ☐ 3
- Vet ikke/ønsker ikke å oppgi ☐ 4

ID: eksp_stalk

Nå kommer noen spørsmål om noen andre typer hendelser som man kan ha opplevd når som helst i livet.

Q23 **Så noen spørsmål om uønsket kontakt eller trakasserende atferd du kan ha opplevd. Inkluder hendelser som involverte fremmede, bekjente, venner, slektninger, og også ektefelle, partner og ekspartner.**

Hvis du nå ser bort fra telefonselgere, meningsmålere og andre som har en grunn til å ta kontakt med deg : Har noen – mann eller kvinne – NOEN GANG skremt deg, bekymret deg, irritert deg eller gjort deg sint ved å...

	Ja	R: * Nei	Vet ikke/ønsker ikke å svare	
	1	2	3	
Følge etter deg eller spionere på deg?	☐	☐	☐	1
Sende deg uønskede brev, e-poster, eller andre skriftlige beskjeder?	☐	☐	☐	2
Ta kontakt med deg på telefon, legge igjen beskjeder på svareren din, eller sende deg tekstmeldinger uten at du ønsker det?	☐	☐	☐	3
Stå utenfor hjemmet ditt, skolen din, eller jobben din?	☐	☐	☐	4

Q23B **Har du noen gang opplevd at en kjæreste, partner eller ektefelle...?**

	Ja	R: * Nei	Vet ikke/ønsker ikke å svare	
	1	2	3	
Kontrollerte hva du brukte tiden på	☐	☐	☐	1
Krevde at du hele tiden måtte gjøre rede for hvor du hadde vært	☐	☐	☐	2
Var sjalu eller mistenksom overfor vennene dine	☐	☐	☐	3

ID: eksp_andre

Q27 Andre belastende hendelser

	Ja	R: * Nei	Ønsker ikke å svare	
	1	2	3	
Har du noen gang hatt en livstruende sykdom?	☐	☐	☐	1
Har du noen gang vært utsatt for en livstruende ulykke?	☐	☐	☐	2
Har et nært familiemedlem, en partner eller en svært nær venn dødd som et resultat av ulykke, drap eller selvmord?	☐	☐	☐	3
Har du noen gang vært til stede da en annen person ble drept? Alvorlig skadet? Utsatt for seksuelt eller fysisk overgrep?	☐	☐	☐	4
Har du noen gang vært i en annen situasjon der du ble alvorlig skadet, eller der det var fare for livet ditt (f.eks. deltatt i krigshandlinger eller bodd i en krigssone)?	☐	☐	☐	5
Har du noen gang vært i en annen situasjon som var svært skremmende eller dypt rystende, eller i en situasjon der du følte deg svært hjelpeløs, som du ikke har nevnt tidligere?	☐	☐	☐	6

ID: hendelser

Q33 **Nå følger noen spørsmål om problemer og plager som man kan ha etter alvorlige hendelser.**

Hvor mye har du vært berørt av hvert av de følgende problemene i løpet av den siste måneden?

R: *

	Ikke i det hele tatt	Litt	Noe	Ganske mye	Veldig mye	Vet ikke/ ønsker ikke å svare	
	1	2	3	4	5	6	
Gjentatte, ubehagelige minner, tanker eller bilder om en alvorlig hendelse du har opplevd	☐	☐	☐	☐	☐	☐	1
Intenst psykisk ubehag når noe minnet deg om en alvorlig hendelse du har opplevd	☐	☐	☐	☐	☐	☐	2
Det å ha unngått aktiviteter eller situasjoner, fordi de minnet deg om en alvorlig hendelse du har opplevd	☐	☐	☐	☐	☐	☐	3
Følelsen av å være fjern fra eller fremmed for andre mennesker	☐	☐	☐	☐	☐	☐	4
Følt deg irritabel eller hatt sinneutbrudd	☐	☐	☐	☐	☐	☐	5
Hatt vanskeligheter med å konsentrere deg	☐	☐	☐	☐	☐	☐	6

