

Interrelationship of daily hassles, daily uplifts, coping strategies and stress-related symptoms, reported by female survivors of sexual abuse: An exploratory mixed-methods approach

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Sammendrag

Bakgrunn: Forskning på vold mot kvinner, fremhever at kvinner som opplever seksuelle overgrep rapporterer dårligere selvoppfattet helse. Det å bli utsatt for seksuelle overgrep er et alvorlig traume som kan utløse en rekke stressreaksjoner. Effekten stress kan ha på helse kan avhenge av faktorer som stresshyppighet, økning av stress i en gitt periode, eller tilstedeværelse av et gjentakende stress i hverdagen med psykologisk betydning. Kvinner som har vært utsatt for seksuelle overgrep kan oppleve en rekke stressende krav og forhold i sin hverdag, som kan oppfattes som irriterende, frustrerende eller føre til økt bekymring, og som tvinger den enkelte til finne måter å håndtere situasjonen på. Motstykket til dette hverdagsstresset (daily hassles) er hverdagsgleder (daily uplifts). Hverdagsgleder kan hjelpe den enkelte med å håndtere stress ved å fungere som "pusterom" fra stressende situasjoner og kan ha gjenopprettende effekt etter skade og/eller tap. Kunnskap om hverdagsstress, hverdagsgleder, mestringsstrategier og hvordan mestringsstrategiene kan påvirke helse og livskvalitet hos kvinner som har opplevd seksuelle overgrep, er viktig kunnskap for helsepersonell i møte med denne gruppen.

Hensikt: Den overordnede hensikten med studiene i denne avhandlingen, var å utvikle ny kunnskap som kan bidra til en større forståelse for hvordan voksne kvinner, som har opplevd seksuelle overgrep, opplever og mestrer hverdagsstress og hva de opplever som hverdagsgleder. Dessuten ønsket vi å få mer kunnskap om hvilken påvirkning dette hverdagsstresset har på helse. Hensikten for den enkelte studie som inngikk i denne avhandlingen var:

- I. Hensikten i studie I var å få en dypere forståelse for hvordan voksne kvinner som har opplevd seksuelle overgrep oppfatter og mestrer hverdagsstress.
- II. I studie II var hensikten å utforske sammenhengen mellom hverdagsstress, hverdagsgleder, mestringsstrategier og stressrelaterte symptomer hos kvinner som har opplevd seksuelle overgrep. Studien undersøkte to hypoteser.

Hypotese 1: Hverdagsstress og lite hensiktsmessige mestringsstrategier er assosiert med en høy grad av stressrelaterte fysiske, emosjonelle, kognitive og målgruppespesifikke symptomer.

Hypotese 2: Hverdagsgleder og hensiktsmessige mestringsstrategier er assosiert med en lav grad av stressrelaterte fysiske, emosjonelle, kognitive og målgruppespesifikke symptomer.

III. I studie III var hensikten å se på sammenheng mellom å ha opplevd seksuelle overgrep og grad av symptom indikasjon på post-traumatisk stresslidelse (PTSD), hverdagsstress, hverdagsgleder, mestringsstrategier og emosjonell stabilitet. Vi tok utgangspunkt i følgende hypoteser:

Hypotese 1: Kvinner som har opplevd seksuelle overgrep, med høy symptom indikasjon på post traumatisk stress lidelse (H-PTSD) vil være assosiert med mer hverdagsstress, færre hverdagsgleder og mer bruk av uhensiktsmessige mestringsstrategier.

Hypotese 2: Kvinner i H-PTSD-gruppen ville rapportere mer alvorlig seksuell utsatthet, mindre ressurssterke sosioøkonomiske forhold og et lavere nivå av emosjonell stabilitet.

Metode og design: I avhandlingen er det benyttet en utforskende kombinert metode design. I den første kvalitative studien ble informantene rekruttert via tre støttesenter (Nok. senter) som bistår personer som har opplevd seksuelle overgrep. Det ble gjennomført dybdeintervjuer med ti voksne kvinner på tre forskjellige Nok. senter. Analysen ble utført ved å bruke prinsippene for den konstante sammenlignende metoden i Grounded theory. Grounded theory ble først benyttet, for å danne en substantiv teori, som illustrerte prosessen relatert til mestring av hverdagsstress i det feltet som ble undersøkt.

Et spørreskjema med både validerte og ny konstruerte målgruppespesifikke variabler ble deretter utviklet på bakgrunn av funn fra studie I. Spørreskjemaet ble brukt til videre datainnsamling for både studie II og III. Spørsmålene var relatert til demografiske og sosioøkonomiske forhold, traumeopplevelse, hverdagsstress og hverdagsgleder (Stress Profile Scale), mestringsstrategier (Brief COPE), stressrelaterte symptomer (Stress Profile Scale), emosjonell stabilitet (Single-Item Measure of Personality) og posttraumatisk stress (PCL). Respondentene var voksne kvinner ($n = 57$) som hadde opplevd seksuelle overgrep og var brukere ved ni av støttesentrene i Norge. Gruppesammenligning ble gjennomført i begge tverrsnitts studiene.

Resultat: I den første kvalitative studie ble den teoretiske modellen, ”Beskyttende skjold i dagliglivet” formet. Den beskriver ettervirkningen av seksuelle overgrep knyttet til mestring av hverdagsstress. Den kan forstås som en prosess med tre faser: (1) unngå og flykte - mestring etter å ha opplevd seksuelle overgrep; (2) akseptere og fortelle - starte en prosess med gjenoppretting; og (3) forsone og ta tilbake - å leve med opplevelsen i nåtid. Det beskyttende skjoldet hadde to funksjoner: stenge ute stressende tanker og mulige stressende situasjoner, og

stenge inne stressende minner, tanker og følelser. Viktige vendepunkt var å fortell om overgrepserfaringen og gjennom det å fortelle finne hjelp.

Gjennom sub-gruppe analyser fant vi en sterk sammenheng mellom hverdagsstress og stressrelaterte symptomer. Kvinnene i den «uhensiktsmessige gruppen» brukte mer uhensiktsmessige mestringsstrategier, opplevde mer skyld og skam. De rapporterte også symptomer på depresjon og maktesløshet. Kvinnene i den «hensiktsmessige gruppen» opplevde mindre hverdagsstress, flere hverdagsgleder og brukte mer hensiktsmessige mestringsstrategier. De rapporterte også at de strevde med noen stressrelaterte fysiske, emosjonelle, kognitive og målgruppespesifikke symptomer. Men alt i alt opplevde de mindre stressrelaterte symptomer enn den «uhensiktsmessige gruppen».

I studie III fant vi at gruppen med høy grad av symptom indikasjon på PTSD, rapporterte betydelig mer hverdagsstress, opplevde færre hverdagsgleder og brukte mer uhensiktsmessige mestringsstrategier. I gruppen med lav indikasjon på PTSD, rapporterte kvinnene mer emosjonell stabilitet, mindre hverdagsstress og flere hverdagsgleder, og de brukte mer hensiktsmessige mestringsstrategier. Gitt det høye antallet ikke signifikante forskjeller mellom de to PTSD undergruppene, var konklusjonen at alvorlighetsgraden av seksuelt misbruk og sosioøkonomiske forhold hadde liten eller ingen effekt på den nåværende indikasjonen for PTSD. Vi fant få forskjeller i gruppeanalysene (Studie II og III) på de sosioøkonomiske og traumerelaterte data.

Konklusjon: Den teoretiske modellen ”Beskyttende skjold i dagliglivet” bidrar til en dypere forståelse av hverdagen til kvinner som har opplevd seksuelle overgrep. De tre fasene i modellen: (1) Unngå og flykte, (2) akseptere og fortelle og (3) forsone og ta tilbake, illustrerer vendepunkter og hvordan kvinnene håndterer sitt hverdagsstress over tid. Resultatene våre fremhever at det å fortelle, finne hjelp og sosial støtte er viktig og bidrar til redusert hverdagsstress, flere hverdagsgleder og bruk av hensiktsmessige mestringsstrategier. Videre indikerte resultatene at det var en sammenheng mellom stressrelaterte symptomer og høy grad av hverdagsstress, få hverdagsgleder og bruk av uhensiktsmessige mestringsstrategier. Høy grad av indikasjon på PTSD var også en indikasjon på mer hverdagsstress og færre hverdagsgleder, mindre emosjonell stabilitet og bruk av mere uhensiktsmessige mestringsstrategier. Resultatene viser viktigheten av at helsepersonell tilegner seg kunnskap om hva dette hverdagsstresset er og er i stand til å avdekke uhensiktsmessige mestringsstrategier. Det kan også være hensiktsmessig å sette søkelys på endring av uhensiktsmessige mestringsstrategier og på å endre stressvurdering og stressrespons atferd.

Abstract

Background: Research on violence against women has highlighted that women who experience sexual abuse report poor self-perceived health. Being sexually abused is a serious trauma that can trigger a number of stress reactions. The impact of stress on health depends on several factors, such as the frequency or level of stress during a given period and the presence of repeated daily hassles of psychological importance. In their everyday lives, female survivors of sexual abuse may experience an array of stressful demands and conditions that are perceived as irritating, frustrating, or stressful events and that force them to act upon these conditions. The opposite of these daily hassles, daily uplifts, can help in the process of coping with stress by serving as “breathers” from regular stressful encounters and functioning restoratively in recovering from harm and loss. Knowledge regarding such daily hassles, uplifts, and coping strategies and how they can affect the health and wellbeing of female survivors of sexual abuse is critical for healthcare professionals.

Aims: The overall aim of the studies in this thesis, was to develop new knowledge that can contribute to a better understanding of how adult women who have experienced sexual abuse experience and cope with stress associated with daily hassles and daily uplifts in their everyday lives. The specific aims of the papers included in this thesis are as follows:

- I. In Paper I, the aim was to gain a deeper understanding of how adult women experience and cope with daily hassles after experiencing sexual abuse.
- II. In Paper II, the aim was to explore the association of daily hassles, daily uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse.

The study examines two hypotheses:

Hypothesis 1: Daily hassles and maladaptive coping strategies are associated with a high frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.

Hypothesis 2: Daily uplifts and adaptive coping strategies are associated with a low frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.

- III. In Paper III, the aim was to compare the characteristics of two groups of female survivors of sexual abuse: one group with a lower indication of posttraumatic stress disorder (PTSD) and one group with a higher indication of PTSD.

Hypothesis 1: Among women with a history of sexual abuse, the H-PTSD group would be associated with more daily hassles, fewer daily uplifts, and more use of maladaptive coping strategies.

Hypothesis 2: Women in the H-PTSD group would report more severe sexual victimization, less resourceful socioeconomic conditions, and a lower level of emotional stability

Methods and design: In this study, an exploratory sequential mixed-method design was used. In Paper I, female participants were recruited through three centers that support survivors of incest and sexual abuse (Nok. centers). In-depth interviews with 10 survivors of sexual abuse were conducted. Analyses were performed using the principles of the constant comparative method in grounded theory. Initially, the grounded theory methodology generated a new substantive theory that illustrated the process related to coping with daily hassles in in this context. A questionnaire with both validated and newly constructed target-group-specific items from the data collection in Paper I was developed and used in two subsequent cross-sectional papers, in line with the chosen mixed method. Measures of socioeconomic conditions, traumatic experiences, daily hassles, and daily uplifts (Stress Profile Scale), as well as those of coping strategies (Brief COPE questionnaire), stress-related symptoms (Stress Profile Scale), emotional stability (Single-Item Measures of Personality), and posttraumatic stress (Posttraumatic Stress Disorder Checklist), were completed by adult female survivors ($n = 57$) at nine support centers for survivors of incest and sexual abuse in Norway. Group comparisons were performed in both studies.

Results: A theoretical model of “protecting armor in daily life” was developed based on the interview data. The aftermath of sexual abuse related to coping with daily stress can be understood as a three-phase process: (1) avoiding and escaping (coping after experiencing sexual abuse), (2) accepting and disclosing (starting a process of recovery), and (3) reconciling and repossessing (living with the experience in the present). Disclosing the abuse and seeking help were found to be key turning points. The protective armor had two functions: shutting out stressful thoughts and potential stressful situations and locking in stressful memories, thoughts, and emotions.

When dividing the study group into subgroups, we found a strong correlation between daily hassles and stress-related symptoms. On the one hand, survivors in the unfavorable profile group used more maladaptive coping strategies, experienced more guilt and shame, and reported more symptoms of depression and powerlessness. On the other hand, survivors in the favorable profile group experienced fewer daily hassles and more daily uplifts and used more

adaptive coping strategies. Although they reported struggling with some stress-related physical, emotional, cognitive, and target-group-specific symptoms, the extent of these symptoms was less than that experienced by the unfavorable profile group.

We also found that survivors with a high indication of PTSD reported significantly more daily hassles, fewer daily uplifts, and greater use of maladaptive coping strategies, whereas those with a lower indication of PTSD reported more emotional stability, fewer daily hassles, and more daily uplifts and used more adaptive coping strategies. Given the low number of significant differences between the PTSD subgroups, we concluded that the severity of sexual abuse and socioeconomic conditions have little or no effect on the current indication for PTSD. Furthermore, we found few differences in the subgroup comparisons in both Papers II and III on socioeconomic and trauma-related data.

Conclusions and implications for healthcare professionals: The theoretical model developed in this study (protecting armor in daily life) contributes to a deeper understanding of the everyday lives of adult female survivors of sexual abuse. The three phases of the model (avoiding and escaping, disclosing the abuse and accepting the need for help, and reconciling and repossessing) illustrate turning points and how such survivors resolve their daily stress over time. The results highlight that disclosure and social support contribute to fewer daily hassles, more daily uplifts, and more adaptive coping strategies. Further results indicate that stress-related symptoms are strongly related to a large number of perceived daily hassles, a small number of daily uplifts, and the use of maladaptive coping strategies. The presence of more symptoms indicating PTSD is also an indication of more daily hassles, fewer daily uplifts, and the use of more maladaptive coping strategies. Overall, the results reveal the importance of healthcare professionals gaining knowledge of what daily hassles comprise, being able to uncover maladaptive coping strategies, and focusing on changing stress appraisals and stress-response behavior.

Abbreviations/Acronyms

BAB	Berit Arnesveen Bronken (co-authors/supervisor)
CPTSD	Complex post-traumatic stress disorder
ICD	International Classification of Diseases
Nok.	Nok. center (before 2020, Center against incest and sexual abuse, SMISO)
NSD	Social science data services
PCL	Posttraumatic Stress Disorder Checklist
PTSD	Post-traumatic stress disorder
PTSS	Post-traumatic stress symptoms
SIMP	Single-Item Measure of Personality
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

List of original papers

- I. Stensvehagen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (2019). How women experience and cope with daily hassles after sexual abuse – a retrospective qualitative study. *Scandinavian Journal of Caring Sciences*, **33**(2), 487–497. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/30628733>. doi:10.1111/scs.12649.
- II. Stensvehagen, M. T., Bronken, B. A., Lien, L. & Larsson, G. (202x). Association of Daily Hassles, Uplifts, Coping Strategies, and Stress-Related Symptoms among Female Survivors of Sexual Abuse – a Cross-Sectional Study. Resubmitted to the *Scandinavian Journal of Caring Sciences*.
- III. Stensvehagen, M. T., Bronken, B. A., Lien, L. & Larsson, G. (2020). Interrelationship of post-traumatic stress, hassles, uplifts, and coping in women with a history of severe sexual abuse: A cross-sectional study. *Journal of Interpersonal Violence*. Open Access doi.org/10.1177/0886260520935479.

1 Introduction

Violence against women is a major public health concern and a large number of women experience violence from childhood to old age. In December 1993, the United Nations (United Nations, 1993) proclaimed the declaration on “the Elimination of Violence against Women”.

Violence against women is in the declaration understood as:

...any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.” (United Nations, 1993).

The World Health Organization’s (WHO’s) typology of violence divides this kind of trauma into five categories: physical, sexual, psychological, deprivation, and neglect (Krug et al., 2002). The violence is either interpersonal (violence between family or intimate partners, usually in the home setting) or collective (violence between unrelated individuals or those who do not know each other, taking place outside the home) (Krug et al., 2002). Interpersonal violence includes various forms of violence and abuse between current and former family members or close relations, and it includes the children who witness the violence. Negative social control, forced marriage, and female genital mutilation also fall under the term. The different categories of violence often occur together. This implies that multiple dimensions may be present at the same time or over time in a family or relationship where violence is being committed (Cicchetti & Toth, 2005; Gilbert et al., 2009).

Working as a nurse I have met many patients with different health-related issues. Some years ago, I worked in the emergency room dealing with a female patient who was admitted time after time due to pain-related issues. She was never dealt with because the doctor could not find anything wrong. Today I know that, as a nurse, I should have devoted more time to her and asked more questions to find out what was really troubling her. A student whom I was guiding on her final assignment disclosed her experiences after she had experienced domestic violence. This affected her everyday life for many years after the violence had ceased. She described her daily stress and how it had changed her life, and this made me want to investigate this topic further.

The research in this thesis has been part of the activities of the trauma research group at Inland Norway University College in Elverum. I was accepted as a Ph.D. student at the University of Oslo, in May 2016. The pronoun “we” or “our research group” in the text, refers to the research team, consisting of my co-authors/supervisors and myself. My main supervisor has been, Professor Gerry Larsson, and my co-supervisors have been, Professor Lars Lien and Associate Professor Berit Arnesveen Bronken. The co-authors/supervisors have made substantial contributions to the three papers in this thesis. My main supervisor formulated the initial topic, based on having done research on the subject of coping with daily hassles, in relation to military personnel and in the context of leadership. The entire research group participated in the development of the data collection, analysis, and suggestions when writing the three papers. As first author, I have participated in the initial discussions, collected the qualitative and quantitative data, and collaborated with my main supervisor on the analysis. I have done most of the writing of the three papers. During the writing of the thesis, I have received valuable feedback from my supervisors. During these years, participating in a Ph.D. student group at the Faculty of Nursing Science, University of Oslo has always been useful.

Several forms of sexual violence exist. The Norwegian Penal Code (Norwegian Penal Code, 2005; Steine et al., 2012), which is used in this thesis, and categorizes the different types of sexual offences as unwanted sexual behaviors, unwanted sexual acts, and unwanted intercourse. The term “sexual abuse” includes all these sexual offenses and can be defined as “as any sexual act that the victim has not consented to, or has been pressured or manipulated to take part in” (Steine et al., 2012, p. 951). In other words, this includes the act of making someone participate in sexual activities against their wishes, or without their agreement. “Sexual abuse” is used as a unifying term in this thesis to refer to all severe forms of sexual violence.

It is crucial to acknowledge that men are also victims of sexual abuse and that their experiences can be equally traumatic. However, since women remain the largest group subjected to sexual abuse, a need exists to explore further how women experience and live with the consequences of their traumatic experience. Therefore, the focus of this thesis is women.

The terms participant and “survivor” are used throughout the thesis when describing the study group, rather than the term “victim.” “Survivor” is a term commonly used in research literature, when describing those who have had this kind of traumatic experience. Being a survivor is linked to inner strength and resilience while coping with victimization and its aftermath (Van Dijk, 2009).

The thesis is based on three interrelated studies and is structured into seven chapters. In the following chapter, the theoretical background regarding reactions to sexual abuse, health consequences, and knowledge on the core concepts in this thesis, daily hassles, daily uplifts, and coping strategies (chapter 2). The main purpose and particular aims are presented in chapter three. Chapter four comprises the research design and methods. In chapter five the main results of Paper I, II and III are presented. The discussion of the main findings and methodological considerations are presented in chapter six. And finally, a presentation of conclusions and implications for healthcare professionals and education in chapter seven.

2 Theoretical background

Violence against women is considered to be one of the most pervasive human rights violations of our time, affecting more than one in three women globally (Fulu, 2016). Over the past 20 years, there has been an increasing focus on violence against women, including domestic violence, in several countries all over the world. Global estimates indicate that 35% of women have experienced some form of physical and/or sexual abuse in their lifetime, and almost 30% of women in a relationship have experienced violence from their intimate partner (World Health Organization, 2013). In a national Norwegian survey, adults were asked about their lifetime experience of sexual abuse: 34% of the women reported having been subjected to some form of sexual abuse (“sexual contact before the age of 13, rape, touching with the use of force or threats, drug-related abuse, pressure to perform sexual acts and / or other sexual offenses and abuse”), and 9,4 % had been raped at least once in their life (Thoresen & Hjemdal, 2014, p. 15). The socioeconomic cost of violence in close relationships in 2010 was estimated to be in the range NOK (Norwegian krone) 4.5–6.0 billion (Rasmussen, 2012). The largest cost to society was, according to their report, lost earnings because of victims of violence falling completely or partially out of working life. The public expenses in 2010 to the police and judicial system, and healthcare and support services for victims amounted to approximately NOK 2.0–2.4 billion (Rasmussen, 2012).

2.1 Sexual trauma

The word trauma comes from the Greek and means injury or wound (Anstorp & Benum, 2014). A traumatic event appraised as highly stressful can be anything from experiencing the loss of a loved one to being in an accident, being threatened by someone at work, or experiencing some form of violence. Sexual violence is defined by World Health Organization (2019b, p. 149) as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work”

Sexual offenses in the legal sense are regulated in the Norwegian Penal Code’s Chapter 26 Sexual Offenses (Norwegian Penal Code, 2005). The categories from the Norwegian Penal Code on sexual violence are used in this thesis (Norwegian Penal Code, 2005; Steine et al., 2012): unwanted sexual behaviors, unwanted sexual acts, and unwanted intercourse. The first

category, unwanted sexual behaviors, can comprise indecent exposure (exhibitionism), peeping, or being shown pornographic pictures or highly sexualized behavior without physical contact (voyeurism). The second category, unwanted sexual acts, refers to being touched on the genitals/breasts (molestation), being forced to masturbate others, or experiencing repeated sexual intercourse or similar movements against one's own body (frottage). The final category, unwanted intercourse (rape), refers to feeling pressured to undertake sexual intercourse without the presence of violence or threats, being forced to partake in sexual intercourse by the use of violence or threatening behavior, or experiencing penetration with fingers, objects, or genitals into the vagina or rectum (Norwegian Penal Code, 2005; Steine et al., 2012).

Being threatened during the traumatic incident and a lack of social support after the event both influence the risk of health-related consequences (Michel, 2014; Ozer et al., 2003). Many survivors of sexual abuse hide their experiences. It is estimated that only between 15% and 25% of all sexual abuse is reported to the police (Thoresen & Hjemdal, 2014, p. 24). This means that there are large numbers of unreported cases in this area, and that few women seek out health services, few report their conditions, and some never tell anyone what they have been exposed to.

2.1.1 Sexual abuse in childhood and/or adulthood

According to the WHO sexual violence afflicts all age groups. The WHO places sexual violence between individuals in two subcategories: family and partner violence and community violence (World Health Organization, 2002, p. 2; see Figure 1). The former category includes the type of violence that primarily occurs between family members and romantic partners. This form of violence is usually, but not always, perpetrated in the home. Conversely, community sexual violence occurs between individuals who do not know each other, and which generally takes place outside of the home.

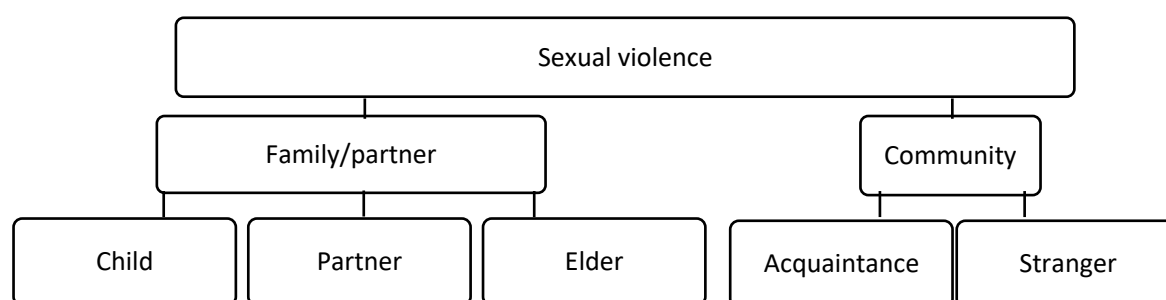


Figure 1. Modified from the WHO violence typology (World Health Organization, 2002)

Sexual abuse related trauma often starts at a young age: one in four young women (aged 15-24 years) who have been in a relationship will have already experienced violence by an intimate partner by the time they reach their mid-twenties (World Health Organization, 2021). Being exposed to violence in childhood has been associated with the risk of being exposed to all types of violence as an adult. The risk for new violence is not limited to the type of violence that occurring in childhood (Aakvaag & Strøm, 2019). According to Thoresen and Hjemdal (2014, p. 62), the prevalence of any sexual contact before the age of 13 with a person at least five years older is 10.2% for women in Norway.

2.1.2 Reactions to sexual trauma

The determining factor in whether a person will have chronic ailments after a traumatic event, is the relationship between the nature and degree of the incident and the person's vulnerability or resilience (Michel, 2014). Factors before the incident occurred include vulnerability due to previous exposure, ongoing life stress, lower socioeconomic status, personality traits, lower intelligence and education, and being a woman or a child (Michel, 2014). Furthermore, if the actual incident has created a subjective experience of being threatened with death and the survivor experience severe reactions or a lack of social support after the incident, this can increase the risk for more long-term consequences for the survivor. In addition, the degree of community support after the event can affect the outcome (Michel, 2014). The political and administrative leadership of the municipalities in Norway have responsibility as providers, according to the "Guidelines for health care services work with violence in close relationships" (Norwegian Center for Violence and Traumatic Stress Studies, 2018). The guideline specify that the services must have sufficient competence and capacity to offer the necessary assistance to survivors and practitioners for addressing the consequences of violence and abuse, as well as for preventing violence.

The experience of sexual abuse can trigger a sequence of survival skills that are crucial and necessary at the time of the attack, but that, over time, they become less crucial or effective (Daniels, 2017). Fright and flight are normal responses to the experience of trauma. According to Daniels (2017), the freeze response is the most dangerous, because it blocks any reaction, leaving the victim motionless and unable to respond. Additional emotional responses to sexual abuse range from triggered fear, sadness, shame, and helplessness to anger (Daniels, 2017).

Abuse severity is also related to self-blame and shame, with certain types of abuse, such as peer-perpetrated child sexual abuse and interpersonal sexual violence, particularly associated with these forms of stigmatization (Kennedy & Prock, 2018). Sexual violence appears to be more psychologically disruptive than other forms of violence, because it affects the individual's most private and vulnerable side (Isdal, 2000).

2.2 Health consequences after sexual abuse

The health effects of exposure to violence are complex and may exert physical and psychological effects, with the greatest consequences being disability and death (World Health Organization, 2013). In the Adverse Childhood Experiences study, Felitti et al. (1998) focused on the relationships between perceived abuse as a child and somatic health problems and leading causes of death in adults found that persons with early trauma were likely to have multiple health risk factors later in life. Health surveys conducted in Norway show that the proportion who experience their own health as poor or not quite good is greater among those who have experienced sexual abuse and greatest among those who have experienced abuse as a child (Hjemdal et al., 2012, p. 60). Sexual abuse adversely affects quality of life and self-perceived health, and shortens life expectancy (Sørbø, 2014, p. 216). Those who experience sexual abuse have a higher incidence of cardiovascular disease, diabetes, asthma, and chronic pain (Bonanno et al., 2003; Hilden et al., 2004; Hjemdal et al., 2012; Jina & Thomas, 2013; Sigurdardottir & Halldorsdottir, 2013; Sørbø, 2014; Trickett et al., 2011).

Wingood et al. (2000) found that women experiencing both sexual and physical abuse were more likely to have a history of multiple sexually transmitted diseases, worry about being infected with HIV, use marijuana and alcohol to cope, attempt suicide, feel as though they have no control in their relationships and rate their abuse as more severe. Several studies that have examined the possible relationship, between sexual trauma and an increased risk of substance abuse (LeTendre & Reed, 2017; Ullman, 2016; Ullman et al., 2006). In this context, intoxication can be a strategy to cope with violence.

The development of mouth problems after oral sexual abuse, as well as triggers such as smell and taste related to memories of the abuse, are common. Some struggle with dental treatment anxiety and are at risk of impaired dental status, which in turn can affect their health (Humphris & King, 2011; Leeners et al., 2007). For women who have experienced sexual abuse, there may also be challenges associated with pregnancy and the parental role may also arise (Montgomery et al., 2015; Wright et al., 2012), such as examinations that require touch, gynecological examination, or examination connected to childbirth (Ades et al., 2019).

The experience of sexual abuse also increases the risk of chronic mental health conditions, including posttraumatic stress disorder (PTSD), depression, and anxiety (Ades et al., 2019; Sigurdardottir & Halldorsdottir, 2013). Although this group of survivors are frequent users of health care, they do not necessarily seek care for the sexual abuse itself (Jina & Thomas, 2013). Eslami et al. (2019) found lifetime sexual abuse associated with the reporting of higher levels of somatic symptoms among older women aged 60-84 years. Self-blame, shame, and stigma are key barriers to disclosure and seeking help after sexual abuse (Kennedy & Prock, 2018).

2.3 Post-traumatic stress symptoms

Stress can be broadly defined as an imbalance between perceived environmental, psychological and/or social demands and an individual's perceived capacity to adapt (Lazarus & Folkman, 1984). The manifestation of post-traumatic stress symptoms (PTSS) may differ according to the type of trauma exposure. Birkeland et al. (2021) found that overall severity of PTSS was higher for those exposed to sexual trauma than for domestic violence, accident/medical trauma and sudden loss/serious illness of a loved one. According to their results, the most endorsed symptoms were psychological cue reactivity, avoidance, and difficulties with sleeping and concentrating. In addition, sexual trauma was to some degree associated with negative beliefs and emotions (Birkeland et al., 2021).

2.3.1 Post-traumatic stress disorder

Being exposed to sexual abuse can cause several stress-related health issues. One of the most invasive stress-related disorders is PTSD, a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape, or who have been threatened with death, sexual violence, or serious injury (American Psychiatric Association, 2013).

Two international diagnostic systems exist, the WHO's *International Classification of Diseases* (ICD; World Health Organization, 2019a) and the *Diagnostic and Statistical Manual of Mental Disorder* (DSM), developed by the American Psychiatric Association (2018). Reaction to trauma and severe stress, according to ICD-11, includes disorders identifiable because of symptoms and the existence of an exceptionally stressful life event (World Health Organization, 2019a). The description of PTSD in ICD-11 includes the following characteristics/symptoms:

- (1) Re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares.
- (2) Avoidance of thoughts and memories

of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events. (3) Persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other areas of functioning (World Health Organization, 2019a).

In DSM-V, there are four features of PTSD that have remained from earlier versions: experiencing or witnessing a stressful event, re-experiencing symptoms of the event that include nightmares and/or flashbacks, efforts to avoid situations, places, and people who are reminders of the traumatic event, and hyperarousal symptoms, such as irritability, concentration problems, and sleep disturbances. An additional criterion of “negative alterations in cognitions and mood” has been added (American Psychiatric Association, 2018; Sareen, 2014).

Complex PTSD (CPTSD) has been introduced as a “sibling” disorder to PTSD (Cloitre et al., 2013). CPTSD “requires the presence of PTSD as well as the presence of at least one symptom in each of three self-organization features (affect, negative self-concept and relational disturbance)” (Cloitre et al., 2013). Problems related to affect can be emotion dysregulation, experiencing prolonged dissociative states, emotional numbing or lack of ability to experience positive emotions (Cloitre et al., 2013). Self-disturbances can be characterized by persistent beliefs about oneself as diminished or worthless. Often accompanied by feelings of shame or guilt (Cloitre et al., 2013). Interpersonal disturbances can be difficulties in sustaining relationships. According to Cloitre et al. (2013, p. 2) «the stressor acts as the “gate” which allows consideration of a diagnosis of either PTSD or complex PTSD». This means that regardless of the nature of the stressor, the diagnosis of PTSD or CPTSD is determined by the symptom profile, rather than the trauma history (Cloitre et al., 2013).

There are certain individual factors associated with an increased risk of PTSD. These are divided into those that existed before the traumatic event, those that occurred during the event itself, and those that had an effect after a serious event (Michel, 2014; Ozer et al., 2003; Sareen, 2014). Factors associated with increased susceptibility to develop PTSD include female sex, childhood trauma, fewer years of schooling, prior mental disorders, exposure to four or more traumatic events, and a history of exposure to interpersonal violence (Lassemo et al., 2017;

Shalev et al., 2017). Personality factors, such as emotional stability (the level of calmness and tranquility) and avoidance coping, have also been associated with increased risk for PTSD, and extraversion (the level of sociability and enthusiasm) has been shown to be protective (Sareen, 2014). Lassemo et al. (2017) found that women developed PTSD more times than men after being exposed to a traumatic event, such as rape, sexual abuse, or being exposed to verbal threats from close relations. Of the women exposed to violence, 20.4% filled the diagnostic criteria of PTSD. They also found that, for women, any pre-existing depressive, anxiety, or somatoform disorder was associated with an increased risk for PTSD (Lassemo et al., 2017). Women with PTSD often seek help from healthcare services and present a diversity of symptoms, such as headaches, sleep disturbances, pain, depression, substance use, or self-harm (Sareen, 2014). According to Sareen (2014), it is important to screen for a history of traumatic events and PTSD in primary care and mental health clinics to uncover past or present trauma experiences.

2.4 Daily hassles, daily uplifts, appraisal, and coping

The term “stress” is frequently used to refer to a number of different processes, such as life events or stressful situations that happen to a person, for example, losing a job or divorcing (Epel et al., 2018). Hans Selye coined the concept of stress in 1935 and established one of the early definitions of stress: “Stress is the nonspecific response of the body to any demand” (Selye, 2013, p. 32). Holmes and Rahe (1967) later developed one of the first modern stress measurement scales: The Social Readjustment Scale. This scale was designed to identify ordinary life changes and the amount of effort needed to cope with them (Lazarus, 1999). Some research in the field of stress has, since the 1980s, had a focus on the smaller everyday events or stressors after a major life event, and that these stressors more strongly affect health and wellbeing (DeLongis, 1982; Lazarus, 1999). Psychological stress is defined as “a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p. 19). People react to life events and natural or man-made disasters differently (Lazarus, 1999, p. 56). Daily life can be filled with experiences that are perceived as stressful. These daily events arise from chronic or recurrent conditions and are endorsed as stressful if they are interpreted as having a stressful significance (Lazarus, 1999, p. 57). Another aspect of chronic stressors that contributes to their individual impact is the lack of control one may have over the onset or remission of these stressors (Serido et al., 2004).

2.4.1 Daily hassles

In the literature, daily stressful events are often referred to as “daily hassles”, which Lazarus defines as “experiences and conditions of daily living that have been appraised as salient and harmful or threatening to the endorser's well-being”(Lazarus, 1984, p. 376). These experiences are a potential source of stress that includes irritating, frustrating, distressing, and distracting everyday events perceived as being negative (DeLongis, 1982; Kanner et al., 1981; Lazarus & Folkman, 1984). Examples may include annoying practical problems, not finding something one is looking for, “traffic,” related to the weather, disappointments, or financial or relationship problems (Kanner et al., 1981; Lazarus & Folkman, 1984). A potential hassle only becomes a hassle if it is appraised as such, not simply because it occurs (Larsson et al., 2016). The frequency and type of daily hassles experienced by an individual may provide a better explanation for associated psychological and somatic health outcomes than the severity of major life events (Serido et al., 2004). Increased stress is associated with the increased reporting of physical symptoms associated with stress in adult survivors of child sexual abuse (Thakkar & McCanne, 2000).

