


EMPIRICAL STUDIES

Association of daily hassles, daily uplifts, coping styles and stress-related symptoms among women exposed to sexual abuse—A cross-sectional study

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Abstract

Background: Women who experience physical or sexual violence report poor self-perceived health. Knowledge of daily hassles, daily uplifts and coping styles, as well as how these factors can affect health and well-being among survivors of sexual abuse, is important for healthcare professionals to understand and target their needs.

Aim: 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.

Methods: A group of women ($n = 57$), exposed to sexual abuse, were recruited from nine support centres in Norway. Participants completed a questionnaire that addressed demographics, socioeconomic conditions, trauma history, daily hassles, daily uplifts, coping styles and stress-related symptoms. Two groups of participants were compared: one group that had above-median scores on uplifts and adaptive coping styles and one group that had above-median scores on daily hassles and maladaptive coping styles.

Results: Results indicate that women who experienced more daily hassles and used maladaptive coping styles reported significantly more stress-related symptoms, and particularly emotional symptoms, than women who experienced more daily uplifts and used adaptive coping styles. There were few differences between the two groups related to socioeconomic conditions and trauma history.

Conclusion: 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 the use of maladaptive coping styles were associated with an increase in stress-related symptoms. Novell's findings indicate that despite severe traumatic experiences, adaptive coping styles and favourable perceptions of stress in everyday life were associated with a lower frequency of stress-related

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symptoms. It may therefore be helpful to focus on altering maladaptive coping styles to reduce stress-related symptoms among sexual abuse survivors.

KEYWORDS

coping styles, cross-sectional, daily hassles, daily uplifts, sexual abuse, stress-related symptoms, 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 abuse from an intimate partner [1]. The World Health Organization has defined sexual abuse as ‘any sexual act to which the victim has not consented or has been pressured or manipulated into’ Ref. ([2], p. 951). Survivors of sexual abuse often report heightened feelings of vulnerability, poor self-perceptions of health and negative long-term health effects [3]. Adults who have been sexually abused are at a heightened risk for physical conditions across several organ systems, including pain-related complaints (e.g. pelvic pain and headache), irritable bowel syndrome, non-epileptic seizures, chronic fatigue syndrome, respiratory dysfunction and fibromyalgia [4–6]. 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 behaviour [7–10].

Women who have experienced sexual abuse often seek help from healthcare services for reasons other than trauma, and many women choose not to disclose experiences related to sexual abuse [11]. Hiding one's emotions may cause added stress and lead to maladaptive coping styles [7, 12–14]. For example, Kennedy and Prock [15] found that self-blame, shame and negative social reactions after sexual abuse were linked to poor outcomes such as post-traumatic stress disorder (PTSD), depression, psychological and physical distress, affect dysregulation and maladaptive coping. Research on the long-term health effects of sexual abuse has focused on psychiatric sequelae (e.g. post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse disorder [3, 4]). Knowledge of the numerous health consequences of sexual abuse is important for healthcare providers, so they can provide their patients with information about these consequences [3, 4].

Survivors of sexual abuse experience several ‘daily hassles,’ defined by Kanner and colleagues as ‘a vast array of demands and conditions in everyday life that are perceived as irritating, frustrating, or stressful’ and that force the individual to act [16–20]. In a prior study, we found that daily hassles experienced by adult women who had

been exposed to sexual abuse included triggers (e.g. smells or sounds linked to memories of the abuse), lack of energy, economic challenges, housing- or work-related challenges and self-harm issues [7].

Conversely, ‘daily uplifts’ 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 [7, 18]. Uplifts experienced by adult women exposed to sexual abuse may include planning for positive experiences, participating in activities they formerly enjoyed, and experiencing control in their daily lives [7, 16].

Coping is defined by Lazarus 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’ ([21], p. 141). Each individual's degree of adaptiveness is situation-specific, which complicates general measurement approaches. However, recurring patterns of coping styles have been demonstrated; therefore, measurements of coping styles may be considered meaningful [22–24]. The present study draws on this perspective in an attempt to measure coping styles related to sexual abuse. Adaptive coping styles allow a person to repeatedly cope with stressors through personal growth, optimism or solution-focused actions and are considered beneficial [25]. Conversely, maladaptive coping styles such as engaging in denial or self-criticism are considered harmful [25].

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 [7, 26]. Smyth et al. [27] have claimed that individual emotional and cognitive responses to daily stress shape health behaviour decisions and daily enactment of those decisions. Additionally, Smyth and colleagues have proposed that ‘stress responses are distinguished by their magnitude (reactivity), persistence (magnitude and/or length of recovery) and frequency (pile-up)’ ([27], p. 3). Over time, these cumulative 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 time to develop and/or manifest. Studying the daily hassles,

uplifts, coping styles 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 symptoms is useful for understanding short-term or transitory health consequences of events [28–31]. Prior studies have focused on additive symptom scales [6, 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 styles used by survivors of sexual abuse, as well as survivors' cognitions and perceptions, to 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 sexual abuse [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]. Researchers have found that the experiences of women with a history of sexual abuse may be 'susceptible to the effects of heightened daily stress and may display this susceptibility in the report of more physical symptoms' ([36], p. 218). In addition, Fergusson, McLeod and Horwood [38] found that women who experienced early sexual abuse reported more doctor and hospital contacts in early adulthood due to physical health concerns. Additionally, Eslami et al. [39] found a positive association between older women's experiences of abuse during a lifetime and reporting of high levels of somatic symptoms. In a prior study, we focused on the relationship between emotional stability, daily hassles and post-traumatic stress disorder [16]. However, few studies have focused on the impact of daily hassles, daily uplifts and coping styles on stress-related symptoms following sexual trauma [7, 36].