Q34_X **Hendelser**

Registreres automatisk

R: 5 1 try \Q6=1:7| \Q7=1:5| \Q8=1 2 try \Q10=1| \Q13=1| \Q14=1| \Q15=1| \Q16=1| \Q18=1| \Q19=1| \Q20=1| \Q22=1 3 try \Q24.1=1|\Q24.2=1| \Q24.3=1| \Q24.4=1| \Q25=1| \Q26.1=1| \Q26.2=1| \Q26.3=1| \Q26.4=1| \Q26.5=1| \Q26.6=1 4 try \Q23.1=1|\Q23.2=1| \Q23.3=1| \Q23.4=1| \Q27.1=1| \Q27.2=1| \Q27.3=1| \Q27.4=1| \Q27.5=1| \Q27.6=1 A: sys_rangec

Vold i familien	☐ 1,
Seksuelle overgrep	☐ 2,
Fysisk vold	☐ 3,
Andre belastende hendelser	☐ 4,
Ekstra	☐ 5.

Q35 **Du har nå krysset av for en hendelse du har opplevd, vi har nå noen spørsmål om reaksjoner man kan ha etter slike hendelser.**

F: \Q34_X.a=1:4#1

	Nei	Ja, litt	Ja, mye	Vet ikke/ ønsker ikke å svare	
	1	2	3	4	
Har du bekymret deg over hva andre mennesker kan tenke om deg etter det som skjedde?	☐	☐	☐	☐	1
Har du forsøkt å skjule det som skjedde, eller noe av det?	☐	☐	☐	☐	2
Har du opplevd at andre har trukket seg vekk fra deg etter det som skjedde?	☐	☐	☐	☐	3
Har du skammet deg over noe av det som skjedde?	☐	☐	☐	☐	4
Har du sett ned på deg selv etter det som skjedde?	☐	☐	☐	☐	5
Har du bebreidet deg selv for noe av det som skjedde?	☐	☐	☐	☐	6
Har du opplevd at noen andre har klandret deg for noe av det som skjedde?	☐	☐	☐	☐	7
Har du hatt plagsomme tanker om noe du kunne ha gjort annerledes for å hindre at det skjedde?	☐	☐	☐	☐	8
Har du hatt plagsomme tanker om at du skulle ha gjort noe annerledes da det skjedde?	☐	☐	☐	☐	9
Har du følt at du gjorde noe galt?	☐	☐	☐	☐	10
Har du hatt skyldfølelse for noe av det som skjedde?	☐	☐	☐	☐	11

Q35B **Du har beskrevet noen hendelser du har opplevd. Vi skal nå stille noen spørsmål om reaksjoner man kan ha etter slike hendelser. Ta utgangspunkt i den hendelsen du synes var den verste...**

F: \Q34_X.a=1:4#2:4

	Nei	Ja, litt	Ja, mye	Vet ikke/ ønsker ikke å svare	
	1	2	3	4	
Har du bekymret deg over hva andre mennesker kan tenke om deg etter det som skjedde?	☐	☐	☐	☐	1
Har du forsøkt å skjule det som skjedde, eller noe av det?	☐	☐	☐	☐	2
Har du opplevd at andre har trukket seg vekk fra deg etter det som skjedde?	☐	☐	☐	☐	3
Har du skammet deg over noe av det som skjedde?	☐	☐	☐	☐	4
Har du sett ned på deg selv etter det som skjedde?	☐	☐	☐	☐	5
Har du bebreidet deg selv for noe av det som skjedde?	☐	☐	☐	☐	6
Har du opplevd at noen andre har klandret deg for noe av det som skjedde?	☐	☐	☐	☐	7
Har du hatt plagsomme tanker om noe du kunne ha gjort annerledes for å hindre at det skjedde?	☐	☐	☐	☐	8
Har du hatt plagsomme tanker om at du skulle ha gjort noe annerledes da det skjedde?	☐	☐	☐	☐	9
Har du følt at du gjorde noe galt?	☐	☐	☐	☐	10
Har du hatt skyldfølelse for noe av det som skjedde?	☐	☐	☐	☐	11

ID: eksp_helse

Q28 **Nå følger noen spørsmål om hvordan du har det nå for tiden**

Hvordan er helsen din nå? Vil du si den er...