2.4.2 Daily uplifts

“Daily uplifts” might be considered the opposite of daily hassles. “Daily uplifts, consist of experiences and conditions of daily living that have been appraised as salient and positive or favorable to the endorser's well-being” (Lazarus, 1984, p. 376). For this reason, they provide an individual with a lift, and make them feel good. Uplifts are prominent experiences in everyday life that are perceived by the person as positive, such as the enjoyment of what is happening, the relief of getting good news, or having slept well and being well rested (Lazarus, 1999, p. 149). These positive experiences can act as breathers, sustainers, or restorers in everyday stress and an incentive to continue striving (Lazarus, 1999, p. 151). The positive active mechanisms involve being able to see things in a positive light and having a personal preference that makes it interesting to experience the joy even in a heavy emotional burden (Kanner et al., 1981).

In summary, daily hassles, worries, and irritations, on the one hand, and daily uplifts, the everyday positive events, and breathers, sustainers, and restorers, on the other, seem to have an impact on health. The idea is that, over time, worries and annoyances can be powerful sources of stress and thus affect psychological and physical health. These recurring stress experiences initiated by the trauma can make previous everyday activities appear different and more unreal

(Fersnes, 2014). To form a comprehensive picture of possible interrelationships of perceived stress in everyday life, illness, and health, it is important to focus on both the positive and the negative experiences of everyday stress (Kanner et al., 1981; Larsson et al., 2016).

2.4.3 Appraisal and coping strategies

As mentioned earlier, trauma experience can set off a sequence of survival skills (fright, flight, and freeze), which are crucial and necessary at the time of the attack, but over time they become less crucial or effective (Daniels, 2017). Throughout a lifetime, people encounter life events that may differ in intensity, be expected or unexpected, and controlled or uncontrollable. Coping is defined as “cognitive and behavioral efforts, which are constantly changing and seeks to deal with specific external and/or internal demands that are interpreted as troublesome or exceed the resources of the person” (Lazarus, 2006, p. 139). Lazarus and Folkman (1984) distinguish, in their transactional model, between a person’s assessment of the situation (appraisal) and what actions to take next (coping mechanisms). In addition, personal characteristics and personal resources affect the appraisal of an event (Ben-Zur, 2019). In the transactional model, there are three types of appraisal: primary, secondary, and reappraisal. According to Lazarus and Folkman (1984), the primary assessment will always be about assessments of the type: “is the situation dangerous for me?,” “does the situation (incident) mean a loss to me?,” “does the situation pose a challenge?,” or “is there a benefit for me?” The secondary assessment will be about what the person can do (change or accept) in relation to their own resources. The concept of reappraisal emphasizes that stress is a process, and appraisals, actions, and outcome can change from one moment to the next, depending on changes in the person or the environment (Ben-Zur, 2019, p. 2).

Coping can be divided into two major functions: problem focused, and emotion focused. Problem-focused strategies are directed at altering the troubled person–environment relationship by acting to improve the situation or solve the problem. Problem-focused coping is generally considered an adaptive coping process. However, it can be considered maladaptive when limited personal control is present (Lazarus & Folkman, 1984). In opposition to adaptive coping, emotion-focused coping strategies are directed at managing or regulating the distressing emotions and physiological reactions to the stressor (Lazarus & Folkman, 1987). These coping strategies are often considered a maladaptive strategy, although they may sometimes be adaptive, such as when nothing rational can be done to combat a stressor.

The theory of stress appraisal and coping enumerates the use of adaptive and maladaptive strategies (Lazarus & Folkman, 1987). The theory states that a history of severe stress exposure or currently experiencing chronic stress greatly affects a person's likelihood of being exposed to frequent daily hassles, and developing maladaptive stress responses (Epel et al., 2018). Stress appraisal, coping processes, and psychological stress symptoms after traumatic events are seen to vary widely based on individual characteristics, resources, situations, and contextual factors (Lazarus, 1999). Folkman and Moskowitz (2000) highlight an interest in positive aspects of the stress-coping process. They describe three classes of coping mechanisms: positive reappraisal, problem-focused coping, and the creation of positive moments. They argue that the frequency of positive emotions, and not the intensity or duration, contributes benefits to the individual.

2.5 Prior research

A broad range of studies have explored daily hassles and daily uplifts in various contexts, such as military personnel (Larsson et al., 2017), students with eating disorders (Macneil et al., 2012), depressive symptoms in native and immigrant adolescents (Stefanek et al., 2012), and women on long-term sick leave due to stress-related disorders (Erlandsson, 2008). Studies assessing coping with daily hassles have previously been conducted in areas, such as female students with depression and body dissatisfaction (Ward & Hay, 2015), women treated for breast cancer (Taha et al., 2012), incident psychopathology among adolescents and young adults (Asselmann et al., 2017), and women on long-term sick leave due to stress-related disorders (Johansson et al., 2012).

Only a few studies have focused on daily hassles among women who have experienced some form of sexual abuse. Thakkar and McCanne (2000) were among the first to examine the interrelationships of sexual abuse, daily hassles, and physical symptoms. Their results indicated that heightened daily stress was associated with increased reporting of physical symptoms (Thakkar & McCanne, 2000). Later, McGuigan and Middlemiss (2005) studied the cumulative impact of having experienced sexual abuse in childhood and in adulthood and found that women who reported more "greater stress over lifes daily hassles reported more depressive symptoms." Tinajero et al. (2020) found that childhood abuse exposure was associated with reported daily hassles and that the cumulative exposure to daily stressors over time may contribute to adverse health outcomes.

In a study of adult rape survivors, the results indicated that women with disruptive or traumatic early life experiences appeared to have their negative views of self and others reinforced, which subsequently interfered with their ability to activate adaptive coping mechanisms (Regehr et

al., 1999). Najdowski and Ullman (2009) found that coping strategies played an important mediating role in determining the effects of traumatic life events, self-blame, and perceived control over recovery from PTSD symptoms and self-rated recovery from adult sexual abuse. They also found that maladaptive coping was associated with increased PTSD symptoms and lower self-rated recovery. Others have found an increased reliance on disengagement methods of coping (wishful thinking, problem avoidance, social withdrawal, and self-criticism) as a function of more extensive child abuse histories (Leitenberg et al., 2004). According to Senn et al. (2007), maladaptive coping strategies, social support, and familial contextual variables including socioeconomic status, may influence the association between sexual abuse and later adverse outcomes. Matheson et al. (2007) found that women exposed to interpersonal violence experienced mental health problems (depression, anxiety, and panic attacks) and coped by self-medicating (marijuana, cocaine, and alcohol or prescription medication) or developing eating disorders.

2.6 Gap in the research

The consequences of sexual abuse for physical and psychological health are well documented. However, less knowledge exists about how women who have been exposed to sexual abuse experience daily hassles over time and how this seemingly minor daily stress interacts with daily uplifts, coping strategies, and stress-related symptoms. Several studies have focused on college/university students and young adult women related to coping and the consequences of sexual abuse. However, few studies have recruited severely traumatized adult women and focused on lifespan trajectory.

To better understand their recovery process or survivors, there is a need to focus on specific coping strategies after sexual abuse, together with their cognitions and perceptions. According to Banyard et al. (2007), future directions of research include the need to understand coping as a process and the identification of coping in relation to adaptive outcomes.

Knowledge about stress-related physical, emotional, and cognitive reactions is useful in understanding short-term or transitory health consequences (Coker et al., 2000; Epel et al., 2018; Fanslow & Robinson, 2004; Folkman, 1985). Although some studies have focused on additive symptom scales (Najdowski & Ullman, 2009; Zoellner et al., 2000), a need exists to explore individual symptoms afflicting women who have experienced sexual abuse. For healthcare workers to be able to provide adequate care for female survivors of sexual abuse, it

is important that they have expertise related to the consequences of sexual abuse (Berglund, 2014).

2.7 Study context and conceptual model

The theoretical standpoint in this thesis addresses coping strategies related to daily hassles and daily uplifts. The relevant theory can be illustrated in a modified theoretical model on appraisal and coping theory (Lazarus & Folkman, 1984) and the theory of everyday stress and health (Larsson, 2021): see Figure 2.

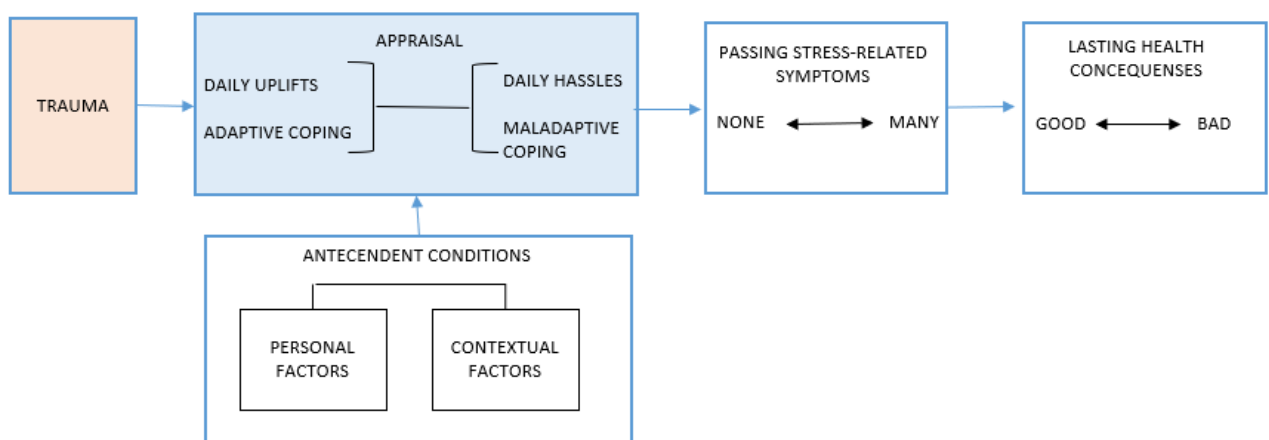


Figure 2. Modified theoretical model on daily hassles, daily uplifts, coping and health related consequences after sexual abuse

As the above figure illustrates, being exposed to a traumatic event affects experience of daily stress, such as irritants, worries (daily hassles), uplifts, appraisal, and coping strategies, used to manage the situation. This appraisal is also affected by personal factors (health and personality) and contextual factors (family, friends, work situation, housing, and society). Based on how the individual copes with their daily hassles, this can lead over time to passing stress-related symptoms. Accumulated over time, through reaction, recovery, and pile-up, this accumulation of daily stress responses can result in lasting health consequences (Larsson, 2021; Smyth et al., 2018).

3 Aims and hypothesis

The overall aim of the studies in this thesis was to develop new knowledge that could contribute to a deeper understanding of how adult women who have experienced sexual abuse experience and cope with stress associated with daily hassles and daily uplifts in everyday life and how these processes are related to health. The specific aims of the studies included in this thesis were:

Paper I:

In Paper I the aim was to gain a deeper understanding of how adult women experience and cope with daily hassles after experiencing sexual abuse.

Paper II:

In Paper II the aim was to explore the association among daily hassles, daily uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse.

Hypothesis 1: Daily hassles and maladaptive coping strategies are associated with a high frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.

Hypothesis 2: Daily uplifts and adaptive coping strategies are associated with a low frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.

Paper III:

The aim in Paper III was to compare the characteristics of two groups of female survivors of sexual abuse, one group with a lower indication of PTSD (L-PTSD) and one group with a higher indication of PTSD (H-PTSD).

Hypothesis 1: Among women with a history of sexual abuse, the H-PTSD group would be associated with more daily hassles, fewer daily uplifts, and more use of maladaptive coping strategies.

Hypothesis 2: Women in the H-PTSD group would report more severe sexual victimization, less resourceful socioeconomic conditions, and a lower level of emotional stability.

4 Method and materials

In the following section, the study methodology, philosophical ground, study design, recruitment process, study participants, data collection and data analysis are presented.

4.1 Methodology

To explore a phenomenon and develop hypotheses that can be further tested, it may be appropriate to begin with an inductive qualitative research method before applying quantitative methods to test the hypotheses. According to Creswell and Creswell (2018), using a mixed methods design has several advantages. including understanding the contradictions between quantitative results and qualitative findings, giving a voice to the study participants, ensuring that the study findings are grounded in the participants' experiences, and providing methodological flexibility (Creswell & Creswell, 2018). Our rationale for using mixed methods was firstly a need for firstly a more complete understanding of a phenomenon, secondly, developing a better contextualized instrument, to reach a population of adult women who had experiences of some form of sexual abuse, thirdly, confirming our quantitative measures with qualitative experiences, and finally, explaining the quantitative results.

Katerndahl et al. (2012) argued that, by combining qualitative and quantitative methods, a richer picture of individual dynamics can be obtained when studying complex phenomena. A second argument for mixing methods is that this can provide a better and deeper understanding of the topics that one wishes to elucidate, thus strengthening the level of confidence in the conclusions (Johnson et al., 2007).

4.1.1 Philosophical ground

Pragmatism is the research paradigm most often associated with using mixed methods. According to Creswell and Creswell (2018), pragmatism is not epistemologically committed to any one system of philosophy While this approach is compatible with qualitative-dominant interpretivist understandings of socially constructed reality, the emphasis is on interrogating the value and meaning of research data through examination of its practical consequences (Morgan, 2014). According to this paradigm, the researcher considers that it is the research question that should drive the research, and that the question is more important than the method (Creswell & Creswell, 2018). Both induction and deduction are important. Generating theory and theory verification can be achieved and the researcher is encouraged to methodical pluralism (Creswell & Creswell, 2018). Tashakkori et al. (1998) contend that pragmatism avoids the researcher engaging in what they see as rather pointless debates about such concepts as truth and reality.

In their view one should “study what interests you and is of value to you, study in the different ways in which you deem appropriate, and use the results in ways that can bring about positive consequences within your value system” (Tashakkori et al., 1998, p. 30). As Feilzer states, “a pragmatic approach to problem solving in the social world offers an alternative, flexible, and more reflexive guide to research design and grounded research.” (2010, p. 7).

4.2 Study design

This thesis has an exploratory sequential mixed methods design and comprises one qualitative and two quantitative studies. The first phase of this research process consisted of qualitatively exploring data from a small sample on coping with daily hassles, in which the data from the interviews was collected from adult female survivors of sexual abuse and who were currently using a support centers (Nok. centers); see Table 1. From this initial exploration, the qualitative findings were used to further develop a quantitative questionnaire that best fitted the aim and that could be tested with a large sample (Creswell & Creswell, 2018, p. 15). In the quantitative phase, validated and newly constructed items, were collected from a sample of female survivors and users of support centers in Norway.

Table 1. Design, sample, and data collection for the papers in this thesis

Paper	Mixed-methods design	Sample	Data collection	Year of data collection
I	Qualitative Grounded theory methodology	10 adult female survivors of sexual abuse, currently using one of three support centers in the Inland County	Individual in-depth interviews	2016
II–III	Quantitative Cross-sectional research method	57 adult female survivors of sexual abuse, currently using one of nine support centers in Norway	Questionnaire (electronic and on paper)	2018

The three studies were interrelated and sequenced as illustrated in Figure 3 below.

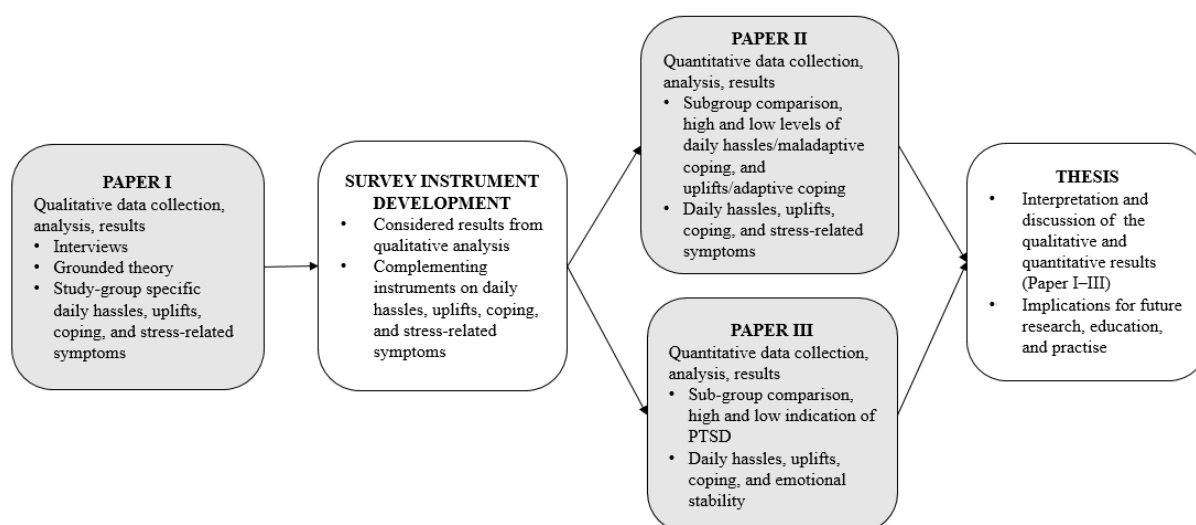


Figure 3. Exploratory sequential mixed-methods design

As Figure 3 illustrates, grounded theory methodology was used to explore the participants' main concerns related to daily hassles, daily uplifts, and coping strategies (Paper I). Based on the results from the interviews, a questionnaire was developed for a cross-sectional survey, which formed the basis for Papers II and III to further test the association between daily hassles, uplifts, coping strategies, and stress-related symptoms (Paper II) and the interrelationship of post-traumatic stress, hassles, uplifts and coping (Paper III). In the final phase, the qualitative and quantitative findings were interpreted through an integrated analysis of the qualitative and quantitative findings. The joint displays are presented in the results section of the thesis.

4.3 Recruitment, samples, and participants

The participants in the three studies were recruited from support centers for survivors of incest and sexual abuse (Nok. centers) in Norway. The support centers are interdisciplinary, free, and low threshold help services for those who have been sexually abused and their relatives. The centers offer counseling by phone, individual counseling, and participation in group events, theme meetings, social activities, and social services. All centers supplement the public welfare system. Based on numbers from The Norwegian Directorate for Children Youth and Family Affairs (2019), a total of 2,870 men and women contacted the centers during 2019. Most of the users were women (84%), and the average age of the women in the 2019 report was 34 years.

Of the female survivors who contacted and used the support centers, 60% had experienced sexual abuse as children (<14 years old) and 21% as adults (>18 years old).

Paper I

In Paper I, we contacted three support centers in the Inland County in Norway. Given the sensitive content of the questions for the interviews, the method for recruiting participants was chosen in collaboration with the center's representatives. The inclusion criteria were: (1) being female, (2) adult (>18 years), (3) understanding Norwegian, (4) having experienced some form of sexual abuse, and (5) using the services of a support center for survivors of incest and sexual abuse. Those who agreed signed a written informed consent to participate.

Papers II and III

For Papers II and III, we contacted 17 of 22 support centers in Norway, with a geographic variation and a variation in the number of female users. Nine centers agreed to help in recruiting participants. The inclusion criteria were: (1) being female, (2) adult (>18 years), (3) understanding Norwegian, (4) having experienced some form of sexual abuse, and (5) using the services of a support center for survivors of incest and sexual abuse. Nine centers responded to the request to assist recruitment. A questionnaire was then distributed to the participants at the participating centers. We initially sent out the questionnaire electronically. After feedback from the centers that some of the users were skeptical about answering electronically, we opted for a paper-based questionnaire. The support center leader or another designated person at the center assisted in the recruitment of participants. The recruiters would initially inform their individual center about the study and hand out information letters to those who expressed an interest in participating. In Papers II and III they consented by answering the questionnaire.

Participants

In the first paper, we recruited women ($n = 10$) from three of the support centers in Norway. In the next two studies, we recruited women ($n = 57$) from nine support centers to ensure geographic spread and a difference between city and country. The three centers from the qualitative data collection also participated in the quantitative data collection. For information on the participants in each paper, see Table 2.

Table 2. Study participants, age, and nationality.

Paper	I	II and III
Participants	(<i>n</i> = 10)	(<i>n</i> = 57)
Age (years)		
18–20	0	1
21–30	0	9
31–40	3	12
41–50	2	22
51–60	4	8
61–70	1	3
Missing ^a		2
Nationality		
Norwegian	9	51
Swedish, Finnish, Danish, or Icelandic	0	2
Another country in Europe	0	2
Country outside Europe	1	2

^a Missing: respondents who did not answer the question on birth year.

4.4 Data collection

The data in this thesis were collected by using both qualitative and quantitative methods. Including qualitative interviews, and data collection using a self-administered questionnaire.

4.4.1 Data collection in Paper I

In Paper I, we had a retrospective approach, and the data collection was conducted by using the principles of grounded theory methodology. The data collection lasted from June to November 2016. A pilot interview was conducted with a center representative who had user experience. One of the supervisors (BAB) participated, mostly as an observer. By conducting a pilot interview, we wanted to test the interview guide. It was also an opportunity for me as the interviewer, to get feedback. The interview was video- and tape-recorded, to be able to evaluate reactions and give feedback. The video was deleted after the feedback. The center representative and the interviewer had a talk on the phone a few days after the interview. Her experience from the interview had been perceived at times as tough, during the interview. However, it had also been useful to recollect prior memories and was considered to be important for others who had similar experiences. The experience from the pilot interview led to no changes being made to the main questions in the interview guide.

Individual in-depth interviews were conducted, and the interviews were recorded and transcribed verbatim. The data were collected using a theoretical sampling process. This refers

to a joint process of collecting, coding, and analyzing the data and deciding what data to collect next (Glaser & Strauss, 2007). I conducted all the individual interviews, which took place at the counseling center that the participants used. An interview guide with open-ended questions was followed up with individually tailored questions (see Appendix). The interview guide was set up in more detail than the criterion for data collection according to grounded theory. Initially, this gave a sense of security in the interview setting for me as an interviewer. The participants were encouraged to speak openly on the following themes:

- Experiences of sexual abuse
- Experiences related to stressful, irritating, or worrying situations in everyday life
- Coping strategies used for resolving stressful, irritating, or worrying situations in everyday life
- Experiences related to feelings of joy, daily uplifts, or happiness in everyday life
- Significant turning points since the sexual abuse happened.

The interviews were conducted in a designated room used for counseling at each support center. All the interviews were relatively long, lasting from 72 - 105 minutes. One explanation for this is that it took time during the interviews, time was needed to build up the trust necessary for the participants to share their experiences and thoughts. To contribute to the interview setting being experienced as safe, the participants chose where they wanted to sit during the interviews. Information on what to expect, when to take a break, and the role of the interviewer was also initially a topic. The interviews were audio recorded and transcribed. Two days after each interview, we contacted the participants via telephone to inquire how each participant had experienced being part of the interview and whether there were any issues they wanted to clarify or had not been able to share during the interview. Most said that it had been a tough, but nevertheless a good, experience to be able to tell and contribute. One of the participants said that she went home and slept until the next morning. In the interview situation, she seemed calm, as if it were not so challenging for her to tell her story. However, it probably was more demanding than it seemed at the time.

4.4.2 Data collection for Papers II and III- instruments and variables

A questionnaire was composed of a combination of six established, validated scales and 35 newly constructed items based on the results from Paper I (Stensvehagen et al., 2019). We added newly constructed items to the Stress Profile Scale (Setterlind & Larsson, 1995). The newly constructed items were developed from the qualitative results and included in addition

to the original items in the Stress Profile Scale (Setterlind & Larsson, 1995). Table 3 illustrates the connection with the qualitative data and quantitative items developed.

Table 3. Instrument development display based on qualitative results (Paper I)

Qualitative findings	Type and item information	Newly developed items
<i>Still a lot of shame, but to a lesser extent... the more I have talked about it, little by little then the worst shame disappears</i>	Emotional symptoms	Felt shame
<i>I can never think about what I am really doing when it is difficult. But I often stay indoors. In a way, I cannot leave the apartment to turn it around. I have a very easy time walling myself in</i>	Cognitive symptoms	Difficulties to think clearly
<i>... going to the store to talk to, or having to give money to someone at the checkout and things like that can be very difficult, because then I can get in physical contact with people, Im not very fond of it</i>	Target-group specific symptoms	Physical touch discomfort
<i>... I can't stand to see my body. Well, I can look in the mirror when I brush my teeth and put on cream. But not for long.</i>	Irritants	Irritation over one's own body
<i>... during many of the assaults, drugs and intoxicants were used to dope me down and that is a big trigger so, I try to avoid...</i>	Worries	Worry of memories from the abuse
<i>... finds great joy in the fact that at home I do what I want, there is no one like my ex, who will constantly tell me how I should be and what I should do about what I should think and what I should feel, so there is much more seriousness in it than just letting a cat walk on the bench somehow, but at home with me we do as we please</i>	Uplifts	Enjoy the little things in everyday life (time with pets, being in nature, etc.)

We sent the questionnaire and received feedback from two of the support centers, which led to some minor changes. One example was a question about the sex of the perpetrator. Due to the feedback, we added the option of a female perpetrator (adult woman or girl), in addition to a male perpetrator (adult man or boy). The data collection for Papers II and III lasted from January to October 2018.

Table 4. Overview of measures from validated scales and newly constructed items in Papers II and III

Name of scale or measure	Object	Type and item information	Ways of scoring	Original psychometric properties	Newly constructed items from Paper I	Paper
The Stress Profile Scale (Setterlind & Larsson, 1995)	Physical, emotional, cognitive, and social stress symptoms during the last month	22 original items: 10 items: physical symptoms 8 items: emotional symptoms 4 items: cognitive symptoms <i>11 newly constructed items were added</i>	Rated on 5-point Likert scale ranging from 1 (Never) to 5 (Very often)	Physical symptoms $\alpha = 0.81$ Emotional symptoms $\alpha = 0.66$ Cognitive symptoms $\alpha = 0.71$	11 newly constructed items on target-group-specific symptoms $\alpha = 0.83$	II
Demographic and socioeconomic questions	Age Nationality Education Employment Marital status Children Economy Social relationships	Study 1: 6 items (age, nationality, education, employment, children and marital status) 11 items (Papers II and III)	Responded to by ticking the one answer option			II and III
Experience of sexual trauma (Norwegian Penal Code, 2005; Steine et al., 2012)	Type of sexual abuse	10 items Four items: unwanted sexual behavior Three items: unwanted sexual acts Three items: unwanted intercourse	Responded to by ticking one or more answer option		18 sexual trauma-related items	II and III
The Stress Profile Scale (Setterlind & Larsson, 1995)	Daily hassles (irritants and worries) during the last month	12 original items <i>10 newly constructed items (worries – seven items – and irritants – three items)</i>	Responded to on a 5-point Likert scale from “Never” (1) to “Very often” (5)	Cronbach’s α : Total daily hassles with 23 items ($\alpha = 0.90$) 12 original items ($\alpha = 0.83$)	10 newly constructed hassle items ($\alpha = 0.82$)	II and III

The Stress Profile Scale (Setterlind & Larsson, 1995)	Daily uplifts during the last month	6 original items 7 <i>newly constructed items were added</i>	Responded to on a 5-point Likert scale from “Never” (1) to “Very often” (5).	Cronbach’s α : 13 total uplift items ($\alpha = 0.91$) 6 original items ($\alpha = 0.85$)	7 newly constructed items ($\alpha = 0.84$)	II and III
The Brief COPE questionnaire (Carver, 1997)	Coping behavior in response to stressful or traumatic situations within the last month	28 original items: 14 subscales are generated representing: 8 adaptive coping strategies 6 maladaptive coping strategies	Ratings on a 4-point Likert scale, ranging from “I don’t do this at all” (1) to “I do this a lot” (4).	Subscales were summed to generate one adaptive coping scale with 16 items ($\alpha = 0.78$) and one maladaptive coping scale with 12 items ($\alpha = 0.71$)		II and III
The PCL-Civilian Version (84) (Weathers et al., 1993)	Assessing how much they were bothered by each PTSD indicator in the past month	17 items	Responses rated on a 5-point Likert scale, ranging from “Not at all” (1) to “Extremely” (5) The PCL-C score can range from 17 to 85, with higher values indicating increased severity	Cronbach’s $\alpha = 0.89$		III
The Single-Item Measures of Personality (SIMP) (Woods & Hampson, 2005)	Personality traits	Five dimensions of personality: extraversion, agreeableness, conscientiousness, emotional stability, and openness	Items are presented as two dichotomous statements of the personality factor in question Each item is measured on a bipolar nine-point graded line			III

As illustrated in Table 4, the following variables were used:

Stress-related symptoms

A checklist from the Stress Profile (Setterlind & Larsson, 1995) was used in Paper II to assess stress-related symptoms. The list contains ten *physical* symptoms, eight *emotional* symptoms,

and four *cognitive* symptoms. In addition, seven newly constructed *target-group-specific* items (five items measuring physical discomfort and two items measuring emotional reactions) were added based on Paper I. Examples of four new items included: “Feelings of shame,” “Feelings of guilt,” “Discomfort or pain during intercourse,” and “Discomfort at certain sounds.” All items were intended to mirror the situation over the last month.

Demographics and socioeconomic conditions

The demographic and socioeconomic variables included 11 items. In Papers II and III the participants were asked to state their year of birth, country of birth, number of years they had been living in Norway, highest level of education, occupational status, number of years working, social network, marital status, whether they had children, current home, and self-assessed economy.

Experience of sexual trauma

Sexual trauma was mapped using the categories from the Norwegian Penal Code: sexually abusive/offensive behavior, action, and unwanted relation/intercourse/rape (Norwegian Penal Code, 2005; Steine et al., 2012). Ten questions about type of sexual trauma were included. In addition, 18 other sexual trauma-related questions were included, based on the qualitative Paper I. Examples of trauma-related questions encompassed: when the abuse started, duration of the abuse, relationship to the abuser, and whether the abuse had been reported.

Daily hassles

Daily hassles were measured with items from the Stress Profile scale (Setterlind & Larsson, 1995). In addition, as Table 4 illustrates, newly constructed items were added based on the results from Paper I. Examples of two of the ten new items included are: “Worry of memories from the abuse” and “Irritation at not being taken seriously.” Participants related their responses to experiences during the last month.

Daily uplifts

Daily uplifts were measured with the Stress Profile scale (Setterlind & Larsson, 1995). In addition, newly constructed items were added based on the results from Paper I. Examples of two of the seven new items included: “Joy of having a place where you are safe” and “Joy of

having energy to perform everyday activities.” Participants related their responses to experiences over the last month.

Coping strategies

The Brief COPE questionnaire (Carver, 1997) was used to measure coping strategies. This is a 28-item questionnaire assessing coping behavior in response to stressful or traumatic situations within the last month. Fourteen subscales were generated, representing eight adaptive coping strategies (positive reframing, accepting, seeking emotional support, seeking instrumental support, humor, planning, active coping, and religion) and six maladaptive coping strategies (self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame). Subscales were summed to generate one adaptive coping scale with 16 items and one maladaptive coping scale with 12 items. In Papers II and III, we used the Norwegian version of the Brief COPE (Kristiansen et al., 2008).

Post-traumatic stress symptoms

Symptoms of post-traumatic stress were measured using the Norwegian version of the PTSD Checklist (PCL) (Hem et al., 2012). The PCL was first introduced by Weathers et al. (1993) and is one of the most frequently used self-reported measures on indications for PTSD. The PCL is a 17-item, self-administered questionnaire that assesses PTSD symptoms from the *Diagnostic and Statistical Manual*, 4th ed. (DSM-IV) (Blanchard et al., 1996). Participants rated how much they were bothered by each symptom over the past month. The PCL score can range from 17 to 85, with higher values indicating increased severity (Hem et al., 2012).

Emotional stability

The Single-Item Measures of Personality (SIMP) was used in Paper III to assess emotional stability (Woods & Hampson, 2005). The item was presented with two dichotomous statements as anchors on a bipolar, 9-point, graded line as follows: (1) am sensitive, easy going, happy, and can be tense, to (9) am relaxed, restrained, rarely irritated, and seldom depressed and sad. The questionnaire has shown good convergent and divergent validities (Woods & Hampson, 2005). We used the Norwegian version of the SIMP (Grøndahl et al., 2013).

4.3 Analysis

In the following section the different analysis in the qualitative and quantitative studies are presented.

4.3.1 Analysis in Paper I (Qualitative)

A grounded theory provides an abstract explanation of how the participants solve their *main concern* through a core category and its subcategories. In Paper I, analyses were conducted using the principles of the *constant comparative method* in grounded theory. The constant comparative method refers to an analytical process that comprises four stages: ‘(i) comparing incidents applicable to each category, (ii) integrating categories and their properties, (iii) delimiting the theory and (iv) writing the theory’ (Glaser & Strauss, 2007, p. 105).

After each of the ten interviews, memos about incidents and notions of concepts were written down immediately. Transcripts from the interviews were analyzed line by line, and incidents in data identified, compared, and coded. While analyzing the transcribed material and the memos, the constant comparative process served as a guide for a *theoretical sampling*, what data to collect next and where to find data in order to develop a theory (Glaser & Strauss, 2007). It was important that the categories were not forced or selected based on a preconceived understanding of the phenomenon that was being researched (Glaser, 2010, pp. 252-253). This was safeguarded by constant comparison of the incidents, codes, and categories. In addition, all the members of the research group read each of the ten interviews and discussed the progressing analysis. The analysis can be illustrated by giving examples of the coding process that established the main categories (Table 5).

Table 5. Illustration of the analysis process from data to the superior category, reproduced from Stensvehaugen et al. (2019, p. 489)

Quote from interview	Incident	Code	Category	Main category	Superior category
<i>... because if I let it happen ... I cannot relate to my story as a story, then it will only be a bad experience that takes over all the time ... Hiding under the couch and crying for three days, getting sick, and I refuse. If this had been a disease, I would have been sick for fourteen years, now I have recovered, and I will not be ill again.</i>	Choosing not to relate to own story	Shutting in emotions	Avoiding emotions	Coping	“Protecting armor”
<i>I am having trouble with relationships ... I spend a very long time before I ... dare to open up to people ... I can nicely say hello to neighbors and stuff like that but ... I will somehow not engage myself in people ... I get very frightened, people are creepy ...</i>	Having trouble with relationships	Shutting other people out	Avoiding other people	Coping	“Protecting armor”

As illustrated in Table 5, by constant comparing incidents, codes and categories to the transcribed text, the categories emerged. The different categories formed the basis for a process explaining how the survivors were coping with daily stress. In the final phase, the interrelationship of the categories and their properties formed the basis for generating a theoretical model (Glaser & Strauss, 2007, p. 62). *Theoretical saturation* in grounded theory means that “no additional data are being found whereby the researcher can develop properties of a category” (Glaser & Strauss, 2007, p. 61). The collection of data in Paper I ceased, when the most recent interviews, not seemed to make a substantial contribution to the categories. At an early stage of theoretical saturation, a search for additional literature was performed and used as a further source of data and integrated into the constant comparative process before reaching saturation (Glaser & Strauss, 2007). The final theoretical model “Protecting armor in daily life” is presented in the results section of this thesis (chapter 5, p. 41).

4.3.2 Analysis in Paper II (Quantitative)

In Paper II the respondents were divided into groups based on an assumption that some individuals under the same conditions do better than others. We utilized two profile groups (see Figure 4), one favorable profile group and one unfavorable profile group. Initially, a positive aspect variable was created by adding the uplifts scale and the adaptive coping scale. Similarly, a negative aspect variable was created by adding the hassles scale and the maladaptive coping scale. Thereafter, the positive aspect and negative aspect variables were median dichotomized.