The aim of the current study is to explore the association of daily hassles, daily uplifts, coping styles and stress-related symptoms among survivors of sexual abuse. The study examines two hypotheses:

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

Hypothesis 2 *Daily uplifts and adaptive coping styles 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 centres for victims of incest and sexual abuse (Nok Center; before 2020, Center against incest and sexual abuse [SMISO]; referred to as 'the support centre' throughout the text [16, 40]). These support centres offer self-help services for adult survivors of incest and sexual abuse and provide opportunities for counselling and aid with the consequences of trauma experiences [41].

The inclusion criteria for the study sample were adult women (>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 centres [16]. The research team contacted 17 of the 22 support centres in Norway. Nine centres agreed to participate in data collection. These nine support centres were geographically varied and represented both large cities and small towns in Norway. Agreements were made with support centre leaders to establish a contact person at each centre who would distribute study information to individuals who came to the centre. The study was advertised through leaflets, social group meetings and the support centre Facebook page. Women who were eligible to participate received an informational letter from the support centre that explained the goals of the study and included statements regarding the voluntary and anonymous nature of participation [16]. If they wanted to participate, women contacted the designated person at the support centre, who provided an electronic anonymous link to the survey. Participants gave their informed voluntary consent to participate by answering the questionnaire. Initially, an electronic questionnaire was used. Based on feedback from support centre staff that some women were hesitant to answer the survey online, a paper-based questionnaire option was also provided. The questionnaire took approximately 45 min to complete [16].

During the planning phase, the estimated sample size was set at 100 participants. However, the recruitment process was slow, and only 57 participants completed the survey. The committee for medical and health research ethics in Norway does not allow collection of data regarding the reasons that people do not consent to participate in research studies. A potential reason for the problems with recruitment may be that similar studies were soliciting participation at the same time. Additionally, more than half of the support centre inquiries are by telephone and not in person, according to

statistics from the Norwegian Directorate for Children, Youth and Family Affairs [40]. Information regarding the total number of potential participants is unavailable due to anonymous participation at the support centres [16].

The study sample of women exposed to sexual abuse ($n = 57$) had a mean age of 41.4 years ($SD = 11.6$; range: 19–69 years [18]). Most of the participants were ethnic Norwegian (93%; 18). Participants reported their highest level of education as primary school ($n = 14$), high school ($n = 17$) or a college or university degree ($n = 26$ [16]).

Data collection and measures

Data were collected from February–October 2018 [16]. The current study, focused on stress-related symptoms, was based on the findings of a previous qualitative study of the ways in which survivors of sexual abuse cope with daily hassles [7]. The qualitative study findings informed the development of a questionnaire that includes validated and newly constructed items [16]. 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 styles used during the last month; and (6) stress-related symptoms during the last month. Measurements for each of these areas relied on a combination of established scales and newly constructed items based on the qualitative study findings [7]. Detailed information regarding the constructs, their origins, scoring and reliability is provided in Table 1.

Analyses

Defining the profile groups

Profile groups were utilised for the study, which were created as follows. First, a positive aspects variable was created by combining the daily uplifts scale and the adaptive coping style scale. Similarly, a negative aspects variable was created by combining the daily hassles scale and the maladaptive coping style scale. Next, the positive aspects and negative aspects variables were median dichotomised. Then, four profiles were created using these median-dichotomised variables: Profile 1 ($n = 19$, Group 1, above the median on positive aspects and below the median on negative aspects); Profile 2 ($n = 19$, Group 2, 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 profile group due to missing data. The subgroup comparisons involving Groups 1 and 2 yielded the clearest results; thus, the Results section of this paper is based on findings from these two profile 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 [16].

Many of the questions regarding type of sexual abuse experienced offered several Yes/No response choices such that more than one response could be selected. 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 [16].

Correlation analyses were performed to examine the relationships between the variables of daily hassles, daily uplifts, adaptive coping styles, maladaptive coping styles and each group of symptoms. Multiple regression analyses were performed using each of the following variables as predictor: daily hassles, daily uplifts, adaptive coping styles and maladaptive coping styles. 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 chi-square, including Fisher's exact test and t -tests. A Bonferroni correction was calculated to counteract the effect of multiple comparisons in a small sample size ($n = 57$ [45]). A Bonferroni-corrected alpha level of $p < 0.0015$ was considered statistically significant. Additionally, Cohen's d was computed to assess the effect size [46].