R: *

Dårlig	☐ 1
Ikke helt god	☐ 2
God	☐ 3
Svært god	☐ 4
Vet ikke/ønsker ikke å svare	☐ 5

ID: alkohol

Q36 **Nå følger noen spørsmål om bruk av alkohol.**

Omtrent hvor mange ganger har du drukket alkohol i løpet av det siste året (siste 12 mnd)?

R: *

- Ingen ganger ☐ 1
- 1-4 ganger ☐ 2
- 5-10 ganger ☐ 3
- Omtrent 1 g. i mnd. ☐ 4
- 2-3 ggr i måneden ☐ 5
- 1-2 ggr i uka ☐ 6
- Oftere ☐ 7
- Vet ikke/ønsker ikke å oppgi ☐ 8

ID: politi1

Q38A **Du har beskrevet ubehagelige ting du opplevde i barndommen. Meldte du dette til politiet?**

F: \Q6=4:7|\Q10=1
R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke ☐ 3
- Vil ikke svare ☐ 4
- Ikke aktuelt å anmelde (⇒ **Q38B**) ☐ 5

Q39A **Hva var grunnen til at du ikke anmeldte hendelsen?**

F: \Q38A=2
R: *

- Det var for bagatellmessig, ikke verd å anmelde .. ☐ 01,
- Det var en familiesak, ikke noen politisak ☐ 02,
- Du mente de ikke kunne hjelpe noe særlig ☐ 03,
- Du fryktet de ikke ville tro på deg ☐ 04,
- Du trodde ikke de ville være særlig imøtekommende ☐ 05,
- Politiet anbefalte meg å ikke anmelde ☐ 06,
- Du liker ikke/er redd politiet ☐ 07,
- Du var redd det bare ville føre til mer vold/overgrep ☐ 08,
- Du orker ikke flere ydmykelser ☐ 09,
- Du ville ikke at det skulle bli rettsak ☐ 10,
- Det hadde andre årsaker ☐ 11,
- Husker ikke ☐ 12e,
- Vil ikke svare ☐ 13e.

Q40A **Var det noen andre som anmeldte?**

F: \Q38A=2
R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke ☐ 3
- Vil ikke svare ☐ 4

Q37 **Omtrent hvor mange ganger har du vært beruset / tydelig beruset / full i løpet av det siste året (siste 12 mnd)?**

F: \Q36=2:8
R: *

- Ingen ganger ☐ 1
- 1-4 ganger ☐ 2
- 5-10 ganger ☐ 3
- Omtrent 1 g. i mnd. ☐ 4
- 2-3 ggr i måneden ☐ 5
- 1-2 ggr i uka ☐ 6
- Oftere ☐ 7
- Vet ikke/ønsker ikke å oppgi ☐ 8

Q41A **Fikk politiet kjennskap til det på annen måte?**

F: \Q40A=2
R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke ☐ 3
- Vil ikke svare ☐ 4

Q42A **Ble saken etterforsket?**

F: \Q38A=1|\Q40A=1|\Q41A=1
R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke ☐ 3
- Vil ikke svare ☐ 4

Q43A **På en skala fra 1 – 5 hvor 1 er veldig misfornøyd og 5 er veldig fornøyd – hvor fornøyd er du med kontakten med politiet i denne saken?**

F: \Q38A=1
R: *

- 1 - Veldig misfornøyd ☐ 1
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 - Veldig fornøyd ☐ 5
- Vet ikke ☐ 6
- Vil ikke svare ☐ 7