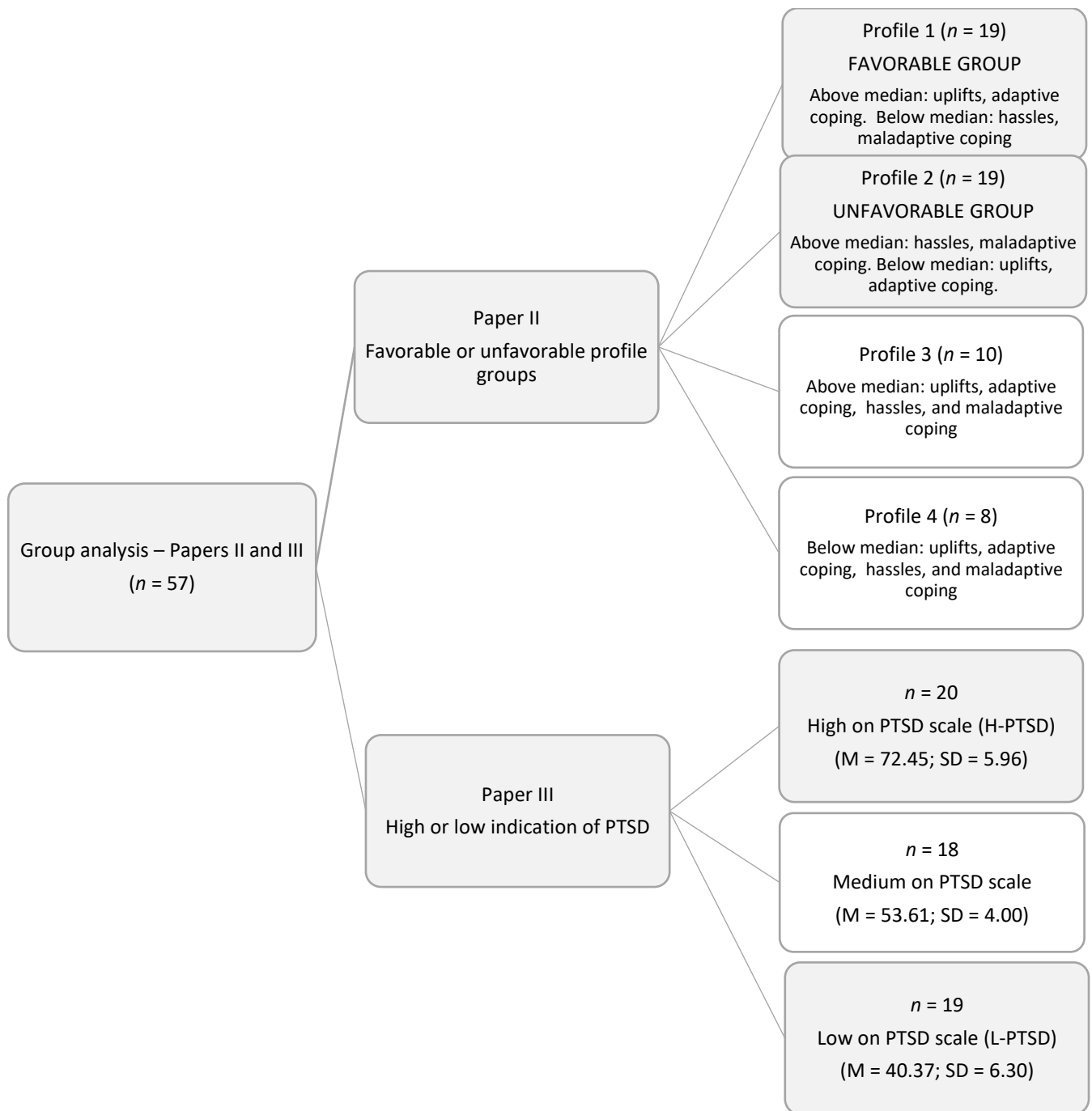


Figure 4. Definition of group analysis in Papers II and III (colored boxes show the groups included in further analysis and results in Papers II and III. The boxes with a white color were excluded after initial analysis). M, mean, SD, standard deviation.

Finally, four *profiles* were created using these median dichotomized variables as follows: Profile 1 ($n = 19$): above median on positive aspects and below median on negative aspects (labeled “Favorable”). Profile 2 ($n = 19$): below median on positive aspects and above median on negative aspects (labeled “Unfavorable”). Profile 3 ($n = 10$): above median on positive as well as negative aspects. Profile 4 ($n = 8$): below median on positive as well as negative aspects. One participant was not included due to missing data. However, as the subgroup comparisons involving Profile 1 (favorable) and Profile 2 (unfavorable) showed the most clear-cut results, further analyses, and results were based on these two profile groups.

In Paper II, we performed correlation analyses to explore the interrelationship of the variables daily hassles, daily uplifts, adaptive coping, maladaptive coping, and each symptom group. Multiple regression analysis was performed using the following variables as predictors: daily hassles, daily uplifts, adaptive coping, and maladaptive coping. The outcome variables were physical symptoms, emotional symptoms, cognitive symptoms, and target-group-specific symptoms. Bonferroni’s correction was calculated to counteract multiple comparisons. The corrected α level of $p < 0.0015$ was regarded as statistically significant. In addition, Cohen’s d was computed to assess effect size (Cohen, 1988).

4.3.3 Analysis in Paper III (Quantitative)

In Paper III, we wanted to explore whether there was any difference between groups with high or low indication of PTSD. As Figure 4 illustrates, participants with scores in the lowest third on the PTSD scale formed the L-PTSD group ($n = 19$). They had a mean score of 40.37 ($SD = 6.30$). The mid-third group (M-PTSD, $n = 18$) had a mean score of 53.61 ($SD = 4.00$). Participants with scores in the highest third on the PTSD scale formed the H-PTSD group ($n = 20$). Their mean score on the PTSD scale was 72.45 ($SD = 5.96$). Initially, all subgroup comparisons were made by including all three subgroups (χ^2 tests and Kruskal–Wallis analysis of variance [ANOVA]). However, as the subgroup comparisons involving the L-PTSD and H-PTSD groups showed the most clear-cut results, the results in Paper III were based on these two groups. In the L-PTSD group, all the women scored lower (from 22 to 46) than the cut-off (≤ 50), indicating PTSD (Weathers et al., 1993). In the H-PTSD group, all the scores were higher (from 61 to 79) than the cut-off (≤ 50), indicating PTSD. Linear trends were noted on all hassles, uplifts, and coping scales, showing that the L-PTSD group scored most favorably and the H-PTSD group least favorably.

After the participants in both study groups had been established, further analyses were carried out. Summary indices were computed on all the instruments, except for the emotional stability single-item scale (SIMP) in Paper III. This was carried out by adding the raw scores of the items belonging to a scale and dividing by the number of items. Another exception was the PCL scale, also in Paper III, where the raw sum was used. Conventional descriptive statistics were computed, and subgroup comparisons performed using χ^2 , including Fisher's exact test, the Kruskal–Wallis one-way ANOVA by rank, and the Mann–Whitney *U*-test. Bonferroni's correction was calculated to counteract multiple comparisons. The corrected α level of $p < 0.0015$ was regarded as statistically significant. In addition, Cohen's *d* was computed to assess effect size (Cohen, 1988). We conducted all the statistical analyses using the Statistical Package for Social Sciences (SPSS), version 24.

4.4 Ethical considerations

All the studies in this thesis were carried out adhering to the ethical principles contained in the Declaration of Helsinki (World Medical Association, 2013) and based on consideration of the potential risk, benefit, and burden to which the study participants were subjected (Polit & Beck, 2017). The three studies were approved by the Norwegian Centre for Research Data (NSD), 15.12.2017, 47920 / AGL. We were not required to notify the Regional Committees for Medical and Health Research Ethics, as the research project was assessed by the Regional committees for medical and health research ethics not to be regulated by the Act on medical and health research (The Health Research Act, 2009) (see Appendix). According to Beauchamp and Childress (2001), there are four moral principles: respect for autonomy, nonmaleficence, beneficence, and justice. Adhering to the principle of autonomy, all participants gave a written informed consent to participate in the research projects. In Paper I, they agreed to participate by signing an information/consent form. In the data collection for Papers II and III, the participants gave their consent by answering the questionnaire electronically or on paper. Participation was voluntary and the women could withdraw from the interview at any time without any reason or negative consequences. All the interviews in Paper I started with a presentation of the participants' rights, being voluntary to answer questions and ending the interview at any time. In research with vulnerable groups about sensitive issues, the tension between ethical and methodological conflicts is to a certain degree unavoidable (Chouliara et al., 2014). The participants in this thesis disclosed highly personal information and private stories, so the need to safeguard them was one of the major ethical considerations. The

participants in Paper I were interviewed at the support center they used. Participant safety was adhered to by opting for counseling after participation in the data collection and to have a counselor present during the interview. All primary contacts employed at the support center were bound by the duty of confidentiality. One of the participants made use of follow-up with her primary contact after the interview. This follow-up had been agreed to before she participated in the interview. One of the other participants had her counselor present during the interview.

5 Results

The following chapter presents the aims and results of the three Paper in this thesis. In conclusion, an integrated analysis of the qualitative and quantitative results is presented in a joint display.

5.1 Paper I (Qualitative)

Stensvehagen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (2019). How women experience and cope with daily hassles after sexual abuse - a retrospective qualitative study. *Scandinavian Journal of Caring Sciences*, 33(2),

The aim in Paper I was to gain a deeper understanding of how adult women experience and cope with daily hassles after experiencing sexual abuse. There were differences in trauma experience from having experienced sexual abuse once or more, and for many of the survivors in childhood. Despite this, there were similarities that they described during the interviews, which formed the basis of the theoretical model of “Protecting armor in daily life.” The model (Figure 5) illustrates that the aftermath of sexual abuse related to coping with daily stress can be understood as a three-phase process: (1) avoiding and escaping – coping after experiencing sexual abuse; (2) accepting and disclosing – starting a process of recovery; and (3) reconciling and repossessing – living with the experience in the present.

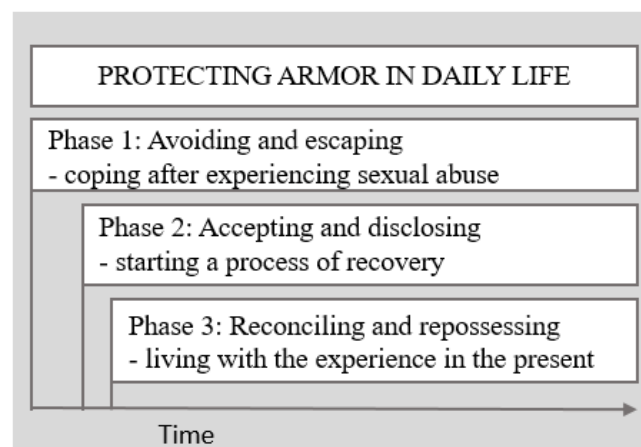


Figure 5. Phases explaining how women experience and cope with daily hassles after experiencing sexual abuse (Stensvehagen et al., 2019, p. 490).

The three phases have different lengths and are intended to be a conceptual rendering to understand the lifespan trajectory that may follow sexual abuse. The codes and categories

provide an understanding of how the women coped with daily hassles and experienced daily uplifts through these three phases. The theoretical core concept '*protecting armor in daily life*' provides an understanding of how the women experience and cope with internal and external stressful experiences and stressful memories and thoughts. The protecting armor has two functions: it shuts stressful thoughts and potential stressful external situations out and it locks stressful memories, thoughts, and emotions inside. The protecting armor protects against daily hassles that are often perceived by others as commonplace and a normal activity, such as going to the store or taking the bus. These daily activities are appraised as threatening and negative, and related to triggers from memories connected to the sexual abuse.

Avoiding and escaping – coping after experiencing sexual abuse

The first phase in the model starts from the time they experience the sexual abuse and lasts until its disclosure and getting help to deal with daily life. Daily hassles in this phase arise from trying to deal with what has happened alone: being overwhelmed by what has happened, trying to find protection by “shutting their feelings off,” avoiding what has happened, escaping and avoiding more abuse, and focusing on surviving and getting on with their daily life.

Accepting and disclosing – starting a process of recovery

The second phase starts with the realization of a need for help and disclosing what has happened to a significant other who understands and takes them seriously. Daily hassles at this phase are still dominated by a “*stressful inner dialogue*” through triggers and stressful memories. Both triggers and flashbacks seem to increase in intensity in the second phase. Accepting what has happened and disclosing are important steps in starting to relate and deal with their experiences related to abuse and finding better coping strategies. The protecting armor in this phase is needed for maintain control while deciding what to disclose and to whom. In this phase, the women have more knowledge of how to find daily uplifts or glimpses of happiness in everyday life.

Reconciling and repossessing – living with the experience in the present

The third phase conceptualizes the strategies used to cope with daily hassles in the present. In this phase, the women have the ability to recognize stressful moments and to better understand how to cope with them. The need for protecting armor' is still present. Nevertheless, at this stage the women are increasingly able to come to terms with what has happened, including attributing blame and starting to take back control and opportunities that have been lost.

Repossessing involves rekindling the possibility of regaining a normal everyday life. However, it is also apparent that something has been lost and this becomes a source of sorrow in their lives and, for some, creates feelings of unresolved anger.

5.2 Paper II (Quantitative)

Stensvehaugen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (202x). Association of daily hassles, uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse – a cross-sectional study

In Paper II, the aim was to explore the association among daily hassles, daily uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse. The study sample ($n = 57$) was the starting point for the two study groups, one (favorable profile) with above-median scores on daily uplifts and adaptive coping, and the other (unfavorable profile) with above-median scores on daily hassles and maladaptive coping strategies, which were compared (see Analysis section above). We wanted to explore the following two hypotheses: Hypothesis 1: Daily hassles and maladaptive coping strategies are associated with a high frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms. Hypothesis 2: Daily uplifts and adaptive coping strategies are associated with a low frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.

All the participants in both profile groups had experienced the most severe type of sexual abuse. Many of the women in the favorable profile group ($n = 12$) and the unfavorable profile group ($n = 17$) had experienced sexual abuse at an early age (<12 years old). The first sexual abuse after the age of 18 was reported only in the favorable profile group ($n = 3$). Most of the women reported knowing their offender and the offender was mostly an adult male. The differences between the two groups were not statistically significant on any of the trauma-related questions. Bivariate correlations were computed on the data for the total sample ($n = 57$) between daily hassles, daily uplifts, stress-related symptoms (physical, emotional, cognitive, and target-group specific), and the two coping scales. The results showed that all correlations were in the expected direction and that 23 out of 28 correlations were statistically significant ($p < 0.05$). Daily hassles and maladaptive coping were positively correlated, and both these scales showed strong associations with the symptom scales. Daily uplifts and adaptive coping were positively correlated and mostly negatively associated with the symptom scales. After Bonferroni's correction, 15 of the 28 correlations remained significant ($p < 0.001$).

Multiple regression analyses were conducted to further examine the interrelationship of physical, emotional, cognitive, and target-group specific symptoms, and the predictor variables, daily hassles, daily uplifts, adaptive coping, and maladaptive coping. The predictor variables explained 51% of the variance when emotional symptoms were used as the outcome variable. The corresponding amount of explained variance on the cognitive symptoms was 43% and, on the target-group-specific symptoms 40%. Daily hassles had significant regression weights ($p < 0.002$) on all the symptom scales. Maladaptive coping had significant regression weight ($p < 0.002$) on the emotional symptoms.

The physical stress-related symptoms data showed statistically significant differences ($p < 0.05$) between the two groups on: “back pain or back problems,” “stomach pain or stomach problems,” and “pressure over the chest or chest pain.” After Bonferroni’s correction, none of these differences remained significant. The results on the emotional symptoms showed that there were significant differences ($p < 0.05$) between the two groups on five of the original variables: “powerlessness/hopelessness,” “depressed/feeling low,” “nervousness or worry,” “sleeping problems,” and “difficulties relaxing.” In addition, significant differences were found on two of the newly constructed target-group-specific emotional symptoms: “felt shame” and “felt guilt.” After Bonferroni’s correction, two original variables (“powerlessness/hopelessness” and “depressed/feeling low”), and the two newly constructed variables (“felt shame” and “felt guilt”), remained significant. Of the cognitive symptoms, three symptoms (“concentration difficulties,” “difficulties to make decisions,” and “difficulties to think clearly”) were initially significant ($p < 0.05$). However, none of the differences between the two study profiles was significant after Bonferroni’s correction. The target-group-specific symptoms relating to discomfort were all initially significant ($p < 0.05$). After Bonferroni’s correction, none of the target-group-specific variables remained significant.

5.3 Paper III (Quantitative)

Stensvehaugen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (2020). Interrelationship of Posttraumatic Stress, Hassles, Uplifts, and Coping in Women with a History of Severe Sexual Abuse: A Cross-Sectional Study. *Journal of Interpersonal Violence*, 886260520935479.

The aim of Paper III was to compare the characteristics of two groups of female survivors of sexual abuse, one group with a lower indication of PTSD (L-PTSD) and one group with a higher indication of PTSD (H-PTSD). We hypothesized that, among women with a history of sexual

abuse, the H-PTSD group would be associated with more daily hassles, fewer daily uplifts, and more use of maladaptive coping strategies. We also hypothesized that women in the H-PTSD group would report more severe sexual victimization, less resourceful socioeconomic conditions, and a lower level of emotional stability.

The mean age of the two groups differed by 2 years (H-PTSD: mean age 39.3 years; L-PTSD: mean age 40.5 years). Most of the women in both groups were born in Norway and had lived in Norway for >6 years. The educational level showed a significant difference between the two groups ($P = 0.013$). The L-PTSD group had the highest educational level. In the H-PTSD group, most had high school as their highest educational level. After Bonferroni's correction, due to the high number of comparisons, no significant differences remained.

Regarding sexual trauma-related characteristics, most of the women in both groups had experienced sexual abuse at an early age (<12 years). First sexual abuse after the age of 18 years was reported only in the L-PTSD group. In both groups, most of the women knew their offender, who overall was an adult male. The differences between the two groups were not statistically significant for any of the trauma-related questions. A Mann–Whitney *U*-test indicated that emotional stability was greater for women in the L-PTSD group, than for those in the H-PTSD group. There were significant differences between the two groups on all the daily hassles scales. The L-PTSD scored most favorably on all. The uplift-related data consisted of three indices (daily uplifts [total], daily uplifts original scale, and daily uplifts newly constructed scale). Of these, “daily uplift total” and “daily uplift newly constructed” showed statistically significant differences between the two groups. The H-PTSD group reported lower frequencies of daily uplifts over the last month. The coping-related data showed that there were significant differences in maladaptive coping strategies. The L-PTSD group reported more adaptive coping strategies and the H-PTSD group significantly more maladaptive coping strategies. In 11 of 12 comparisons on the hassle, uplift, and coping scales, the results showed significant differences between the L-PTSD and the H-PTSD groups. After Bonferroni's correction, the following differences remained significant: daily hassles (total), worries (total), worries original scale, worries newly constructed scale, irritant (total), irritant newly constructed scale, and maladaptive coping.

5.4 Joint display of the qualitative and quantitative findings

In the following section, the results from an integrated analysis of the three papers are presented in a joint display. Each table is structured in the following order: quantitative results, then the qualitative results, and finally mixed-methods interferences. Mixed-methods interferences are used to assess the fit between the qualitative and quantitative results as confirmation (results reinforced each other), expansion (diverging or expanded insight), or discordance (contradictory or in disagreement (Fetters et al., 2013)). The results from the joint display regarding stress-related physical symptoms (see Table 6), emotional symptoms (see Table 7), and cognitive and target-group specific symptoms (see Table 8) confirm each other. The quantitative and qualitative findings regarding daily hassles, daily uplifts, coping strategies, and emotional stability (see Table 9) also confirm each other and provided expanded insight. During the three phases, the qualitative results include a decrease of daily hassles, an increase of daily uplifts, and moreover a shift in coping with stress from using more maladaptive to more adaptive coping strategies.

Table 6. Joint display of stress-related physical symptoms

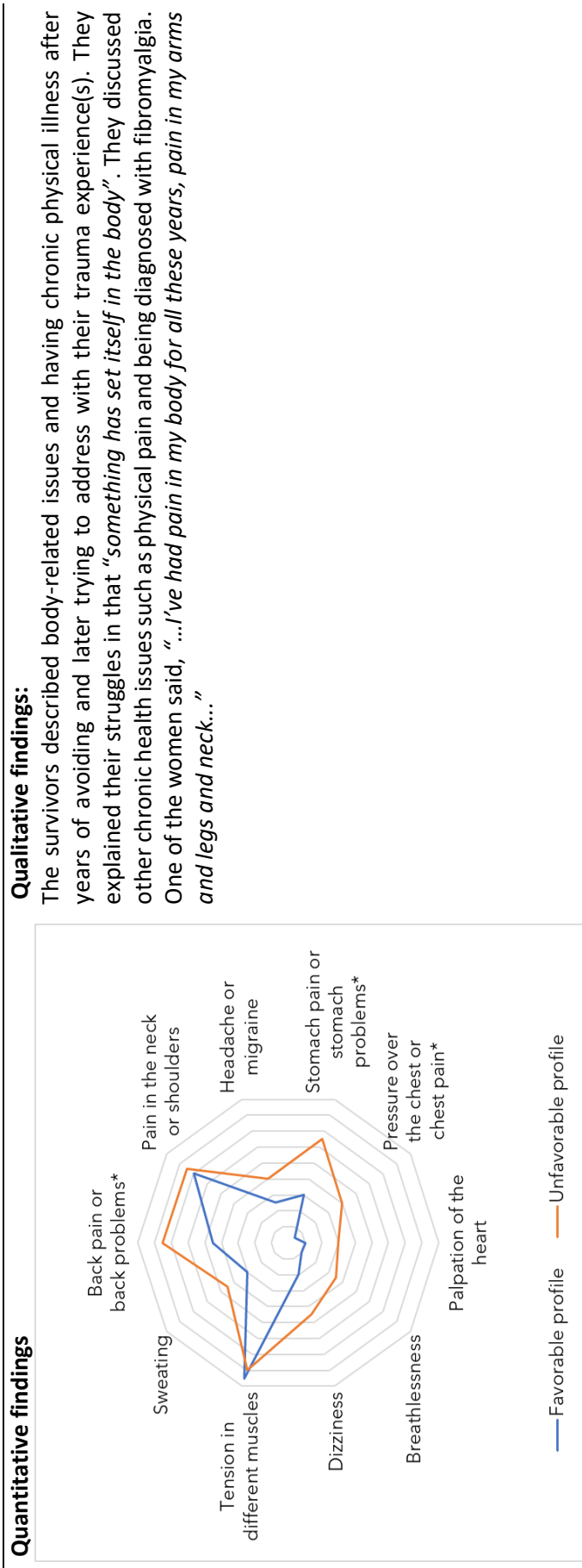


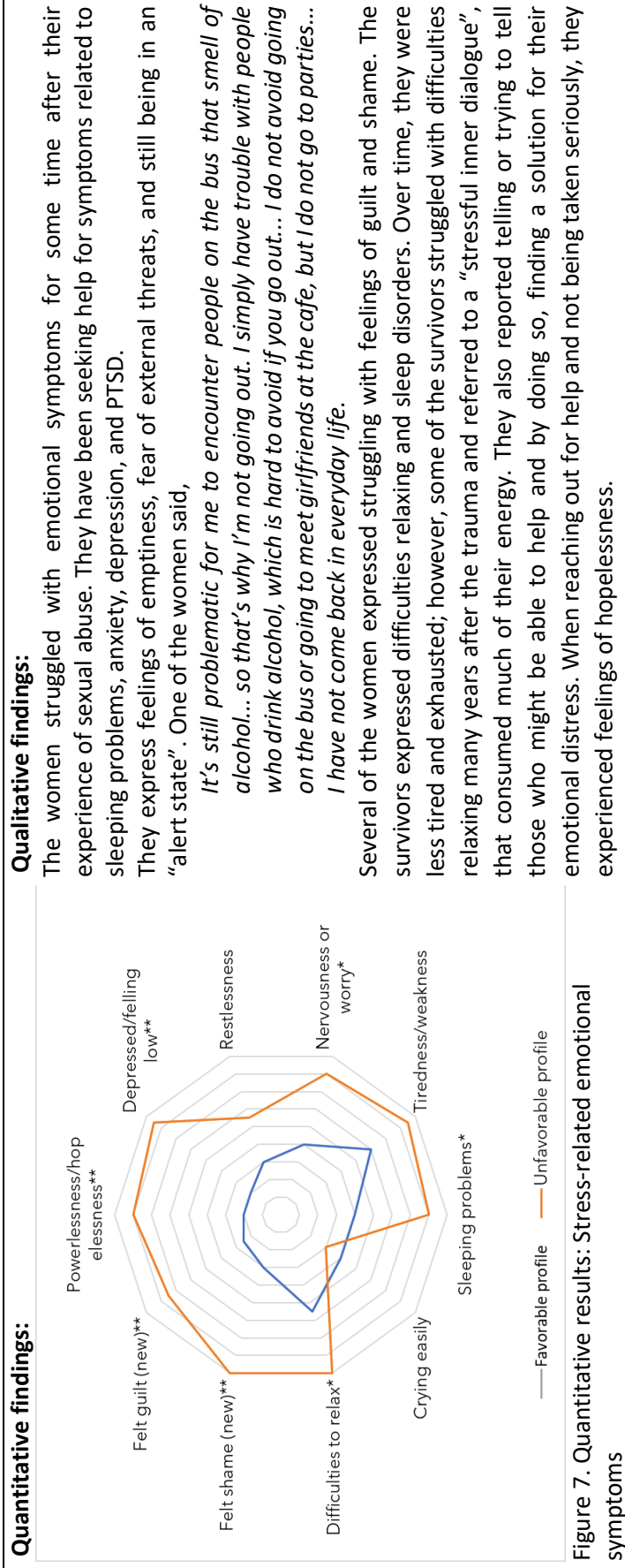
Figure 6. Quantitative results: Stress-related physical symptoms

Mixed-methods inferences: Confirmation

Qualitative and quantitative findings regarding stress-related physical symptoms confirmed each other, since both indicated that pain-related issues were reported by the women, even though the qualitative results indicated that these symptoms improved over time and became easier to explain and relate to. Their lives were not pain free, and this was an issue they had to reconcile. The quantitative data illustrate the differences between the unfavorable and favorable groups. This confirms that some struggle somewhat less, however, they still struggle in both groups of survivors.

Notes: *p < 0.05; ** statistically significant after Bonferroni correction

Table 7. Joint display of stress-related emotional symptoms



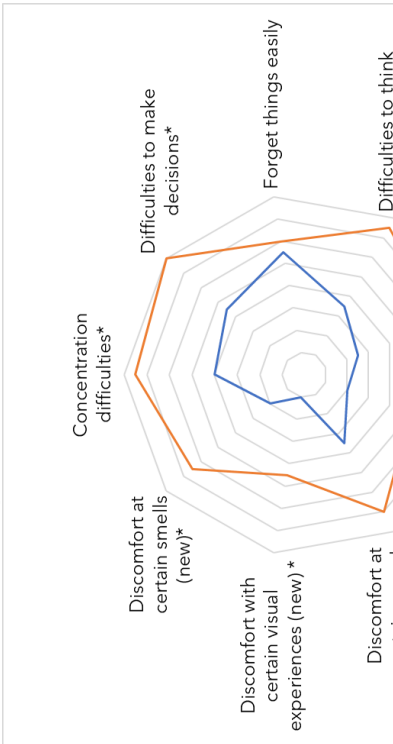
Mixed-methods inferences: Confirmation

Qualitative and quantitative findings regarding stress-related emotional symptoms confirmed each other, since both indicated that consequences for the survivors related to stress-related symptoms was a major problem for those experiencing more daily hassles and fewer daily uplifts and using more maladaptive coping strategies. In returning to the qualitative results, they could further expand the quantitative results.

Notes: *p < 0.05; ** statistically significant after Bonferroni correction. “New” refers to newly constructed items, from the qualitative data

Table 8. Joint display of stress-related cognitive and target-group specific symptoms

Quantitative findings:



Symptom Category	Favorable Profile (Blue)	Unfavorable Profile (Orange)
Concentration difficulties*	Low	High
Difficulties to make decisions*	Low	High
Forget things easily	Low	High
Difficulties to think clearly*	Low	High
Physical Touch Discomfort (new)*	Low	High
Discomfort or pain during intercourse (new)*	Low	High
Discomfort at certain sounds (new)*	Low	High
Discomfort with certain visual experiences (new)*	Low	High
Discomfort at certain smells (new)*	Low	High

Qualitative findings:

The qualitative findings show that the survivors, after many years, have continued difficulties concentrating. However, it becomes easier to find rest and “charge the batteries.” They find solutions for how to live with reduced cognitive abilities (using a mobile alarm to remember).

Memories from the sexual abuse, flashbacks, and triggers are still present many years after the sexual abuse. However, there are fewer triggers and fewer reactions to triggers in the third phase. As one of the survivors said, *“I think over time there are less triggers, less annoyances... because everything’s been a lot worse before... but I’ll never have a trigger-free or completely emotionally free life.”*

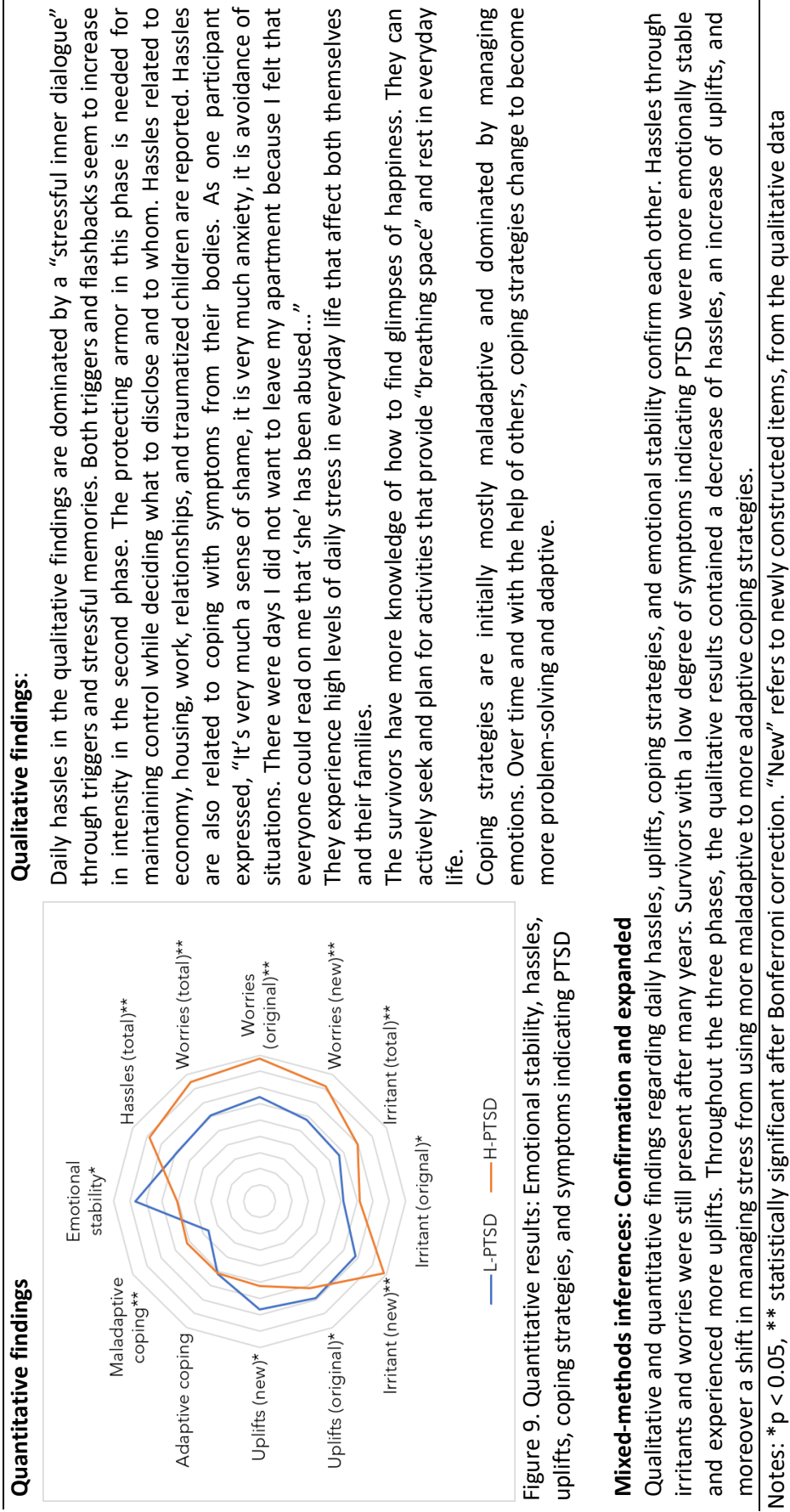
Figure 8. Quantitative results: Stress-related cognitive and target-group specific symptoms

Mixed-methods inferences: Confirmation

Qualitative and quantitative findings regarding stress-related cognitive and target-group specific symptoms confirm each other. The target-group stress-related symptoms yielded additional findings when they were added to the instrument on stress-related symptoms.

Notes: *p < 0.05; ** statistically significant after Bonferroni correction. “New” refers to newly constructed items, from the qualitative data

Table 9. Joint display of daily hassles, daily uplifts, coping strategies, and emotional stability



6 Discussion

The discussion is divided into three main parts: (1) a general discussion of the main findings encompassing all three studies based on the main purpose of this study; (2) a methodological discussion; and (3) a discussion of the implications for healthcare professionals and education, as well as recommendations for further research.

6.1 General discussion of the results

The main purpose of this mixed-methods thesis was to develop new knowledge that can contribute to a better understanding of how adult female survivors of sexual abuse experience and cope with daily hassles in their everyday lives, as well as the impact of stress-related symptoms on their health and wellbeing.

6.1.1 Strategies used to cope with daily hassles

The theoretical model of “protecting armor in daily life” illustrates how survivors of sexual abuse resolve their main concern, coping with daily hassles. In this model, the coping strategies used throughout the three phases were initially avoiding and escaping, then later accepting, and disclosing, and finally reconciling and repossessing. The coping strategy of avoiding and escaping is expressed as shutting out stressful situations and locking in stressful memories and thoughts. Although in the first phase this was considered an adaptive coping strategy, over time, it became a maladaptive one. After some time, when sexual abuse survivors accept the need for help and disclose the abuse, they also become more aware of having used strategies that over time are more maladaptive. Although the need for protection remains to some degree over time, by seeking help, such survivors can learn more adaptive coping strategies. However, they still struggle to some degree with feelings of guilt, shame, and repressed anger and become unsure regarding whom to trust and how to go back to their normal lives. The last phase illustrates that those survivors also acknowledge that they experience feelings of loss. At the same time, by seeking help, they report finding the energy and determination to repossess some opportunities that they thought they had lost, such as continuing their education or going back to work. Walsh et al. (2010) found that coping with sexual trauma is a prolonged process that involves different coping strategies at the various stages of recovery from abuse. Survivors retrospectively reported a variety of strategies that evolve and change with shifts in the phases of coping with the trauma.

In line with these findings, Walsh et al. (2010) found that avoidant coping strategies are related to increased levels of distress in adulthood, whereas cognitive coping strategies (e.g., finding meaning, mastery) are related to more adaptive outcomes later in life. In our studies many women were found to use maladaptive coping strategies and to experience more daily hassles and few uplifts. Leitenberg et al. (2004) found that younger women with a history of abuse partly rely on maladaptive coping strategies to deal with various new stressors later in life. In the qualitative study (Paper I), a significant turning point was the decision regarding when to disclose the abuse and seek help, which demonstrated how women took action and turned to a more active and adaptive way of coping to move on in their recovery process. Other studies have also shown that disclosure of abuse represents a pivotal moment and is part of a healthy process of coping (Anderson & Hiersteiner, 2008; Phanichrat & Townshend, 2010). Spangaro et al. (2011) found that women disclose their abuse after making active judgments regarding safety on three dimensions: from the abuser, from shame, and from relinquishing control. In our studies, the survivors who struggled the most also reported struggling with stronger feelings of shame and guilt. Relinquishing and regaining control are important factors that are also present in the three phases of the theoretical model. Each phase represents a turning point and includes common features in the narratives of experiencing and coping with daily hassles. One interesting finding is the need for some form of protection to cope with daily hassles. This illustrates the need for protection to gain control over the situation. The need for protection is initially crucial and over time remains to some degree. Phanichrat and Townshend (2010) found that coping strategies seem to mediate later adaptive functioning. Understanding the survivors' coping strategies might facilitate the development of more effective treatments to help them overcome their difficulties (Phanichrat & Townshend, 2010). The results show that focusing on reducing maladaptive coping strategies and increasing daily uplifts can eventually help the survivors of sexual abuse have a better life.

