
FEMALE MULTIPLE VICTIMIZATION: LIFE STORIES, DEPRESSION AND COPING STRATEGIES¹

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ABSTRACT. Research suggests the existence of a relationship between multiple victimization and greater symptomatology complexity. However, some women exposed to cumulative adversity do not develop psychological adjustment issues. With that in mind, this study aimed to identify women's coping strategies to deal with lifetime multiple victimization. For such a purpose, thirty semi-structured interviews were conducted with women, focusing on their life stories. The content of the interviews was subjected to thematic analysis. Results revealed that these women used diverse and spontaneous coping strategies. In addition, these coping strategies are heterogeneous and can be labeled as active (e.g., problem solving, self-confidence, search for social support). Moreover, women with and without depressive symptoms mostly report problem-focused coping strategies in face of victimization. In conclusion, results reinforce the need, regarding support processes, to identify and promote coping mechanisms spontaneously activated by the victims in order to favor their psychological adjustment

Keywords: Multiple victimization; women; depression; coping.

VITIMIZAÇÃO MÚLTIPLA FEMININA: HISTÓRIAS DE VIDA, DEPRESSÃO E COPING

RESUMO. Estudos da área de Psicologia indicam a existência de uma correlação entre vitimização múltipla e maior complexidade na sintomatologia. Contudo, há mulheres expostas à adversidade cumulativa que não desenvolvem problemas de ajustamento psicológico. Este estudo procurou identificar as estratégias de *coping* pelas quais as mulheres, com e sem sintomatologia depressiva, lidam com a vitimização múltipla que sofreram ao longo da vida. Para tal, recorreu-se a um roteiro de entrevistas semiestruturadas, o qual foi administrado a 30 mulheres com perguntas sobre as suas histórias de vida. Os conteúdos das entrevistas posteriormente foram alvo de uma análise temática, cujos resultados revelam a presença de um *coping* diversificado, heterogêneo e espontâneo, que se caracteriza por ser essencialmente de tipo ativo (e.g., resolução de problemas, autoconfiança, procura de suporte social). As mulheres com e sem sintomatologia depressiva reportam, sobretudo, estratégias de *coping* focado no problema face à vitimização. Os resultados reforçam a necessidade de, nos processos de apoio, se identificar e potenciar tais mecanismos de *coping* ativados pelas vítimas de forma a promover o seu ajustamento psicológico.

Palavras-chave: Vitimização múltipla; mulheres; depressão; *coping*.

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VICTIMIZACIÓN MÚLTIPLE FEMENINO: HISTORIAS DE LA VIDA, DEPRESIÓN, ESTRATEGIAS DE COPING

RESUMEN. La investigación documenta la existencia de una relación entre la victimización múltiple y mayor complejidad en la sintomatología. Sin embargo, hay mujeres expuestas a adversidad acumulada que no desarrollan problemas de ajuste psicológico. Este estudio trata de identificar las estrategias de *coping* de las mujeres ante la victimización múltiple sufrida durante toda la vida. Las 30 entrevistas semiestructuradas acerca de sus historias de vida fueron sometidas a un análisis temático. Los resultados patentizan la presencia de un *coping* diverso, heterogéneo y espontáneo, que se caracteriza por ser activo (por ejemplo, la resolución de problemas, la autoconfianza, la búsqueda de apoyo social). Las mujeres con y sin síntomas depresivos expresan estrategias de *coping* centralizadas en la resolución de problemas ante la victimización. Los resultados refuerzan la necesidad de, en los procesos de apoyo, se identificar y desarrollar esas estrategias activadas autónomamente por las víctimas con el fin de favorecer su adaptación psicológica.

Palabras-clave: Victimización múltiple; mujeres; depresión; coping.

On the (in)visibility of female multiple victimization

A recent study by the European Union Agency for Fundamental Rights (2014) involving all 28 Member States estimated that 13 million women have been victims of physical violence and that 3.7 million have suffered sexual violence in the 12 months preceding the study. Studies like this about violence against women have made this form of violence be considered as one of the main human rights problems and a significant threat to the physical health and well-being of women. (Djikanovic, King, & Bjegovic-Mikanovic, 2013). In this regard, although initially the study of some specific forms of violence has been privileged (e.g., marital violence), we have been progressively witnessing an expansion in research about other forms of victimization (e.g., dating violence, stalking, human trafficking, etc.) (Caridade, Conde, Matos, & Gonçalves, 2014). However, the research on victimization has been focusing on individual forms of violent victimization, overlooking the fact that there are other more indirect and collective forms of victimization, such as state violence (e.g., police violence) and institutional violence (e.g., discrimination), which are present in the lives of many people, especially of the most underprivileged ones.

More recently, the scientific community has been seeking to explore the phenomenon of lifelong multiple victimization, mainly through the work by Finkelhor and colleagues (2005a, 2005b), with special focus on its prevalence rates and impact worldwide (e.g., Cuevas, Sabina, & Millosi, 2012; Nurius, Greena, Logan-Greene, & Borja, 2005) and within the context of scientific research in Portugal (Matos, Conde, & Peixoto, 2013; Sousa, 2011). Multiple victimization is a concept of difficult consensus (see Caridade et al., 2014) and refers to different types of victimization in a given period of time or throughout life. A systematic review of the literature (see Matos et al., 2013) on female multiple victimization documents the existence of high indicators standing between 13% (Gage, 2005) and 66.2% (Cuevas et al., 2012). The pernicious impact of this type of victimization on the psychological adjustment of the victims is also well documented in the literature, namely the existence of a significant relationship between multiple victimization, psychopathology development (e.g., Posttraumatic Stress Disorder – PTSD, depression, anxiety, among others) (Cuevas et al., 2012), and deficits in interpersonal relationships and coping (Messman-Moore & Resick, 2002). Thus, to consider the multiple forms of victimization is essential to understanding how victims deal with this stressful and adverse living condition.

Nevertheless, violence may have quite different effects on the victims and vary depending on the type and characteristics of the violence suffered, the story of each victim, and the sociocultural context where he/she is inserted (Caridade et al., 2014). Thus, and although a considerable number of studies point to the existence of a relationship between this multiple victimization and greater complexity in terms of symptoms, some victims exposed to high levels of cumulative adversity do not develop psychological adjustment problems (e.g., DuMont, Widom, & Czaja, 2007).

However, despite the knowledge we have about crime victims in general being increasing, research has primarily privileged the analysis of the negative impact and deficit associated with multiple victimization. There is still a small scientific investment in the study of protective factors and skills that could mediate and/or weaken the relationship between multiple victimization and psychological adjustment problems, such as coping strategies.

Coping and female multiple victimization

The study of coping has suffered changes in theoretical and methodological terms, with multiple definitions that emerge about the concept of coping, directly influencing on the type of measure used to assess this construct (see Folkman & Lazarus, 1980). Lazarus and colleagues (Folkman & Lazarus, 1980), pioneers in this field of research, propose a comprehensive and integrating approach of the complexity involved in situations in which the individual has to activate coping – the cognitivist approach –, which advocates that the individual and the environment establish a reciprocal relationship in which they are mutually affected. According to this theoretical model, coping is defined as an ever-changing set of cognitive and behavioral efforts that the individual employs in order to manage, tolerate or reduce internal and external demands and the conflicts between each other that are perceived as exceeding his/her individual resources (Folkman & Lazarus, 1980). This is also the definition we adopt in this study.

The coping categorization system proposed by Folkman and Lazarus (1980), which is based on the emotion-focused coping versus problem-focused coping taxonomy, is one of the most referenced and tested in the scientific literature. Problem-focused coping requires the development of cognitive and behavioral efforts to regulate stress – it is geared towards a certain goal – and, in this sense, is generally perceived as an adaptive way of dealing with the problem. Emotion-focused coping, in turn, involves behavioral efforts to deal with emotions and regulate emotional stress and can be considered as active (e.g., elaboration of suffering or cognitive reformulation of the stressor – adaptive) or avoidant (maladaptive, for instance, to make use of denial so as to avoid suffering) (Holahan & Moss, 1990, cited by Green et al., 2010). According to Folkman and Lazarus (1980), the use of coping strategies centered on the problem or emotion depends on the type of evaluation that the individual performs concerning the stress-generator situation in which he/she is inserted. Thus, and even though problem-focused coping is in general more commonly used in situations perceived as being changeable, and emotion-focused coping in situations identified as unchangeable, both can be used in different stress situations.

Effectively, scientific evidence (e.g., Hetzel-Rigging & Meads, 2011; Iverson et al., 2013) has shown that coping responses centered on avoidance – emotion-focused coping – in the face of stressful situations increment psychological maladjustment, while the use of constructive coping, namely problem-focused coping, might lessen the possibility of stressful life events promoting psychological maladjustment and/or decreasing the risk of revictimization.

Another study (Futa, Nash, Hansen, & Garbin, 2003) that sought to analyze coping mechanisms used by women who had experienced several stories of abuse found that they, in comparison with the group without history of abuse, tend in particular to employ detachment and self-blame. The authors also concluded that different types of abuse require a unique combination of coping strategies to deal with the memories of the abuse, and that the combined trauma of different abusive stories requires an increase in and diversification of coping strategies.

A more recent and specific study (Young-Wolff, Hellmuth, Jaquier, Swan, Connell, & Sullivan, 2014) that integrated multiply-victimized women shows that victimization (past and recent) is associated with different patterns in the use of resources (e.g., social support, healthcare, legal resources), suggesting the importance of considering the heterogeneity of suffered victimization experiences.

Specifically speaking, that study found that women exposed to more severe forms of victimization tended in an active manner to use a variety of resources (90% resorted to social support and 70% used legal resources; 63% searched for healthcare services and 62% appealed to other support services). Furthermore, that study concluded that women tend mostly to use informal support resources (e.g., religious and spiritual services, social support) compared with formal and traditional services.

This study sought to identify the coping processes through which women with and without depressive symptoms deal with the victimization they have gone through in the course of their lives, in order to shed some light on the psychosocial practice, making it more capable of producing effective changes in the trajectory of these women.

Method

Participants

A total of 30 women participated in this study, in accordance with the following criteria for inclusion in the sample: a) having experienced multiple victimization (e.g., marital violence, stalking, discrimination, institutional violence); b) not having benefited from psychotherapeutic intervention (excluding crisis intervention); c) possessing minimum cognitive skills necessary to understand and report situations, problems and events.

The age of the participants ranged from 19 to 59 years old, and the mean age was 34.37 years old ($SD = 9.32$). A significant number of participants (16) were separated/divorced, 10 were single and only 4 were married. The majority of participants were Caucasian (25) and only 5 were black. Employment status was essentially characterized by unemployment condition (20) or precarious employment status (6), and only 4 were professionally integrated. Almost all women had children under their responsibility ($n=27$). The study counted with women living in shelters ($n=15$) or who had lived in shelters in the past ($n=3$), and women who had never being in such a situation ($n=12$).

With regard to the lifelong history of victimization of the participants, the most prevalent forms of victimization were physical and psychological violence (83.3%, respectively), followed by vicarious violence (60%), sexual violence (40%), discrimination (44%) and negligence (22%). Throughout life, institutional violence was reported less frequently (2.7%), just as happened with childhood (3.3%) and adolescence (3.3%). As for adulthood, we found a higher prevalence of institutional violence (46.7%).

Instruments

To analyze the life story of the participants, we used the Interview on Life Story (Matos & Dias, 2012), adapted from McAdams' interview (2008). Each of the participants were asked to tell the story of their lives, covering the topics of the script (e.g., a summary of main life stages, the most remarkable events, challenges, plans for the future, personal values and beliefs). Despite this prior structure, the interviews were conducted so as to allow the speech to flow according to the interest of the participants.

In order to assess the multiple victimization to which the participants had been subjected we resorted to the Lifelong Victimization Questionnaire (Matos, Dias, & Costa, 2012), adapted from the Lifetime Trauma and Victimization History (LTVH), Adult Protocol PhenXToolkit by Widom and colleagues (2010), which assesses the experiences of multiple victimization at different life stages (childhood, adolescence, adulthood) and explores the most significant/remarkable victimization experiences in terms of the experience and perceived impact.

To assess depressive symptomatology, we employed the Beck Depression Inventory (BDI II; adapted Portuguese version, Coelho, Martins, & Barros, 2002), a self-report instrument composed of 21 items, with high internal consistency (Cronbach's $\alpha = 0.89$). Each item consists of 4-7 statements classified according to the gravity of the symptoms, and the participant chooses the one which she judges to be the closest to her current state. This instrument allows indicating minimal symptoms (score of 0-13), mild depression (14-19), moderate depression (20-28) and severe depression (29-63).

Procedures

For the recruitment of participants, it was necessary, first, to contact via e-mail different institutions for victim support, which were informed about the purposes of this study; most of them accepted to

participate. After the participants' informed consent, interviews were conducted at the facilities of those institutions and at the University of Minho, lasting between 45 and 180 minutes. The interviews were conducted by researchers with experience in interviews with adult victims and specific training for conducting said interviews. Due to the possibility of addressing potentially disturbing experiences, the participants were also warned about potential effects arising from the interview, having been offered and received later specialized support whenever necessary. The interviews, held between March 2012 and January 2013, were recorded and fully transcribed, preserving the integrity of the reports for analysis.

According to the results obtained in the BDI II, two contrasting groups were formed: a) the symptomatic group (S) composed of 16 participants ($M = 23.7$; $SD = 9.19$) and the nonsymptomatic group (NS) composed of 14 participants ($M = 8.14$; $SD = 4.37$). The coping strategies used by the two groups were subjected to comparative analysis..

Data analysis

Thematic data analysis was used, which, based on a constructionist perspective, allows understanding phenomena, their meaning and how they are experienced, socially constructed and reproduced (Braun & Clarke, 2006). Thus, the inductive coding procedure was adopted, showing that the identified themes were strongly linked to the data (data-driven), without seeking adjustment to a pre-existing coding framework such as that advocated by Braun and Clarke (2006). Coding was as inclusive as possible so as to avoid hiding any potentially important extract in the theme. We used the Nvivo 10.0 software for the process of data organization, coding and interpretation. To ensure the reliability and credibility of our results, we proceeded to their validation. Thus, two independent judges with experience in qualitative data analysis methods and who were unaware of the clinical characteristics of the participants coded the transcribed interviews. One of the judges coded the entire sample independently, and the other judge 20% of the sample (six interviews), obtaining 89% according to the themes. A senior researcher audited the whole coding process.

Results

In an overall analysis and considering the areas, categories and sub-categories with larger representation (more referenced by the participants), the female victims pointed to the use of coping strategies in two central domains - problem-focused coping and emotion-focused coping -, as shown in Table 1.

Characterization of coping strategies concerning multiple victimization

Broadly speaking, it was possible to find the presence of a diverse, heterogeneous coping developed autonomously by the participants. It was characterized predominantly by active strategies present in all the reports produced ($N=30$). More specifically, there was a greater expression of answers related to problem-focused coping ($N=30$) compared with emotion-focused coping ($N=23$).

About problem-focused coping, the problem-solving strategy emerged in the report of twenty-seven women, who mostly ($N=22$) report the implementation of actions/behaviors aimed at changing the problematic situation, whether when they found themselves in the violence relationship, whether after the end of said relationship. More specifically, the participants reported leaving home to take refuge at shelters or with relatives and significant others ($N=18$), filing reports and formal complaints ($N=8$), looking for information from victim support institutions ($N=7$), requesting police intervention and/or others to stop the situation of violence ($N=6$), seeking for measures to promote their autonomy ($N=4$) (e.g., request of parental custody, job search), requesting separation from their partners and asking for

them to leave home (N=3), and preserving their protection (N=2) (e.g., by changing phone number, hiding location) at a stage after the relational break. Still about problem solving, eight participants highlighted cognitions that translate an analytical attitude in the face of the problem and which involve the awareness of the victimization experience (N=3), the weighting of strategies that ensure protection to their children (N=3), the perception of need for outside help to solve the problematic situation (N= 2) and the consideration of possible consequences (N=2). The participants' reports included, at the emotional level, references to feelings of encouragement, determination and confidence in the efforts made towards solving problems (N=14).

Table 1 - Category and sub-category system concerning coping strategies (N=30)

Category/N	Sub-category	Sub-category description	N
Problem-focused coping n=30 (100%)	(i) Problem solving	Describes cognitive and behavioral efforts to regulate stress and actively solve the problem	27
	(ii) Self-sufficiency and self-confidence	Describes the use of personal resources to deal with the problem	24
	(iii) Search for formal and informal support	Describes concrete efforts in the search for information, emotional and instrumental support from formal and informal resources	26
Confrontational n=23 (76.6%)	(i) Active	Describes efforts made towards emotional elaboration or cognitive reformulation of the problem (e.g., negotiation, self-control)	5
	(ii) Avoidant	Describe cognitive, behavioral and emotional efforts to escape from or avoid the problem	21
	(iii) Confrontational	Describes confrontation in the face of the problem and other elements that sustain or maintain it, suggesting a degree of hostility and risk	9

Another problem-focused coping strategy involved the search for informal and formal support. Seventeen participants reported resorting, simultaneously, to informal support (family members and friends) and formal support (helping professionals). Only six stressed the search for informal support, and three admitted having formal support as their only recourse. Informal support, specifically family members and friends, emerge in the narratives of the female victims as resources (N=19) particularly relevant in problem management process, playing a key role in the validation of the victimization experience, in the weighting of alternatives and solutions available and in the re-establishment of personal competence (*"I have this coworker who said "you are going to the police and I am going with you and you are not going back... So I realized that that was the right thing indeed"*).

The elements that composed informal support also prove fundamental in terms of emotional and instrumental support (*"My sister and an aunt of mine were present both in my decision and when I went to the institution for help. That was very important. I said "enough" and went to my parents' house"*) contributing to a perception of greater sense of control and self-confidence. More specifically, 14 of the participants highlighted religious beliefs and search for spiritual support as a resource that favors greater self-control (*"I really believe in God and wake up every day believing that I will be able to fight for what I want"*). Still on this matter, seven of the participants indicated the central role of their children in the mobilization of an active coping before the problem (*"And he said "Mom, let's go because dad does not like us" and I followed my son's advice"*).

In terms of formal support, the resorting to support professionals stood out in the speeches of most of the women (N=18) as having a significant impact on the management of and/or change in the problematic situation (*"The big turning point in my life was when I asked for them to help me. It was a good decision, with wisdom"*). Concretely, search for help from specific victim support entities was described as having contributed to the validation of victimization experience and the women's rights (*"After I went to the APAV, it was when someone made me see it differently"*), to the provision of emotional support (*"They gave me courage and strength and told me that I would not lose my children"*), legal support (*"They helped me a lot. Today I already have the documents, my daughter already has her birth certificate, and I hope that with all this I will be able to get back to Brazil with her"*), social support (*"I had no conditions to get a house of my own and live there with my boys. I have no job, but with the help of the doctors I think I can get one"*), and psychological support (*"We had people helping us a lot. He joined a therapy group; he did not become another man, but he changed, he changed"*). The help from the police was reported by eight of the participants and occurs particularly in situations perceived by the victims as extreme situations posing a high risk to their physical and psychological integrity (*"he grabbed my neck ... so hard ... that I thought he was going to strangle me ... and then at that point I called the GNR and filed a complaint"*). The reference to seeking support from healthcare professionals was scarce. It was mentioned by only three women who presented essentially complaints of psychological order which motivated the appealing to Psychiatry consultation.

Still at the level of problem-focused coping, an expressive number of participants (N=24) evidenced a self-sufficiency/self-confidence discourse, which translates into references to the use of their own resources for problem management. This coping strategy involved essentially cognitions that reflect the construction of meanings associated with the self (brave, strong, fighter) throughout their victimization trajectories, and feelings of self-worth and personal validation through the recognition of personal qualities that reinforce the perception of personal competence and sense of control of the participants (*"I had to be wise, right? And know how to live ... because it was not easy. I think that sometimes I can overcome myself"*).

When it comes to emotion-focused coping, avoidant coping strategies were referenced by 21 female victims, with highlight to answers showing submission and accommodation before the situation of violence (N=17). The use of these strategies appears to be associated with fears concerning children (*"I'd rather take a beating every day and have my children with me than being without them"*) and family unity (*"I learned to try to keep my family always together"*), concerning situations of economic and emotional dependence on the perpetrator and hope of change (*"The more I said I hated him, the more I liked him"*), and concerning the perception of threat/serious risk associated with the violence (*"He said that if I left him again he would kill me"*). Another dimension of this type of coping refers to avoidance, isolation and alienation before the victimization experience (N=8). These speeches essentially convey feelings of hopelessness and anguish, isolation, detachment from reality (e.g., to avoid thinking, suicidal thoughts, suicide attempts, use of medication) as means to deal with the violence (*"Fear terrorized me in such a way that I could not even speak. All I did was crying"*). Even though referenced by a small number of participants (N=5), another aspect was found, being tied to feelings of powerlessness and inability to deal with problems (*"The worst thing is that you see no way out"*).

Answers about confrontational coping had lower expression in the narratives of the participants (N=9) and translated an attitude of criticism and confrontation against the aggressor (*"One day I faced him and threw everything I saw at him"*), also reflecting a change of attitude in the face of the situation of violence (*"I remember that I saw a commercial on TV saying that five out of seven women are victims (...) and on that day I had had a huge discussion with him and then he said he was really sorry (...) I saw that commercial and thought 'I am so stupid, I am sick and tired of hearing this but never do anything about it'. That day, when he came home, instead of letting him beat me I said 'you will not touch me again, you will not even look at me again because you are a monster'"*).

Active coping, mentioned by five of the participants, emerge linked to strategies of negotiation with the aggressor so as to come to an agreement (*"And I told him that if we wanted to stay together, things would have to change, or he would seek treatment; otherwise, we would break up"*), and to efforts towards self-regulating feelings and actions (*"I have my son, I cannot do anything while I am mad, I have to let things calm down"*).

Comparison between groups with and without depressive symptomatology

To compare groups, we took as reference the suggestion by Hill, Thompson, and Williams (1997). Considering the differentiation of the Symptomatic (S) and Nonsymptomatic (NS) groups we only present categories referenced by more than half of the participants from each group (see Table 2).

Table 2 - Comparison between symptomatic (S) and nonsymptomatic (NS) groups

Category	Sub-category	S (N = 16)	NS (N=14)
Problem-focused coping	Problem solving	14 (87.5%)	13 (92.8%)
	Self-sufficiency and self-confidence	12 (75%)	12 (85.7%)
	Search for formal and informal support	14 (87.5 %)	11 (78.5%)
	Total	15 (93.8%)	14 (100%)
Emotion-focused coping	Avoidant	10 (62.5%)	10 (71.4%)
	Submission/Accommodation	7 (43.7%)	9 (64.285)
	Total	12 (75%)	10 (71.4%)

Through an overall analysis of coping in terms of presence versus absence of depressive symptoms, it was possible to observe that both groups (S and NS) tend to report mostly problem-focused coping strategies before their victimization experience. In a more specific analysis, both groups made a similar use of problem-solving and self-sufficiency/self-confidence strategies, but the symptomatic group tended to resort more to informal and formal support, compared with the nonsymptomatic group (see Table 2).

With regard to emotion-focused coping, through an analysis of specific strategies, it was evidenced that the participants resort to avoidance identically, more specifically to submission and accommodation strategies in the face of violence (see Table 2).

Discussion of results

The presence of coping strategies in the discourse of all the women who were part of this study is, in itself, a positive result, especially because it is an autonomous type of coping, since none of the participants have benefited so far from psychotherapeutic support interview. In their reports, there are, in fact, several spontaneous references to various coping strategies activated or developed throughout their lives in face of multiple victimization, even though they have not been specifically questioned about it. Other recent studies (e.g., Futa et al., 2003) also suggested the presence of this type of active and diverse coping in multiply-victimized population, arguing that the combined trauma of different abusive stories requires an increase in and diversification of coping strategies. The variety of strategies activated by these women to deal with victimization can also be explained by the type of threat faced, in this case considered as being of great proportion. A significant number of participants requested support from professionals (and lived in shelters) for experiencing continuous and severe violence within intimacy context. The fact that this sample is mostly characterized by a condition of social exclusion (e.g., unemployment condition or precarious employment) makes this result even more surprising, given that social exclusion associated with multiple victimization promotes diverse

constraints. The predominantly active character of the problem-focused coping adopted (e.g., problem solving, self-sufficiency/self-confidence, search for social support) documents the ability of this type of victim to deal with adversity, challenging the traditional stereotype of the victim as being someone "fragile, inactive and powerless". The predominant appeal to problem-focused coping, which has been associated with a decreased risk of victimization (e.g., Hetzel-Riggin & Meads, 2011; Iverson et al., 2013), also shows that these women tend to perceive the violence as a stressor that can be changed. On the other hand, this finding also contradicts some studies (e.g., Coffey et al., 1996, cited by Shorey et al., 2012) which argue that the victims resort mostly to emotion-focused coping.

Nevertheless, the participants of this study also appeal to emotion-focused coping. At this level, they resort to different strategies considered adaptive (e.g., negotiation, self-control), but also maladaptive (e.g., submission, accommodation), which is consonant with other investigations (e.g., Nadjowski & Ullman, 2011) that show that women who go through multiple victimization use different coping strategies (adaptive and/or maladaptive) to deal with adverse experiences.

Concomitantly, and in addition to the heterogeneity of coping strategies observed among the study participants, it is possible to observe in a subgroup (N=17) of these women the simultaneous use of problem-focused coping (namely self-sufficiency and self-confidence reports) and emotion-focused coping, of avoidant type, a result on which it is worth reflecting. By means of a thorough analysis of the discourses of these participants, it can be observed that nine of these women were at the time of data collection in institutional context. Throughout their life narratives, their reports evidence the resorting to avoidance strategies that translate their accommodation and submission to the situation of violence; however, there is a progressive prominence of self-sufficiency and self-confidence strategies after their integration in shelters that validate meanings of strength and courage (motivated by the cessation of violence and exit from the abusive relationship). On the other hand, the narratives of eight women show an oscillation between the use of problem-focused coping strategies and emotion-focused coping strategies, which seems to be explained by the participants' life circumstances. Although these women prove capable of articulating affections, cognitions and behaviors towards solving the problem (e.g., recognition of their own resources, cessation of violence, feelings of wellbeing), they are challenged by external demands (difficulties in obtaining/maintaining economic autonomy, length of court proceedings) and often confronted with the absence/lack of answers from their formal and informal support system, which motivates feelings of powerlessness, avoidance and detachment from reality. These results suggest that the accessibility to and availability of resources (individual, family, legal, social) are key variables in the understanding of coping processes and, consequently, of the adjustment of these victims. As supported by Poletto and Koller (2008), the way that victims deal with adversity depends not only on their individual characteristics, but also on the resolution of abusive events, on the support provided at the moment, on their reciprocity and subsequent events.

The contrasting groups, defined by levels of symptomatology presented by the participants during the interview, show that, although all participants had been exposed to high levels of cumulative adversity, not all of them showed depressive symptoms (14 women did not show depressive symptoms). This allows corroborating in part the literature (DuMont et al., 2007) that claims that the multiple victimization condition alone not always leads to psychological maladjustment. Although it is hard to explain, this subclinical condition may mean that women in this group may have already overcome an earlier stage of maladjustment and experienced a process of spontaneous remission of eventual symptoms (i.e., the symptoms disappeared without any technical-professional intervention). This psychological adjustment condition may also result from some resilience factors present in the lives of these women involving personal characteristics (e.g., an active stance, perceived self-control, positive self-image, perception of self-efficacy) and the quality and effectiveness of formal and informal support (e.g., Sabina & Banyard, 2015). These conditions, associated with the coping developed, might have allowed these women to preserve their ability to function despite living with adversity.

The fact that both groups, with and without symptoms, resort mainly to problem-focused coping strategies before their victimization experience is a surprising result in that research (e.g., Hetzel-Riggin & Meads, 2011; Iverson et al., 2013) informs that this type of coping tends to increase psychological adjustment. In turn, the use of other maladaptive coping strategies (e.g., denial, self-distraction) tends to interfere negatively with the psychological recovery of the victims (Orzeck, Rokach, & Chin, 2010).

Nevertheless, these results may be also due to the sample characteristics, namely the fact that all participants were being assisted (the vast majority have lived in shelters) and/or have requested some sort of support, which somehow can help to understand this evidence of a greater proactivity in problem solving. Likewise, this condition of having experience in living in shelters may also help to understand the fact that the participants, with and without symptoms, resort to informal and formal support, contrarily to what is found in other studies (e.g., Young-Wolff et al., 2014) according to which victims especially resort to a more informal support.

In short, this study thus proposes that all coping strategies can be important in the life-changing trajectories of these women, regardless of their direction and expectations.

Final considerations

Limitations and implications

This study allows us filling in some important gaps in research in this field: the focus on the analysis of coping strategies among adult women, targets of lifelong multiple, cumulative and continuous victimization. The fact that we have a heterogeneous sample (with and without symptoms) is another positive aspect to be highlighted.

Nevertheless, this study had some limitations. Firstly, it is worth noting the small size of the sample, which was due to the fact that the population studied is of difficult access (e.g., because of the high mobility of this population, motivated by the risk of revictimization in the face of abusive intimate partners). The use of a semi-structured interview about their life story for data collection also contains some limitations in that it does not allow direct exploration of the coping strategies that the women employed to face the traumatic experiences. However, in the future, we intend to expand the results obtained so far by increasing the sample as well as using other specific instruments for assessing coping that allow us to draw a more complete and comprehensive picture of the type of coping used by this type of victims. Another limitation was our focus, in terms of impact, only on depressive symptomatology to assess psychological adjustment, which may have caused another type of compromise to remain “invisible”. The type of participants involved in the study may also explain some of the results (e.g., the fact that most of them were separated from their abusive partners, or had already had some sort of institutionalization experience). We also have not assessed the perception that these participants have about multiple victimization, which certainly interferes with the impact and coping in face of the multiple victimization suffered as well. Similarly, we have not carried out an analysis of the available types of support (formal and informal).

Notwithstanding these limitations, this study has important implications on support processes for this population, inside and outside psychotherapeutic context. Particularly, it is worth stressing the relevance of identifying coping mechanisms, seeking to empower them so as to promote the psychological adjustment of the victims. If this does not happen, we might revictimize these women by failing to comply with this dimension. Thus, it is essential that professionals, namely “first-line” professionals (e.g., healthcare, law, social service professionals), identify and reinforce adaptation efforts independently developed by these women so they could deal and cope with the adverse experiences which they have gone through in the course of their lives, and which allowed them to transform their lives. This study comes to reinforce the need and importance of support professionals focusing primarily on the resources and skills of female victims, beyond the deficits associated with the cumulative condition of social exclusion and multiple victimization. Concomitantly and taking into account the evidence that documents the negative implications of avoidant coping on the development of diverse symptomatology (PTSD, depression), it becomes fundamental that in the support provided to this type of victims one seeks to weaken this form of coping, promoting coping strategies considered as more active and adaptive and which promote the psychological adjustment of the victims (such as problem-focused coping). In psychotherapeutic support processes, the type of coping strategies used emerges equally associated with the degree of therapeutic involvement of patients; in this way, approaches that encourage an active therapeutic engagement from patients should be developed in

order to facilitate positive results of the therapy (Lewandowski, D'iuso, Blake, Fitzpatrick, & Drapeau, 2010). Models which are more focused on empowerment should therefore be privileged in the face of more educational approaches (e.g., crisis management models). Henceforth, further longitudinal studies should be developed in order to assess the evolution of coping strategies over time and their effectiveness in the promotion of psychological adjustment of women who have suffered lifelong multiple victimization.

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