Q44A **Kom saken for retten?**

F: \Q42A=1
R: *

- Ja ☐ 1
- Nei ☐ 2
- Vet ikke ☐ 3
- Vil ikke svare ☐ 4

Q45A **På en skala fra 1 – 5 hvor 1 er veldig misfornøyd og 5 er veldig fornøyd – hvor fornøyd er du med måten du ble behandlet på i retten?**

F: \Q44A=1
R: *

1 - Veldig misfornøyd	☐ 1
2	☐ 2
3	☐ 3
4	☐ 4
5 - Veldig fornøyd	☐ 5
Vet ikke	☐ 6
Vil ikke svare	☐ 7

Q46A **Ble den eller de som hadde begått volden dømt?**

F: \Q44A=1
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4

Q47A **Har du mottatt noen erstatning fra den som begikk volden?**

F: \Q46A=1
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4

Q48A **Har du søkt voldsoffererstatning?**

F: \Q47A=2
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4

Q49A **Har du fått innvilget erstatning?**

F: \Q48A=1
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4

ID: politi2

Q38B **Du har beskrevet ubehagelige seksuelle hendelser du har opplevd som voksen. Meldte du dette til politiet?**

F: \Q13=1|
\Q14=1|
\Q15=1|
\Q16=1|
\Q18=1|
\Q19=1|
\Q20=1|
\Q22=1
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4
Ikke aktuelt å anmelde (⇒ **Q38C**)	☐ 5

Q39B **Hva var grunnen til at du ikke anmeldte hendelsen?**

Hjelp eventuelt til

F: \Q38B=2
R: *

Det var for bagatellmessig, ikke verd å anmelde	☐ 01,
Det var en familiesak, ikke noen politisak	☐ 02,
Du mente de ikke kunne hjelpe noe særlig	☐ 03,
Du fryktet de ikke ville tro på deg	☐ 04,
Du trodde ikke de ville være særlig imøtekommende	☐ 05,
Politiet anbefalte meg å ikke anmelde	☐ 06,
Du liker ikke/er redd politiet	☐ 07,
Du var redd det bare ville føre til mer vold/overgrep	☐ 08,
Du orker ikke flere ydmykelser	☐ 09,
Du ville ikke at det skulle bli rettsak	☐ 10,
Det hadde andre årsaker	☐ 11,

Ikke les opp

Husker ikke	☐ 12e,
Vil ikke svare	☐ 13e.

Q40B **Var det noen andre som anmeldte?**

F: \Q38B=2
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4

Q41B **Fikk politiet kjennskap til det på annen måte?**

F: \Q40B=2
R: *

Ja	☐ 1
Nei	☐ 2
Vet ikke	☐ 3
Vil ikke svare	☐ 4

Q42B **Ble saken etterforsket?**

F: \Q38B=1| \Q40B=1| \Q41B=1
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4

Q43B **På en skala fra 1 – 5 hvor 1 er veldig misfornøyd og 5 er veldig fornøyd – hvor fornøyd er du med kontakten med politiet i denne saken?**

F: \Q38B=1
R: *

1 - Veldig misfornøyd 1
2 2
3 3
4 4
5 - Veldig fornøyd 5
Vet ikke 6
Vil ikke svare 7

Q44B **Kom saken for retten?**

F: \Q42B=1
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4

Q45B **På en skala fra 1 – 5 hvor 1 er veldig misfornøyd og 5 er veldig fornøyd – hvor fornøyd er du med måten du ble behandlet på i retten?**

F: \Q44B=1
R: *

1 - Veldig misfornøyd 1
2 2
3 3
4 4
5 - Veldig fornøyd 5
Vet ikke 6
Vil ikke svare 7