6.1.2 Target-group-specific daily hassles and daily uplifts

Identifying target-group-specific daily hassles and daily uplifts is important to fully understand the impact of these daily stressors on the daily lives of this group of trauma survivors. As mentioned earlier, few studies have investigated the types of daily hassles that women experience after sexual abuse. The participants were found to have few difficulties identifying their daily hassles, because for most of them feelings of worry and irritants in their daily lives were a new normal. There were initially many stressful incidents each day, and many of these

women used a large amount of energy to cope with these stressful events, leaving little time and energy for activities that they used to enjoy. This daily stress was found to have a major impact on everyday activities that were not perceived as stressful before the abuse. Stressful memories manifesting in a “stressful inner dialog” were a key source of irritants and worries. Harman and Lee (2010) found that high levels of shame are associated with high levels of self-critical thinking and low levels of self-reassuring thinking.

In the studies, we explored daily hassles through in-depth interviews and quantitative data collection and covered a period retrospectively. Other research has shown that being under some form of chronic stress increases the risk of experiencing more severe life events and more daily hassles, as well as reporting more perceived stress (Epel et al., 2018). Epel et al. (2018) have argued that duration is a defining characteristic of a stressor. In paper I, we found that, for most of the women, daily hassles decreased over time, although they remained to some degree after many years. According to Cloitre et al. (2013), the diagnosis of PTSD or CPTSD is determined by the symptom profile rather than the trauma history. Many of the survivors in the study group had an indication of PTSD. We initially recruited adult women and were not especially looking for prior trauma during childhood. The results still indicated that some of the survivors could have an indication of CPTSD since many of them also struggled with affect dysregulation, negative self-concept, and interpersonal problems, in line with the results of Cloitre et al. (2013).

The importance of experiencing positive aspects, such as daily uplifts, is one of the main elements of the results of this study. We identified areas that are perceived as positive by the study group and that can stimulate maintaining their struggle for a more stress-free life. According to Lazarus (1999), actively planning for a positive event or initiating a positive event is often the result of an active search for ease from unrelenting stress. The results indicated that the survivors of sexual abuse who experience more daily uplifts experience fewer daily hassles. Positive affect and positive beliefs serve as important resources helping people to cope with stress (Khosla, 2006). Data from qualitative interviews demonstrated that it is more challenging to identify daily uplifts than to identify daily hassles. The results show that survivors of sexual abuse with an indication of PTSD, or those who experience more daily hassles and use maladaptive coping strategies, experience fewer daily uplifts. One explanation is that, for these individuals, their all-consuming focus was for some time on dealing with stress, triggers, and other obstacles in their daily lives. Another explanation is that the moments of breathing space

are rare and private. However, when they reflected on what daily uplifts could be, they identified what they mentioned as “the little things and moments of joy” and were able after the interview to acknowledge this reflection as important. In particular, they were able to recognize having moved on: “Everything was not black; there was a glimmer of light,” as one of the women interviewed expressed. Daily uplifts were scarce in the first phase, but they increased over time and became easier to recognize. Again, finding support was an important turning point, which also influenced the degree of daily uplifts. In a similar vein, other studies have highlighted the importance of focusing on the role of daily uplifts and general positive processes across the lifespan (Aldwin et al., 2014; Folkman & Moskowitz, 2000).

6.1.3 Some struggle more after an experience of sexual abuse

By dividing the study population into two groups on the basis of the level of daily stress, coping strategies, symptoms of PTSD, or stress-related symptoms, we found that some struggled more than others, and we were able to explore these antecedent personal factors between these two groups. We found that, despite the trauma burden, demographic and socioeconomic data were quite similar between the study groups in Papers II and III. Participants who used more favorable coping strategies and experienced more daily uplifts also reported a lesser symptom burden and lower feelings of guilt and shame. Those with low levels of symptoms indicating PTSD and those who used more adaptive coping strategies experienced more daily uplifts, more emotional stability and reported fewer daily hassles. Sareen (2014) found that emotional stability and avoidance coping, were associated with increased risk for PTSD. According to (Lazarus, 1999, 2006), antecedent personal factors, such as sex, personality, and age, and contextual factors, such as socioeconomic conditions, shape the meaning that an individual ascribes to a situation, their coping effects, and their emotional conditions. Most study participants experienced sexual abuse during childhood or adolescence and were not able to change their situation because of the little support, if any, they received when they tried to disclose or even stop the abuse. The importance of ongoing support is, therefore, considered a significant issue. Michel (2014) highlights that the degree of community support after a traumatic event can affect the outcome. Knowing whom to contact for help is important and in recent years the focus on violence in close relationship has increased in the municipalities in Norway (Ministry of Justice and Public Security, 2018). Draucker et al. (2011) identified four stages that structure healing from sexual abuse during childhood: (1) grappling with the meaning of sexual abuse, (2) figuring out the meaning of sexual abuse, (3) tackling the effects of sexual abuse, and (4) laying claim to one’s life. These stages resemble the phases that we

identified, starting with a lonely inner process of trying to understand what happened and gradually taking back control in daily life.

The target-group-specific items, that is, guilt and shame, may be indicators of how stress-related emotional symptoms and unfavorable coping strategies can contribute to social isolation. Kennedy and Prock (2018) found that the severity of abuse and maladaptive coping strategies are associated with self-blame and feelings of shame. Kline et al. (2021) examined longitudinal associations between PTSD symptom severity and behavioral self-blame after sexual assault. They found that behavioral self-blame following sexual assault may be particularly relevant to the onset of PTSD symptoms. While PTSD symptoms themselves appear to intensify subsequent perceptions of behavioral self-blame (Kline et al., 2021). This is in line with the findings obtained herein, and these factors may contribute to the struggles reported among the unfavorable sub-groups and in this thesis.

6.1.4 Association among daily hassles, daily uplifts, coping strategies, and stress-related symptoms

We found a strong correlation between daily hassles and stress-related symptoms. Those who experienced more daily hassles were found to use more maladaptive coping strategies and reported more stress- and pain-related symptoms. Nelson et al. (2012) found that those with early sexual abuse experiences are at a higher risk for suffering from physical symptoms across several organ systems, including gastrointestinal, gynecological, neurological, upper respiratory, and chronic pain symptoms. They also found that reporting medically unexplained symptoms is related to some form of somatic translation of emotional distress, such as anxiety, depression, or panic disorder. The results show that women in the unfavorable profile group struggled with a diversity of stress-related symptoms and that many of these symptoms led to a more challenging daily life. Smyth et al. (2018, p. 15) highlighted three specific components of daily stress responses: stress reactivity, stress recovery, and stress pile-up. They claimed that an individual's emotional and cognitive responses to daily stress shape their health behavior decisions and daily enactment. Thus, when these responses accumulate over time, they may give rise to long-term negative health outcomes. Struggling with physical pain may, over time, lead to difficulties in relaxing and sleeping (Miller-Graff et al., 2015; Sigurdardottir & Halldorsdottir, 2013; Tinajero et al., 2020). Results pertaining to coping strategies show that maladaptive coping and emotional symptoms are correlated. Women in the unfavorable profile group were found to use more maladaptive coping strategies, experienced heightened feelings

of guilt and shame and reported more symptoms of depression and powerlessness. This outcome is supported by findings on survivors of childhood sexual abuse, sexual assault, and interpersonal violence, which show that self-blame, feelings of shame, and negative social reactions are linked to poor outcomes, physical and psychological distress, and affect dysregulation and maladaptive coping (Kennedy & Prock, 2018). Therefore, we suggest that it may be effective for afflicted individuals and healthcare personnel to focus on reducing the use of maladaptive coping strategies. In addition, establishing a routine of healthcare personnel asking about previous traumatic experiences and acknowledging such experiences can over time reduce the stigma and shame that many survivors experience for their whole lives.

6.1.5 Interrelationship of daily hassles, daily uplifts, coping strategies, and post-traumatic stress symptoms

Daily hassles were found to be strongly correlated with having symptoms indicative of PTSD. A high degree of perceived daily hassles, a small number of daily uplifts, the use of maladaptive coping strategies, and a low level of emotional stability were found to be strongly related to PTSD symptom intensity among severely sexually abused women. We found few significant differences regarding the demographic and socioeconomic data and severity of sexual abuse in the different group analyses. Font and Maguire-Jack (2016) found that some associations between childhood sexual abuse and health risks during adulthood can be explained by socioeconomic status. We found a significant difference regarding emotional stability between the low-PTSD and high-PTSD groups. Those with symptoms indicative of PTSD scored low on emotional stability. Emotional stability may be a factor with a positive influence on the subgroup with a low indication of PTSD. Bosmans et al. (2015) found that people with a high tendency to experience negative emotions also experience high levels of traumatic stress. This suggests that victims with lower emotional stability are more likely to experience high levels of traumatic stress and usually evaluate their ability to overcome the consequences of the event more negatively (Bosmans et al., 2015). This can according to their research, lead to a more chronic course of PTSD symptoms.

Previous research on daily stress after major life events has shown that these stressors more strongly affect health and wellbeing than the trauma itself (DeLongis, 1982; Lazarus, 1999; Serido et al., 2004). More recent research on the network theory of mental disorders has suggested that mental disorders such as PTSD and CPTSD arise from the causal interaction between symptoms in a network (Borsboom, 2017, p. 6). This model implies that symptoms

continue to activate each other, even after the triggering cause of the disorder has receded. Identifying these patterns may allow them to act as guides for addressing intervention.

The results also indicate that daily hassles are influenced by the severity of PTSD, the use of maladaptive coping strategies, few daily uplifts, feelings of guilt and shame, avoidance of memories from the trauma, and avoidance of other people. Addressing symptoms related to emotional stress, such as feelings of guilt and shame, in an intervention may prove to be a useful strategy to help the survivors of sexual abuse move forward. This may result in less avoidance of other people and fewer reminders of the trauma.

6.2 Methodological considerations

In the following section, methodological considerations regarding the use of an explorative sequential mixed-methods design are addressed. An analysis is presented to illustrate the uniqueness and transparency of the papers included in this thesis. In addition, methodological considerations; the reliability, validity, and trustworthiness of the qualitative data; and ethical considerations are presented.

6.2.1 Design

Using a GT methodology, we were able to identify the participants' main concern regarding coping with daily stress. We added more target-group-specific questions in the data collection for Papers II and III from the qualitative results, in line with the mixed-methods design. This contributed to the perceived relevance when participants were answering the questions in the questionnaire. We were then able to statistically test different hypotheses to further explore the associations and interrelations between coping with daily stress and its potential health-related consequences.

Generally, a mixed-methods design can be complex to plan and implement, and it requires researchers to have experience in both qualitative and quantitative research. Our research group had broad experience in research projects using both qualitative and quantitative methodologies. This broad experience of the research group contributed to discussions regarding data collection and analysis, which in turn led to a broader perspective on the topics studied in this thesis. According to Wisdom and Creswell (2013), using a mixed-methods design requires openness to methods that may not be within one's area of expertise and may require increased resources and time. Although it would have been less time consuming to

conduct a single-method study, using both methods helped strengthen the relevance and validity of the results.

6.2.2 Uniqueness analysis

As mentioned above, the three papers included in this thesis are based on two data collection strategies: qualitative and quantitative. According to ethical guidelines, text recycling can occur when sections of the same text appear in more than one of an author's own publications (The Committee on Public Ethics, 2020). Publishing multiple papers from a single dataset may, according to Kirkman and Chen (2011), limit the unique contribution of a paper and violate the ethical standards adopted by journals. Table 10 is an attempt to accommodate the criteria of uniqueness and transparency, inspired by Kirkman and Chen (2011). As the overall aim was to gain new knowledge on how women cope with daily hassles after sexual abuse, exploring the phenomenon among different subgroups was chosen as a strategy. Subgroup analysis aims to measure change within and between groups and is defined by characteristics measured at baseline (Supplee et al., 2013). The subgroups in the quantitative papers were characterized by variables indicating favorable or unfavorable profiles (on coping, daily hassles, and daily uplifts) and variables on high and low degrees of symptoms indicating PTSD (Paper III). As Table 10 illustrates, some overlap occurs in describing the phenomenon of coping with daily hassles, because some of the theories and variables have been used in two or three of the papers. However, we argue that there is still sufficient new material is in fact present in each paper.

Table 10. Uniqueness analysis of three papers published from two datasets in this thesis

Paper	I	II	III
	Stensvehagen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (2019). How women experience and cope with daily hassles after sexual abuse – a retrospective qualitative study. <i>Scandinavian Journal of Caring Sciences</i> , 33 (2), 487–497.	Stensvehagen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (202x). Association of daily hassles, uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse – a cross-sectional study	Stensvehagen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (2020). Interrelationship of posttraumatic stress, hassles, uplifts, and coping in women with a history of severe sexual abuse: A cross-sectional study. <i>Journal of Interpersonal Violence</i> , 886260520935479.
Research aims	In Paper I, the aim was to gain a deeper understanding of how adult women experience and cope with daily hassles after experiencing sexual abuse.	In Paper II the aim was to explore the association among daily hassles, daily uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse.	The aim in Paper III was to compare the characteristics of two groups of female survivors of sexual abuse, one group with a lower indication of PTSD (L-PTSD) and one group with a higher indication of PTSD (H-PTSD).
Research hypothesis		Hypothesis 1: Daily hassles and maladaptive coping strategies are associated with a high frequency of stress-	Hypothesis 1: Among women with a history of sexual abuse, the H-PTSD group would be associated with more daily

		related physical, emotional, cognitive, and target-group-specific symptoms. Hypothesis 2: Daily uplifts and adaptive coping strategies are associated with a low frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.	hassles, fewer daily uplifts, and more use of maladaptive coping strategies. Hypothesis 2: Women in the H-PTSD group would report more severe sexual victimization, less resourceful socioeconomic conditions, and a lower level of emotional stability.
Theories used	Theory on daily hassles, daily uplifts, and coping strategies	Theory on daily hassles, daily uplifts, coping strategies, and stress-related symptoms	Theory on daily hassles, daily uplifts, coping strategies, emotional stability, and symptoms indicating PTSD
Constructs/variables	Individual interviews, GT analysis	Demographic and socioeconomic factors; experience of sexual abuse; daily hassles; daily uplifts; coping strategies; and stress-related physical, emotional, cognitive, and target-group specific symptoms	Demographic and socioeconomic factors, experience of sexual abuse, daily hassles, daily uplifts, coping strategies, emotional stability, and indications of PTSD
Theoretical implications	A theoretical model on coping with daily hassles and daily uplifts Results from qualitative data collection used in the development of the questionnaire in Papers II and III	Results indicating that stress-related symptoms among severely sexually abused women are strongly related to a large number of perceived daily hassles, a small number of daily uplifts, and frequent use of maladaptive coping strategies	Providing support for women with more symptoms indicating PTSD, who report experiencing significantly increased daily hassles and fewer daily uplifts and use more maladaptive coping strategies The L-PTSD group reported increased emotional stability, reduced daily hassles, and increased daily uplifts and used more adaptive coping strategies.
Implication for practice	The results support development of target-group-specific knowledge on daily hassles and daily uplifts as well as knowledge regarding how daily stress, daily uplifts, and coping strategies change over time.	The results reveal the importance of uncovering maladaptive coping strategies and focusing on changing stress appraisals and stress-response behaviors in therapy and counseling.	Major life events, such as sexual abuse, may not be under the victims' control. Appraisal and coping with everyday events can be effective and offer interesting possibilities for intervention.

Notes: ^a L-PTSD: Low symptom indication of PTSD. H-PTSD: ^b High symptom indication of PTSD

6.2.4 Qualitative approach in this thesis

In the following section, a discussion in a broad sense of the quality in the qualitative part of this thesis is presented, followed by the use of the criteria for quality in GT.

Kitto et al. (2008) outline eight criteria for assessing the overall quality of qualitative research. The first two, *clarification* and *justification*, refers to the study research question (Kitto et al.,

2008). Our overall aim was to gain more knowledge regarding how women cope with daily hassles after experiencing sexual abuse. We found it useful to conduct an exploratory sequential mixed-methods design. The qualitative interviews formed the initial hypothesis and basis for the quantitative data collection that we then could further test on a larger group of survivors. Through the process of data collection and analysis and the presentation of the results, we attempted to adhere to the constant comparative method and the third criterion, *procedural rigor* (Kitto et al., 2008).

The fourth criterion is *representativeness*, which addresses how we recruited the participants (Kitto et al., 2008). The study group was selected in a specific context, by attending a support center, although there were differences in how actively participants used these support centers. Our aim was to adhere to the theoretical sampling technique. The study group in Paper I comprised survivors who had had some encounters with sexual abuse during childhood, while only a few of them encountered sexual abuse as adults. One strong point in that study is that by examining age variation, we could identify the processes that these women continue to endure over many years after being abused.

To adhere to the fifth criterion, *interpretative rigor* (Kitto et al., 2008), all the participants in our research group joined in discussing the data from the interviews and participated in the ongoing analysis. Since the other participants in the research group had worked with this topic for many years, this contributed to safeguarding the data obtained from the interviews and analysis. The seventh criterion, *reflexivity and evaluative rigor*, addresses the influence of our research group on the results in the qualitative part of this thesis (Kitto et al., 2008). Although my experience with the study group and their traumatic experiences was initially limited, this may have been a positive factor. This is because, in the interview setting the participants were encouraged to explain their experiences, as well as the consequences on their daily lives, as the experts of their own stories. In this manner, the balances of power in the interview setting was arguable more even. According to Kitto et al. (2008), *transferability* is the final general quality criterion, which in this case refers to how well the results can explain how female survivors of sexual abuse in other contexts cope with daily hassles. The theoretical model of protecting armor illustrates in many ways the lengthy process that such individuals endure after sexual abuse, especially for those who had early encounters of sexual abuse. Notably, adult survivors in the sample with experiences of sexual abuse during adulthood underwent the same phases, although they progressed from the first phase to the next much more quickly. The primary

features of this model can be helpful when used in any healthcare setting in a dialogue with survivors who disclose similar experiences of abuse. However, more research on a broader group of female survivors of sexual abuse is still needed to further develop the model.

In the GT methodology, four criteria are available for evaluating credibility: fit, workability, relevance, and modifiability (Glaser, 2010, pp. 252-253). *Fit* is used instead of validity in GT and refers to the categories generated systematically on the basis of the data. In general, the developed theory must fit the substantive area in which it is applied (Glaser & Strauss, 2007, p. 237). We followed the process of constantly going back to the data to examine whether we found a fit with the data, and we attempted to remain open to any events that occurred during the data collection and analysis.

The concept of *workability* is used to evaluate how emerging concepts can be related to the participants' main concern (Glaser, 2010, pp. 252-253). After many discussions within our research group, the substantive theory of protecting armor in daily life emerged. This theory explains the participants' coping strategies and need for protection from the ongoing exposure to stress both during the abuse and many years after the abuse has ceased. The theory of protecting armor in daily life demonstrates the struggles that survivors of sexual abuse experience in their daily lives, as well as the significant turning points and the increases in daily uplifts and decreases in daily hassles over time. By explaining what is occurring in the data, predicting what is going to happen, and being able to explain what is happening in the area being researched, our aim was to meet the criteria of work in GT (Glaser, 2010, pp. 252-253). To ensure *relevance* in GT, we conducted interviews with as few predetermined questions as possible to ensure that the participants' main concern or problems arose instead of what we, as researchers, assumed (Glaser, 2010). Although we specified the concept of daily hassles in the interview guide, it was an open question, and the informants were able to tell their stories and define their main concerns in relation to worries and irritants in daily life. The level of detail in the initial interview guide for the first interviews was more extensive than is suggested in GT. This occurred due to a lack of experience with interviewing; it also served to contribute to interviewer confidence. I learned early on that I could move away from this level of detail and only deal address a few introductory questions to get the conversation started. A point here is also that the informants expressed an expectation they had of themselves to "answer correctly." Based on this feedback from the participant, the second interview began by explaining the interviewer's and that "all answers are good answers." Although the aim is to not to force data in GT, one there must have a starting point for the data collection; this was solved by creating an interview guide with a few open questions.

Modifiability pertains to GT having partial closure, because new ideas and more data can change or modify the developed substantive theory. This is, therefore, an ongoing process, and all GT studies have the potential for further development (Glaser, 2010, pp. 252-253). In general, several sources of new ideas and possibilities exist via which the substantive theory of protecting armor in daily life could be modified. The first source is to include a group of women who differ from those using a support centers, as mentioned above. The second possibility is to interview male survivors and explore gender differences with regard to coping with daily hassles after sexual abuse. In addition, the potential exists to further explore the theory about the diversity of stress-related symptoms experienced after sexual abuse. By further exploring the theoretical model, this could spur the model's developing into a grounded formal theory transferable to a broader area (Glaser & Strauss, 2007, p. 80).

6.2.5 Assessment of the methodological quality of the quantitative approach of this thesis

This section discusses the rigor of the quantitative part of this thesis. *Validity* in cross-sectional studies refers to how accurately the concepts are measured, and *reliability* refers to the accuracy of the chosen instruments (Heale & Twycross, 2015). The Appraisal Tool for Cross-Sectional Studies was used to assess the quality and risk of bias (Downes et al., 2016).

Sample and recruitment

Generalizing significant results to a population outside the study sample is a key purpose of quantitative studies. This quality norm is largely related to a representative sample that has sufficient power to detect significant results at a set significance level (Polit & Beck, 2017). In the present studies, the target population was adult women who have experienced sexual abuse. The study participants were recruited from Norwegian support centers that cater to people who have been exposed to sexual abuse. These support centers allow access to a broad and sufficient number of participants within the typical time frame of a Ph.D. study. The inclusion criteria were wide and included women who were 18 years of age or above, who had experienced sexual abuse, and who spoke Norwegian. Generally, women who have been exposed to sexual abuse are regarded as difficult to recruit compared to other groups with less sensitive and shameful trauma. Due to their trauma experience they can be more socially isolated, prone to harm if they participate, and their experiences of sexual abuse may still be undisclosed (Ellard-Gray et al., 2015).

A total of 17 support centers (Nok. centers) were invited to assist in the recruitment of the participants. Nine of these centers responded to the request and facilitated recruitment. We recruited participants from the centers where we conducted the 10 qualitative interviews (Paper I). The recruitment process was slow even though it was possible to respond to the questionnaire both electronically and on paper. After 10 months of recruitment, the sample size reached only 57 female survivors of sexual abuse recruited from nine support centers. The recruitment process was, therefore, concluded because of the time frame of the study. We were unable to discern why eligible female survivors were hesitant to participate even though the participants were required to provide their consent to participate by answering the questionnaire. Two possible reasons might be the sensitive nature of the questions and the vulnerable group. Mistrust in the research process and helpers serving as gatekeepers in the recruitment process may have also been reasons that some did not participate (Ellard-Gray et al., 2015). For some individuals, it may have been too demanding to answer all the questions. Questions related to their sexual trauma experiences may trigger flashbacks and memories from the abuse. In a study in which psychiatric inpatients ($n = 223$) were interviewed about PTSD and childhood physical and sexual assault experiences, in rating how upsetting, helpful, or useful they found the interview, 71% reported experiencing relatively low levels of distress and 51% found participation to be useful (Carlson et al., 2008). The interviews were regarded as upsetting because they made the participants remember or relive the past, and they were regarded as useful because they led to new insights and were an opportunity to talk about past experiences (Carlson et al., 2008). Most of the survivors of sexual abuse who were interviewed (Paper I) found it helpful to tell their stories, with their major motivation being to help others. This is supported by Larsen and Berenbaum (2014) who found that the participants in their study reported lower levels of negative affect one week after participating and raise the possibility that participating can be helpful. In hindsight, we could have been even more critical about the extent of the number of questions in the survey. Trauma-related questions were placed at the end of the questionnaire to avoid triggering memories from the abuse and to help the participants by allowing them to first answering questions that were not directly linked to the traumatic experience. However, feelings of shame or guilt and threats from others may have prevented some survivors of sexual abuse from participating (Kennedy & Prock, 2018; Reitsemá & Grietens, 2016). Any errors in recruiting study participants and factors affecting participation in the study can cause selection bias, which may be a threat to the validity of cross-sectional studies (Tripepi et al., 2010).

Another potential explanation for the low response rate may be that the MeToo movement in 2017 led to increased inquiries about participation in research at support centers. For example, at one center with no respondents, the recruiters could not explain why none of their users answered the questionnaire. This means that we do not have information regarding the characteristics of those who chose not to participate. Nonresponse is a particular problem that affects cross-sectional studies and can result in bias and threaten the outcomes and external validity of a study (Altman & Bland, 2007). Hence, it is recommended to increase the sample size to allow for losses of nonresponse (Altman & Bland, 2007). During the planning phase, the estimated sample size was set at 100 participants. However, after the recruitment period, only 57 participants answered the questionnaire. According to statistics from The Norwegian Directorate for Children Youth and Family Affairs (2019), more than half of the inquiries to support centers are telephone inquiries rather than physical attendance at a support center. Although we used Facebook to contact informants, they had to contact an employee at the support center to conduct the survey. This may be one reason for a low response rate. According to these statistics, eight out of every 10 users have been exposed to sexual abuse, with the majority of users being abused by a person they knew before and only 16% being abused by an unknown person. This corresponds closely with the traumatic experiences reported among the study sample (The Norwegian Directorate for Children Youth and Family Affairs, 2019).

However, the small sample size led to some limitations regarding the statistical power of the analyses and the external validity of the results. To counteract the effect of multiple comparisons and the small sample size, a Bonferroni-corrected alpha level of $p < 0.0015$ was calculated and considered to be statistically significant (Armstrong, 2014). Additionally, Cohen's d was computed to assess effect size (Cohen, 1988).

Data collection and instruments

The two cross-sectional studies were based on data from the same survey or data collection. The questionnaire consisted of a combination of established and validated scales and newly constructed target-group-specific items. In total, the questionnaire consisted of 179 questions, of which 42 were newly constructed target-group-specific items, generated from the findings in the qualitative part of the thesis, in line with mixed-methods design. Adding target-group-specific items to the established and validated scales was considered to increase the relevance for the target group and, thereby, strengthen the content validity of the data collection. However, these newly constructed questions have not been validated before, which is considered a

limitation. All the validated scales, except for one, showed satisfactory reliability coefficients, as described and demonstrated in Section 4 (Table 4, p. 38). However, in Paper II, the Emotional Symptoms Scale had a reported alpha value under .7 and should be interpreted with care (Polit & Beck, 2017).

The questionnaire was pilot tested before the main data collection started. This was done by support center representatives who themselves were sexual abuse survivors and at the time worked at one of two centers. We received feedback that the questions were easy to understand and perceived as relevant but somewhat time-consuming to answer. The same feedback was confirmed by those responsible for recruiting participants at the centers. This outcome may indicate that the face validity was satisfactory (Polit & Beck, 2017). According to Creswell and Creswell (2018) a good procedure, in exploratory mixed-methods, is to draw the qualitative and quantitative study samples from the same population. In addition to make sure that the individuals for the two samples are not the same. We recruited participants for the qualitative and quantitative studies from some of the same support centers. We can therefore not be sure if some of the participants in the interviews also answered the questionnaire. This is a weakness in the data collection (Creswell & Creswell, 2018).

In general, survey respondents may have a tendency to answer questions in a manner that is viewed favorably by others, and this factor can lead to social desirability bias (Polit & Beck, 2017). However, whether the participants in the studies overreported “good behavior” or underreported “undesirable behavior” is difficult to determine.

Information bias can result from systematic distortions when collecting information in a study (Tripepi et al., 2010, p. 95). In the electronic questionnaire, all the questions had to be answered to move on to the next question. Those who completed the electronic questionnaire answered all of the questions. In the paper-based version, it was possible to skip some of the questions. Only two answers were missing in relation to birth year, in the paper-based version. All other questions were completed by the participants. The limited amount of missing data strengthened the data's validity (Altman & Bland, 2007).

In all three studies, we asked the participants about past sexual abuse exposure. Many reported having their first experience of sexual abuse as children or adolescents. Even though the period addressed in the questionnaire primarily related to the previous month, answering the questionnaire may have still resulted in recall bias, which may have influenced the results (Polit & Beck, 2017).

Data analysis and integration

The qualitative and quantitative data were at first analyzed separately and then integrated for interpretation (Creswell & Creswell, 2018). The intent was “to determine if the qualitative themes in the first phase could be generalized to a larger sample” (Creswell & Creswell, 2018, p. 226).

Data analysis showed that the study group was diverse regarding the onset of the abuse and experiences related to the type of sexual abuse. Most of the study participants had been exposed to the most severe type of sexual abuse and had a history of sexual abuse experiences during both childhood and adulthood. Many of them had been retraumatized, and some had a lifetime of abuse experiences. The lack of differences on the sexual abuse scales may be due to a ceiling effect, as most participants experienced severe sexual abuse, which left less opportunity to comment on women who had experienced less severe abuse. Furthermore, because all participants visited support centers, they were assumed able to disclose their sexual abuse experiences and find help. Based on the results and the theoretical model developed in Paper I, this may mean that this study group functioned somewhat better than those who have not yet disclosed their sexual abuse experiences.

Despite the small sample size, the sample of women with severe sexual abuse experiences generated important results regarding the interrelationships and associations between daily hassles, daily uplifts, coping strategies, and stress-related symptom burden in a group that has likely been difficult to recruit outside of the support centers or by other means. As such, this is regarded as a strong point of the results from the present study. Our knowledge is scarce regarding other traumatic experiences that the participants have experienced, which may also lead to symptoms indicating PTSD and other stress-related symptoms; this knowledge gap can be considered a confounder in the data analysis and the results of Papers II and III.

Women attending support centers are a selected group who receive support and counseling, which means that selection bias could be a threat to the validity of the outcomes. If we had used other means of recruiting the participants, such as social media, it may have resulted in a more representative sample and possibly other results. Furthermore, the participants in the three studies were mostly Norwegian women. Hence, the results are not generalizable to women from other countries or cultures.

Several studies have included young women or college students and have not focused on the long-term effects of sexual abuse (Asselmann et al., 2017; DeLoveh & Cattaneo, 2017; Leitenberg et al., 2004). The present cross-sectional studies include a study population that represents adult women aged 19–69 and addressed long-term stress-related health effects. This approach adds new knowledge to the research field and is a strong point of the results obtained from the present study group. Notably, the small sample size led to limitations regarding the statistical power to detect significant differences between the study subgroups and the generalizability of the findings. Because of this relatively small sample, the results should be interpreted with caution.

To correct for type I errors resulting from multiple analyses, we calculated Bonferroni's correction. In addition, we calculated the effect size while assessing the groups using Cohen's *d*. This, however, may increase the risk of type II errors, as is the case with a small sample size. As with all cross-sectional data, we can assess associations only and cannot make assumptions regarding the causal directions of the variables (Sedgwick, 2014).

6.2.6 Strengths and weaknesses of using a mixed-methods approach

We chose a mixed-methods design to build a better measure for a sample of a population, in this case, female survivors of sexual abuse and how they cope with daily hassles. Both the qualitative and quantitative data were gathered sequentially within a time frame of 1.5 years, and equal emphasis was placed on both data sets. By merging the data through a joint display, we could connect the qualitative result to the quantitative results and display interference. The results in this thesis illustrate that the newly developed items show statistical significance. The results also show that the qualitative results confirm the quantitative results, and thus contribute to the validity of the qualitative results. This contributes to strengthening the choice of method and the results in this thesis.

6.3 Ethical considerations

According to Beauchamp and Childress (2001), the four principles of ethics (autonomy, nonmaleficence, beneficence, and justice) must often be balanced against each other. Safeguarding and not adding to the levels of daily stress were important when recruiting the participants in the three studies. To protect the participants, we worked with representatives from the support centers to ensure that those who participated in both the interviews and the

survey could receive counseling afterwards, if needed. Allowing the participants to decide where to sit during the interviews and when to take a breaks helped them perceive some level of control over the interview setting. Participating in a study, although somewhat challenging, should overall be a positive experience. Participating in an interview may be considered meaningful and challenging and a learning experience for both the person being interviewed and the researcher. Many of the survivors of sexual abuse who were interviewed reported that reflecting on and sharing their stories were meaningful. Being challenged to focus on daily uplifts and how their lives turned out was also perceived as positive and useful by the survivors.

7 Conclusions and implications

The overall aim of this mixed-methods thesis was to develop new knowledge that could contribute to a deeper understanding of how adult women who have experienced sexual abuse experience and cope with stress associated with daily hassles and daily uplifts in everyday life and how these processes are relate to health.

The developed theoretical model of protecting armor in daily life includes three phases: (1) avoiding and escaping, (2) accepting and disclosing, and (3) reconciling and repossessing. The model demonstrates the complex process that women who have been exposed to sexual abuse may endure in their everyday lives and also illustrates the process of coping with daily hassles and the influence of daily uplifts and stress reactions characteristic of the target group.

We further tested the model by comparing favorable groups (above-median scores on daily uplifts and adaptive coping, below-median scores on daily hassles and maladaptive coping strategies) and unfavorable groups (above-median scores on daily hassles and maladaptive coping, below-median scores on daily uplifts and adaptive coping strategies). The results indicated that stress-related symptoms among severely sexually abused women are strongly related to a high number of daily hassles, a low number of daily uplifts, and frequent use of maladaptive coping strategies. When sexual abuse survivors with H-PTSD and L-PTSD levels were compared, those with more symptoms indicating PTSD reported significantly more daily hassles, fewer daily uplifts, and more maladaptive coping strategies. Emotional stability, fewer daily hassles, and more daily uplifts were associated with fewer indications of PTSD and more use of adaptive coping strategies. Few differences were found between the groups with regard to the severity of sexual abuse, demographic and socioeconomic conditions.

The mixed-methods approach provided an opportunity to explore individual symptoms afflicting women who have experienced sexual abuse. Despite a small sample, the data analysis and sub-group comparison show that there were significant differences related to stress symptoms. By looking at the results of the three studies through a joint display. We found that the qualitative data both confirmed and expanded the quantitative results in this thesis.

In summary, the results reported in this thesis provide some grounds for optimism with regard to offering help and opportunities for recovery to this severely traumatized group. Increasing awareness regarding how even small daily uplifts can decrease maladaptive coping strategies and increase adaptive coping strategies can offer a positive way forward. Such traumatic events have already occurred and cannot be undone, but at least it is possible to affect the future.

Changes can be achieved by the survivor herself with the help of significant others and professional helpers.

The results highlight that disclosure and social support are pivotal and, over time, contribute to fewer daily hassles, more daily uplifts, and more adaptive coping strategies.

The overall results also reveal the importance of healthcare personnel in identifying stress-related symptoms and in looking for cause of the symptoms that may be related to trauma, as well as in uncovering maladaptive coping strategies and focusing on changing stress appraisals and stress-response behaviors through interventions. Reducing the stigma of being a victim of any form of sexual violence, allows the survivors to reclaim a more stress-free life.

7.1 Implications and recommendations for clinical practice and education

Given the proportion of individuals who report encountering sexual abuse, health professionals are highly likely to encounter patients with a history of trauma. In this regard, healthcare professionals should acknowledge how early and long-lasting traumatic experiences can shape psychological, physical, and interpersonal functioning in survivors of sexual abuse.