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki [47], and the methodology was approved by the Norwegian Centre for Research Data (15.12.2017, 47,920/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 [16, 48]. To ensure participant anonymity online, each participant was assigned a username and password. Only the recruiters at each support centre had access to personal information about the participants. Participants were offered an opportunity to talk with a counsellor at the support centre after answering the questionnaire [16]. Each participant consented to participate in the study by responding to the

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, 42]	Self-report questionnaire, with 10 items including: <i>Unwanted sexual behaviours</i> including indecent exposure/peeping, being shown pornographic pictures, being exposed to highly sexualised behaviour 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 behaviour; experiencing penetration with fingers, objects, or genitals in the vagina or rectum. <i>Questions related to the victimisation</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 behaviours</i> , the scale ranges from 0 to 4. <i>Unwanted sexual acts</i> , the scale ranges from 0 to 3. <i>Unwanted intercourse</i> , the scale ranges from 0 to 3.	Cronbach's α coefficients for the original 23 items ($\alpha = 0.90$), 13 original items ($\alpha = 0.83$) and 10 newly constructed items ($\alpha = 0.82$)
3a. Daily hassles during the last month	^b The Stress Profile scale [43]	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 [7]. 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 coefficient for the uplifts scales were total 13 uplift items ($\alpha = 0.91$); six original items ($\alpha = 0.85$) and seven newly constructed items ($\alpha = 0.84$)
3b. Daily Uplifts during the last month	^b The Stress Profile Scale [43]	Self-report questionnaire, with six items measuring uplifts. ^a In addition, seven newly constructed items were added based on the qualitative study [7]. 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 ($\alpha = 0.84$)

(Continues)

TABLE 1 (Continued)

Construct	Instrument/origin	Description	Scoring	Reliability
3c. Physical, emotional, cognitive and target group-specific stress-related symptoms during the last month	^b The Stress Profile [43]	Self-report questionnaire, with: ten physical symptoms (e.g. back pain, stomach pain or chest pain), eight emotional symptoms (e.g. hopelessness, feeling low or sleeping problems) and four cognitive symptoms (e.g. concentration difficulties, difficulties to make decisions or difficulties to think clearly). ^a In addition, seven newly constructed target group-specific items (five items measuring physical discomfort and two items measuring emotional reactions [7]. The newly constructed items included 'Feelings of shame', 'Feelings of guilt', 'Discomfort or pain during intercourse' and 'Discomfort at certain sounds'	Responded to on a 5-point Likert scale ranging from 'Never' (1) to 'Very often' (5)	Cronbach's alpha coefficient of these scales ranged from 0.66 to 0.83 (physical symptoms $\alpha = 0.81$, emotional symptoms $\alpha = 0.66$; cognitive symptoms $\alpha = 0.71$; target group-specific symptoms $\alpha = 0.83$)
4. Coping styles during the last month	^b The Brief COPE questionnaire [22]	Self-report questionnaire, with 28 items assessing coping behaviour in response to stressful or traumatic situations. The items generate fourteen subscales representing eight adaptive coping styles (positive reframing, accepting, seeking emotional support, seeking instrumental support, humour, planning, active coping and religion) and six maladaptive coping styles (self-distraction, denial, substance use, behavioural disengagement, venting and self-blame). The Norwegian version of the Brief COPE was used [44]	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 styles scale with 16 items ($\alpha = 0.78$) and one maladaptive coping styles scale with 12 items ($\alpha = 0.71$)

^aNewly constructed items based on the qualitative study of experiencing and coping with hassles and uplifts after sexual abuse [7].

^bValidated scale.

questionnaire. After each participant completed the survey, the survey data were anonymised.

RESULTS

Demographic and socioeconomic characteristics

The mean age of Group 1 was higher than that of Group 2 (Group 1: mean age = 43 years, $SD = 2.48$, range = 23–69 years; Group 2: mean age = 40, $SD = 2.98$, range = 24–63 years); however, this difference was not statistically significant ($p = 0.441$). The majority of the women in both groups were born in Norway (Group 1: $n = 17$; Group 2: $n = 18$), and the majority of both groups had lived in Norway for more than ten years (Group 1: $n = 18$; Group 2: $n = 19$). The remaining demographic and socioeconomic data are based on participant responses to eight questions (see [Table 2](#)).

Only three of the comparisons between the two groups yielded statistically significant differences ($p < 0.05$): educational level ($p = 0.016$), social network ($p = 0.022$) and current home ($p = 0.046$). As illustrated in [Table 2](#), the women in Group 1 were more likely than those in Group 2 to report college/university as their highest level of education, whereas the women in Group 2 were more likely than those in Group 1 to report high school as their highest level of education. The women in Group 1 were more likely than those in Group 2 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 Group 1 owned their own home, whereas several participants in Group 2 rented their home. However, after Bonferroni correction ($p < 0.0015$), none of these sociodemographic comparisons remained significant.

Sexual trauma-related characteristics

Based on Norwegian legal terms, all 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 (Group 1: $n = 12$, mean = 1.89, $SD = 1.24$; Group 2: $n = 17$, mean = 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 (Group 1: $n = 4$; Group 2: $n = 2$). Only a few participants in Group 1 ($n = 3$) had experienced sexual abuse for the first time as an adult.