Q46B **Ble den eller de som hadde begått overgrepet dømt?**

F: \Q44B=1
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4

Q47B **Har du mottatt noen erstatning fra den som begikk overgrepet?**

F: \Q46B=1
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4

Q48B **Har du søkt voldsoffererstatning?**

F: \Q47B=2
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4

Q49B **Har du fått innvilget erstatning?**

F: \Q48B=1
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4

ID: politi3

Q38C **Du har beskrevet at du har blitt angrepet fysisk i voksen alder. Meldte du dette til politiet?**

F: \hjelpeboks2.a=1:6
R: *

Ja 1
Nei 2
Vet ikke 3
Vil ikke svare 4
Ikke aktuelt å anmelde ..... **(⇒ Q50)** 5

Q39C **Hva var grunnen til at du ikke anmeldte hendelsen?**

Hjelp eventuelt til

F: \Q38C=2
R: *

Det var for bagatellmessig, ikke verd å anmelde .. 01,
Det var en familiesak, ikke noen politisak 02,
Du mente de ikke kunne hjelpe noe særlig 03,
Du fryktet de ikke ville tro på deg 04,
Du trodde ikke de ville være særlig imøtekommende 05,
Politiet anbefalte meg å ikke anmelde 06,
Du liker ikke/er redd politiet 07,
Du var redd det bare ville føre til mer vold/overgrep 08,
Du orker ikke flere ydmykelser 09,
Du ville ikke at det skulle bli rettsak 10,
Det hadde andre årsaker 11,

Ikke les opp

Husker ikke 12e,
Vil ikke svare ..... 13e.

Q40C **Var det noen andre som anmeldte?**

F: \Q38C=2
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q41C **Fikk politiet kjennskap til det på annen måte?**

F: \Q40C=2
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q42C **Ble saken etterforsket?**

F: \Q38C=1| \Q40C=1| \Q41C=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q43C **På en skala fra 1 – 5 hvor 1 er veldig misfornøyd og 5 er veldig fornøyd – hvor fornøyd er du med kontakten med politiet i denne saken?**

F: \Q38C=1
R: *

1 - Veldig misfornøyd ..... ☐ 1
2 ..... ☐ 2
3 ..... ☐ 3
4 ..... ☐ 4
5 - Veldig fornøyd ..... ☐ 5
Vet ikke ..... ☐ 6
Vil ikke svare ..... ☐ 7

Q44C **Kom saken for retten?**

F: \Q42C=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q45C **På en skala fra 1 – 5 hvor 1 er veldig misfornøyd og 5 er veldig fornøyd – hvor fornøyd er du med måten du ble behandlet på i retten?**

F: \Q44C=1
R: *

1 - Veldig misfornøyd ..... ☐ 1
2 ..... ☐ 2
3 ..... ☐ 3
4 ..... ☐ 4
5 - Veldig fornøyd ..... ☐ 5
Vet ikke ..... ☐ 6
Vil ikke svare ..... ☐ 7

Q46C **Ble den eller de som hadde begått volden dømt?**

F: \Q44C=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q47C **Har du mottatt noen erstatning fra den som begikk volden?**

F: \Q46C=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q48C **Har du søkt voldsoffererstatning?**

F: \Q47C=2
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q49C **Har du fått innvilget erstatning?**

F: \Q48C=1
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2
Vet ikke ..... ☐ 3
Vil ikke svare ..... ☐ 4

Q50 **Har du som følge av hendelsene du har vært utsatt for noen gang vært i kontakt med:**

Gjelder hendelser som har vært omtalt i intervjuet.

F: \Q34 _X.a=1:4
R: *

Krisesenter	☐ 01,
Krisetelefon	☐ 02,
Sosialkontor	☐ 03,
Familievernkontor	☐ 04,
Advokat	☐ 05,
Politiet	☐ 06,
Fastlege	☐ 07,
Legevakt	☐ 08,
Tannlege	☐ 09,
Helsestasjon	☐ 10,
Psykolog/psykiater	☐ 11,
Barnevern	☐ 12,

Noter: _____

_____

Noter: _____

_____

Noter: _____

_____

Ingen av disse	☐ 16e,
Vet ikke/ ønsker ikke å svare	☐ 17e.