In Norway, all social and health-related higher-education programs, have recently been revised. There is now an increased focus for students to gain knowledge on topics such as violence, sexual abuse, substance abuse, and socioeconomic problems (Regulations on national guideline for nursing education, 2019). Over time, this will contribute to increased knowledge and attention for several groups of healthcare personnel. More research is needed to ensure that nurses and other healthcare professionals have sufficient knowledge to help the group of survivors addressed in this thesis. Sexual abuse is still “silenced” by shame and guilt, and healthcare professionals must be competent to address this topic so that they can conduct proper evaluations and provide help that is well tailored to survivor’ needs. Knowledge of daily hassles, daily uplifts, and coping strategies and how they can affect health and wellbeing in the aftermath of sexual abuse is important for healthcare professionals. The theoretical model of protecting armor may help women who have had similar experiences reflect on their past and present situations.

7.2 Recommendations for further research

1. Recruiting participants who have experienced less severe sexual abuse and adopting other means and sources of recruitment may provide other perspectives and are recommended for further research.
2. Group comparisons with female survivors of sexual abuse should be replicated in larger populations across different groups and cultures.
3. In addition to considering the frequency of stress-related symptoms, future research should focus on understanding the subjective degree of importance that these symptoms have in the daily lives of sexual abuse survivors after trauma.
4. It would be interesting to perform similar studies with male survivors to determine whether there are gender differences or similarities with regard to daily hassles, daily uplifts, use of coping strategies, and stress-related symptoms.
5. Future research should explore interventions that address stress-related symptoms, social support, emotional problems, and how altering maladaptive coping strategies may promote recovery among both male and female survivors of sexual abuse.

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Errata

Doctoral candidate: Marianne Torp Stensvehagen

Dissertation title: Interrelationship of daily hassles, daily uplifts, coping strategies and stress-related symptoms, reported by female survivors of sexual abuse: An exploratory mixed-methods approach

Changes:

1. Figure 5 (page 53). Phases explaining how women experience and cope with daily hassles after experiencing sexual abuse. The figure should have a line from phase 3 to the timeline as illustrated below.

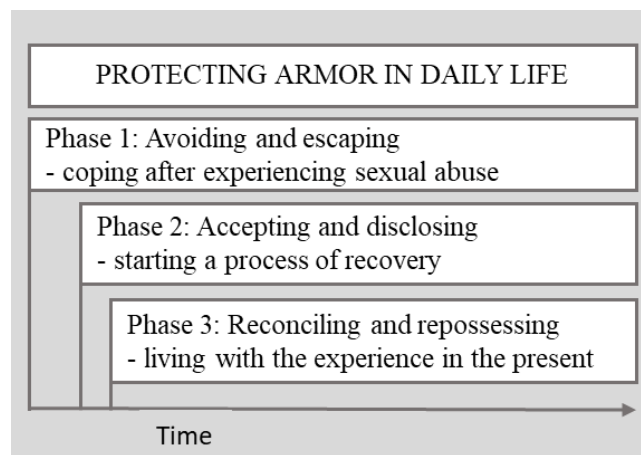



Figure 5. Phases explaining how women experience and cope with daily hassles after experiencing sexual abuse (Stensvehagen et al., 2019, p. 490)

How women experience and cope with daily hassles after sexual abuse – a retrospective qualitative study

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How women experience and cope with daily hassles after sexual abuse – a retrospective qualitative study

The impact of stress on health can depend on factors such as frequency, heightening of stress during a given period or the presence of one or a few repeated hassles of psychological importance. The aim of this study was to gain a deeper understanding of how adult women experience and cope with daily hassles after sexual abuse. Ten interviews were analysed using the grounded theory method. The theoretical model of 'protecting armor in daily life' emerged. The aftermath of sexual abuse related coping with daily stress can be understood as a three-phase process: (1) avoiding and

escaping—coping after experiencing sexual abuse; (2) accepting and disclosing—starting a process of recovery; and (3) reconciling and repossessing—living with the experience in the present. The model contributes to a deeper understanding of the everyday life of women who have experienced sexual abuse. Increased knowledge of coping behaviours that can be used to deal with daily hassles may also serve as a tool for health professionals, other helpers and family to help these women rebuild a good life.

Keywords: sexual abuse, women, daily hassles, daily uplifts, coping strategies, stress reactions.

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Introduction

Violence against women is a common public health concern and one in three women worldwide, experiences physical or sexual violence in their lifetime (1). The World Health Organization (2) defines sexual violence as:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work. (p. 11)

Sexual abuse may include everything from sexualised language/behaviour to more severe abuse like intimate touching and rape (3). According to the World Health Organization (4), one in five women reports having been sexually abused as a child and one in three women has been a victim of physical or sexual violence by an

intimate partner at some point in her lifetime. Aakvaag et al. (5) found that women who have experienced sexual abuse during childhood often have been exposed to other childhood violence as well. Childhood violence also seems to be associated with rape and intimate partner violence in adult age (5). Women who have experienced sexual abuse, or have been exposed to several types of violence or have been victims of violence from a person they know, appear to be more vulnerable and report poorer self-perceived health and more negative health effects (6–8). In addition to mental illness such as depression, anxiety and posttraumatic stress disorder (PTSD), many women struggle with pain-related physical ailments, stomach problems, gynaecological disorders, cardiovascular disease, obesity, metabolic syndrome and autoimmune diseases (4, 5, 9, 10). For some women who have experienced sexual abuse, this can lead to an unhealthy lifestyle with smoking, use of alcohol and/or drugs and/or risky sexual behaviour (11, 12). These women are also at risk of being major users of healthcare services (9).

Research on stress and health took a new direction in the 1980s. Shifting from a focus on major life events, to

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a growing body of research suggested that smaller everyday events or stressors strongly affect well-being and health (13, 14). It is often difficult to have any influence on most major traumatic events, because they have already occurred (15). Because of diverse personal agendas, stress appraisals and coping process, the psychological symptoms experienced vary widely (16). Focusing on everyday events and stressors can be useful to understand how individuals cope after a traumatic event. Daily stress is often referred to in the psychological literature as 'hassles' (14, 15, 17). Hassles, the little things that irritate and upset people, are prominent, annoying, frustrating and distracting everyday events perceived by the individual as negative. The impact of hassles on physical and mental health can depend on factors such as frequency, heightening of hassles during a given period or the presence of one or a few repeated hassles of psychological importance (14, 15, 17). Studies focusing on possible associations between daily hassles and health in female victims of childhood sexual abuse have shown that increased daily hassles are associated with more reporting of stress-related physical symptoms (18). Research has shown that women who had experienced sexual abuse had significantly higher levels of stress from daily hassles and that stress over daily hassles increased depressive symptoms (19). In addition, women were engaged in fewer social activities and had less sense of control in their lives and less ability to cope with pain, than women not exposed to this type of trauma (20).

A counterpart to daily hassles are daily uplifts, or occurrences appraised by the individual as positive. These uplifts can help in the process of coping with stress by serving as 'breathers' from regular stressful encounters, sustainers of coping activity and restorers in recovering from harm and loss (15). When these daily uplifts are initiated by individuals themselves, they are more likely to produce positive feelings than naturally occurring positive events.

As shown, consequences of sexual abuse for physical and psychological health are well-documented. There is less knowledge of how women who have been exposed to sexual abuse experience daily hassles over time and how these seemingly minor daily stressors interact with daily uplifts, coping and stress reactions. In order for healthcare workers to be able to provide good care for women after experiencing sexual abuse, it is important that they have expertise related to the consequences of abuse (21). The aim of this study was to gain a deeper understanding of how adult women experience and cope with daily hassles after experiencing sexual abuse.

Method

The methodological approach was based on the grounded theory method (GTM) (22). The GTM is a general

inductive method based on a concept-indicator model where the aim is to generate new theory and to present the processes related to solving a main concern in the substantive field (23).

Participants

Participants were women recruited from three Support Centre for Victims of Incest and Sexual Assault (SMISO) in Norway. SMISO has expertise in understanding trauma, counselling and dealing with the consequences of sexual abuse. The criteria for inclusion were having experienced sexual abuse or assault, being 18 years or older and speaking Norwegian. The centre leader made the first contact with potential participants, provided information about the study and obtained written informed consent. The first author contacted the participants by telephone and agreed upon a time for the interview.

Ten women aged 32–61 years old were included. Six of the women were living alone, and four were in a partnership or married. Three of the participants worked full time, and five were either on full or partial disability benefits. All the participants had experienced severe sexual abuse one or several times in their life. Eight of the participants had their first experience of sexual abuse as children or adolescents, the remaining two as adults. Of the women who had been abused as children, two had experiences from interpersonal violent relationships as adults. The perpetrators were all male, mostly adults but also adolescents. Eight of the women reported being abused by a person they knew: parental figures, a partner or an acquaintance in their neighbourhood. Two of the participants were abused by an unknown perpetrator.

Data collection

The first author conducted all the individual interviews. The interviews took place at the SMISO counselling centre the individual participant used. An interview guide with open-ended questions was followed up with individually tailored questions. The participants were encouraged to speak openly on the following themes:

- Experiences of sexual abuse
- Experiences related to stressful, irritating or worrying situations in everyday life
- Coping strategies used for resolving stressful, irritating or worrying situations in everyday life
- Experiences related to feelings of joy, uplifts or happiness in their everyday life
- Significant turning points since the sexual abuse happened

The interviews lasted from 72 to 105 minutes and were recorded and transcribed verbatim. Two days after each interview, the first author contacted the participant by

phone and offered them an opportunity to talk about their experience in the interview setting and indicate whether they wanted to add or remove something from the interview text. In addition, participants were given the opportunity to read the transcribed interview. Two of the participants agreed to this and reported it useful to go back and read what they had said during the interview. None of these initiatives for participants led to any changes in the transcribed material.

Ethics

The participants in this study disclosed highly personal and private stories, and the need to safeguard them was one of the major ethical considerations. Participation was voluntary and the women could withdraw at any time without any reason or negative consequences. The study was carried out adhering to the ethical principles contained in the Declaration of Helsinki (24). In addition to the written consent, every participant had the opportunity to have their primary contact at the SMISO centre present during the interview and/or a follow-up after the interview. One of the participants had her primary contact present during the interview. All primary contacts employed at the centre was bound by the duty of confidentiality. One participant made use of a follow-up with her primary contact after the interview.

Data analysis

Analysis was conducted by using the principles of the constant comparative method. The constant comparative method refers to an analytical process that comprise four stages: (i) comparing incidents applicable to each category, (ii) integrating categories and their properties, (iii) delimiting the theory and (iv) writing the theory' (22, p. 105). Memos about incidents and notions of concepts were written down immediately after each interview. Transcripts from the interviews were analysed line by

line, and incidents in data were identified, compared and coded. While analysing the transcribed material and the memos, the constant comparative process served as a guide for theoretical sampling. All the members of the research group read each of the ten interviews and discussed the progressing analysis. The analysis can be illustrated by giving examples of the coding process that established the main categories (Table 1).

In the final phase, a model was constructed based on the categories. A literature review was then performed, used as a further source of data and integrated into the constant comparative process in accordance with classic grounded theory (22).

Results

Based on data from the interviews, a theoretical model was developed describing three phases these women went through to cope with their challenges after experiencing sexual abuse. While daily hassles, daily uplifts and coping strategies are closely intertwined, they have been separated for analytical model building purposes in this study. The results will be presented in terms of a three-phase process based on important turning points in the women's stories: (1) avoiding and escaping—coping after experiencing sexual abuse; (2) accepting and disclosing—starting a process of recovery; and (3) reconciling and repossessing—living with the experience in the present (Fig. 1). The three phases, which are of different lengths, are intended as a conceptual rendering to understand the lifespan trajectory that may follow sexual abuse. The underpinning codes and categories provide an understanding of how the women in this study expressed how they coped with daily hassles through these three phases.

The theoretical core concept 'protecting armor in daily life' provides an understanding of how the women experience and cope with internal and external stressful experiences and stressful memories and thoughts. The protecting armour has two functions, it shuts stressful

Table 1 Illustration of the analysis process from data to the superior category

Quote from interview	Incident	Code	Category	Main category	Superior category
... because if I let it happen... I cannot relate to my story as a story, then it will only be a bad experience that takes over all the time... Hiding under the couch and crying for three days, getting sick, and I refuse. If this had been a disease, I would have been sick for fourteen years, now I have recovered and I will not be ill again.	Choosing not to relate to own story	Shutting in emotions	Avoiding emotions	Coping	'Protecting armor'
I am having trouble with relationships... I spend a very long time before I... dare to open up to people... I can nicely say hello to neighbours and stuff like that but... I will somehow not engage myself in people... I get very frightened, people are creepy...	Having trouble with relationships	Shutting other people out	Avoiding other people	Coping	'Protecting armor'

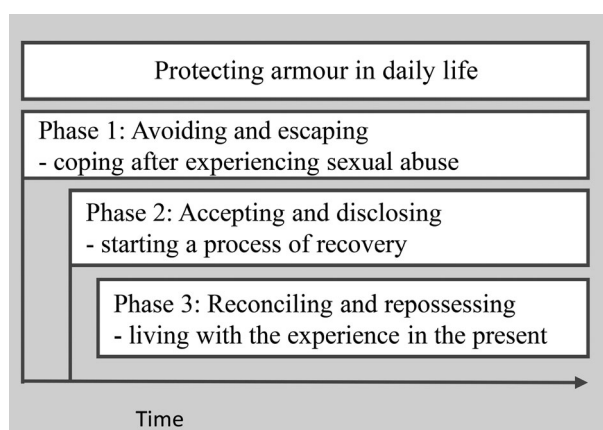


Figure 1 Phases explaining how women experience and cope with daily hassles after experiencing sexual abuse.

thoughts and potential stressful external situations out and it locks stressful memories, thoughts and emotions inside. Protecting armour protects against stressful daily events or hassles often perceived by others as commonplace and normal activity, such as going to the store or taking the bus. These daily activities are appraised as threatening, negative and related to triggers from memories connected to the sexual abuse.

In the following, the three phases are presented in more detail, each with a table showing daily hassles, daily uplifts, coping strategies and stress reactions. The tables in the results section are rich in text and supposed to be self-explanatory and therefore described in less detail here.

Phase 1: Avoiding and escaping—coping after experiencing sexual abuse

The first phase starts from the time the woman experiences sexual abuse and lasts until she tells someone about her experience and feels that she gets help.

As Table 2 shows, daily hassles in this phase arises from trying to deal with what has happened alone. They are overwhelmed by what has happened, try to find protection by ‘shutting their feelings off’, avoid what has happened, and focus on surviving and getting on with their daily life.

Avoiding. Dealing with a ‘stressful inner dialogue’ of thoughts, emotions and memories while not letting others know what has happened and feeling unsafe is overwhelming. A lack of control, lack of safety and trust in others also contribute to this stressful inner dialogue when trying to pursue normal activity. Seeking help for other issues, for various physical and psychological symptoms is common during this phase. Some turn to self-harming, develop an eating disorder or considering suicide, which contributes to even more daily stress. Coping strategies

such as trying to be invisible and avoiding others are also linked to shame. As one participant expressed it;

It’s very much a sense of shame, it is very much anxiety, it is avoidance of situations. There were days I did not want to leave my apartment because I felt that everyone could read on me that ‘she’ has been abused...

Avoiding situations that evoke what happened or doing something to ensure nothing else happens, brings a form of uplift and creates ‘breathing space’. Avoiding the abuser or other potentially threatening people is crucial, and for some women, this leads to isolation and a lonely and limited life.

Escaping. By trying to escape, some women find ways of getting on with their life. Self-blame is common, even among those who were children when the abuse started. The self-blame contributes to not telling others about what has happened. Some find it hard to continue normal activities like education or work. Others have the opposite reaction and try to continue with everyday activities as if nothing has happened. Some women escape by ‘shutting the body off’, distancing themselves from their own body and neglecting symptoms that are related to the abuse.

Phase 2: Accepting and disclosing—starting a process of recovery

The women move into the second phase when realising a need for help and that they have to disclose what has happened to a significant other that hopefully understand and take them seriously (Fig. 1).

As shown in Table 3, stress in daily life at this stage is still dominated by a stressful inner dialogue through triggers and stressful memories. Both triggers and flashbacks seem to increase in intensity in the second phase. Accepting what has happened and disclosing are important steps in starting to deal with experiences related to abuse and finding better ways of coping. The protecting armour in this phase is needed for maintaining control while deciding what to disclose and to whom. In this phase, the women have more knowledge of how to find glimpses of happiness in everyday life.

Accepting. Seemingly normal activities are appraised as stressful and related to memories from the abuse: going out of the apartment; meeting other people, hearing voices that are similar to the abusers; and having to touch others when paying in a store or standing in a queue. However, after many years of daily stress the women realise that they must take hold of their lives by seeking help.

Earlier, I could not go to the mailbox because there were so many triggers out there. However, it is like, you do not have a life when you live between the

Table 2 Phase 1: Avoiding and escaping—coping after experiencing sexual abuse

Daily hassles		Daily uplifts	
Self			
<ul style="list-style-type: none">• Overwhelming triggers (internal memories and/or external events that evoke stress reactions)• Lack of trust• Lack of control• Lack of feeling of safety• Physical and psychological signs/symptoms• Put on a brave face		<ul style="list-style-type: none">• Finding a safe place• Days without abuse	
Family/friends			
<ul style="list-style-type: none">• Excluding family and friends• Lack of support			
Society			
<ul style="list-style-type: none">• Participating in normal activity in daily life			
Coping strategies			
Focus on emotions		Focus on problem solving	
<ul style="list-style-type: none">• Avoiding emotions• ‘Shutting the body off’• Negative self-talk• Escaping by using alcohol, drugs or medication• Having something to do, making plans (escaping your own thoughts)• Taking risks—victim of new violations• ‘Finding ways to hurt oneself’: turning to self-harm, eating disorders, considering suicide, cutting• Making themselves invisible		<ul style="list-style-type: none">• Avoiding/escaping (abuser, family/friends)• Trying to get help but not disclosing the abuse/assault• Striving to maintain a normal life• Seeking help for different symptoms	
Stress reactions			
Physical	Cognitive	Emotional	Social
<ul style="list-style-type: none">• Difficulty relaxing (tiredness, exhaustion, sleep disorders, fatigue).• Using sleeping medication or not wanting to use any medication (afraid of losing control)• Reacting physically to triggers, for example nausea	<ul style="list-style-type: none">• Self-blaming• Existential reflections, living or suicide?• Brooding (ruminate), should I tell someone?	<ul style="list-style-type: none">• Guilt and shame• Not able to feel happiness (Hard to feel joy)• Feeling of being unsafe in everyday life• Feeling of being alone• Irritation and frustration about not being understood• Feeling of constant stress• Low irritation threshold to surroundings (irritability when others demand something of them)	<ul style="list-style-type: none">• Not trusting other people of the same sex as the perpetrator (e.g. all men because a stepfather was the abuser) or of the sex they expected would help them (adult women, foster mother, female teacher)• Nobody knows what has happened—or somebody knows, but they are not helping• Dangerous/reckless behaviour (men, alcohol, drugs)• Not able to do what you used to do

mailboxes and your apartment. It will not work in the end.

Being at ease with and accepting their own body is also an issue for these women because they have struggled with physical and/or psychological symptoms for some time. They have been seeking help for symptoms related to pain, sleeping problems, anxiety and other complaints, but the helpers have not been given or had any information about their trauma experience. This has resulted in trying out different forms of therapy and medication. Trying to find relief through alcohol or drugs is another coping strategy some women make use of.

Putting up façade and maintaining it, also adds to the women's daily stress. Through a growing desire to deal with their stressful daily life, they start to seek help more actively. Up to this phase, most women spend a lot of time deliberating on their own, trying to decide who they should tell, when, the consequences of telling, and so on. Some have been violated again, and re-traumatisation makes it even more difficult to trust others.

Disclosing. Getting support from others is crucial for starting to confront their own stressful inner dialogue. Some have tried telling a relative and been told to keep

Table 3 Phase 2: Accepting and disclosing—starting a process of recovery

<i>Daily hassles</i>	<i>Daily uplifts</i>		
Self			
<ul style="list-style-type: none"> • Tired, exhausted from triggers • Flashbacks when trying to deal with what has happened • Physical and psychological symptoms, distancing from the body • Problems with finances, housing, work, relationships, traumatised children • Maintaining a façade • Guilt and shame 	<ul style="list-style-type: none"> • Escaping triggers • Learning about the mechanisms of why they hurt themselves • Glimpse of happiness (walking the dog, seeing the cats play, nature, helping others) • Experiencing some control • Learning who to trust and that not everybody is an abuser • Getting relief from medication • Talking about the experience (SMISO, health care, family/friends) • Receiving support from other survivors • Meeting people who understand and take you seriously • Attributing blame (learning about oneself) • 'Getting out of the apartment' 		
Family/friends			
<ul style="list-style-type: none"> • Reactions from others when they decide to tell (dealing with anger from loved ones to what has happened). 			
Society			
<ul style="list-style-type: none"> • Not getting the right help 			
<i>Coping strategies</i>			
Focus on emotions	Focus on problem solving		
<ul style="list-style-type: none"> • Opening up • Dealing with emotions • Letting others in behind the façade • Confronting emotions and stress reactions • Self-harming 	<ul style="list-style-type: none"> • Trusting someone • Challenging oneself when it comes to situations perceived as dangerous • Committing to formal and/or informal therapy • Seeking and finding ways other than alcohol, drugs or medication to deal with pain and 'the stressful inner dialogue' • Seeking and finding options besides suicide • Putting life on hold • Seeking help for pain (cannot be seen on X-ray) 		
<i>Stress reactions</i>			
Physical	Cognitive	Emotional	Social
<ul style="list-style-type: none"> • Difficulty relaxing (Tiredness, exhaustion, sleep disorders, fatigue?) • Psychological and physical reactions (anxiety, nausea, vomiting, headaches, pain) • Addiction 	<ul style="list-style-type: none"> • Difficulties with memory and concentration • Difficulty adapting to everyday life • Not being able to control one's thoughts • Filling the day with activity that takes your thoughts away 	<ul style="list-style-type: none"> • Fear of external threats, (anxiety, feeling unsafe) • Symptoms of PTSD • Never having a chance to relax • Glimpse of joy • Alternating between being depressed, lonely and upset • Anger—angry because it happened to you 	<ul style="list-style-type: none"> • Learning who to trust • Attending (trying out) social arenas that feel safe, no demands, music, meeting those who don't know what happened to you

it to themselves and not to tell others. Disclosing then becomes an even greater challenge.

I remember the first time I told...I was 17 when I told a teacher that I had confidence in, the first year of high school...at the end of the year...I fainted because I had not eaten for a long time and things like that. So she drove me home from school...she said that if there was anything I wanted to talk about, she would listen. She knew that there was something.

Disclosing their story is a major turning point and a first step towards recovery. As they begin to get help from professional helpers, friends or family, they learn about themselves, how, and why they react as they do in certain situations, and why they struggle both physically and psychologically. Confronting their own emotions is sometimes painful and exhausting. Despite the fact that it is exhausting to tell, it can also be positive and a breathing space to be able to tell about their experiences.

Phase 3: Reconciling and repossessing—living with the experience in the present

In the third phase, reconciling and repossessing conceptualises the strategies used to cope with daily hassles in the present. In this phase, the women have the ability to recognise stressful moments and better understand how to handle them. They are now in a phase where they need to resume ordinary everyday activities. The need for 'protecting armor' is still present (Table 4).

Nevertheless, at this stage the women are increasingly able to come to terms with what has happened, including attributing blame and starting to take back control and opportunities that have been lost along the way. Repossessing involves rekindling the possibility of having a normal life in the future. It also becomes apparent that something is lost and this becomes a source of sorrow in their life or creates feelings of unresolved anger.

Reconciling. Having to reconcile themselves to how life had turned out, represents a partial defeat for some women, but it is also a recognition of their own strength as survivors. Some women consider starting to work again. Others who are reaching retirement, see this as both a positive and somewhat negative phase—positive because they are tired of struggling and looking forward to retiring. Negative because of wishes such as having a career or becoming a parent turned out to be impossible. Daily hassles in this phase are still triggers, as one woman explained:

I think over time there are less triggers, less annoyances...because everything's been a lot worse before... but I'll never have a trigger-free or completely emotional free life then...I've had, pain in my body in all these years, more or less pain in my arms and legs and neck...

Reconciling is also linked to coping with bodily issues. The women described having chronic physical illness after years of avoiding and later trying to deal with what has happened, explaining that 'something has set itself in the body'. Problems with finances, housing, work, and relationships, traumatised children and threats from former abusive partners are a part of the daily hassles in this phase.

The women have tried numerous kinds of formal and informal therapy and treatments over a number of years. As a result of this effort, most of the women have found someone or some kind of therapy or treatment that they find helpful.

Repossessing. Having identified some kind of help and support, the women are able to deal more actively with their memories and the consequences of sexual abuse. Taking back what is lost is a key motivation for

continuing to fight. Repossessing by trying to challenge fears, remaining triggers, characterises this phase.

It's still problematic for me to encounter people on the bus that smell of alcohol...so that's why I'm not going out. I have simply trouble with people who drink alcohol, which is hard to avoid if you go out... I do not avoid going on the bus or going to meet girlfriends at the café, but I do not go to parties...I have not come back in everyday life.

Knowing oneself better and having more energy contributes to more active planning of positive experiences. Daily uplifts in this phase are having activities that give joy, meaning or breathing space. For those who have been in a violent relationship, being able to make decisions about their own life and making their own choices is a positive experience.

Repossessing is also about making daily life better by being able to help others in the same situation. Gaining motivation from and finding daily uplifts in music, painting, writing or being in nature, also helps some of the women to keep fighting for their recovery.

I started with, now I'll try to paint it as dark as it is possible...the task I asked myself, to know about it, visualize it, what I constantly try to get away from... it was not easy, I continued for a while...in that picture, then it became like a glimpse of hope...it was not possible to paint only the nasty or what would be threatening...this has been very good for me.

Being proud of having survived, attributing blame and choosing not to be a victim all come after finding inner strength and gradually taking back some control in daily life.

Discussion

The aim of this study was to gain a deeper understanding of how adult women experience and cope with daily hassles after experiencing sexual abuse.

Analysing the retrospective narratives, allowed us to develop a model illustrating three phases: (1) avoiding and escaping—coping after experiencing sexual abuse; (2) accepting and disclosing—starting a process of recovery; and (3) reconciling and repossessing—living with the experience in the present. Each phase represents a turning point and includes common features in the narratives of experiencing and coping with daily hassles. The need for protection after experiencing abuse indicates how the women resolved their main concern. The duration of each of the three phases for each individual, illustrates individual differences within this framework. According to Phanichrat and Townshend (25), traumatic experience of abuse may surface and resurface and requires a variety of strategies. Draucker (26) found that personal factors such as

Table 4 Phase 3: Reconciling and repossessing—living with the experience in the present

<i>Daily hassles</i>	<i>Daily uplifts</i>		
Self	<ul style="list-style-type: none"> • Having activities that give joy or meaning (music, hockey, nature, work) • Confronting triggers and learning how to live with them • Making one's own decisions (those who have been in a violent relationship) • Making one's own life choices • Finding inner strength and resources • Humour • Planning for positive experiences • Having energy for activities formerly enjoyed • Having some control in everyday life • Feeling some degree of safety in everyday life (safe place, being in the nature, house pets, family, coworkers, work) • Embracing positive challenges and activities like sporting events, travelling abroad, music concerts • Helping others 		
<ul style="list-style-type: none"> • Remaining exhausting triggers (flashbacks—not as often as before, but still there; but they understand why they have them) • Lack of energy • Regrets • Tired of being angry • Problems with finances, housing, work, relationships, traumatised children • Body issues • Chronic physical and psychological symptoms, chronic symptoms (pain)—‘something has set itself in the body’ • Self-harming • Experiencing threats 			
Family/friends			
<ul style="list-style-type: none"> • Expectations from others to get on with your life, education, work 			
Society			
<ul style="list-style-type: none"> • Having to relate to other people 			
<i>Coping strategies</i>			
Focus on emotions	Focus on problem solving		
<ul style="list-style-type: none"> • Returning to self • Forgiving or not • Rumination 	<i>Taking back</i> <ul style="list-style-type: none"> • Confronting those to blame. • Striving for a normal life • Positive reappraisal • Finding other ways to avoid hurting themselves or finding those who motivate them (someone they look up to) • Reclaiming wishes and dreams • Avoiding alcohol and drugs—take away control and remind about the abuse or assault 		
	<i>Finding motivation/meaning making through:</i>		
	<ul style="list-style-type: none"> • Music • Painting • Writing • Helping others 		
	<i>Reconstructing/learning</i>		
	<ul style="list-style-type: none"> • Formal and informal therapy • Achieving acceptance • Helping oneself <ul style="list-style-type: none"> ◦ Looking ahead 		
<i>Stress reactions</i>			
Physical	Cognitive	Emotional	Social
<ul style="list-style-type: none"> • Less tiredness, exhaustion <ul style="list-style-type: none"> ◦ Still some difficulty relaxing ◦ Some sleep disorders • Fewer triggers and fewer reactions to triggers and tools to handle triggers when or if they appear <ul style="list-style-type: none"> ◦ Chronic health issues; pain; different diagnoses like fibromyalgia, anxiety, depression 	<ul style="list-style-type: none"> • Difficulty adapting to everyday life • Remaining difficulty concentrating but being better at finding rest and ‘charging the batteries’ • Learning how to live with reduced cognitive abilities (mobile alarm) • Questioning one's ability to ever have a normal life 	<ul style="list-style-type: none"> • Fear of external threats • Depression • PTSD • Expectations from others to get on with one's life • Feeling of emptiness • Alternating between being depressed, lonely and upset and feeling pride at being a survivor • Still having an alert state (preparedness in the body) • Tired of being angry • Angry on behalf of other abused women or traumatised children 	<ul style="list-style-type: none"> • Struggling to start new relationships • Difficult being among others in a social setting (triggers) • Come to terms with living on their own • Come to terms with not becoming a parent

personal agency, personal resolve and a commitment to transcend the abuse, as well as contextual factors enabled movement from one stage to the next. The need for some form of 'protecting armor' to cope with daily hassles is an interesting finding. Initially, the focus was mostly on avoiding and escaping as coping strategies. Avoidant coping strategies are also reported as a major theme by Phanichrat and Townshend (25).

The stress of everyday life was dominated by memories of the abuse, lack of trust, lack of control and lack of a sense of safety. This daily stress had a major impact on everyday activities that had not been perceived as stressful prior to the abuse. The daily hassles changed over time, but remained to some degree through all three phases. In the current study, stressful memories manifesting in a 'stressful inner dialogue' is a key source of daily hassles.

The importance of ongoing support was a significant issue in this study, as the consequences of lacking support. Draucker (26) identifies four stages that structure healing from childhood sexual abuse (CSA): (i) grappling with the meaning of CSA, (ii) figuring out the meaning of CSA, (iii) tackling the effects of CSA and (iv) laying claim to one's life. These stages bear a resemblance to the phases we identified, starting with a lonely inner process of trying to understand what has happened and gradually taking back more control in daily life. In this study, we found that disclosing and seeking support is one of the most important steps on the road to recovery. Other studies have also shown that disclosing abuse represents a pivotal moment, a turning point, and is part of a healthy process of coping (25, 27). Spangaro et al. (28) found that women disclosed their abuse after making active judgments about safety on three dimensions: from the abuser, from shame and from relinquishing control. Losing, relinquishing and regaining control are important factors that are also present in the three stages in our model.

This study shows that being able to recognise, seek out and actively stimulate daily uplifts can be an important factor for coping with daily hassles. Daily uplifts are scarce in the first phase, but increase over time and become easier to recognise. In a similar vein, Phanichrat and Townshend (25) also suggest the importance of a positive attitude, and hope in particular, which may underpin a turning point and facilitate the process of seeking support, positive cognitive engagement and acceptance.

Being able to recognise and stimulate uplifts can be an important step towards recovery. One surprising finding was that some activities, like going to a hockey game with lots of triggering factors, were considered to be a positive experience, although only in the final phase. During the first and the second phases, such activities were for most of the women perceived as stressful.

The literature review, performed after the model on protecting armour in daily life was formulated, revealed lack of research on how adult women who have experienced sexual abuse deal with hassles and uplifts in daily life. We suggest that the model of protecting armour in daily life adds new knowledge and can contribute to a greater understanding of the everyday life situation of women who have experienced sexual abuse.

We will now turn to some methodological issues. The participants in this study are a select group, recruited from SMISO in Norway. In this study, we look at a very diverse group in terms of trauma intensity and duration and of whether the perpetrator was someone they knew or not. This variation is in agreement with the grounded theory method (22). All the women had been exposed to severe sexual abuse, one or several times in their life. Therefore, we suggest that our result has trustworthiness for those who have experienced severe abuse. At the time of the interviews, the participants were in either phase two or three since they all had disclosed their abuse story (Fig. 1). Although the participants represent a select group, the diversity of their experience (age at onset, known or unknown perpetrator) could be considered a positive aspect, which hopefully contribute to a broader perspective on the phenomena. It is important to note that recruiting participants who had experienced less severe sexual abuse and using other means and sources of recruitment could have given other perspectives and is recommended for further studies.

The participants meet the characteristics of women who are more vulnerable, report poorer self-perceived health, and have more negative health effects after exposure to violence (6). Draucker (29) found that although the risk of lasting harm stemming from participation in trauma research is a legitimate concern, the benefits of confiding a traumatic experience to a trustworthy other seem to outweigh the immediate distress that accompanies discussion of painful experiences. In this study, the feedback was that the opportunity to reflect on how their life had been affected was both positive and difficult but nevertheless worthwhile. Being involved in supporting other survivors has also been shown to be important for many women who have experienced sexual abuse (25, 30, 31). This is also in line with our findings.

From 2 to 57 years had passed since the participants in this study experienced sexual abuse for the first time. The amount of time passed between the first instance of sexual abuse and the interview could be considered a weakness of this study. On the other hand, the participants placed a lot of emphasis on the course their life had taken, after experiencing sexual abuse and their narratives were rich in detail.

For most of the participants in this study, the abuse began at an early age. It is therefore important that health professionals who meet children, adolescents and

adults have knowledge of the signs and reactions connected with sexual abuse. Other authors have also emphasised knowledge about the consequences of abuse (9). Helping women who have experienced abuse, requires not only treating the physical damage, but also evaluating the particularities of the experience's emotional impact on each woman and its psychosocial repercussions (32). The findings in this study show that despite the fact that daily hassles, daily uplifts, and coping strategies change over time, disclosing and getting help is an important factor for preventing negative consequences. The model of protecting armour may serve as a tool to help other women who have had similar experiences reflect about their situation.

Conclusion

The developed model of protecting armour in daily life, includes the three phases: (1) avoiding and escaping—coping after experiencing sexual abuse; (2) accepting and disclosing—starting a process of recovery; and (3) reconciling and repossessing—living with the experience in the present. The model demonstrates the complex process women who have been exposed to sexual abuse can face in daily life. The model illustrates the process of coping, daily hassles, everyday uplifts and stress reactions, characteristic for the target group. Our results highlight that disclosure and social support are pivotal and contribute to less daily stress, more daily uplifts and better coping strategies. The model of protecting armour in daily life can

be used as a basis for future studies and intervention in the research field. More research is needed to understand and meet the need of women exposed to sexual abuse.

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Author contributions

All authors have made substantial contribution to the article. Marianne Torp Stensvehaugen collected and analysed data, wrote the initial draft of the manuscript and was involved in revising the manuscript. Berit A. Bronken and Lars Lien participated in data analysis and were involved in revising the manuscript. Gerry Larsson conceived the initial design of the study, participated in data analysis and was involved in revising the manuscript.