The majority of participants reported that they knew their abuser. In most cases, the abuser was an adult

man (Group 1: $n = 16$; Group 2: $n = 15$). In some cases, the abuser was a young man (<18 years old; Group 1: $n = 9$; Group 2: $n = 10$). Some participants in each profile group had experienced sexual abuse perpetrated by an adult woman (Group 1: $n = 3$; Group 2: $n = 3$), and a small number of participants in each group reported that their abuser was a woman younger than 18 (Group 1: $n = 1$; Group 2: $n = 2$). However, none of these differences between the two profile groups' responses to the trauma-related questions were found to be statistically significant.

Correlation and multiple regression analyses

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 style scales (see [Table 3](#)). The results indicate that all correlations were in the expected direction. Daily uplifts and adaptive coping styles were positively correlated with one another and had significant negative correlations with all symptom scales. Daily hassles and maladaptive coping styles were also positively associated with one another and had positive correlations with all symptom scales. Additionally, 23 of the 28 identified correlations were found to be statistically significant ($p < 0.05$).

Daily hassles and maladaptive coping styles were positively correlated with one another, and both scales had strong positive associations with the symptom scales. Daily uplifts and adaptive coping styles were positively correlated and had negative associations with the symptom scales. After Bonferroni correction, 15 of the 28 correlations remained significant ($p < 0.001$).

Multiple regression analyses were conducted to examine the relationships between physical, emotional, cognitive and target group-specific symptoms and the predictor variables of daily hassles, daily uplifts, adaptive coping styles and maladaptive coping styles (see [Table 4](#)).

As illustrated in [Table 4](#), 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 target group-specific symptoms. Daily hassles had significant regression weight ($p < 0.002$) on each of the symptom scales. Maladaptive coping styles had significant regression weight ($p < 0.002$) on the emotional symptoms scale.

Individual stress-related symptoms

The stress-related symptom data consisted of four indices: physical, emotional, cognitive and target group-specific symptoms. In total, 29 comparisons were made between participants in Groups 1 and 2. Statistically significant differences ($p < 0.05$) were found in 18 of the comparisons, and participants in the favourable profile group (Group 1) consistently reported fewer symptoms than the participants in the unfavourable group (Group 2). However, after Bonferroni correction, only two of the original emotional variables ('powerlessness/hopelessness' and 'depressed/feeling low') and two of the newly constructed emotional variables ('felt shame' and 'felt guilt') remained significant.

DISCUSSION

The primary aim of the present study was to examine whether daily hassles and maladaptive coping styles were associated with a high frequency of stress-related symptoms for survivors of sexual abuse. The secondary aim of the study was to determine whether daily uplifts and adaptive coping styles 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 styles was associated with an increase in experiences of stress-related symptoms. These results support the study hypotheses and are consistent with existing research findings [36, 39, 50, 51]. The present study adds to the existing research that the use of adaptive coping styles and frequent experiences of daily uplifts were associated with a decrease in the frequency of stress-related symptoms. Despite this finding, participants in Group 1 reported struggling with muscle tension, being tired, forgetting things easily and experiencing other discomfort-related triggers.

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

A strong correlation was found between daily hassles and stress-related symptoms. Women who experienced a high frequency of daily hassles and used maladaptive coping styles reported more pain-related symptoms than other study participants. In a review of the existing literature, Nelson and Baldwin [5] 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, gynaecological, 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 Group 2 struggled with a diversity of stress-related symptoms, many of which led to challenges in their daily lives. Over time, struggles with physical pain may lead to difficulties with relaxing and sleeping [50, 52].

Two of the target group-specific items—guilt and shame—may explain why stress-related emotional symptoms and maladaptive coping styles contribute to social isolation. Kennedy and Prock [15] found that abuse severity and maladaptive coping styles were associated with self-blame and shame. The present study findings align with these results, indicating that guilt and shame may be two factors that contribute to the individuals in Group 2 experiencing more difficult struggles than those in Group 1.

Some individuals cope better than others under the same stressful circumstances. Karimzade and Besharat [24] have claimed that 'use of efficient coping styles suitable with personality traits can make stressful situations more manageable and less damaging' (p. 801). In the present study, both groups had experienced severe sexual abuse. However, women who used adaptive coping styles and experienced more daily uplifts reported a lower burden of stress-related symptoms, as well as less guilt and shame, than their peers in Group 2. Experiences of fewer daily hassles and more daily uplifts, as well as use of adaptive coping styles, may result in lower stress reactivity, improved stress recovery and fewer stress pile-ups, as proposed by Smyth et al. [27]. The present results suggest that individuals in Group 1 also experienced struggles; however, their struggles were less severe than those experienced by individuals in Group 2.

The present study results indicate a correlation between maladaptive coping styles and emotional stress-related symptoms. The women in Group 2 used more maladaptive coping styles, experienced more guilt and shame and reported more symptoms of depression and powerlessness, than their peers in Group 1. 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 styles, among survivors of child sexual abuse, sexual assault and interpersonal violence [15]. Therefore, it may be effective for afflicted individuals and healthcare personnel to focus on reducing the use of maladaptive coping styles among survivors of sexual abuse.