ID: sosial

Q52

R: *

	Aldri	Sjelden	Noen ganger	Ofte	Veldig ofte eller alltid	Ønsker ikke å svare	
	1	2	3	4	5	6	
Når du har behov for å snakke, hvor ofte er noen villig til å lytte til deg?	☐	☐	☐	☐	☐	☐	1
Kan du snakke om dine tanker og følelser?	☐	☐	☐	☐	☐	☐	2
Viser folk deg sympati og støtte?	☐	☐	☐	☐	☐	☐	3
Er det noen som kan gi deg praktisk hjelp?	☐	☐	☐	☐	☐	☐	4
Har du noen gang følt deg sviktet av folk som du regnet med ville støtte deg?	☐	☐	☐	☐	☐	☐	5
Hender det at du føler deg ensom?	☐	☐	☐	☐	☐	☐	6

Q32 **Hvor mye har du opplevd av de følgende plagene den siste uken:**

	Ikke plaget	Litt plaget	Gans-ke mye plaget	Veldig mye plaget	Vet ikke/ ønsker ikke å svare	
	1	2	3	4	5	
Plutselig frykt uten grunn	☐	☐	☐	☐	☐	1
Føler deg redd eller engstelig	☐	☐	☐	☐	☐	2
Matthet eller svimmelhet	☐	☐	☐	☐	☐	3
Føler deg anspent eller oppjaget	☐	☐	☐	☐	☐	4
Lett for å klandre deg selv	☐	☐	☐	☐	☐	5
Søvnproblemer	☐	☐	☐	☐	☐	6
Nedtrykt, tungsindig	☐	☐	☐	☐	☐	7
Følelse av å være unyttig, lite verd	☐	☐	☐	☐	☐	8
Følelse av at alt er et slit	☐	☐	☐	☐	☐	9
Følelse av håpløshet mht. framtida	☐	☐	☐	☐	☐	10

ID: demografi

DEM_SIVST **Så noen bakgrunnsspørsmål.**

Er du ....

- ☐ 1 Gift
- ☐ 2 Samboer
- ☐ 3 Ugift/Aldri vært gift
- ☐ 4 Tidligere gift eller samboer/Separert/Fraskilt
- ☐ 5 Enke/Enkemann

STATSBORGER **Er du norsk eller utenlandsk statsborger?**

R: *

- ☐ 1 Norsk
- ☐ 2 Utenlandsk
- ☐ 3 Vet ikke/ ønsker ikke å svare

LAND **I hvilket land ble du født?**

R: *

- ☐ 1 Norge
- ☐ 2 Resten av Norden
- ☐ 3 Europa unntatt Tyrkia
- ☐ 4 Afrika
- ☐ 5 Asia med Tyrkia
- ☐ 6 Nord-Amerika
- ☐ 7 Sør- og Mellom-Amerika
- ☐ 8 Oseania
- ☐ 9 Vet ikke/ ønsker ikke å svare

BODD_NORGE **Hvor lenge har du bodd i Norge?**

F: !\land.a=1
R: *

- ☐ 1 0-2 år
- ☐ 2 3-5 år
- ☐ 3 6-10 år
- ☐ 4 11-20 år
- ☐ 5 Mer enn 20 år
- ☐ 6 Vet ikke/ ønsker ikke å svare

LAND_MOR **I hvilket land ble moren din født?**

R: *

- ☐ 1 Norge
- ☐ 2 Resten av Norden
- ☐ 3 Europa unntatt Tyrkia
- ☐ 4 Afrika
- ☐ 5 Asia med Tyrkia
- ☐ 6 Nord-Amerika
- ☐ 7 Sør- og Mellom-Amerika
- ☐ 8 Oseania
- ☐ 9 Vet ikke/ ønsker ikke å svare