Ethical approval

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Paper II

**Association of Daily Hassles, Uplifts, Coping Strategies, and Stress-Related Symptoms
among Female Survivors of Sexual Abuse – a Cross-Sectional Study**

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Abstract

Research on violence against women has found that women who experience physical or sexual violence report poor self-perceived health. Knowledge of daily hassles, daily uplifts, and coping strategies, as well as how these factors can affect health and well-being among survivors of sexual abuse, is important for healthcare professionals. The aim of the current study was to explore the association of daily hassles, daily uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse. A group of female sexual abuse survivors ($n = 57$) was recruited from nine support centers in Norway. Participants completed a questionnaire that addressed demographics, socioeconomic conditions, trauma history, daily hassles, daily uplifts, coping strategies, and stress-related symptoms. Two groups of participants were compared: one (favorable profile) that had above-median scores on uplifts and adaptive coping strategies and one (unfavorable profile) that had above-median scores on daily hassles and maladaptive coping strategies. Results indicate that women in the unfavorable profile group reported significantly more stress-related symptoms, and particularly emotional symptoms, than women in the favorable profile group. Four of the ten identified differences between groups remained significant after Bonferroni correction. There were few differences between the two groups related to socioeconomic conditions and trauma history. The results indicate that women in both groups struggle with stress-related physical, emotional, cognitive, and target-group-specific symptoms. However, high incidence of daily hassles and use of maladaptive coping strategies were associated with an increase in stress-related symptoms. It may be helpful to focus on altering maladaptive coping strategies to reduce stress-related symptoms among sexual abuse survivors.

Keywords: Adaptive coping strategies, cross-sectional, daily hassles, maladaptive coping strategies, sexual abuse, stress-related symptoms, daily uplifts, women

Introduction

Violence against women is a global public health concern (1). According to the World Health Organization, 30% of women worldwide have experienced physical and/or sexual violence from an intimate partner (1). Sexual abuse is defined as any sexual act to which the victim has not consented or for which they have been pressured or manipulated (2,3). Survivors of sexual abuse often experience heightened feelings of vulnerability, report poor self-perceptions of health, and experience negative long-term health effects (4-8). Adults who have been sexually abused are at a heightened risk for conditions across several organ systems, including pain-related complaints (e.g., pelvic pain, headache) and conditions such as irritable bowel syndrome, non-epileptic seizures, chronic fatigue syndrome, chronic pelvic pain, respiratory dysfunction, and fibromyalgia (6,7,9). For some women, the experience of sexual abuse can also lead to unhealthy lifestyle choices such as smoking, alcohol or drug use, and risky sexual behavior (8,10-12).

Women who have experienced sexual abuse often seek help from health care services for reasons other than the trauma, and many choose not to disclose their experiences related to sexual violence (5). Hiding one's emotions may cause added stress and lead to maladaptive coping mechanisms (8,13-15). For example, Kennedy and Prock (16) have found that severe abuse and subsequent maladaptive coping were associated with feelings of self-blame and shame. Knowledge of the numerous health consequences of sexual abuse is important to equip survivors with information that will reduce their risk of re-victimization (4, 6). Prior research has found that "women's sociodemographic conditions may function as potential risk factors for and consequences of victimization" (17). According to Byrne, Resnick (17) victimization seems to increase the risk in adulthood for unemployment, reduced income and divorce. Fergusson, McLeod (18) found that increasing exposure to child sexual abuse was associated

with socioeconomic consequences in early adulthood, such as “leaving school without qualifications, welfare dependence and lower gross personal income”.

Coping is defined as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (19). Each individual’s degree of adaptiveness is situation-specific, which makes general measurement approaches difficult. However, recurring patterns of coping strategies do seem to exist, and therefore such measurements are meaningful (20). The present study draws on this perspective to attempt to measure coping strategies related to sexual abuse. “In any stressful encounter, on average, people use almost all coping strategies available to them” (21). These coping strategies are based on experience and what seems useful at the time. A stressful encounter such as experiencing sexual abuse is a complex process, because of the threatening elements of the situation (21). Strategies that allow a person to cope with stressors through personal growth, optimism, or solution-focused actions are considered beneficial and are referred to as adaptive coping strategies (22). Conversely, strategies such as engaging in denial or self-criticism are considered harmful and are referred to as maladaptive coping strategies (22).

Female survivors of sexual abuse often experience several “daily hassles,” defined as the vast array of demands and conditions in everyday life that are perceived as irritating, frustrating, or stressful and that force the individual to take action (3,23-26). Daily hassles experienced by adult female survivors of sexual abuse may include triggers (e.g., smells or sounds linked to memories from the abuse), lack of energy, economic challenges, housing- or work-related challenges, and issues related to self-harm (3,8).

“Daily uplifts,” a counterpart to hassles, can support the process of coping with stress by offering “breathers” from regular stressful encounters, sustaining coping activity, and supporting individuals who are recovering from harm and loss (8,24). Uplifts experienced by

adult female survivors of sexual abuse may include planning for positive experiences, participating in activities they had formerly enjoyed, and experiencing control in their daily lives (3, 8).

Stress appraisals, coping processes, and experiences of psychological stress symptoms following traumatic events vary widely based on an individual's characteristics, resources, situational, and contextual factors (8,21). Smyth et al. claim that individual emotional and cognitive responses to daily stress shape health behavior decisions and daily enactment (27). "Stress response are distinguished by the magnitude (reactivity), persistence (magnitude and/or length of recovery) and frequency (pile-up) of stress responses" (27). Accumulated over time, these responses may result in long-term negative health outcomes (27). Additionally, stress-related symptoms may serve as early warning signs of stress-related diseases, which often take a long time to develop and/or manifest. Studying the daily hassles, uplifts, coping strategies, and stress-related symptoms of women who have experienced sexual abuse can help to explain the long-term consequences of traumatic events on health outcomes (28).

Knowledge of stress-related physical, emotional, and cognitive reactions is useful for understanding short-term or transitory health consequences of events (28-31). Prior studies have focused on additive symptoms scales (7,32,33); however, little research has explored the individual symptoms that afflict women who have experienced sexual abuse. Such research should focus on specific coping strategies used following sexual abuse, as well as survivors' cognitions and perceptions, to fully describe the recovery process (31).

The existing research on health consequences of traumatic experiences has focused on issues such as long-term sick leave due to stress-related disorders (34), depression following interpersonal trauma (35), daily stressors and physical symptoms among college-aged women with a childhood history of sexual abuse (36), and daily hassles following military duty (37).

Research has found that women with a history of sexual abuse experiences may be “susceptible to the effects of heightened daily stress and may display this susceptibility in the report of more physical symptoms” (36). In addition, Fergusson, McLeod (18) found that those who experienced early sexual abuse reported more doctor/hospital contacts in early adulthood, due to physical health. Eslami, Di Rosa (38) also found a positive association between the experience of abuse during a lifetime, in older women, and the reporting of higher levels of somatic symptoms. In a prior study we focused on the relationship between emotional stability, daily hassles, and post-traumatic stress disorder. However, few studies have focused on the impact of daily hassles, daily uplifts, and coping strategies for addressing stress-related symptoms following sexual trauma (8,36).

The aim of the current study was to explore the association of daily hassles, daily uplifts, coping strategies, and stress-related symptoms among female survivors of sexual abuse. The study examines two hypotheses. *Hypothesis 1*: Daily hassles and maladaptive coping strategies are associated with a high frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms. *Hypothesis 2*: Daily uplifts and adaptive coping strategies are associated with a low frequency of stress-related physical, emotional, cognitive, and target-group-specific symptoms.

Method

Participants

Participants were recruited from a network of Norwegian support centers for victims of incest and sexual abuse (Nok center, before 2020, Center against incest and sexual abuse (SMISO) referred to as “the support center” throughout the text) (3,39). The support centers are selfhelp services for adult survivors of incest and sexual abuse and provide opportunities for counselling and aiding with the consequences of trauma experiences (40).

The inclusion criteria were female adults (>18 years) who understood Norwegian, had experienced sexual abuse at some time in their life and had used the services of one of the support centers (3). The research team contacted 17 of the 22 support centers in Norway. Nine support centers agreed to participate in the data collection. These nine support centers were geographically varied and represented both large cities and small towns in Norway. Agreements were made with the support center leaders to establish a contact person at each center who would distribute study information to individuals who came to the center. The study was advertised through leaflets, social group meetings, and the support center Facebook page. Women who were eligible to participate received an information letter from the support center that explained the goals of the study and statements regarding the voluntary and anonymous nature of participation (3). If they wanted to participate, the women contacted the designated person at the support center who offered an electronic anonymous link to the survey. The participants gave their informed voluntary consent to participate by answering the questionnaire. Initially, an electronic questionnaire was used. Based on feedback from the support center staff, some of the women were hesitant to answer the survey online. Therefore, a paper-based questionnaire option was also provided. The questionnaire took approximately 45 minutes to complete (3).

During the planning phase, the estimated sample size was set at 100 participants. The recruitment process went slow, and only 57 completed the survey. The committee for medical and health research ethics in Norway does not allow collection of data about reasons for persons who do not consent to participate in research. Tentative reasons for the problems with recruitment may be rival studies at the time, and that more than half of the inquiries to support centers are telephone inquiries, and not attendance at the support center according to statistics from The Norwegian Directorate for Children Youth and Family Affairs (39). Information

regarding the total number of potential participants is unavailable, due to anonymous participation at these centers (3).

The study sample ($n = 57$) of female survivors of sexual abuse had a mean age of 41.4 years ($SD = 11.6$; range: 19 – 69 years) (3). Most of the participants were ethnic Norwegian (93%) (3). The participants reported their highest level of education, which included primary school ($n = 14$), high school ($n = 17$), or a university college or university degree ($n = 26$). (3).

Data collection and Measures

Data were collected from February–October 2018 (3). The current study, focused on stress-related symptoms, was based on a previous qualitative study of the ways in which survivors of sexual abuse cope with daily hassles (8). The qualitative study resulted in the development of a questionnaire that includes validated and newly constructed items. The questionnaire items used in the present study cover the following six areas: (1) demographic and socioeconomic variables; (2) experiences of sexual trauma; (3) daily hassles during the last month; (4) daily uplifts during the last month; (5) coping strategies during the last month; and (6) stress-related symptoms during the last month. Measurement for these areas relied on a combination of established scales and newly constructed items based on the qualitative study findings (8). Detailed information regarding the constructs, their origin, scoring, and reliability is provided in Table 1.

[Table 1 near here]

Analyses

Defining an unfavorable and favorable group

Two profile groups were utilized for the study, a favorable group and an unfavorable group, and these groups were created through the following steps. First, a positive aspects variable was created by adding the Daily uplifts scale and the Adaptive coping scale. Similarly, a negative aspects variable was created by adding the Daily hassles scale and the Maladaptive coping scale. Next, the Positive aspects and Negative aspects variables were median dichotomized. Then, four profiles were created using these median-dichotomized variables:

Profile 1 ($n = 19$, “favorable”): above the median on Positive aspects and below the median on Negative aspects; Profile 2 ($n = 19$, “unfavorable”): below the median on positive aspects and above the median on negative aspects; Profile 3 ($n = 10$): above the median on positive and negative aspects; and Profile 4 ($n = 8$): below the median on positive and negative aspects.

One participant was not included in any of the profile groups due to missing data. The subgroup comparisons involving Profile 1 (favorable) and Profile 2 (unfavorable) yielded the clearest results; thus, the Results section of this paper is based on findings from these two groups.

Statistical analyses were conducted using the Statistical Package for Social Sciences (SPSS) version 24. Summary indices were computed for each of the instruments mentioned by adding the raw scores of the items that belonged to each scale, then dividing the total by the number of items (3).

Many of the questions regarding the type of sexual abuse experienced had several Yes/No response choices so that more than one response could be chosen. However, few participants selected multiple Yes/No options. Thus, in cells with an expected count of less than five,

Fisher’s exact test was used (3).

Correlation analyses were performed to examine the relationships between the variables of daily hassles, daily uplifts, adaptive coping strategies, maladaptive coping strategies, and each group of symptoms. Multiple regression analyses were performed using each of the following variables as predictor: daily hassles, daily uplifts, adaptive coping strategies, and maladaptive coping strategies. The outcome variables included physical symptoms, emotional symptoms, cognitive symptoms, and target-group-specific symptoms. Conventional descriptive statistics were computed, and subgroup comparisons were performed using χ^2 , including Fisher's exact test, Kruskal-Wallis' one-way analysis of variance by rank, and Mann-Whitney *U*-tests (3). A Bonferroni correction was calculated to counteract the effect of multiple comparisons in a small sample size ($n = 57$). A Bonferroni corrected alpha level of $p < .0015$ was considered statistically significant. Additionally, Cohen's *d* was computed to assess the effect size (44).

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki (45), and the methodology was approved by the Norwegian Centre for Research Data (15.12.2017, 47920 / AGL). Participants were informed that they could withdraw from the study at any time for any reason with no negative consequences, in accordance with the principles of The Norwegian National Committee for Medical and Health Research Ethics (3,46). To ensure participant anonymity on the Internet, each participant was assigned a username and password. Only the recruiters at each support center had access to personal information about the participants. Participants were offered an opportunity to talk with a counselor at the support center after answering the questionnaire (3). Each participant consented to participate in the study by responding to the questionnaire. After the completion of the study, the data from the survey has been anonymized.

Results

Demographic and socioeconomic characteristics

The mean age of the favorable profile group was three years greater than the mean age of the unfavorable profile group (favorable: mean age = 43 years, $SD = 2.48$, range = 23–69 years; unfavorable: mean age = 40, $SD = 2.98$, range = 24–63 years); however, this difference was not statistically significant ($p = .441$). The majority of the women in both groups were born in Norway (favorable: $n = 17$; unfavorable: $n = 18$), and the majority had lived in Norway for more than ten years (favorable: $n = 18$; unfavorable: $n = 19$). The remaining demographic and socioeconomic data are based on participant responses to eight questions (see Table 2).

[Table 2 near here]

Only three comparisons, between the favorable and unfavorable groups yielded statistically significant differences ($p < .05$). These three comparisons were educational level ($p .016$), social network ($p .022$), and current home ($p .046$). As Table 2 illustrates, the women in the favorable group were more likely than those in the unfavorable group to report College/University education as their highest educational degree. Conversely, women in the unfavorable group were more likely than those in the favorable group to report High School as their highest level of education.

Another statistically significant difference between the profile groups related to social network/close relations. The women in the favorable group were more likely than those in the unfavorable group to report that they had more than two close relations in their social network whom they could rely upon or contact if they had any problems.

Additionally, the majority of the women in the favorable group owned their own home, whereas several participants in the unfavorable group reported renting a home. However, after

Bonferroni correction ($p < .0015$), none of the sociodemographic comparisons remained significant.

Sexual trauma-related characteristics

Based on Norwegian legal terms, all of the study participants in both profile groups had experienced severe sexual abuse. Many of the survivors in both profile groups had experienced sexual abuse before age 12 (favorable group: $n = 12$, mean = 1.89, $SD = 1.24$; unfavorable group: $n = 17$, $M = 1.21$, $SD = 0.63$). Some women in each group had experienced sexual abuse for the first time when they were 13–17 years old (favorable group: $n = 4$; unfavorable group: $n = 2$). Only the survivors in the favorable group ($n = 3$) had experienced sexual abuse for the first time as an adult.

[Table 3 near here]

The majority of participants reported that they knew their abuser. In most cases, the abuser was an adult male (favorable: $n = 16$; unfavorable: $n = 15$). In some cases, the abuser was a male younger than 18 (favorable: $n = 9$; unfavorable: $n = 10$). Some participants in each profile group had an adult female abuser (favorable: $n = 3$; unfavorable: $n = 3$), and a small number of participants in each group reported that their abuser was a female younger than 18 (favorable: $n = 1$; unfavorable: $n = 2$). The differences between the two profile groups' responses to the trauma-related questions were not statistically significant. The Cohen's d calculation indicated a small effect size on type of sexual trauma (see Table 3).

Correlation and multiple regression analyses of daily hassles, daily uplifts, coping strategies and stress-related symptoms

Bivariate correlations were computed for the total sample ($n = 57$) between daily hassles, daily uplifts, stress-related symptoms (physical, emotional, cognitive, and target-group-specific), and the two coping scales (see Table 4). The results indicate that all correlations were in the expected direction; additionally, 23 out of the 28 identified correlations were statistically significant ($p < .05$).

[Table 4 near here]

Daily hassles and maladaptive coping strategies were positively correlated, and both scales had strong positive associations with the symptom scales. Daily uplifts and adaptive coping strategies were positively correlated and had negative associations with the symptom scales. After Bonferroni correction, 15 of the 28 correlations remained significant ($p < .001$).

Multiple regression analyses were conducted to examine the relationship between physical, emotional, cognitive, and target-group-specific symptoms and the predictor variables of daily hassles, daily uplifts, adaptive coping strategies, and maladaptive coping strategies (see Table 5).

[Table 5 near here]

As Table 5 illustrates, the predictor variables explained 51% of the variance when emotional symptoms were used as the outcome variable. The corresponding amount of explained variance was 31% for physical symptoms, 43% for cognitive symptoms, and 40% for

targetgroup-specific symptoms. Daily hassles had significant regression weight ($p < .002$) on each of the symptom scales. Maladaptive coping strategies had significant regression weight ($p < .002$) on the emotional symptoms scale.

Individual stress-related symptoms

The symptom data consisted of four indices: physical, emotional, cognitive, and target-group-specific symptoms. In total, 29 comparisons were made between participants in the favorable and unfavorable profile groups. Statistically significant differences ($p < .05$) were found in 18 of the scales, and the participants in the favorable profile group consistently reported fewer symptoms than the participants in the unfavorable group. However, after Bonferroni correction only two of the original emotional variables (“powerlessness/hopelessness” and “depressed/feeling low”) and the two newly constructed emotional variables (“felt shame” and “felt guilt”) remained significant.

Discussion

The present study aimed to examine whether daily hassles and maladaptive coping strategies were associated with a high frequency of stress-related symptoms for survivors of sexual abuse. The second aim of the study was to determine whether daily uplifts and adaptive coping strategies were associated with a low frequency of stress-related symptoms for survivors of sexual abuse. The results indicate that a high incidence of daily hassles and maladaptive coping strategies was associated with an increase in experiences of stress-related symptoms. These results support the study hypotheses and are consistent with existing research findings that the aftermath of sexual abuse is associated with negative consequences for both physical and psychological health (36,38,48,49). Use of adaptive coping strategies and frequent experiences of daily uplifts were associated with a decrease in the frequency of

stress-related symptoms. Despite this finding, participants in the favorable profile group reported struggles with muscle tension, being tired, forgetting things easily, and other discomfort-related triggers.

Daily hassles, daily uplifts, coping strategies, and stress-related symptoms

A strong correlation was found between daily hassles and stress-related symptoms. The women who experienced a high frequency of daily hassles and used maladaptive coping strategies reported more pain-related symptoms than other study participants. In a review of the existing literature, Nelson, Baldwin (9) found that people who had early experiences of sexual abuse had a heightened risk of suffering from physical symptoms across several organ systems, including gastrointestinal, gynecological, neurological, upper respiratory, and chronic pain symptoms. This review also found that the presence of medically unexplained symptoms was often related to some form of somatic translation of emotional distress, such as anxiety, depression, or panic disorder. The present study results indicate that women in the unfavorable profile group struggled with a diversity of stress-related symptoms, many of which led to challenges in daily life. Over time, struggling with physical pain may lead to difficulties with relaxing and sleeping (48,50).

Two of the target-group-specific items—guilt and shame—may explain why stress-related emotional symptoms and unfavorable coping strategies contribute to social isolation. Kennedy and Prock (16) found that abuse severity and maladaptive coping strategies were associated with self-blame and shame. The present study findings align with these results, and guilt and shame may be two factors that contribute to individuals in the unfavorable profile group experiencing more difficult struggles than those in the favorable profile group.

Some individuals cope better than others under the same stressful circumstances. In the present study, both groups had experienced severe sexual abuse. However, women who used adaptive coping strategies and experienced more daily uplifts reported a lower burden of

stress-related symptoms, as well as less guilt and shame, than their peers in the unfavorable profile group. Experiences of fewer daily hassles and more daily uplifts, as well as use of favorable coping strategies, may, in line with Smyth, Sliwinski (27), result in lower stress reactivity, improved stress recovery and fewer stress pile-ups. The present results suggest that individuals in the favorable profile group also experience struggles; however, their struggles are less severe than those in the unfavorable profile group.

The present study results indicate a correlation between maladaptive coping strategies and emotional symptoms. The women in the unfavorable profile group used more maladaptive coping strategies, experienced more guilt and shame, and reported more symptoms of depression and powerlessness, than their peers in the favorable profile group. These results support prior findings that self-blame, shame, and negative social reactions are linked to poor outcomes, such as physical and psychological distress, dysregulation, and maladaptive coping strategies among survivors of child sexual abuse, sexual assault, and interpersonal violence (16). Therefore, it may be effective for afflicted individuals and healthcare personnel to focus on reducing the use of maladaptive coping strategies among survivors of sexual abuse.

Trauma-related aspects, demographics, and socioeconomic factors

Few significant differences were identified between the two profile groups regarding trauma experiences and the nature of victimization. The female survivors in the current study had all experienced severe sexual trauma, and most of these experiences had occurred in childhood. The lack of difference in the sexual abuse scales could possibly be attributable to a statistical ceiling effect in the between-group analyses. Participants' demographic and socioeconomic data revealed few significant differences between the groups in the present study. This is in

line with Font and Maguire-Jack (51) who found that childhood experiences of physical, emotional, and sexual abuse were not mediated by socioeconomic status.

Strengths and limitations

A strength of the study is that the recruited participant group included severely traumatized women. It is uncertain whether this group could have been successfully reached using other recruitment strategies (3). The present study is one of the first to develop and test contextspecific questions regarding daily hassles, daily uplifts, and stress-related symptoms among female survivors of sexual abuse (3,8).

The current study is descriptive; therefore, associations can be observed but assumptions cannot be drawn about the causal directions of these relationships. Participant non-response is a problem that may have biased the outcome measures. Many women choose not to talk about their trauma and are therefore difficult to recruit for studies (3,52). The study sample represents a group of survivors who received support and counseling. The results indicate that many of these women struggled with stress-related symptoms; however, it is notable that the recruited participant sample may include the healthiest of sexual abuse survivors (3).

The study sample size was small, which limits the generalizability of the findings. A Bonferroni correction was used to account for the small sample size. It is possible that the inclusion criteria were too strict. Participants were recruited from support centers that have had a recent increase in requests for research participation; this trend may explain why some women may have hesitated to participate in the study. Participants were able to respond to the questionnaire both electronically and by mail; however, the response rate was persistently low (3).

The study sample consists of female survivors of sexual abuse, most of whom are Norwegian; therefore, the results are not generalizable to women from other countries or cultures (3). Participants were asked about past exposure during the one month preceding the survey, which could have resulted in recall bias (3).

Moreover, survey respondents tend to answer questions in a favorable manner, which can lead to a social desirability bias (3). In this case, it is difficult to determine whether the participants may have over-reported “good behavior” or under-reported “undesirable behavior.” Feedback from the study recruiters indicates that the survey questions were relevant. However, it was time-consuming to respond to the survey.

Research implications

In addition to considering the frequency of stress-related symptoms, future research should focus on understanding the subjective degree of importance that such symptoms have in trauma survivors’ daily lives. There is also a need for research to distinguish the experiences of different groups of survivors of sexual abuse, such as those who experienced abuse in childhood and in adulthood or those who experienced a single incident of sexual violence and those who had repeated and long-lasting traumatic experiences. These research directions would help to clarify the effect of daily stress on health outcomes. Ideally, group comparisons could be replicated among large populations of female sexual abuse survivors across different cultures. Future research should also assess interventions that address stress-related symptoms, social support, and emotional problems, as well as the impact of altering maladaptive coping strategies to promote recovery among survivors of sexual abuse.

Implications for practice

Given the high proportion of individuals who report experiences of interpersonal trauma, health professionals are likely to encounter patients who have a history of trauma (3). Prior research has emphasized that health professionals must acknowledge the impact of both early and long-lasting trauma experiences on psychological and interpersonal functioning to properly evaluate and provide treatment that addresses the survivors' needs (52,53).

Healthcare professionals should understand the concepts of daily hassles, daily uplifts, and coping strategies, as well as how these factors can affect health and well-being among survivors of sexual abuse. Sexual abuse continues to be “silenced” by survivors' experiences of shame and guilt, and healthcare professionals require competence to address this topic. To build such competence, health professionals must learn the definitions of violence and abuse and the consequences and risk factors of being exposed as a survivor of sexual abuse. Health professionals must also learn how to identify survivors of violence and abuse and how to provide resources to survivors, such as aid agencies and relief measures. Training must be provided for healthcare providers regarding how to talk with patients about violence and abuse. When daily hassles “pile up” and daily uplifts are scarce, being able to get help can significantly affect the long-term consequences of sexual abuse experiences for survivors.

Conclusion

The current study compared health outcomes among two groups of sexual abuse survivors. One group (favorable profile) had above-median scores on daily uplifts and adaptive coping strategies and below-median scores on daily hassles and maladaptive coping strategies, and the second (unfavorable profile) had above-median scores on daily hassles and maladaptive coping strategies and below-median scores on daily uplifts and adaptive coping strategies. The study findings indicate that stress-related symptoms among female survivors of severe

sexual abuse were strongly related to high incidence of daily hassles, low incidence of daily uplifts, and frequent use of maladaptive coping strategies. Few differences were found between the two profile groups related to demographic factors, socioeconomic factors, sexual abuse experiences, or the severity of those experiences. The results indicate that it is important to identify and address maladaptive coping strategies and to focus on changing stress appraisals and stress response behaviors in therapeutic and counseling interventions for sexual abuse survivors.

Table 1. Constructs and instruments with scoring and reliability

Construct	Instrument/origin	Description	Scoring	Reliability
1. Demographic and socioeconomic variables		Self-report questionnaire, with 11 items including year of birth, country of birth, number of years living in Norway, level of education, occupational status and number of years working, social network, marital status and whether they had children, current home, and self-assessed economic status.	Responded to by choosing one answer option	
2. Experience of sexual trauma up to the date answering the survey	The Norwegian Penal Code ^(2,41)	Self-report questionnaire, with 10 items including: <i>Unwanted sexual behaviors</i> including indecent exposure/peeping, being shown pornographic pictures, being exposed to highly sexualized behavior without physical contact. <i>Unwanted sexual acts</i> including being touched on genitals/breasts; being forced to masturbate others; experiencing repeated sexual intercourse or similar movements against one's own body. <i>Unwanted intercourse</i> including feeling pressured to sexual intercourse without the presence of violence or threats; forced sexual intercourse by the use of violence or threatening behavior; experiencing penetration with fingers, objects, or genitals in the vagina or rectum. <i>Questions related to the victimization</i> : age when the first incident of sexual abuse occurred, the sex and age of the abuser, and their relation to their offender.	Responded to by choosing one or more of several answer options: <i>Unwanted sexual behaviors</i> , the scale could range from 0 to 4. <i>Unwanted sexual acts</i> , the scale could range from 0 to 3. <i>Unwanted intercourse</i> , the scale could range from 0 to 3.	
3. Daily hassles during the last month.	^b The Stress Profile scale ⁽⁴²⁾	Self-report questionnaire, with 13 items measuring worries and irritants. ^a In addition, ten newly constructed items (seven items for worries and three items for irritants) were added based on the qualitative study ⁽⁸⁾ . Some of the newly included items: "Worry of memories from the abuse" and "Irritation of not being taken seriously."	Responded to on a 5-point Likert scale from "Never" (1) to "Very often" (5).	Cronbach's α coefficients for the original 23 items (α = 0.90), 13 original items (α = 0.83), and 10 newly constructed items (α = 0.82).

4. Daily Uplifts during the last month.	^b The Stress Profile Scale ⁽⁴²⁾	Self-report questionnaire, with six items measuring uplifts. ^a In addition, seven newly constructed items were added based on the qualitative study ⁽⁸⁾ . Some of the newly included items: “Joy of having a place where you are safe” and “Joy of having energy in everyday activities”.	Responded to on a 5-point Likert scale from “Never” (1) to “Very often” (5).	Cronbach’s α coefficient for the uplifts scales were: total 13 uplift items ($\alpha = 0.91$); six original items ($\alpha = 0.85$), and seven newly constructed items ($\alpha = 0.84$).
5. Coping strategies during the last month.	^b The Brief COPE questionnaire ⁽²⁰⁾	Self-report questionnaire, with 28-items assessing coping behavior in response to stressful or traumatic situations. The items generate fourteen subscales representing eight adaptive coping strategies (positive reframing, accepting, seeking emotional support, seeking instrumental support, humor, planning, active coping, and religion) and six maladaptive coping strategies (self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame). The Norwegian version of the Brief COPE was used ⁽⁴³⁾ .	Responses on a 4-point Likert scale, ranging from “I did not do this at all” (1) to “I did this a lot” (4).	The subscales were summed to generate one adaptive coping scale with 16 items ($\alpha = 0.78$) and one maladaptive coping scale with 12 items ($\alpha = 0.71$) (19).

Table 2. Demographic and socioeconomic comparisons of the study profile groups.

Background data ^a	Favorable profile (<i>n</i> = 19)	Unfavorable profile (<i>n</i> = 19)	Pearson's χ^2	df	<i>p</i>
Educational level			8.23	2	.016
Primary school	6	1			
High school	2	9			
College/University	11	9			
Occupational status			1.29	2	.524
Employed ^b	8	5			
Unemployed ^d	6	9			
Work assessment allowance ^c	5	5			
Number of years working			0.23	1	.631
≤ 3 years	7	6			
>3 years	10	12			
Social network/close relationships			5.22	1	.022
≤ 2 close relations	7	14			
> 2 close relations	12	5			
Marital status			0.49	1	.485
Single	12	14			
Married/partner	7	5			
Children			0.95	1	.330
Yes	8	11			
No	11	8			
Current home			3.98	1	.046
Rent an apartment or house	3	9			
Own an apartment or house	15	10			
Self-assessed economy			1.05	1	.305
Not so good	11	14			
Good/Very good	8	5			

Note: Favorable profile = above median scores on uplifts and adaptive coping, below median scores on hassles and maladaptive coping. Unfavorable profile = above median scores on hassles and maladaptive coping, below median scores on uplifts and adaptive coping.

^aCategorical data. ^bEmployed: fulltime or part-time employment. ^cUnemployed; student, retired, on sick leave or on disability benefit. ^dWork assessment to people impaired by at least 50 % (47).

Table 3. Trauma-related data comparison of the subgroups.

	Favorable profile (<i>n</i> = 19)		Unfavorable profile (<i>n</i> = 19)		Mann-Whitney <i>U</i>	<i>p</i>	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Sexual trauma-related data							
Sexual abuse total ^a	5.37	1.80	4.89	2.28	161.00	.525	0.23
Unwanted sexual behaviors ^b	0.53	0.84	0.68	0.82	158.50	.525	-0.18
Unwanted sexual acts ^c	2.37	1.07	2.05	1.13	158.00	.751	0.29
Unwanted intercourse ^d	2.16	0.76	2.16	1.01	169.00	.583	0.00

Note: Favorable profile = above median scores on uplifts and adaptive coping, below median scores on hassles and maladaptive coping. Unfavorable profile = above median scores on hassles and maladaptive coping, below median scores on uplifts and adaptive coping.

^a Range from 0 to 10. ^b Range from 0 to 4. ^c Range from 0 to 3. ^d Range from 0 to 3.

Cohen's *d* measures the effect size: *d* = 0.2 (small); *d* = 0.5 (medium); *d* = 0.8 (large) (44).

Table 4. Descriptive statistics and Pearson product-moment correlation between hassles, uplifts, coping and stress-related symptoms.

Scale	(n=57)						
	1	2	3	4	5	6	8 <i>SD</i>
1. Daily uplifts	-						3.02 0.70
2. Daily hassles	-.40**	-					3.39 0.62
3. Adaptive coping	.75***	-.41**	-				2.41 0.51
4. Maladaptive coping	-.37**	.56***	-.49***	-			2.42 0.61
5. Physical symptoms ^a	-.23	.54***	-.23	-.35**	-		3.38 0.82
6. Emotional symptoms ^c	-.34**	.64***	-.48***	.62***	.65***	-	3.79 0.58
7. Cognitive symptoms ^c	-.04	.57***	-.18	.43**	.56***	.65***	3.90 0.71
8. Target group specific symptoms ^b	-.08	.58***	.27*	.44**	.61***	.61***	3.38 1.04

Note: All scales can vary between 1 (Never) and 5 (Very often). ^a Stress Profile (42). ^b Newly constructed items (8). ^c Combination of Setterlind & Larsson (42) items and newly constructed target-group specific items (8).

*p < .05 ** p < .01 ***p < .001. Bonferroni correction (p < .0015). Significant after correction ***.

Table 5. Hierarchical regression analysis of predictor scales on stress-related symptoms.

(n = 57)					
Variable:	<i>B</i>	<i>SE</i>	<i>t</i>	<i>p</i>	<i>R</i> ² / <i>adj. R</i> ²
Physical symptoms^a					0.31/0.25
Uplifts ^b	-.09	.17	-.543	.590	
Hassles ^b	.63	.19	3.302	.002	
Adaptive coping ^b	.29	.26	1.086	.282	
Maladaptive coping ^b	.09	.19	.497	.622	
Emotional symptoms^{a, c, d}					0.51/0.47
Uplifts ^b	-.04	.10	-.365	.717	
Hassles ^b	.38	.12	3.288	.002	
Adaptive coping ^b	.02	.16	.096	.924	
Maladaptive coping ^b	.36	.12	3.185	.002	
Cognitive symptoms^a					0.43/0.39
Uplifts ^b	.18	.13	1.349	.183	
Hassles ^b	.62	.15	4.081	<.001	
Adaptive coping ^b	.33	.21	1.602	.115	
Maladaptive coping ^b	.26	.15	1.719	.092	
Target-group specific symptoms^{a, d}					0.40/0.35
Uplifts ^b	.28	.20	1.407	.165	
Hassles ^b	.90	.23	3.957	<.001	
Adaptive coping ^b	.16	.32	.498	.620	
Maladaptive coping ^b	.37	.23	1.636	.108	

Note: a Dependent variable, b Predictor. c Stress Profile (42). d Newly constructed items (8). For more information on the stress-related symptoms, see Table 5.
Bonferroni correction (p < .0015). Significant after correction in bold.

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Interrelationship of Posttraumatic Stress, Hassles, Uplifts, and Coping in Women With a History of Severe Sexual Abuse: A Cross-Sectional Study

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Abstract

Experiencing trauma, such as sexual abuse, increases the risk of a negative health outcome. The aim of the present study was to compare two groups of female survivors of sexual abuse, one group with a lower indication of posttraumatic stress disorder (L-PTSD) and one with a higher indication of posttraumatic stress disorder (H-PTSD). We hypothesized that, with a history of sexual abuse, higher levels of PTSD symptoms would be associated with more daily hassles, fewer daily uplifts, and more maladaptive coping strategies, and that there would be more reporting of severe types of sexual victimization, less resourceful socioeconomic conditions and a lower level of emotional stability.

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A questionnaire, including measures of socioeconomic conditions, trauma experience, emotional stability (the Single-Item Measures of Personality), Posttraumatic Stress Disorder Checklist (PCL), daily hassles and uplifts (the Stress Profile), and coping strategies (the Brief Coping Orientation to Problems Experienced [COPE] questionnaire), was completed by 57 female users at nine support centers for survivors of incest and sexual abuse in Norway. The results show that the H-PTSD group reported significantly more daily hassles, fewer daily uplifts, and more use of maladaptive coping strategies. The L-PTSD group reported more emotional stability, fewer daily hassles, and more uplifts, and used more adaptive coping strategies. However, few differences were found between the H-PTSD and the L-PTSD groups with regard to severity of sexual abuse and socioeconomic conditions. The results on the hassle, uplift, and coping scales are potentially interesting from an interventional point of view. Major life events such as sexual abuse may be out of control for the afflicted victim. Appraisal of and coping with everyday events, however, can be affected and offer interesting possibilities for interventions directed at the survivor, her significant others, and professional helpers.