TABLE 2 Demographic and socioeconomic comparisons of the study profile groups

Background data ^a	Group 1	Group 2	Pearson's		
	(n = 19)	(n = 19)	χ^2	df	p
Educational level			8.23	2	0.016
Primary school	6	1			
High school	2	9			
College/University	11	9			
Occupational status			1.29	2	0.524
Employed ^b	8	5			
Unemployed ^d	6	9			
Work assessment allowance ^c	5	5			
Number of years working			0.23	1	0.631
≤3 years	7	6			
>3 years	10	12			
Social network/close relationships			5.22	1	0.022
≤2 close relations	7	14			
>2 close relations	12	5			
Marital status			0.49	1	0.485
Single	12	14			
Married/partner	7	5			
Children			0.95	1	0.330
Yes	8	11			
No	11	8			
Current home			3.98	1	0.046
Rent an apartment or house	3	9			
Own an apartment or house	15	10			
Self-assessed economy			1.05	1	0.305
Not so good	11	14			
Good/Very good	8	5			

Note: Group 1 = above median scores on uplifts and adaptive coping, below median scores on hassles and maladaptive coping. Group 2 = 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 % [49].

Trauma-related aspects, demographics and socioeconomic factors

Few significant differences were identified between the two profile groups regarding trauma experiences and the nature of victimisation. The survivors in the current study had all experienced severe sexual trauma, and most of these experiences had occurred in childhood. Child sexual abuse is associated with poor health outcomes and relational problems later in life [53, 54]. The lack of difference

between the profile groups regarding the sexual abuse scales could be attributable to a statistical ceiling effect in the between-group analyses. Participants' demographic and socioeconomic data revealed significant differences ($p < 0.05$) between groups regarding educational level, social network and current home. However, after Bonferroni correction, none of the sociodemographic comparisons remained significant. Font and Maguire-Jack [55] found that experiences of physical, emotional and sexual abuse were not mediated by socioeconomic status. Due to the nature

TABLE 3 Descriptive statistics and Pearson product-moment correlation between hassles, uplifts, coping and stress-related symptoms

Scale	(n = 57)									
	1	2	3	4	5	6	7	8	M	SD
1. Daily uplifts	-								3.02	0.70
2. Daily hassles	-0.40**	-							3.39	0.62
3. Adaptive coping styles	0.75***	-0.41**	-						2.41	0.51
4. Maladaptive coping styles	-0.37**	0.56***	-0.49***	-					2.42	0.61
5. Physical symptoms ^a	-0.23	0.54***	-0.23	-0.35**	-				3.38	0.82
6. Emotional symptoms ^c	-0.34**	0.64***	-0.48***	0.62***	0.65***	-			3.79	0.58
7. Cognitive symptoms ^c	-0.04	0.57***	-0.18	0.43**	0.56***	0.65***	-		3.90	0.71
8. Target group-specific symptoms ^b	-0.08	0.58***	0.27*	0.44**	0.61***	0.61***	0.61***	-	3.38	1.04

Note: All scales can vary between 1 (Never) and 5 (Very often). * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$. Bonferroni correction ($p < 0.0015$). Significant after correction ***.

^aStress Profile [43].

^bNewly constructed items [7].

^cCombination of Setterlind & Larsson [43] items and newly constructed target group-specific items [7].

of the likely multifactorial relationship between trauma-related and sociodemographic factors, these findings should be further assessed in a larger sample population.

Strengths and limitations

A strength of the study is that the recruited participant group included severely traumatised women. It is uncertain whether this group could have been successfully reached using other recruitment strategies [16]. The present study is one of the first to develop and test context-specific questions regarding daily hassles, daily uplifts and stress-related symptoms among survivors of sexual abuse [7, 16]. The results indicate that the existing overarching theoretical framework on daily stress, coping styles and health outcomes retains relevance in a group of severely traumatised women. In this respect, the findings constitute a theoretical contribution.

The current study is descriptive; therefore, associations can be observed but assumptions cannot be drawn about the causal directions of these relationships. Participant nonresponse may have biased the outcome measures. Many women choose not to talk about their trauma, and it is therefore difficult to recruit trauma survivors for study participation [16, 56]. The study sample represents a group of women who received support and counselling. The results indicate that many of these women struggle with stress-related symptoms; however, it is notable that the recruited participant sample may be skewed towards relatively healthy survivors of severe sexual abuse [16].

The study sample size was small, which limits the generalisability of the findings. A Bonferroni alpha level of $p < 0.0015$ was calculated [45] to account for the small sample size and considered to be a statistically significant correction. It is possible that the inclusion criteria were too strict. Participants were recruited from support centres 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 [16].