LAND_FAR **I hvilket land ble faren din født?**

R: *

- ☐ 1 Norge
- ☐ 2 Resten av Norden
- ☐ 3 Europa unntatt Tyrkia
- ☐ 4 Afrika
- ☐ 5 Asia med Tyrkia
- ☐ 6 Nord-Amerika
- ☐ 7 Sør- og Mellom-Amerika
- ☐ 8 Oseania
- ☐ 9 Vet ikke/ ønsker ikke å svare

RAAD **Hvor god råd synes du at familien din har i forhold til folk flest?**

R: *

- ☐ 1 Bedre råd
- ☐ 2 Omtrent som folk flest
- ☐ 3 Dårligere råd
- ☐ 4 Vet ikke
- ☐ 5 Vil ikke svare

UTDANNING **Hva er din høyeste fullførte utdannelse?**

R: *

Universitet/høgskole mer enn 4 år ..... ☐ 1
Universitet/høgskole inntil 4 år ..... ☐ 2
Allmennfaglig studieretning / studieforberedende opplæring på videregående skole ..... ☐ 3
Yrkesskole/ Yrkesfaglig studieretning/ yrkesfaglig opplæring på videregående skole ..... ☐ 4
Grunnskole ..... ☐ 5
Ingen fullført utdannelse ..... ☐ 6
Vil ikke svare ..... ☐ 7

HUSH_INNTEKT **Hva vil du anslå husstandens samlede brutto inntekt til pr. år?** Altså all samlet inntekt før skatt og fradrag.

R: *

Inntil kr. 100.000 ..... ☐ 01
Kr. 100.-199.000 ..... ☐ 02
Kr. 200.-299.000 ..... ☐ 03
Kr. 300.-399.000 ..... ☐ 04
Kr. 400.-499.000 ..... ☐ 05
Kr. 500.-599.000 ..... ☐ 06
Kr. 600.-749.000 ..... ☐ 07
Kr. 750.000 til 999.000 ..... ☐ 08
Kr. 1 mill. eller mer ..... ☐ 09
Ville ikke svare ..... ☐ 10
Visste ikke ..... ☐ 11

POST **Hva er ditt postnummer?**

R: *

Noter postnr. ..... ____ 1

KONTAKT **Vi vil gjerne ha anledning til å gjennomføre tilleggsundersøkelser med noen av de som har deltatt i denne undersøkelsen. Er du villig til at vi kontakter deg igjen senere for et nytt intervju?**

Vi ber ikke nå om ditt samtykke til å være med neste gang, bare om din tillatelse til å ta kontakt med deg igjen og spørre deg om du ønsker å være med.

R: *

Ja ..... ☐ 1
Nei ..... ☐ 2

FULLFORT **Da er intervjuet snart fullført. Vi vil gjerne få takke deg for at du har deltatt, og stille deg et par avsluttende spørsmål.**

Hvordan synes du det var å svare på denne undersøkelsen – var det greit eller var noen spørsmål følelsesmessig belastende?

R: *

Greit ..... ☐ 1
Noen spørsmål var belastende ..... ☐ 2
Ønsker ikke å svare ..... ☐ 3

SNAKKE **Er det slik at du har behov for å snakke med noen om dette?**

F: \fullfort.a=2;3
R: *

Ja ..... ☐ 1
Nei ..... ☐ 2

LABEL110 **Synes du at du har noen å snakke med om dette, eller ønsker du en oppfølgingssamtale?**

F: \snakke.a=1
R: *

Ja, ønsker oppfølgingssamtale ..... ☐ 1
Nei, ønsker ikke oppfølgingssamtale ..... ☐ 2
Vil ikke svare ..... ☐ 3

LABEL111 **Denne undersøkelsen har tilknyttet støtte fra helsepersonell. De som ønsker det, kan få en times samtale med en psykolog. Har du behov for det?**

F: \Label110.a=1;3
R: *

Ja ..... ☐ 1
Nei . ☐ 2

Det er det oppfølgingstilbudet som er i denne studien. Du har anledning til å be om en oppfølgingssamtale senere, hvis du vil. Da kan du bruke den mailadressen som står i følgemailen du fikk, men da må du huske å gjøre det innen en uke.