Keywords

sexual assault, PTSD, domestic violence, sexual abuse, child abuse

Introduction

Sexual abuse is a serious traumatic experience that can lead to physical and psychological health consequences (Jina & Thomas, 2013). Sexual abuse can be defined as any sexual act to which the victim has not consented, or has been pressured or manipulated to take part (Steine et al., 2012). Worldwide, almost 35% of women have experienced physical and/or sexual violence by an intimate partner or sexual violence by a stranger (World Health Organization, 2019). In Norway, 9.4% of women report to have been subjected to sexual assault as adults and 4% have experienced some form of sexual abuse before the age of 13 years (Thoresen & Hjemdal, 2014). Wamser-Nanney et al. (2017) found that experiencing sexual trauma was more strongly related to posttraumatic stress disorder (PTSD) than the death of a loved one, suggesting the importance of trauma type in understanding event centrality and adverse outcomes. Chang et al. (2017) found that both negative life events and sexual abuse victimization uniquely predicted both positive and negative outcomes, including life satisfaction, negative affect, depressive symptoms, hopelessness, and suicidal behaviors.

PTSD is characterized by re-experiencing the trauma, avoidance of stimuli that are trauma related, and negative alterations of cognition, mood arousal, and reactivity after exposure to a stressor (American Psychiatric Association [APA], 1994). Higher rates of health care contact for physical illness, lower self-esteem, and lower life satisfaction are also reported (Dugal et al., 2016; Fergusson et al., 2013; Gekker et al., 2018). A substantial proportion of individuals report interpersonal trauma, and health professionals are likely to encounter patients with this kind of trauma history. Knowledge about how these experiences can influence psychological and interpersonal functioning is therefore important (Dugal et al., 2016).

Research on stress and health took a new direction in the 1980s. It shifted from a focus on major life events to a growing body of research suggesting that smaller everyday events or stressors caused by the event affect wellbeing and physical health more than the event itself (DeLongis et al., 1982; Larsson et al., 2017; Serido et al., 2004). Hassles are demands and conditions in everyday life that are perceived as irritating, frustrating, or stressful (Kanner et al., 1981; Stefanek et al., 2012). Daily hassles experienced by female survivors of sexual abuse may include triggers (smell or sounds linked to memories from the abuse), flashbacks (fragments of memories), guilt, shame, and lack of energy or issues relating to their own bodies (not liking, not relating to, or self-harming their bodies) (Stensveghagen et al., 2019). The frequency and perceived severity of daily hassles are more strongly associated with, or better predictors of, psychopathological symptoms than major life events (Kanner et al., 1981; Lazarus, 1999, 2006).

A counterpart to daily hassles is daily uplifts. These uplifts can help in the process of coping with stress by serving as “breathers” from regular stressful encounters, sustainers of coping activity, and restorers in the recovery from harm and loss (Kanner et al., 1981; Lazarus, 1999, 2006). Uplifts experienced by adult female survivors of sexual abuse may include finding a safe place, escaping triggers, or having the energy for activities that were formerly enjoyed (Stensveghagen et al., 2019).

The effect of hassles, uplifts, and coping strategies in everyday life after the experience of sexual abuse is not well understood. One study investigated the cumulative impact of sexual abuse in childhood and adult interpersonal violence on depressive symptoms in a nonclinical sample of women (McGuigan & Middlemiss, 2005). The results indicated that women who reported greater stress due to daily hassles reported more depressive symptoms. In a review of the interrelationship of childhood physical abuse, sexual abuse, and adult health problems, Sachs-Ericsson et al. (2009) found that current life stressors mediate the relationship between abuse and health problems, and that stress exacerbates health problems in survivors of abuse.

The impact of socioeconomic conditions must also be considered, because strong connections link the experience of trauma with adult health and adult socioeconomic status (Conroy et al., 2010; Fergusson et al., 2013). Font and Maguire-Jack (2016) found that respondents reporting early adverse experiences had a significantly higher probability of dropping out of high school and being either divorced or separated, and a lower probability of having a college degree or being married or widowed.

Reactions under stress cannot be predicted without reference to personality traits and processes that account for the individual differences in the ways in which people respond to a stressful stimulus (Lazarus, 1999, 2006). Personality trait theory often uses five dimensions to describe personality: extraversion, agreeableness, conscientiousness, emotional stability, and openness to experience (DeNeve & Cooper, 1998; McCrae & Costa, 1999). Lee and Song (2017) found that women who experienced sexual abuse early in their life had a lower level of emotional stability than their counterparts. They also found that the effects of early experiences of sexual abuse could leave a long-lasting effect and influence social and psychological development, which can affect personality traits. Bosmans et al. (2015) found that emotional stability strongly predicted the ability to cope effectively with life challenges after a traumatic event.

As a result of diverse personal resources, stress appraisals, and coping processes, the psychological symptoms that were experienced vary widely (Lazarus, 1990). A focus on everyday events and stressors can be useful in understanding how individuals cope after a traumatic event. Some individuals react more strongly and some do better after experiencing a traumatic event. The meaning constructed by a person about what is happening is crucial to the arousal of stress reactions (Lazarus, 1999, 2006).

The theoretical framework of the study draws heavily on the writings of Lazarus (1999, 2006). This implies that the interaction of antecedent personal factors such as sex, age, and personality, and contextual factors such as socioeconomic conditions, shape the meaning that an individual ascribes to a situation, their coping effects, and their emotional conditions.

The aim of the present study was to compare the characteristics of two groups of female survivors of sexual abuse, one group with a lower indication of PTSD (L-PTSD) and one group with a higher indication of PTSD (H-PTSD). We hypothesized that, among women with a history of sexual abuse, the H-PTSD group would be associated with more daily hassles, fewer daily uplifts, and more use of maladaptive coping strategies. We also hypothesized that women in the H-PTSD group would report more severe sexual victimization, less resourceful socioeconomic conditions, and a lower level of emotional stability.

Method

Sampling

The criteria for participation were being female, aged 18 years or older, having experienced sexual abuse, and speaking Norwegian. The participants in this study were recruited from support centers for survivors of incest and sexual abuse (SMISOs) in Norway. The centers receive central and local government funding and are primarily a self-help service for adults who have been subjected to sexual abuse. According to numbers from the Norwegian Directorate for Children, Youth and Family Affairs (2019), 60% of the female survivors who contact and use these support centers have experienced sexual abuse as children (aged <14 years) and 19% of the women as adults (aged >18 years). In 2017, the support centers had 1,447 users, both men (20%) and women (80%) (Norwegian Directorate for Children, Youth and Family Affairs, 2019). These centers have expertise in understanding trauma, trauma counseling, and aiding adult survivors with the consequences of their past or more recent trauma experience.

We initially contacted 17 of 22 support centers in Norway, with a geographic variation and variation in the number of users. Nine centers agreed to help in recruiting participants. The data collection lasted from February to October 2018. We lack information about how many women could have participated in the data collection, because some users of SMISOs are anonymous and participation at the center is voluntary. According to the Norwegian Directorate for Children, Youth and Family Affairs (2019), the mean age and nationality of the study participants corresponded fairly well with the overall picture at the SMISO centers.

The study was announced through leaflets, social group meetings at the different centers, and social media (the center's Facebook site). Those women who wanted to participate received an information letter at the center with details of the goals of the survey, and statements about the voluntary and anonymous nature of participation. Also it detailed that they could withdraw at any time for no reason and with no negative consequences. Those who wanted to participate contacted a designated person at the support center, and received a user name and password to access the self-report questionnaire electronically. Through this, it was not possible to track the web address to the individual participant. Only the recruiter at each center had information about the users who wanted to participate. After some weeks of data collection, we opened up the option to answer the questionnaire on paper and send answers by mail. This option came after feedback, from some of the recruitment personnel, that potential participants were hesitant to send their answers electronically.

The survey took about 30–45 min to complete. The participants were offered an opportunity to talk with a counselor at the center if they needed to, because answering questions about traumatic events could activate thoughts and feelings that could lead to distress.

Fifty-seven women completed the questionnaire: 53% responded electronically and 47% on paper. The mean age of participants was 41.4 years ($SD = 11.6$; range = 19–69). Of the participants 93% were ethnic Norwegian; the remaining 7% were from another Scandinavian country, another European country, or a country outside Europe.

Measures

The questionnaire was composed of a combination of established, validated scales and newly constructed items based on a recent qualitative study of daily hassles, uplifts, and coping after sexual abuse (Stensvehagen et al., 2019).

Demographics and socioeconomic conditions. The demographic and socioeconomic variables included 11 items. The participants were asked to state their birth year, country of birth, number of years living in Norway, level of education, occupational status, number of years working, social network, marital status and whether they had children, current home, and self-assessed economy.

Experience of sexual trauma. The participants were asked to specify what kind of sexual trauma they had experienced up to the date of the survey using the categories from the Norwegian Penal Code: unwanted sexual behaviors, unwanted sexual acts, or unwanted intercourse (Penal Code, 2005; Steine et al., 2012). The first category, unwanted sexual behaviors, can be indecent exposure, peeping, or being shown pornographic pictures or highly sexualized behavior without physical contact. The second category, unwanted sexual acts, refers to being touched on the genitals/breasts, being forced to masturbate others, or experiencing repeated sexual intercourse or similar movements against one's own body. The last category, unwanted intercourse, refers to feeling pressured to undertake sexual intercourse without the presence of violence or threats, forced sexual intercourse by the use of violence or threatening behavior, or experiencing penetration with fingers, objects, or genitals into the vagina or rectum. In addition, the participants were asked questions in relation to the victimization: age when the first sexual abuse occurred, and the sex and age of the abuser, as well as their relationship to him or her.

Many of the questions had several “yes/no” response choices, where more than one could be checked. To illustrate this, the respondents were asked about the sex and age of the abuser(s). The following four response choices were available: (a) adult male, (b) adult female, (c) boy (aged <18 years), and (d) girl (aged <18 years). This question resulted in five possible comparisons: the sum scores of “yes” responses (Mann–Whitney *U*-test) which in this case could range from 0 to 4, and each of the four yes/no response choices (χ^2 tests). Many of the “yes/no” choices were endorsed by only a few women. Thus, in cells with an expected count <5, Fisher’s exact test was used.

Emotional stability. The Single-Item Measures of Personality (SIMP) was used to assess emotional stability (Woods & Hampson, 2005). The items were presented with two dichotomous statements as anchors on a bipolar, 9-point graded line as follows: (1) am sensitive, easy going, happy, and can be tense, to (9) am relaxed, restrained, rarely irritated, and seldom depressed and sad. The questionnaire has shown good convergent and divergent validities (Woods & Hampson, 2005).

Daily hassles. Daily hassles were measured using 13 items from the Stress Profile Scale (Setterlind & Larsson, 1995), which was responded to on a 5-point Likert scale from “never” (1) to “very often” (5). In addition, 10 newly constructed items (worries: seven items; irritants: three items) were added based on the qualitative study of experiencing and coping after sexual abuse (Stensvehagen et al., 2019). Examples of new items included are: “Worry of memories from the abuse” and “Irritation at not being taken seriously.” Participants related their responses to experiences over the last month. The following Cronbach’s α coefficients were obtained for the hassle scales: total hassles with 23 items ($\alpha = .90$); 13 original items ($\alpha = .83$); and 10 newly constructed hassles ($\alpha = .82$).

Daily uplifts. This was measured with six items from the Stress Profile Scale (Setterlind & Larsson, 1995), with responses on a 5-point Likert scale from “never” (1) to “very often” (5). In addition, seven newly constructed items were added based on the qualitative study of experience of and coping after sexual abuse (Stensvehagen et al., 2019). Examples of new items included: “Joy at having a place where you’re safe” and “Joy at having energy in everyday activities.” Participants related their responses to experiences over the last month. Cronbach’s α for the uplift scales were 13 total uplift items ($\alpha = .91$), six original items ($\alpha = 0.85$), and seven newly constructed items ($\alpha = .84$).

Coping strategies. The Brief Coping Orientation to Problems Experienced (COPE) questionnaire (Carver, 1997) was used to measure coping strategies. This is a 28-item questionnaire assessing coping behavior in response to stressful or traumatic situations within the last month. The responses are rated on a 4-point Likert scale, ranging from “I don’t do this at all” (1) to “I do this a lot” (4). Fourteen subscales are generated representing eight adaptive coping strategies (positive reframing, accepting, seeking emotional support, seeking instrumental support, humor, planning, active coping, and religion) and six maladaptive coping strategies (self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame). Subscales were summed to generate one adaptive coping scale with 16 items ($\alpha = .78$) and one maladaptive coping scale with 12 items ($\alpha = .71$). In the present study, we used the Norwegian version of the Brief COPE (Kristiansen et al., 2008).

Posttraumatic stress. Symptoms of posttraumatic stress were measured using the Norwegian version of the Posttraumatic Stress Disorder Checklist (PCL; Hem et al., 2012). The PCL was first introduced by Weathers et al. (1993) and it is one of the most frequently used self-reported measures on indications for PTSD. The PCL is a 17-item, self-administered questionnaire that assesses PTSD symptoms from the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; APA, 1994) (Blanchard et al., 1996). Participants rated how much they were bothered by each symptom over the past month, using a 5-point Likert scale, ranging from “not at all” (1) to “extremely” (5). The PCL score can range from 17 to 85, with higher values indicating increased severity ($\alpha = .89$) (Hem et al., 2012).

Statistical Analysis

We conducted the statistical analyses using the Statistical Package for Social Sciences (SPSS) version 24. Summary indices were computed on all the aforementioned instruments, except for the emotional stability scale (SIMP). This was carried out by adding the raw scores of the items belonging to a scale and dividing by the number of items. An exception was the PCL scale when the raw sum was used. Conventional descriptive statistics were computed and subgroup comparisons were performed using χ^2 tests, including Fisher’s exact test, Kruskal–Wallis one-way analysis of variance (ANOVA) by ranks, and Mann–Whitney *U*-tests. Statistical significance was assumed at $p < .05$. Bonferroni correction was calculated to counteract multiple comparisons. In addition, Cohen’s *d* (Cohen, 1988) values were computed to assess effect size.

Ethics

The present study was carried out adhering to the ethical principles contained in the Declaration of Helsinki (World Medical Association, 2013), and was approved by the Norwegian Center for Research Data (December 15, 2017, 47,920/AGL).

Results

Defining a Lower, Mid, and Higher PTSD Group

Participants with scores in the lowest third on the PTSD scale formed the L-PTSD group ($n = 19$). They had a mean score of 40.37 ($SD = 6.30$). The mid-third group (M-PTSD, $n = 18$) had a mean score of 53.61 ($SD = 4.00$). Participants with scores in the highest third on the PTSD scale formed the H-PTSD group ($n = 20$). Their mean score on the PTSD scale was 72.45 ($SD = 5.96$). Initially, all subgroup comparisons were made by including all three subgroups (χ^2 tests and Kruskal–Wallis ANOVA). However, as the subgroup comparisons involving the L-PTSD and the H-PTSD groups show the most clear-cut results, the remaining part of this section is based on these two groups.

In the L-PTSD group, all the women scored lower (from 22 to 46) than the cut-off (≤ 50), indicating PTSD (Weathers et al., 1993). In the H-PTSD group, all the women scored higher (from 61 to 79) than the cut-off (≤ 50), indicating PTSD. Linear trends were noted on all hassle, uplift, and coping scales, showing that the L-PTSD group scored most favorably and the H-PTSD group least favorably.

Demographic and Socioeconomic Characteristics

The mean age of the two groups differed by 2 years (H-PTSD: mean age 39.3 years [$SD = 10.82$], range 20–59 years; L-PTSD: mean age 40.5 years [$SD = 11.42$], range 23–69 years). This difference was not statistically significant. Most of the women in both groups were born in Norway (L-PTSD: $n = 17$; H-PTSD: $n = 19$), and most had lived in Norway for more than 6 years (L-PTSD: $n = 18$; H-PTSD: $n = 20$). The remaining demographically and socioeconomically related data are based on eight questions (Table 1). Of these, only one comparison between the H-PTSD and L-PTSD groups was statistically significant. The educational level showed a significant difference between the two groups ($p = .013$). The L-PTSD group had, overall, the highest educational level, with most reporting having finished

Table 1. Demographic and Socioeconomic Comparison of L-PTSD and H-PTSD Subgroups.

Background Data ^a	L-PTSD (<i>n</i> = 19) <i>n</i>	H-PTSD (<i>n</i> = 20) <i>n</i>	Pearson's χ^2	<i>df</i>	<i>p</i>
Highest educational level			8.70	2	.013
Primary school	7	4			
High school	2	11			
College/University	10	5			
Occupational status			4.98	2	.083
Employed ^b	9	3			
Unemployed ^c	5	10			
Work assessment allowance ^d	5	7			
Number of years working			0.89	1	.345
≤3	7	5			
>3	10	14			
Social network			1.25	1	.264
≤2 close relationships	8	12			
>2 close relationships	11	8			
Marital status			0.03	1	.855
Single	11	11			
Married/partner	8	9			
Children			3.09	1	.079
Yes	7	13			
No	12	7			
Current home			0.04	1	.839
Rents an apartment or house	12	12			
Owns an apartment or house	7	8			
Self-assessed economy			1.37	1	.243
Not so good	12	16			
Good/Very good	7	4			

Note. L-PTSD = lowest third on PTSD symptom scale; PTSD = posttraumatic stress disorder; H-PTSD = highest third on PTSD symptom scale.

^aCategorical data. ^bEmployed: full-time or part-time employment. ^cUnemployed: student, retired, on sick leave, or on disability benefit. ^dA work assessment allowance allows a person who is impaired by at least 50% to have an income in periods during which they are ill or injured and need assistance from the Norwegian Labor and Welfare Administration to return to work (Norwegian Labour and Welfare Administration, 2020).

college/university. In the H-PTSD group, most had high school as their highest educational level. However, after Bonferroni correction, due to the high number of comparisons, no significant differences remained.

Table 2. Trauma-Related Data Comparison of the L-PTSD and H-PTSD Subgroups.

Sexual Trauma–Related Data	L-PTSD		H-PTSD		Mann–Whitney	<i>p</i>	Cohen's <i>d</i>
	<i>(n = 19)</i>		<i>(n = 20)</i>				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Sexual abuse (total) ^a	5.11	2.11	5.40	2.16	171.00	.607	0.14
Unwanted sexual behaviors ^b	0.63	0.90	0.80	0.83	164.50	.478	0.20
Unwanted sexual acts ^c	2.16	1.17	2.55	1.19	146.50	.224	0.33
Unwanted intercourse ^d	2.00	0.94	2.00	1.03	187.00	.945	0.00

Note. Cohen's *d* measures the effect size: *d* = 0.2 (small); *d* = 0.5 (medium); *d* = 0.8 (large) (Cohen, 1988). L-PTSD = lowest third on PTSD symptom scale; PTSD = posttraumatic stress disorder; H-PTSD = highest third on PTSD symptom scale.

^aSexual abuse (total) includes all possible response choices included in the three subcategories unwanted sexual behavior, unwanted sexual acts and unwanted intercourse (the scale could range from 0 to 10).

^bUnwanted sexual behaviors include the following possible response choices (the scale could range from 0 to 4): indecent exposure/peeping; being shown pornographic pictures; being exposed to highly sexualized behavior without physical contact. ^cUnwanted sexual acts include the following possible response choices (the scale could range from 0 to 3): being touched on genitals/breasts; being forced to masturbate others; experiencing repeated sexual intercourse or similar movements against one's own body. ^dUnwanted intercourse includes the following possible response choices (the scale could range from 0 to 3): feeling pressured to sexual intercourse without the presence of violence or threats; forced sexual intercourse by the use of violence or threatening behavior; experiencing penetration with fingers, objects, or genitals in the vagina or rectum.

Sexual Trauma–Related Characteristics

Table 2 shows that, when counting all the “yes” answers, in legal terms, all the women in both groups had experienced the most severe type of sexual abuse.

Most of the women in both groups had experienced sexual abuse at an early age (age <7 years); the L-PTSD: *n* = 11 (*M* = 1.79, *SD* = 0.25) and the H-PTSD: *n* = 12 (*M* = 1.55, *SD* = 0.17). First sexual trauma after the age of 18 years was reported only in the L-PTSD group (*n* = 2).

In both groups, most of the women knew their offender: L-PTSD: *n* = 18; H-PTSD: *n* = 17. Some of the women also reported being sexually abused by an unknown offender: L-PTSD: *n* = 6; H-PTSD: *n* = 5. The offender was mostly an adult male (L-PTSD: *n* = 16; H-PTSD: *n* = 20). In some cases the offender was aged <18 years (L-PTSD: *n* = 8; H-PTSD: *n* = 7). Some had also had their experience with adult female offenders (L-PTSD: *n* = 3; H-PTSD: *n* = 2). In a few cases the offender was female and aged <18 years (L-PTSD: *n* = 1; H-PTSD: *n* = 2). The differences between the two groups were not statistically significant on any of the trauma-related questions.

Table 3. Emotional Stability, Hassles, Uplifts, and Coping Comparison of the L-PTSD and H-PTSD Subgroups.

Variable	L-PTSD (<i>n</i> = 19)		H-PTSD (<i>n</i> = 20)		Mann–Whitney		<i>p</i>	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>U</i> test	<i>df</i>		
Emotional stability^a	3.84	1.21	2.55	1.85	8.93	2	.004	0.82
Hassles (total)^b	2.95	0.49	3.91	0.51	25.98	2	<.001	1.93
Worries (total)	3.04	0.58	4.23	0.53	27.43	2	<.001	2.13
Worries original scale	3.20	0.58	4.40	0.50	26.00	2	<.001	2.20
Worries newly constructed scale	2.90	0.68	4.08	0.69	22.03	2	<.001	1.72
Irritant (total)	2.83	0.54	3.50	0.68	11.99	2	.001	1.09
Irritant original scale	2.58	0.67	3.09	0.70	5.69	2	.030	0.75
Irritant newly constructed scale	3.40	0.65	4.43	0.81	17.52	2	<.001	1.40
Uplifts (total)^c	3.38	0.56	2.83	0.76	8.90	2	.022	0.83
Uplifts original scale	3.44	0.66	3.09	0.81	6.91	2	.020	0.47
Uplifts newly constructed scale	3.34	0.57	2.61	0.76	10.15	2	.004	1.08
Coping^d								
Adaptive coping	2.59	0.47	2.57	0.40	0.92	2	.967	0.05
Maladaptive coping	1.82	0.36	2.59	0.47	21.75	2	<.001	1.84

Note. Text in bold refers to significance after Bonferroni correction. Cohen's *d* measures the effect size: *d* = 0.2 (small); *d* = 0.5 (medium); *d* = 0.8 (large) (Cohen, 1988). L-PTSD = lowest third on PTSD symptom scale; PTSD = posttraumatic stress disorder; H-PTSD = highest third on PTSD symptom scale.

^aEmotional stability: Single Item Measure of Personality (SIMP); a single-item measure presented as two dichotomous statements. The item was measured on a bipolar 9-point graded line. ^bStress profile from Setterlind and Larsson (1995). Hassles measured on a 5-point Likert scale from "never" (1) to "very often" (5). Hassles (total) includes worries (total) and irritant (total) from the original scale and newly constructed scale (Stensveghagen et al., 2019). ^cStress profile from Setterlind and Larsson (1995). Uplifts measured on a 5-point Likert scale from "never" (1) to "very often" (5). Uplifts (total) includes items from the original scale and newly constructed scale (Stensveghagen et al., 2019). ^dCoping is computed from items in the Brief COPE Questionnaire (Carver, 1997). Ratings on a 4-point Likert scale, "I don't do this at all" (1) to "I do this a lot" (4). The scale is divided into adaptive and maladaptive coping strategies, according to Carver (1997).

Emotional Stability

A Mann–Whitney *U*-test indicated that emotional stability was greater for women in the L-PTSD group, than for those in the H-PTSD group (Table 3).

Daily Hassles, Uplifts, and Coping

The hassle-related data consist of seven indices. As Table 3 shows, there were significant differences between the groups on all these scales. The L-PTSD scored most favorably on all.

The uplift-related data consist of three indices. Of these, "uplift total" and "uplift newly constructed" showed statistically significant differences between the H-PTSD and the L-PTSD groups (Table 3). Thus, the H-PTSD group reported lower frequencies of daily uplifts over the last month.

The coping-related data consist of two indices. The results show that there were significant differences in maladaptive coping strategies (Table 3). In the L-PTSD group, we found more adaptive coping strategies and in the H-PTSD group significantly more maladaptive coping strategies. In 11 of 12 comparisons on the hassle, uplift, and coping scales the results showed significant differences between the L-PTSD and the H-PTSD groups. After Bonferroni correction, seven of the differences remained significant.

Discussion

In the present study, we compared two groups of female survivors of sexual abuse with either a higher or a lower total score indicating PTSD. We compared the two groups on trauma-related, demographic and socioeconomic conditions, personality traits, and the hassle, uplift, and coping variables. The present study provides support for the first hypothesis that higher levels of PTSD symptoms were associated with more daily hassles, fewer daily uplifts, and more maladaptive coping strategies.

The differences between the L-PTSD and H-PTSD groups on the hassle and uplift scales are in the expected direction, showing that women who reported high levels indicating PTSD also reported more daily hassles, which is in line with the limited existing research (McGuigan & Middlemiss, 2005; Thakkar & McCanne, 2000). This is in agreement with Walsh et al. (2010) who found, in their review of adults coping after sexual abuse, that survivors reported a variety of coping strategies, which evolved and changed as the phases of coping with trauma changed.

We also hypothesized that women with higher levels of PTSD symptoms would report more severe sexual victimization, less resourceful socioeconomic conditions, and a lower level of emotional stability. The hypothesis was unsupported, except for emotional stability. Given the high number of nonsignificant differences between the L-PTSD and the H-PTSD groups, the conclusion is that severity of sexual abuse and socioeconomic conditions had little or no effect on the current indication of PTSD.

The lack of differences on the sexual abuse scales could be due to a ceiling effect. The two groups in this study were selected from a sample in which all reported severe trauma experiences. Most (17 in the L-PTSD group and 20 in the H-PTSD group) of the women had experienced sexual abuse before the age of 18 years, many before the age of 7 years (11 women in the L-PTSD group and 12 women in the H-PTSD group). Research has shown that childhood sexual abuse influences a number of adult developmental outcomes such as mental disorders, psychological wellbeing, sexual risk taking, physical health, and socioeconomic wellbeing (Fergusson et al., 2013). Most of the

women in the study group had experienced unwanted intercourse. As almost everyone had experienced the most serious kind of abuse, our data do not give an answer on whether the degree of severity of the abuse is associated with high or low levels indicating PTSD.

The results concerning demographic and socioeconomic data revealed marginal differences between the two groups. However, the participants all attended a support center for survivors of incest and sexual abuse. These centers may contribute to a different kind of social network, through activities arranged at the center. This can be an important contribution that also safeguards some form of social network, which is an important contributor to recovery (Stensvehagen et al., 2019). A downside to this is if the centers, over time, become the only link to social support and a substitute for family and friends. In a summary of the demographic and socioeconomic factors, we do not rule out that these factors may have an effect on PTSD symptoms after sexual abuse, because this has been shown in previous research (Gekker et al., 2018). However, this was not the case in the present study of severely victimized women. Once again, one explanation is that the severity of the sexual abuse outweighed the potential impact of demographic and socioeconomic factors.

According to Almeida (2005), personality traits are one of several factors that influence resilience and vulnerability to daily stressors. In the present study, we found that there was a significant difference in emotional stability between the two groups. Those with high levels indicating PTSD scored low on emotional stability. Lee and Song (2017) also found that low emotional stability was significantly associated with childhood abuse (physical, emotional, and sexual). Based on this cross-sectional study, it cannot be concluded whether either the sexual abuse caused a lower emotional stability or a lower emotional stability resulted in higher symptom reporting. Drawing on a more general psychological framework, it could be argued that there is a bidirectional causality, but that the main influence route would be that a lower emotional stability would contribute to an increased vulnerability to highly stressful events (Lazarus, 1999, 2006).

The novelty of the present study lies in the results that indicate that PTSD symptom intensity among severely sexually abused women was strongly related to a high degree of perceived daily hassles, low amounts of daily uplifts, a lot of use of maladaptive coping strategies, and a low level of emotional stability, combined with little or no relationship to demographic and socioeconomic factors and severity of the sexual abuse. The results on the hassle, uplift, and coping scales are potentially interesting from an interventional point of view. Major life events such as sexual abuse may be out of control for the afflicted woman. Appraisal of and coping with everyday

events, however, can be affected and offer interesting possibilities for interventions directed at the survivors, their significant others, and professional helpers.

We now turn to some limitations of the present study. As with all cross-sectional data, we can access only the association and cannot make assumptions about the causal directions of our variables. Nonresponse is a particular problem affecting cross-sectional studies and can result in bias of the measures of outcome. Many women never talk about their trauma, suffer in silence, and are difficult to recruit (McTavish et al., 2019). In the present study, we recruited women attending a support center for survivors of incest and sexual abuse, which indicates that our sample is a selected group receiving support and counseling. Recruitment of a more representative sample may have revealed other answers to our hypothesis.

Our sample size was small and this limits statistical power to detect significant differences between the H-PTSD and L-PTSD groups and the generalizability of our findings. To correct for Type 1 error, resulting from multiple analyses and a small sample, we calculated Bonferroni correction. In addition, we calculated effect size when measuring two groups through the use of Cohen's *d*. The results in the present study, which were significant before Bonferroni correction and not significant after, showed a medium (0.5) or large (0.8) effect size when using Cohen's *d*. This indicates that, even though the sample size was small, these results still show that there were differences between the L-PTSD and the H-PTSD groups.

The centers, from which we recruited participants, have in recent years been subjected to several requests for research participation, and this could be one explanation for a reluctance to participate. For some it may have been too demanding to answer the questionnaire. In addition, shame, guilt, and threats from others can be contributing factors to women choosing not to participate (Kennedy & Prock, 2018; Reitsema & Grietens, 2016).

We know little about those who chose not to respond to the survey. The overall feedback from the recruiters at the support centers was positive, and they reported that the feedback from participants was that the questions were perceived as meaningful. Some skepticism was reported toward answering the questions electronically. Although there was the opportunity to participate through answering the questions both electronically and on paper, participation was still low. In retrospect, we think that, by using only a questionnaire on paper from the start of the data collection, possibly a larger number of women would have answered the questionnaire in our study.

The participants in this study were a selected group of mostly Norwegian women, so our results are not transferrable to women from other countries or cultures.

We also asked participants about past exposure, even though the period addressed in the questionnaire was in the last month. Still, this could result in a recall bias that may have influenced our results (Polit & Beck, 2017).

It is a known fact that survey respondents may have a tendency to answer questions in a manner viewed favorably by others, and that this can lead to social desirability bias (Polit & Beck, 2017). Whether the participants in this study overreported “good behavior” or underreported undesirable behavior is difficult to determine. The feedback from those responsible for recruiting participants at the centers was that the survey had been perceived as relevant, although somewhat time-consuming to respond to.

A strong point of our sample is that we have recruited a group of severely traumatized women. It is not certain that we would have managed to reach this group using other recruitment methods. Finally, the present study is one of very few studies that have developed and tested more context-specific questions on hassles and uplifts in a group of female survivors of sexual abuse.

Research Implications

Future research would benefit from the development of coping instruments, which incorporate concepts hypothesized to be specific to trauma, as suggested by Walsh et al. (2010). Comparison of groups of female survivors of sexual trauma should be replicated in larger populations across different cultures. It is important to acknowledge that, even though our focus has been on female survivors of sexual abuse, it is important to focus on male survivors. It would be interesting to carry out a similar study with male survivors, to find out whether there are gender differences or similarities with regard to daily hassles, uplifts, and use of coping strategies.

Conclusion

In the present study we compared groups of female survivors of sexual abuse with high (H-PTSD) and low (L-PTSD) levels indicating PTSD. All of the women had experienced severe sexual abuse. The study provides support for the hypothesis that the women with more symptoms indicating PTSD (H-PTSD) reported having significantly more daily hassles and fewer daily uplifts, and used more maladaptive coping strategies. The L-PTSD group reported more emotional stability, fewer daily hassles, and more uplifts, and used more adaptive coping strategies. Few differences were found between the H-PTSD and the L-PTSD groups with regard to severity of sexual abuse and socioeconomic conditions. Major life events

such as sexual abuse may be out of control for the afflicted victim. Appraisal and coping with everyday events can be affected and offer interesting possibilities for interventions.

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Author Biographies

Marianne Torp Stensvehagen, RN, MCN, is a PhD student at the University of Oslo and Inland Norway University of Applied Sciences. Her research area is trauma-related stress after sexual abuse. She is a member of a research group on treatment and follow-up after trauma.

Gerry Larsson is a licensed psychologist and a professor of Leadership Psychology at the Swedish Defence University. He is also an adjunct professor of Stress Psychology at Inland Norway University of Applied Sciences. He has published more than 135 journal articles, 87 books or chapters in books and more than 525 research reports.

Berit Arnesveen Bronken, PhD/RN, is an associate professor at the Inland Norway University of Applied Sciences. Her research area is psychosocial well-being after stroke. She is a member of a research group on treatment and follow-up after trauma. She is leader of the Continuing Education in Rehabilitation, Leadership and Collaboration.

Lars Lien, MD, PhD, is head of the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders and professor at Inland Norway University of Applied Sciences. He has published in international journals ranging from qualitative studies to brain scan and immunology within the trauma area.

Appendices

1. Approval Norwegian Centre for Research Data (NSD)
2. Request for research participation (Paper I)
3. Interview guide (Paper I)
4. Request for research participation (Paper II and III)
5. Questionnaire (Paper II and III)

Appendix 1

Approval Norwegian Centre for Research Data (NSD)

Appendix: Approval Norwegian Centre for Research Data (NSD)

Hei

Vi viser til skjema for framleggingsvurdering, mottatt 16.02.2016, vår referanse 2016/265.

Prosjektets tittel er: «Seksuelle overgrep og mestring av hverdagsstress».

Henvendelsen er vurdert av komiteens leder, Finn Wisløff.

Helseforskningsloven gjelder for medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger, jf § 2. Medisinsk og helsefaglig forskning defineres som virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom, jf §4 bokstav a.

Det er formålet med prosjektet som er avgjørende for om prosjektet skal legges frem for REK, ikke om forskningen utføres av helsepersonell eller på pasienter eller benytter helseopplysninger.

Formålet med prosjektet er å utvikle ny kunnskap som bidrar til større forståelse for hvordan kvinner som har opplevd seksuelle overgrep erfarer og mestrer stress knyttet til hverdagsproblemer "hassles" og hverdagsgleder "uplifts". Videre vil man undersøke om det er sammenheng mellom personlige og kontekstuelle faktorer, opplevd hverdagsstress og helse.

Basert på opplysningene som gis, er ikke formålet med prosjektet å fremskaffe ny kunnskap om helse, sykdom, diagnostikk eller behandling, slik det forstås i helseforskningsloven. Prosjektet faller utenfor helseforskningslovens virkeområde, og kan derfor gjennomføres uten godkjenning av REK.

Det er institusjonens ansvar på å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern samt innhenting av stedlige godkjenninger.

Jeg gjør oppmerksom på at konklusjonen er å anse som veiledende jfr. forvaltningsloven § 11.

Dersom dere likevel ønsker å søke REK vil søknaden bli behandlet i komitémøte, og det vil bli fattet et enkeltvedtak etter forvaltningsloven.