The study sample consists of women who have experienced sexual abuse, most of whom are Norwegian; therefore, the results are not generalisable to women from other countries or cultures [16]. Participants were asked about past experience of symptoms during the one month preceding the survey, which could have resulted in recall bias [16]. Moreover, social desirability bias may lead survey respondents to answer questions in a favourable manner [16]; thus, participants may have over-reported 'good

TABLE 4 Hierarchical regression analysis of predictor scales on stress-related symptoms

Variable	(n = 57)				R ² /adj. R ²
	B	SE	t	p	
Physical symptoms ^a					0.31/0.25
Uplifts ^b	-0.09	0.17	-0.543	0.590	
Hassles ^b	0.63	0.19	3.302	0.002	
Adaptive coping styles ^b	0.29	0.26	1.086	0.282	
Maladaptive coping styles ^b	0.09	0.19	0.497	0.622	
Emotional symptoms ^{a,c,d}					0.51/0.47
Uplifts ^b	-0.04	0.10	-0.365	0.717	
Hassles ^b	0.38	0.12	3.288	0.002	
Adaptive coping styles ^b	0.02	0.16	0.096	0.924	
Maladaptive coping styles ^b	0.36	0.12	3.185	0.002	
Cognitive symptoms ^a					0.43/0.39
Uplifts ^b	0.18	0.13	1.349	0.183	
Hassles ^b	0.62	0.15	4.081	<0.001	
Adaptive coping styles ^b	0.33	0.21	1.602	0.115	
Maladaptive coping styles ^b	0.26	0.15	1.719	0.092	
Target-group specific symptoms ^{a,d}					0.40/0.35
Uplifts ^b	0.28	0.20	1.407	0.165	
Hassles ^b	0.90	0.23	3.957	<0.001	
Adaptive coping styles ^b	0.16	0.32	0.498	0.620	
Maladaptive coping styles ^b	0.37	0.23	1.636	0.108	

^aDependent variable.^bPredictor.^cStress Profile [43].^dNewly constructed items [7]. Bonferroni correction ($p < 0.0015$). Significant after correction in bold.

behaviour' or under-reported 'undesirable behaviour.' 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 researchers 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 compared with adulthood or those who experienced a single incident of sexual abuse compared with 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 sexual abuse survivors across different cultures. Future research should also assess interventions intended to address stress-related symptoms, social support and emotional problems, as well as the impact of altering maladaptive coping styles 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 [16]. Prior research has emphasised 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 survivors' needs [57, 58]. It is important that health professionals pay attention to the association between daily hassles, daily uplifts and coping styles, as well as the impact of these factors on health and well-being among survivors of sexual abuse.

Sexual abuse continues to be 'silenced' due to survivors' experiences of shame and guilt, and health professionals must build competence to address this topic. To do so, health professionals should learn the definitions of violence and abuse and the consequences and risk factors of being exposed as a survivor of sexual abuse. Health professionals should also learn how to identify survivors of violence and abuse and how to provide resources, such as aid agencies and relief measures, to survivors. Health providers should receive training in how to talk with patients about violence and abuse. When daily hassles 'pile up' and daily uplifts are scarce, the ability 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 (Group 1) had above-median scores on daily uplifts and adaptive coping styles and below-median scores on daily hassles and maladaptive coping styles, and the second (Group 2) had above-median scores on daily hassles and maladaptive coping styles and below-median scores on daily uplifts and adaptive coping styles. The study findings indicate that stress-related symptoms among 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 styles. Few differences were found between the two profile groups regarding 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 styles and to focus on changing stress appraisals and stress response behaviours in therapeutic and counselling interventions for sexual abuse survivors.

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CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.


AUTHOR CONTRIBUTIONS

All authors have made substantial contribution to the article. Marianne Torp Stensvehagen participated in design and data collection, conducted data analysis, wrote the draft of the paper and approved the final paper. Gerry Larsson participated in design and coordination, conducted data analysis, revised manuscript and approved the final paper. Berit A. Bronken participated in design, edited manuscript and participated in approval of the final paper. Lars Lien participated in design, edited manuscript and participated in approval of the final paper.

ETHICAL APPROVAL

The study was approved by the Norwegian Centre for Research Data (15.12.2017, 47920/AGL).

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REFERENCES

1. World Health Organization. Violence against women: Intimate partner and sexual violence against women: evidence brief: World Health Organization; 2019. Available from: <https://apps.who.int/iris/bitstream/handle/10665/329889/WHO-RHR-19.16-eng.pdf?sequence=1>.
2. Steine IM, Milde AM, Bjorvatn B, Grønli J, Nordhus IH, Mrdalj J, et al. Forekomsten av seksuelle overgrep i et representativt befolkningsutvalg i Norge [In Norwegian]. *Tidsskrift for Norsk Psykologforening*. 2012;49(10):950–7.
3. Ades V, Goddard B, Pearson Ayala S, Greene JA. Caring for long term health needs in women with a history of sexual trauma. *BMJ*. 2019;367:l5825.
4. Sigurdardottir S, Halldorsdottir S. Screaming body and silent healthcare providers: a case study with a childhood sexual abuse survivor. *Int J Environ Res Public Health*. 2018;15(1):94.
5. Nelson S, Baldwin N, Taylor J. Mental health problems and medically unexplained physical symptoms in adult survivors of childhood sexual abuse: an integrative literature review. *J Psychiatr Ment Health Nurs*. 2012;19:211–20.
6. Trickett PK, Noll JG, Putnam FW. The impact of sexual abuse on female development: lessons from a multigenerational, longitudinal research study. *Dev Psychopathol*. 2011;23(2):453–76.

7. Stensvehaugen MT, Bronken BA, Lien L, Larsson G. How women experience and cope with daily hassles after sexual abuse - a retrospective qualitative study. *Scand J Caring Sci*. 2019;33(2):487–97.
8. Jina R, Thomas LS. Health consequences of sexual violence against women. *Best Pract Res Clin Obstet Gynaecol*. 2013;27(1):15–26.
9. Nemeroff CB. Paradise lost: the neurobiological and clinical consequences of child abuse and neglect. *Neuron*. 2016;89(5):892–909.
10. Sørbo M. Helsekonsekvenser av vold mot kvinner (health consequences of violence against women). In: Narud K, editor. *Vold mot kvinner*. Oslo: Cappelen Damm Akademisk; 2014. p. 211–28.
11. Hilden M, Schei B, Swahnberg K, Halmesmaki E, Langhoff-Roos J, Offerdal K, et al. A history of sexual abuse and health: a Nordic multicentre study. *BJOG*. 2004;111(10):1121–7.
12. Sigurdardottir S, Halldorsdottir S, Bender SS. Consequences of childhood sexual abuse for health and well-being: gender similarities and differences. *Scand J Public Health*. 2014;42(3):278–86.
13. Ormon K, Torstensson-Levander M, Bahtsevani C, Sunnqvist C. The life course of women who have experienced abuse—a life chart study in general psychiatric care. *J Psychiatr Ment Health Nurs*. 2015;22(5):316–25.
14. Ormon K, Torstensson-Levander M, Sunnqvist C, Bahtsevani C. The duality of suffering and trust: abused women’s experiences of general psychiatric care—an interview study. *J Clin Nurs*. 2014;23(15–16):2303–11.
15. Kennedy AC, Prock KA. “I still feel like I am not normal”: a review of the role of stigma and stigmatization among female survivors of child sexual abuse, sexual assault, and intimate partner violence. *Trauma Violence Abuse*. 2018;19(5):512–27.
16. Stensvehaugen MT, Bronken BA, Lien L, Larsson G. Interrelationship of posttraumatic stress, hassles, uplifts, and coping in women with a history of severe sexual abuse: a cross-sectional study. *J Interpers Violence*. 2020;37:2289–309.
17. DeLongis A, Folkman S, Lazarus RS. The impact of daily stress on health and mood: psychological and social resources as mediators. *J Pers Soc Psychol*. 1988;54(3):486–95.
18. Kanner AD, Coyne JC, Schaefer C, Lazarus RS. Comparison of two modes of stress measurement: daily hassles and uplifts versus major life events. *J Behav Med*. 1981;4(1):1–39.
19. Serido J, Almeida DM, Wethington E. Chronic stressors and daily hassles: unique and interactive relationships with psychological distress. *J Health Soc Behav*. 2004;45(1):17–33.
20. Stefanek E, Strohmeier D, Fandrem H, Spiel C. Depressive symptoms in native and immigrant adolescents: the role of critical life events and daily hassles. *Anxiety Stress Coping*. 2012;25(2):201–17.
21. Lazarus RS, Folkman S. *Stress, appraisal, and coping*. New York: Springer Publishing Company; 1984.
22. Carver CS. You want to measure coping but your protocol’s too long: consider the brief cope. *Int J Behav Med*. 1997;4(1):92–100.
23. Haren EG, Mitchell CW. Relationships between the five-factor personality model and coping styles. *Psychol Educ*. 2003;40(1):38–49.
24. Karimzade A, Besharat MA. An investigation of the relationship between personality dimensions and stress coping styles. *Procedia Soc Behav Sci*. 2011;30:797–802.
25. Brown LJ, Bond MJ. The pragmatic derivation and validation of measures of adaptive and maladaptive coping styles. *Cogent Psychol*. 2019;6(1):1568070.
26. Lazarus RS. *Stress and emotion: a new synthesis*. London: Springer Publishing Company; 1999.
27. Smyth JM, Sliwinski MJ, Zawadzki MJ, Scott SB, Conroy DE, Lanza ST, et al. Everyday stress response targets in the science of behavior change. *Behav Res Ther*. 2018;101(101):20–9.
28. Folkman S, editor. *The relationship between coping and health: where should we look?* August, Los Angeles, CA: American Psychological Association Meeting; 1985.
29. Epel ES, Crosswell AD, Mayer SE, Prather AA, Slavich GM, Puterman E, et al. More than a feeling: a unified view of stress measurement for population science. *Front Neuroendocrinol*. 2018;49:146–69.
30. Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical health consequences of physical and psychological intimate partner violence. *Arch Fam Med*. 2000;9(5):451–7.
31. Fanslow J, Robinson E. Violence against women in New Zealand: prevalence and health consequences. *N Z Med J*. 2004;117(1206):U1173.
32. Najdowski CJ, Ullman SE. PTSD symptoms and self-rated recovery among adult sexual assault survivors: the effects of traumatic life events and psychosocial variables. *Psychol Women Q*. 2009;33(1):43–53.
33. Zoellner LA, Goodwin ML, Foa EB. PTSD severity and health perceptions in female victims of sexual assault. *J Trauma Stress*. 2000;13(4):635–49.
34. Johansson G, Eklund M, Erlandsson LK. Everyday hassles and uplifts among women on long-term sick-leave due to stress-related disorders. *Scand J Occup Ther*. 2012;19(3):239–48.
35. McGuigan WM, Middlemiss W. Sexual abuse in childhood and interpersonal violence in adulthood: a cumulative impact on depressive symptoms in women. *J Interpers Violence*. 2005;20(10):1271–87.
36. Thakkar RR, McCanne TR. The effects of daily stressors on physical health in women with and without a childhood history of sexual abuse. *Child Abuse Negl*. 2000;24(2):209–21.
37. Larsson G, Ohlsson A, Berglund AK, Nilsson S. Daily uplifts and adaptive coping as a buffer against everyday hassles: relationship with stress reactions over time in military personnel. *Scandinavian Psychologist*. 2017;4:1–19.
38. Fergusson DM, McLeod GF, Horwood LJ. Childhood sexual abuse and adult developmental outcomes: findings from a 30-year longitudinal study in New Zealand. *Child Abuse Negl*. 2013;37(9):664–74.
39. Eslami B, Di Rosa M, Barros H, Torres-Gonzalez F, Stankunas M, Ioannidi-Kapoulou E, et al. Lifetime abuse and somatic symptoms among older women and men in Europe. *PLoS One*. 2019;14(8):e0220741.
40. The Norwegian Directorate for Children Youth and Family Affairs. *Rapportering fra sentrene mot incest og seksuelle overgrep 2019* [Reporting from the centers against incest and sexual abuse 2019]. Oslo: The Norwegian Directorate for Children, Youth and Family Affairs. 2019; 2021.
41. The Norwegian Directorate for Children Youth and Family Affairs. *Regelverk for statlig tilskudd til sentre mot incest og seksuelle overgrep og ressursentre mot voldtekt* [Regulations for state grants to centers against incest and sexual abuse and

- resource centers against rape]. In: Affairs BTNDfCYaF, editor 2021.
42. Norwegian Penal Code. The penal code (penal code). The second part. The criminal acts. Chapter 26 Sexual Offenses 2005.
 43. Setterlind S, Larsson G. The stress profile: a psychosocial approach to measuring stress. *Stress Med.* 1995;11(1):85–92.
 44. Kristiansen E, Roberts GC, Abrahamsen FE. Achievement involvement and stress coping in elite wrestling. *Scand J Med Sci Sports.* 2008;18(4):526–38.
 45. Armstrong RA. When to use the Bonferroni correction. *Ophthalmic Physiol Opt.* 2014;34(5):502–8.
 46. Cohen J. *Statistical power analysis for the behavioral sciences.* 2nd ed. Hillsdale, NJ: Erlbaum; 1988.
 47. World Medical Association. Declaration of Helsinki: ethical principles for medical research involving human subjects. 2013. Available from: <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>.
 48. Hvinden B, Bang KJ, Fjørtoft K, Holand I, Johnsen R, Kolstad I, et al. Forskningsetiske retningslinjer for samfunnsvitenskap, humaniora, juss og teologi. Oslo: De nasjonale forskningsetiske komiteene; 2016 27. April 2016.
 49. The Norwegian Labour and Welfare Administration. Work assessment allowance 2020. Available from: <https://www.nav.no/en/home/benefits-and-services/relatert-informasjon/work-assessment-allowance-aap>
 50. Sigurdardottir S, Halldorsdottir S. Repressed and silent suffering: consequences of childhood sexual abuse for women's health and well-being. *Scand J Caring Sci.* 2013;27(2):422–32.
 51. Sachs-Ericsson N, Cromer K, Hernandez A, Kendall-Tackett K. A review of childhood abuse, health, and pain-related problems: the role of psychiatric disorders and current life stress. *J Trauma Dissociation.* 2009;10(2):170–88.
 52. Miller-Graff LE, Cater AK, Howell KH, Graham-Bermann SA. Victimization in childhood: general and specific associations with physical health problems in young adulthood. *J Psychosom Res.* 2015;79(4):265–71.
 53. Oberg M, Skalkidou A, Heimer G, Lucas S. Sexual violence against women in Sweden: associations with combined childhood violence and sociodemographic factors. *Scand J Public Health.* 2021;49(3):292–300.
 54. Sigurdardottir S, Halldorsdottir S. Persistent suffering: the serious consequences of sexual violence against women and girls, their search for inner healing and the significance of the # MeToo movement. *Int J Environ Res Public Health.* 2021;18(4):1849.
 55. Font SA, Maguire-Jack K. Pathways from childhood abuse and other adversities to adult health risks: the role of adult socioeconomic conditions. *Child Abuse Negl.* 2016;51:390–9.
 56. Agudelo SF, Mendoza ZU, Tejada PA, Quintero LB. Narrative approaches to health interventions of women and girl survivors of sexual assault in Bogota's "Southwestern network", 2003–2004. *Rev Colombiana Psiquiatr.* 2007;36(3):390–410.
 57. Downes J, Kelly L, Westmarland N. Ethics in violence and abuse research—a positive empowerment approach. *Sociol Res Online.* 2014;19(1):29–41.
 58. Dugal C, Bigras N, Godbout N, Bélanger C. Childhood interpersonal trauma and its repercussions in adulthood: an analysis of psychological and interpersonal sequelae. A multidimensional approach to post-traumatic stress disorder— from theory to practice. London: IntechOpen; 2016. p. 71–107.

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