Dersom du ønsker en times samtale med en psykolog, ta kontakt med Kristin Pran i Ipsos MMI som vil formidle kontakten. E-postadressen er kristin.pran@ipsos.com

Hvis du ønsker mer informasjon om undersøkelsen kan du gå inn på senterets websider nkvts.no Dersom du senere ønsker å trekke deg fra undersøkelsen finner du også informasjon om hvordan du går frem på nkvts.no. Eller du kan ta kontakt med IPSOS MMI. Du kan da også kreve at data om deg som ikke allerede er benyttet i analyser blir slettet.

Tusen takk for hjelpen!

ID: cawi_slutt

KOMPLETT **Komplett**

R: 1
A: sys_range
c

OK ..... ☐ 1.

SCREENED **Screened**

F: !
\Komplett=1
R: 1
A: sys_range
c

OK ..... ☐ 1.

KJONN_KVOTE **Kjonn - komplette intervju.**

F: \kjonn.a=
1;2
R: 1 try
\kjonn=1 2
try \kjonn=2
A: sys_range
c

Menn ..... ☐ 1
Kvinner ..... ☐ 2

ALDER_KVOTE **Alder - komplette intervju.**

F:
\alder.a.1=
18:99
R: 1 try
\alder.1=15
:24 2 try
\alder.1=25
:39 3 try
\alder.1=40
:59 4 try
\alder.1=60
:99
A: sys_range
c

18-24 år ..... ☐ 1
25-39 år ..... ☐ 2
40-59 år ..... ☐ 3
60 år+ ..... ☐ 4

TARGET_FYLKE **Fylkesfordeling**

F: \post.a.1=* R: 1 try \post.1= 1500:1539; 1560:1899; 1950 2 try \post.1= 1300:1499; 1540:1556; 1900:1949; 1951:2099; 2150:2170 3 try \post.1= 0001:1299 4 try \post.1= 2100:2145; 2190:2599; 2610;2612; 2616 5 try \post.1= 2600:2609; 2611;2613 :2615;2617 :2999;3520 :3522;3528 6 try \post.1= 3000:3059; 3300:3519; 3523:3526; 3529:3649 7 try \post.1= 3060:3299 8 try \post.1= 3650:3999 9 try \post.1= 4724:4999 10 try \post.1= 4400:4450; 4473:4720; 4740;4750 :4752 11 try \post.1= 4000:4399; 4460:4465; 5500:5549; 5560:5589; 5595 12 try \post.1= 5000:5499; 5550:5559; 5590:5594; 5596:5715; 5719:5739; 5750:5959; 5981:5999 13 try \post.1= 5716:5718; 5740:5749; 5960:5980; 6700:6996 14 try \post.1= 6000:6699 15 try \post.1= 7000:7119; 7127:7499; 7540:7566; 7580:7599; 7740:7744; 7748 16 try \post.1= 7120:7126; 7500:7533; 7570;7600 :7739;7745 :7746;7750 :7977;7983 :7999 17 try \post.1= 7980:7982; 8000:8408; 8410:8985; 9436;9441 :9444;9448 18 try \post.1= 8409;9000 :9435;9438 :9440;9445 :9447;9449 :9499 19 try \post.1= 9500:9998 A: sys_range c

Østfold ..... ☐ 01
Akershus ..... ☐ 02
Oslo ..... ☐ 03
Hedmark ..... ☐ 04
Oppland ..... ☐ 05

SLUTTID **Sluttid**

A a: sys_timenowf c
Sluttidspunkt 1

SLUTTDATO **Sluttdato**

A a: sys_date c
Sluttdato 1

Takk for at du deltok. Dessverre er du ikke i målgruppen for denne undersøkelsen.