Med vennlig hilsen

Gjøril Bergva

Komitésekretær
REK sør-øst D
Tlf: 22 84 55 29

BEKREFTELSE PÅ ENDRING

Hei, viser til endringsmelding registrert hos personvernombudet 15.12.2017.

Vi har nå registrert gjennomføring og detaljer til delstudie 2 og 3.

Vedrørende lagring av datamaterialet: Ombudet forutsetter at all deling av data med eksterne brukere kun skjer etter eksplisitt samtykke fra utvalget. Informasjonsskrivet må derfor inneholde alle nødvendige opplysninger om hvem som skal ha tilgang, og eventuelt hvem som kan, og hvordan andre forskeres kan, få tilgang til datamaterialet. Videre skal alle andre prosjekter som bruker data fra dette prosjektet meldes som separate prosjekter til personvernombudet.

Merk at datamaterialet skal anonymiseres innen 31.12.2020, noe utvalget også må informeres om. Dette punktet skiller seg fra anonymisering i publikasjoner.

Ombudet forstår det slik at Checkbox skal brukes som lokal løsning for gjennomføring og oppbevaring av spørreundersøkelsen, det er en forutsetning at dette er en intern løsning, hvor Checkbox-ansatte på ingen måte har tilgang til datamaterialet. Data skal kun skal lagres ved Høgskolen i Innlandet sine systemer.

Ombudet vil også minne om den særlig sensitive siden ved prosjektet og typen data som samles, vi viser da til de forskningsetiske retningslinjer og det særlige ansvar forskere er pålagt når de forsker på utsatte, svake og/eller sårbare grupper, se kapittel A, B og C: <https://www.etikkom.no/forskningsetiske-retningslinjer/Samfunnsvitenskap-jus-og-humaniora/> vi anbefaler derfor at informasjonsskrivet som sendes og som vises på første siden av undersøkelsen er utførlig utformet, og har et åpent språk uten for sterk bruk av appellerende formuleringer for å sikre deltakelse.

Personvernombudet forutsetter at prosjektopplegget for øvrig gjennomføres i tråd med det som tidligere er innmeldt, og personvernombudets tilbakemeldinger.

Vi vil ta ny kontakt ved prosjektslutt.

--

Vennlig hilsen | Best wishes

Audun G. Løvlie

seniorrådgiver | Senior Adviser

Seksjon for personverntjenester | Data Protection Services

T: (+47) 55 58 23 07

NSD – Norsk senter for forskningsdata AS | NSD – Norwegian Centre for Research Data

Harald Hårfagres gate 29, NO-5007 Bergen

T: (+47) 55 58 21 17

Appendix 2

Request for research participation (Paper I)



Høgskolen i Hedmark

Forespørsel om deltakelse i forskningsprosjektet

«Mestring av hverdagsstress og helse for kvinner som har opplevd seksuelle overgrep».

Bakgrunn og hensikt

Dette er en forespørsel til deg om å delta i en forskningsstudie for å undersøke om tidligere overgrepserfaringer kan ha betydning for håndtering av stress i hverdagen og helse. Forskning har vist at seksuelle overgrep er en skjult årsak til mange og ulike helseproblemer. Hvilke konsekvenser tidligere overgrep får for mestring av stress i hverdagen og helse relaterte problemer er tidligere lite beskrevet. Studien inngår i forskningsprosjektet "Hverdagsstress og helse" for sykepleier og doktorgradsstipendiat Marianne Torp Stensvehagen ved Institutt for klinisk medisin ved Universitetet i Oslo.

Hva innebærer studien?

Deltakelse i studien innebærer et intervju. Dersom du vil delta vil vi gjerne at du forteller om din hverdag, stress som du opplever i hverdagen, følelser knyttet til hverdagshendelser som oppleves som positive og negative, hva du gjør for å mestre det som er negativt og for å forsterke det som er positivt. Intervjuet vil foregå på det SMISO senteret du benytter eller et sted som er ønskelig for deg. Intervjuet vil ta 1-2 timer og ønskes tatt opp på lydbånd.

Mulige fordeler og ulemper

For å kunne gi et best mulig tilbud til kvinner som tidligere har vært utsatt for overgrep er det viktig at frivillige hjelpere og helsepersonell får mer kunnskap om opplevelse av hverdagsstress, mestringsstrategier og helse relaterte problemer. De som deltar bidrar til ny kunnskap og bevissthet om det å ha opplevd overgrep. Du er med i forskning som kan hjelpe andre som har opplevd seksuelle overgrep. Dersom intervjuet skulle føre til etterreaksjoner gis et tilbud om hjelp i form av samtaler ved det senteret du benytter deg av.

Hva skjer med informasjonen om deg?

Det er kun stipendiaten som vet hvem som deltar i studien. I presentasjonen av studien vil vi bruke sitat. Alle personidentifiserbare opplysninger vil da være fjernet, slik at det ikke vil være mulig å føre noe tilbake til den enkelte. Både lydopptak og utskrifter vil bli behandlet som fortrolige opplysninger og oppbevart forsvarlig i et låsbart skap på Høgskolen i Hedmark. Datafiler blir lagret på et eget område for forskning ved høgskolen. Du har rett til innsyn i opplysningene om deg selv, og du kan be om at feil rettes eller opplysninger slettes. Det vil bli skrevet en vitenskapelig artikkel om funnene fra intervjuene i denne studien. Prosjektet forventes avsluttet vår 2019. Det kan bli aktuelt å benytte data fra intervjuene og kontakte de som har deltatt på nytt ved en senere anledning. Det er derfor fint hvis du på side to kan krysses av i aktuell rubrikk for eventuelt senere deltagelse. Dine kontaktopplysninger for senere deltagelse vil bli oppbevart i 3 år. Studien er meldt til NSD – Norsk senter for forskningsdata AS.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til deltagelse. Det vil ikke få noen konsekvenser. Vi har ikke anledning til å gi honorar, men evt. reiseutgifter vil bli refundert. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på neste side i to eksemplar. Den ene beholder du selv og det andre returnerer du i vedlagt frankert konvolutt.

Dersom du har spørsmål til studien, kan du kontakte:

Doktorgradsstipendiat/sykepleier	Professor/psykolog	Professor/psykiater	l.amanuensis/sykepleier
Marianne Torp Stensvehagen tlf. 454 57 402 marianne.stensvehagen@hihm.no	Gerry Larsson gerry.larsson@fhs.se	Lars Lien Lars.lien@sykehuset- innlandet.no	Berit Arnesveen Bronken Berit.bronken@hihm.no

Samtykke til deltakelse i studien

(sett kryss i aktuell rute)

Jeg er villig til å delta i studien «Mestring av hverdagsstress og helse for kvinner som har opplevd seksuelle overgrep» ☐

Jeg samtykker til at det gjøres lydopptak av intervjuet ☐

Jeg samtykker til å bli kontaktet ved oppfølging av dette prosjektet ☐

Jeg ønsker ikke å bli kontaktet senere ☐

Fyll inn ditt navn og telefonnummer samt tidspunkt når du ønsker å bli kontaktet.

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Kontaktinformasjon til deltager i studien:

Telefonnummer: _____

Kan kontaktes i tidsrommet: _____

Appendix 3:

Interview guide (Paper I)

I intervjuet oppfordres kvinnen til å fortelle om og utdype sin erfaring med å håndtere og mestre hverdagsproblemer og hverdagsgleder.

Informant nummer:				
Fase 1: Ramme- setting	1. Løst prat (5 min) <ul style="list-style-type: none"> Introdusere meg og mål med prosjektet 			
	2. Informasjon (5 min) <ul style="list-style-type: none"> Hva skal informantene bidra med: erfaringer, oppfatninger og sine tanker rundt temaet hverdagsstress, hverdagsgleder og mestring/håndtering av stresset. Ingen svar er feil Er det noe som er viktig for informanten underveis: tilgang til noe å skrive på, tid til å tenke seg om når spørsmål stilles, osv. Hvis det oppleves som belastende be om pause eller stoppe. Avtale pauser i intervjuet Dataene slettes når studien er avsluttet Etisk: Samtykke, frivillig å delta, kan trekke seg når som helst, mulighet til å velge å ikke svare på spørsmål, taushetsplikt, konfidensialitet ifht materialet (navn/gjenkjennbare data), informer om opptak. Kort om hvordan intervjuet er bygget opp. Min rolle i intervjuet, respons på det som kommer frem i intervjuet. Informere om at det er mulighet for samtale med en person på SMISO i etterkant av intervjuet hvis det er behov for oppfølging. Noe du vil spørre om? Start opptak 			
Fase 1: Åpnings- spørsmål	Alder	Sivilstand	Utdanning	Jobb
		Enslig	Ungdomsskole	Heltid
		Samboer	Videregående	Deltid %
		Gift	Høgskole	Type arbeid:
		Har egne barn	Universitet	Ufør
Fase 2: Erfaringer		Omsorg for andres barn	Er i utdanning nå:	Pensjonist
	3. Overgangsspørsmål: (5 min) <p>Kan du fortelle om hva som kan oppleves som stress i hverdagen (19.09.16)</p> <ul style="list-style-type: none"> Følelser knyttet til hverdagshendelser som oppleves som positive og negative 			
Fase 3: Fokusering	4. Tema: (30 min) <p>Hverdagsproblemer:</p>			

	<ul style="list-style-type: none"> • Kan du fortelle om noe som gjør deg stresset/ irriterende/urolig i hverdagen (triggere) • Kan du fortelle om hva du gjør for å håndtere problemer/irritasjoner/uro i hverdagen. • Merker du noe forskjell over tid? • Mestring over tid gjør du noe annet nå enn tidligere? • Vendepunkt! (11/10-16) • Er det noe du er fornøyd med at du har fått til? (11/10-16) <p>Hverdagsgleder:</p> <ul style="list-style-type: none"> • Kan du fortelle om hva som oppleves som gleder/» pusterom» i hverdagen • Kan du fortelle om hva du gjør for å forsterke disse gledene • Merker du noe forskjell over tid? <p>(Oppfølgingsspørsmål: Det du sa om ... synes jeg var interessant. Kan du utdype det noe mer? Du snakket om ... Hva betyr det? Da du opplevde det, hva følte du da? Har det alltid vært sånn? Har noe endret seg over tid?</p>
Fase 4: Tilbakeblikk	<p>5. Oppsummering og avslutning (10 min)</p> <ul style="list-style-type: none"> • Hva ville du gitt som råd til en som akkurat har vært utsatt for overgrep, hva ville det være? • Hva har du lært om deg selv gjennom disse årene/året? • Er det noe du vil legge til? • Eventuelt: <ul style="list-style-type: none"> ○ Ønske om å lese det transkriberte intervjuet? ○ Ta kontakt en-to dager senere for å høre om informanten har tenkt på noe etter intervjuet og høre hvordan hun har det

Appendix 4:

Request for research participation (Paper II and III)

Forespørsel om deltakelse i forskningsprosjektet

«Hverdagsstress og mestring etter seksuelle overgrep».

Bakgrunn og hensikt

Dette er en forespørsel til deg om å delta i en spørreundersøkelse. Vi ønsker å undersøke om tidligere overgrepserfaringer, kan ha betydning for håndtering av stress i hverdagen og hvilke sammenhenger det er mellom hverdagsproblemer, hverdagsgleder, mestring og stressrelaterte reaksjoner. Studien inngår i forskningsprosjektet "Seksuelle overgrep og mestring av hverdagsstress" som gjennomføres av sykepleier og doktorgradskandidat Marianne Torp Stensvehagen ved Universitetet i Oslo, i samarbeid med Høgskolen i Innlandet.

Hva innebærer studien?

Deltakelse i studien innebærer å svare på et elektronisk spørreskjema.

De som rekrutteres til denne studien er kvinnelige brukere ved Senter mot incest og seksuelle overgrep (SMISO, SMI, DIXI).

I spørreundersøkelsen spør vi deg om: bakgrunnsinformasjon, spørsmål relatert til det du har opplevd knyttet til seksuelle overgrep, hverdagsstress, hverdagsgleder, mestring og stressreaksjoner.

Mulige fordeler og ulemper

De som deltar bidrar til ny kunnskap om det å ha opplevd overgrep. Du er med i forskning som kan hjelpe andre som har opplevd seksuelle overgrep.

Hva skjer med informasjonen om deg?

Det er kun daglig leder ved det enkelte senter som vet hvem som deltar i studien. I presentasjon av studien vil alle personidentifiserbare opplysninger være fjernet. Det vil ikke være mulig å føre noe tilbake til den enkelte deltager, siden resultatene er anonymisert og vil bli presentert på gruppenivå.

Datafiler blir sikkert lagret. Resultatene fra spørreundersøkelsen vil bli presentert i internasjonale tidsskrift, på fagkonferanser og i undervisning.

Datamaterialet vil bli anonymisert og prosjektet forventes avsluttet innen 31.12.2020.

Studien er godkjent for gjennomføring av **Personvernombudet for forskning**, 02.01.2018.

Frivillig deltakelse

Det er frivillig å delta i studien. Du samtykker til deltagelse ved å svare på spørreundersøkelsen via en nettlénke som du mottar fra daglig leder ved ditt senter.

Dersom du har spørsmål til studien, kan du kontakte:

Doktorgradsstipendiat/sykepleier Marianne T. Stensvehagen tlf. 454 57 402 marianne.stensvehagen@inn.no	Professor/psykolog Gerry Larsson Gerry.larsson@fhs.se	Professor/psykiater Lars Lien Lars.lien@sykehuset-innlandet.no	1.amanuensis/sykepleier Berit Arnesveen Bronken Berit.bronken@inn.no
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Appendix

Questionnaire (Paper II and III)



Spørreundersøkelse:

Hverdagsstress og mestring etter seksuelle overgrep.

INFORMASJON:

Takk for at du ønsker å delta i undersøkelsen. På denne måten hjelp
er du oss med å få mer kunnskap om
hverdagsstress og hvordan kvinner som
har opplevd seksuelle overgrep, håndterer stress i sin hverdag.
Spørreundersøkelsen er anonym. Spørreundersøkelsen kan gjennom
føres både elektronisk og på papir.
informasjon om elektronisk gjennomføring får du på senteret.

Undersøkelsen inneholder en del spørsmål og tar ca. 30 minutter å g
jennomføre. Noen av spørsmålene kan oppleves som gjentakelse.
Årsaken til det er at vi benytter spørsmål fra flere standardiserte
spørreskjema og kan derfor ikke endre på originalteksten.

Tusen takk for hjelpen!

Marianne Torp Stensvehagen

Doktorgradskandidat/prosjektleder

1. Hvilket år ble du født?

Skriv inn i boksen.

*2. I hvilket land er du født?

- ☐ I Norge
- ☐ I Sverige, Finland, Danmark eller Island
- ☐ Annet land i Europa
- ☐ Annet land utenfor Europa

*3. Hvor mange år har du bodd i Norge?

- ☐ Mindre enn 1 år
- ☐ 1-5 år
- ☐ 6-10 år
- ☐ Mer enn 10 år

*4. Hva er den høyeste utdanningsgraden du har fullført?

- ☐ Grunnskole
- ☐ Videreutdanning
- ☐ Høgskole/universitet mindre enn 4 år
- ☐ Høgskole/universitet 4 år
- ☐ Høgskole/universitet mer enn 4 år

*5. Hva er din sivilstatus?

- ☐ Enslig/singel
- ☐ Gift/samboer

*6. Har du barn?

- ☐ Ja
- ☐ Nei

*7. Har du hatt vansker i forbindelse med svangerskap, fødsel eller barseltid som kan relateres til overgrep?

- ☐ Ja
- ☐ Nei
- ☐ Ikke relevant

*8. Hvor mange personer står deg så nær, at du kan regne med dem hvis du har store personlige problemer?

- ☐ Ingen
- ☐ 1-2
- ☐ 3-4
- ☐ 5 eller flere

*9. Hvilken tilknytning har du til arbeidslivet?

- ☐ Jobber i 100 % stilling
- ☐ Jobber i 50 % stilling
- ☐ Jobber i deltidstilling (mindre enn 50 %)
- ☐ Er student/skoleelev
- ☐ Er pensjonist
- ☐ Er sykemeldt
- ☐ Er uføretrygdet
- ☐ Er arbeidsledig
- ☐ Er på arbeidsavklaring

*10. Antall år du har vært i arbeid?

- ☐ Mindre enn 1 år
- ☐ 1-3 år
- ☐ 3-10 år
- ☐ Mer enn 10 år

*11. Hva er din nåværende bolig?

- ☐ Eget hus

- ☐ Egen leilighet
- ☐ Leier hus
- ☐ Leier leilighet
- ☐ Annet (spesifiser):

*12. Hvor god økonomi synes du at du har?

- ☐ Ikke så god
- ☐ God
- ☐ Svært god

*13. Hvordan var din barndom?

- ☐ Vanskelig
- ☐ God
- ☐ Svært god

*14. Hvordan vurderer du selv din egen helse?

- ☐ Meget god
- ☐ God
- ☐ Verken god eller dårlig
- ☐ Dårlig
- ☐ Meget dårlig

15. Hvilke helsetjenester bruker du mest? (Flere kryss mulig)

- ☐ Legevakt
- ☐ Fastlege
- ☐ Hjemmesykepleie
- ☐ Hjemmehjelp
- ☐ Spesialistlege (psykolog, psykiater)
- ☐ Ergo/fysioterapeut
- ☐ Sykehus grunnnet fysiske sykdom
- ☐ Sykehus grunnnet psykisk sykdom
- ☐ Sykehus grunnnet rusrelaterte problemer

- Alternativ behandling
- Annet (spesifiser):

*16. Hvordan vurderer du de helsetjenestene du får?

- Meget tilfredsstillende
- Tilfredsstillende
- Lite tilfredsstillende
- Dårlig

17. Hvor ofte er du på senteret (DIXI, SMI eller SMISO) du er tilknyttet?

- Svært ofte (ukentlig)
- Ofte (hver måned)
- Sjelden (en gang i halvåret)
- Veldig sjelden (siste år)

18. Hvordan benytter du senteret (DIXI, SMI eller SMISO)? (Flere kryss mulig)

- Benytter tilbud på senteret (samtale, aktiviteter, lunsj osv)
- Har telefonkontakt med ansatte på senteret
- Følger senteret via nettside eller Facebook

I hverdagen opplever man mange små gleder, bekymringer og irritasjonsmoment. Angi nedenfor hvor ofte du har opplevd disse i løpet av den siste måneden.

Kryss av for det alternativet som passer best for deg!

*Glede over å ha lyktes med noe eller oppnådd et mål
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å være sammen med mine nærmeste
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over avkobling og rekreasjon (f.eks. litteratur, musikk, tur, sport)
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å ha noen å snakke med som vil lytte
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å ha det bra
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å ha et sted du er trygg

☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å oppleve færre triggerer eller minner fra overgrep
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over de små ting i hverdagen (tid med husdyr, være i naturen ol)
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å ha overskudd til hverdagslige aktiviteter
☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å ha meningsfylte aktiviteter

☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

*Glede over å kunne hjelpe andre i samme situasjon

☐ Aldri ☐ Sjelden ☐ Iblant ☐ Ofte ☐ Veldig ofte

* Glede over å tørre å utfordre egne grenser

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring over å ikke ha tilstrekkelig med kraft og energi

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for egen prestasjonsevne

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for eget utseende

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for helsen i fremtiden

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for familiemedlem eller slektning

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for praktiske forhold (f.eks. økonomi, bolig og bil)

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for å ikke ha kontroll

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for å ikke føle seg trygg

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for minner fra overgrep

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

* Bekymring for å ikke kunne møte andres forventninger (jobb, utdanning)

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for trusler fra overgriper

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Bekymring for å møte overgriper

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

* Bekymring for å ikke kunne være i en nær relasjon (ha kjæreste, bli samboer/gift, få egne barn)

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon for å ha glemt hvor jeg legger saker og må lete

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over kolleger

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over sjef/leder

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over familiemedlemmer

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over venner

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over å bli avbrutt og ikke rekke å gjøre ferdig ting

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over manglende overskudd i hverdagen

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

*Irritasjon over egen kropp

☐ Aldri ☐ Sjelden ☐ Ibland ☐ Ofte ☐ Veldig ofte

Under er det en rekke utsagn som beskriver ulike måter å takle stress på. Det jeg er interessert i, er hvordan du takler stress. Jeg ønsker å vite i hvilken grad du har gjort det som utsagnene beskriver, hvor mye, eller hvor ofte. Ikke svar ut fra hva du tror vil virke eller ikke, bare om du gjør det eller ikke.

- *Jeg har gjort andre ting for å få tankene mine bort
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har konsentrert meg om å gjøre noe med situasjonen jeg er i
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har sagt til meg selv "Dette er ikke sant"
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har brukt alkohol eller piller for å føle meg bedre
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har fått sympati eller støtte fra andre
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har gitt opp å prøve å takle det
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har gjort ulike ting for å prøve å gjøre situasjonen bedre
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har nektet å tro at det har hendt
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har sagt ulike ting for å få de ubehagelige følelsene til å forsvinne
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har fått hjelp og råd fra andre
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye

- *Jeg har brukt alkohol og/eller piller for å klare å komme gjennom det
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har prøvd å se det i et annet lys for å se mer positivt på situasjonen
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har kritisert meg selv Ikke i det hele tatt Litt Ganske mye Veldig mye
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har prøvd å komme på en strategi for å takle det
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har fått støtte og forståelse hos noen
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har gitt opp å prøve å mestre det
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har prøvd å se etter noe positivt i det som skjedde
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har prøvd å spørre med det
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har gjort noe for å la være å tenke så mye på det (kino, sett på TV, lest, sovet eller lignende)
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har akseptert at det faktisk har hendt
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har gitt utløp for de negative følelsene mine
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye
- *Jeg har prøvd å finne trøst i troen eller religionen min
 - ☐ Ikke i det hele tatt
 - ☐ Litt
 - ☐ Ganske mye
 - ☐ Veldig mye

*Jeg har prøvd å få råd og hjelp fra andre om hva jeg skal gjøre

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har lært meg å leve med det

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har tenkt mye på hva jeg skal gjøre

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har lagt skylden på meg selv for at dette skjedde

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har bedt til Gud om hjelp

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har prøvd å le av det hele

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg selvskader (har spiseforstyrrelse, kutter/risper hud, selvmordstanker o.l)

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har konfrontert den eller de som har skyld

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har prøvd å leve et normalt liv

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har tatt tilbake kontrollen

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har unngått rusmidler og medikamenter for å beholde kontroll

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har fokusert på fremtiden

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har ikke latt andre få vite hvor ille det er

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har trent

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har utfordret meg selv for å håndtere minner fra overgrep

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har fokusert på hjelpe andre

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

*Jeg har brukt musikk, kunst eller andre kreative måter for å forstå egne følelser og reaksjoner

☐ Ikke i det hele tatt ☐ Litt ☐ Ganske mye ☐ Veldig mye

Jeg har gjort noe totalt annerledes enn det ovenfor nevnte.

Vennligst beskriv hva du har gjort i tekstruten nedenfor

.

Ta stilling til hvert symptom under og velg hvor ofte i løpet av den siste måneden du har opplevd følgende symptomer.

Kryss for det svar alternativet som passer best for deg!

*Ryggsmerter eller ryggplager

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Smerter i nakke eller skuldre

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Hodepine eller migrene

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Magebesvær eller magevondt

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Trykk over brystet eller brystsmarter

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Hjerteklapp

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Tungpusten/åndenød

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Svimmelhet

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Spenninger i ulike muskler

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Svette

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Ubehag ved fysisk berøring

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Ubehag eller smerter ved samleie

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Ubehag ved enkelte lyder

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Ubehag ved enkelte synsopplevelser

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Ubehag ved enkelte lukter

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Nedstemt eller depriment

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Rastløshet

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Nervøsitet eller uro

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Trøtthet eller kraftløshet

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Søvnproblemer

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Lett for å gråte

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Vansker med å slappe av

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Følt skam

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Hatt skyldfølelse

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Konsentrasjonsvansker

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

*Hatt vansker med å ta beslutninger

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

* Lett for å glemme

☐ Aldri ☒ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

* Hatt vansker med å tenke klart

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

* Hatt tanker om hevn

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

* Hatt vansker med å være sosial

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

* Hatt vansker med å forholde deg til menn

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

* Hatt vansker med å forholde deg til kvinner

☐ Aldri ☐ Nesten aldri ☐ Noen ganger ☐ Ganske ofte ☐ Svært ofte

Nedenfor finner du en liste over problemer og plager som personer kan ha etter alvorlig belastende hendelser. Angi hvor mye du har vært berørt av problemet i løpet av den siste måneden. I hvilken grad har du den siste måneden vært berørt av:

* Gjentatte forstyrrende minner, tanker eller mentale bilder om hendelsen.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Gjentatte, forstyrrende drømmer om hendelsen.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Plutselig å handle eller føle som om hendelsen skjer igjen (som om du gjenopplever den).

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Føler deg veldig opprørt når noe minner deg om hendelsen.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Fysiske reaksjoner (for eksempel hjertebank, åndenød, svette), når noe minner deg om hendelsen.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Unngår å tenke på eller snakke om hendelsen, eller unngår å ha følelser forbundet med den.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Unngår aktiviteter eller situasjoner fordi de minner deg om hendelsen.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Vanskeligheter med å huske viktige deler av hendelsen.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

* Tapt interesse for aktiviteter som tidligere gledet deg.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Føler deg fjern eller avskåret fra andre mennesker.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Kjenner deg følelsesmessig nummen eller ute av stand til å ha varme følelser for de som står deg nær.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Opplevelsen av en avkortet fremtid uten muligheter.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Vanskeligheter med å falle i søvn eller sove uavbrutt.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Føler deg irritabel eller har sinneutbrudd.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Vanskeligheter med å konsentrere deg.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Er overdrevent oppmerksom, skjerpet eller på vakt.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Føler deg skvetten eller lettskremt.

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

Under finner du en liste over ulike plager. Har du opplevd noe av det te de siste 14. dagene?

*Plutselig frykt uten grunn

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Følelse av håpløshet mht. framtiden

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Føler deg redd eller engstelig

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Matthet eller svimmelhet

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Føler deg anspent eller oppjaget

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Lett for å klandre deg selv

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Søvnproblemer

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Følelse av å være unyttig, lite verdt

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

*Nedtrykt, tungsindig (trist)

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

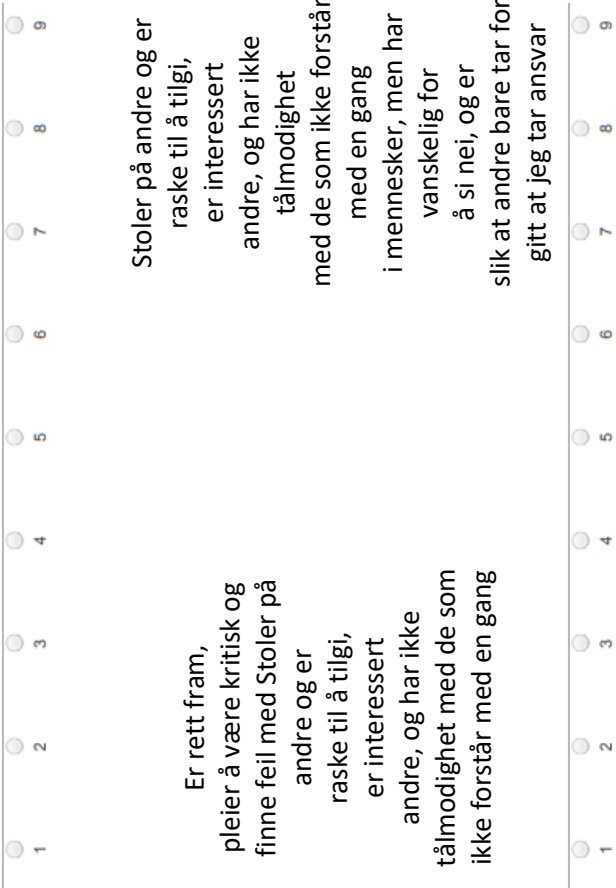
*Følelse av at alt er et slit

☐ Slett ikke ☐ Litt ☐ Moderat ☐ Mye ☐ Svært mye

Nedenfor finner du fem par med beskrivelser. Marker på skalaen fra 1-9 hvor godt du synes at respektive beskrivelser stemmer med deg. Hvis en av beskrivelsene stemmer mest med deg, markerer du i nærheten av denne beskrivelsen. Hvis begge stemmer markerer du midt på skalaen.

Liker å snakke, er utadvendt, liker å være rundt mennesker, men kan være høyløyt og søker oppmerksomhet

Er reservert, ønsker å være alene, liker ikke å få andres oppmerksomhet og kan være sjenert med fremmede



Er rett fram, pleier å være kritisk og finne feil med Stoler på andre og er raske til å tilgi, er interessert andre, og har ikke tålmodighet med de som ikke forstår med en gang

Stoler på andre og er raske til å tilgi, er interessert andre, og har ikke tålmodighet med de som ikke forstår med en gang i mennesker, men har vanskelig for å si nei, og er slik at andre bare tar for gitt at jeg tar ansvar

Er følsom, lett blir glade og kan være anspent

Er avslappet, behersket, blir sjelden irritert og blir sjelden nedstemt og lei meg.



Liker å planlegge, liker å ha god orden, legger vekt på detaljer, men kan være noe rigid eller ubøyelig

Må ikke alltid jobbe etter en tidsplan, pleier å være fleksibel, men uorganisert og glemmer ofte å sette ting på sin rette plass

* Er praktisk og ikke interessert i teoretiske ideer, foretrekker jobbene som følger en rutine, og har noen kunstneriske interesser

Bruker tid til å tenke over tingene, har en livlig fantasi og liker å tenke på nye måter å gjøre ting på, men kan være upraktisk

I siste del av spørreundersøkelsen ønsker vi informasjon om det du har opplevd knyttet til seksuelle overgrep.

1. Hva slags type seksuell krenkelse eller overgrep har du opplevd?

(Flere kryss mulig)

- ☐ Blotting/kikking
- ☐ Vist pornografiske bilder/filmer
- ☐ Følt deg presset til å sende nakenbilder av deg selv
- ☐ Blitt utsatt for sterkt seksualiserende adferd/tale uten fysisk kontakt
- ☐ Blitt befølt på kjønnsorganer/bryst
- ☐ Tvunget til å onanere andre
- ☐ Opplevd gjentatte samleieliknende bevegelser mot egen kropp
- ☐ Opplevd inntrenging med fingre, gjenstand eller kjønnsorgan i vagina eller endetarm
- ☐ Tvunget til samleie ved bruk av vold eller truende atferd
- ☐ Følt deg presset til samleie uten at det forelå vold eller rusler
- ☐ Annet (spesifiser):

*2. Alder ved første seksuelle overgrep?

- ☐ Under 7 år
- ☐ 7-12 år
- ☐ 13-17 år
- ☐ 18 år eller eldre
- ☐ Vet ikke

*3. Hvor lenge har overgrep pågått?

- ☐ Engangshendelse

- ☐ Inntil et år
- ☐ 1 - 4 år
- ☐ 5 - 10 år
- ☐ Lenger enn 10 år

*4. Pågår overgrepene fortsatt?

- ☐ Ja
- ☐ Nei

*5. Antall overgripere?

- ☐ En
- ☐ To
- ☐ Flere enn to

6. Blitt misbrukt eller krenket av (Flere kryss mulig)

- ☐ Mann
- ☐ Kvinne
- ☐ Gutt (under 18 år)
- ☐ Jente (under 18 år)

7. Relasjon til overgriper (Flere kryss mulig)

- ☐ Biologisk foreldre
- ☐ Ikke biologisk foreldre
- ☐ Fosterforeldre
- ☐ Søsknen
- ☐ Ikke biologiske søsknen
- ☐ Biologisk besteforeldre
- ☐ Ikke biologisk besteforeldre
- ☐ Ektefelle/partner/kjæreste
- ☐ Annen slektning/familie

- ☐ Bekjent
- ☐ Nabo
- ☐ Kollega
- ☐ Ukjent person
- ☐ Annen relasjon (spesifiser):

*8. Hvor lang tid gikk det fra overgrep et skjedde til du fortalte om det?

- ☐ Fortalte umiddelbart (i løpet av en uke)
- ☐ Mindre enn 1 år
- ☐ 1 - 4 år
- ☐ 5 - 9 år
- ☐ 10 - 20 år
- ☐ Mer enn 20 år

9. Hvem har du fortalt om overgrepet til? (Flere kryss mulig)

- ☐ Foreldre
- ☐ Helseøster
- ☐ Partner/samboer
- ☐ Venner
- ☐ Familie
- ☐ Fastlege
- ☐ Andre (spesifiser):

*10. Ble du trodd da du fortalte om det du hadde opplevd?

- ☐ Ja
- ☐ Nei

11. Hadde du noen du fikk hjelp eller støtte av når overgrepene pågikk? (Flere kryss mulig)

- ☐ Ingen
- ☐ Familie
- ☐ Helseøster
- ☐ Annet helsepersonell
- ☐ Lærer
- ☐ Venner
- ☐ Personell på overgrepsmottak
- ☐ Ansatte på SMISO
- ☐ Andre (spesifiser):

12. Hvem fikk du hjelp eller støtte av når overgrepene opphørte? (Flere kryss mulig)

- ☐ Ingen
- ☐ Familie
- ☐ Helseøster
- ☐ Annet helsepersonell
- ☐ Lærer
- ☐ Venner
- ☐ Personell på overgrepsmottak
- ☐ Ansatte på SMISO
- ☐ Andre (spesifiser):

13. Hvilken type hjelp fikk du? (Flere kryss mulig)

- ☐ Samtale
- ☐ Medisiner
- ☐ Henvisning
- ☐ Informasjon om SMISO
- ☐ Informasjon om videre oppfølging i egen kommune
- ☐ Annet (spesifiser):

14. Har du skadet deg selv etter at overgrepet(ene) skjedde? (Flere kryss mulig)

- ☐ Ja (skade av hud)
- ☐ Ja (selvmordsforsøk)
- ☐ Ja (spiseforstyrrelse) Ja (rusmidler eller medikamenter)
- Nei (Hvis nei gå videre til spørsmål 17)

15. Har du vært til behandling på grunn av at du har skadet deg selv?

(Flere kryss mulig)

- ☐ Ja
- ☐ Nei

16. Har du skadet deg selv i løpet av den siste måneden?

- ☐ Ja
- ☐ Nei

17. Er overgrepssaken(e) anmeldt?

- ☐ Ja (Hvis ja fortsett til spørsmål 19)
- ☐ Noen av sakene er anmeldt
- ☐ Nei

18. Hva var grunnen til at du ikke valgte å anmelde?

(Flere kryss mulig)

- ☐ Det var for bagatellmessig
- ☐ Det var en familiesak
- ☐ Du mente de ikke kunne hjelpe noe særlig
- ☐ Du fryktet de ikke ville tro på deg
- ☐ Du trodde ikke de ville være særlig imøtekommande
- ☐ Politiet anbefalte meg å ikke anmelde
- ☐ Du liker ikke/er redd politiet
- ☐ Du var redd det bare ville føre til mer vold/overgrep
- ☐ Du orker ikke flere ydmykelser

- ☐ Du ville ikke at det skulle bli rettsak
- ☐ Det hadde andre årsaker
- ☐ Husker ikke

19. Hvis anmeldt, hva er skjedd i saken(e)? (Flere kryss mulig)

- ☐ Domfellelse
- ☐ Henlagt på grunn av foreldelse
- ☐ Henlagt på grunn av andre forhold Ikke fellende dom
- Fortsatt under etterforskning
- ☐ Ukjent

20. Er det noe du ikke har fått fortalt knyttet til stress i hverdagen og mestring av stress etter overgrep, eller andre kommentarer til spørreundersøkelsen, kan du skrive det nedenfor: