An Investigation of Trauma Responses to Intimate Partner Violence

by

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Foreword

Violence against women is a recognised international social phenomenon that occurs across age, social class, culture, region, country, and religion. It is viewed by many as originating from historically unequal power relations that have existed, and continue to exist, between men and women as well as in persistent discrimination against women (United Nations, 2008; Victorian Health Promotion Foundation, 2014; World Health Organization, 2004). This research is not intended to either blame or pathologise those women who are victims of intimate partner violence, nor remove the responsibility from the perpetrator or those who support such violence. Rather, this thesis seeks to understand and make sense of the victims’ experiences and their trauma symptoms, recognising that the ongoing safety of victims and their children is the highest priority. The purpose of the research is to identify ways in which mental health professionals can support victims who seek mental health treatment whilst coping with ongoing abuse from their current or previous partner.

Careful consideration was given to how to refer to those who experience, or have experienced, intimate partner violence. The term “victim” is common in public discourse, however there are people who feel this is disempowering to the individual, and prefer the term “survivor”. In accordance with the terminology adopted by the Special Taskforce on Domestic and Family Violence in Queensland (2015), it was decided to use the terms “victim” and “survivor” interchangeably in this thesis. This decision attempts to demonstrate an understanding that intimate partner violence is a process of victimisation where the experience of partner abuse may be beyond the individual’s power, but where the individual may also survive the violence and continue with her life (Special Taskforce on Domestic and Family Violence in Queensland, 2015).
Overview of the Investigation

There is increasing evidence that those who are survivors of intimate partner violence (IPV) are at increased risk of experiencing a wide range of mental health issues. Among the most significant of these is posttraumatic stress disorder (PTSD), although little is known about the course and onset of this presentation in this particular group. It has also been suggested that a diagnosis of PTSD is not always appropriate for understanding the effects of repeated trauma, with the construct of complex posttraumatic stress disorder (Complex PTSD) proposed as a more useful way of accounting for the complex array of symptoms that result from prolonged exposure to interpersonal trauma. Few investigations to date have, however, explored the applicability of the Complex PTSD construct to the experiences of survivors of IPV.

This thesis reports the findings of two studies. The aim of the first study was to identify the prevalence of both PTSD and Complex PTSD symptoms among female survivors of IPV who attend an Australian domestic violence centre. A sample of 59 adult women who had experienced intimate partner violence completed self-report measures of trauma symptoms and IPV. All reported having experienced psychological abuse, 97% reported physical abuse, and 86% reported sexual abuse, with almost two-thirds indicating that they had experienced ‘high’ to ‘severe’ levels of lifetime intimate partner abuse. Items designed to measure DSM-IV-TR (2000) core PTSD symptom criteria were endorsed by over two thirds (68%) of participants. The majority (80%) reported at least one significant alteration of Complex PTSD, and at least 3 of the 6 complex trauma alterations were endorsed by half (49%) of the women. The most common alteration, endorsed by 54% of participants, was an alteration in relationships with others, with nearly all (92%) disclosing an inability
to trust others. Many participants also reported a sense of permanent damage in their self-perception (69%), and feelings of despair or hopelessness (69%).

The first study also explored the relationship between trauma symptoms and the chronicity and severity of intimate partner violence. The analysis suggested that chronicity of partner violence was related to PTSD symptoms but not Complex PTSD alterations, and the severity of lifetime intimate partner violence was unrelated to either the presence of trauma symptoms or meeting the diagnostic criteria for PTSD or Complex PTSD.

The second study, a qualitative analysis of the experiences of women who reported at least 3 Complex PTSD alterations, explored how complex trauma symptoms affected the thoughts and behaviour of survivors of IPV, and how this relates to their ongoing safety. The analysis identified four themes associated with trauma symptoms and intimate partner violence, three of which highlight both protective and risk factors. The identified themes were understanding and adapting to intimate partner violence, trauma symptoms themselves, treatment, and resilience. Given that trauma symptoms and associated behaviours may serve as both risk and protective measures from partner violence, it is argued that intimate partner violence survivors who experience ongoing trauma symptoms require unique treatment options. This suggests that without specialised treatment, the alleviation of some targeted trauma symptoms may, therefore, be detrimental to the maintaining behaviours and thoughts that preserve the safety of the survivors and their children.

Another unique aspect of this group is that they seek trauma treatment whilst remaining at risk and under threat from the perpetrator, even years after separation. This suggests they have different treatment needs to those who seek trauma treatment after discontinued historical interpersonal abuse or single
occurrence trauma incidents. These findings are discussed in terms of their relevance to the development and delivery of more tailored and effective mental health treatments and interventions for survivors of intimate partner violence.
Intimate partner violence (IPV) is abuse that is perpetrated by a current or former spouse, de facto, boyfriend/girlfriend or other intimate partner (Saltzman, Fanslow, McMahon, & Shelley, 1999). Those who have just met and are in the preliminary stages of intimacy also fall within the scope of this definition (Intimate Partner Abuse and Relationship Violence Working Group, 2001). The term IPV is often used synonymously with terms such as ‘family violence’, ‘spousal abuse’, ‘domestic violence’ or ‘battering’ to describe an array of different behaviours including physical (e.g., slapping, kicking), psychological (e.g., intimidation, humiliation), sexual (e.g., forced intercourse, sexual coercion), and economic violence (e.g., withholding money), as well as a range of other ‘controlling’ behaviours such as isolating the victim from family and friends or monitoring his or her movements (see Centers for Disease Control and Prevention, 2009; Victorian Health Promotion Foundation [VicHealth], 2004). Although these different forms of abuse often co-exist, they can also occur in isolation (Taft, Hegarty, & Flood, 2001).

The Council of Australian Governments (COAG) provides the following definition:

Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. While there is no single definition, the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal.
Domestic violence includes physical, sexual, emotional and psychological abuse (COAG, 2011, p. 2).

Violence by an intimate partner is one of the most common forms of violence against women (World Health Organization [WHO], 2009). In Australia, the national Personal Safety Survey (Australian Bureau of Statistics [ABS], 2013) revealed that since the age of 15, 16.9% of women (1 in 6) and 5.3% of men (1 in 19) had experienced physical or sexual violence from an intimate partner, and 1 in 4 women and 1 in 7 men had experienced emotional abuse. Nearly two thirds (63%) of females and half (43%) of males reported anxiety or fear of emotional abuse by their partners. These statistics are consistent with those reported in the recent Global Status Report On Violence Prevention by WHO (2014) which identified that one in three women has been a victim of physical or sexual violence by an intimate partner at some point in her lifetime.

However, although a large percentage of adult women will experience IPV, less than one in five will report the violence to police (ABS, 2006) meaning that current knowledge of the effects of partner violence is based largely on the experiences of the subset of those victims who utilise social services (García Fuster, 2002). Reports of physical IPV to the police in Australia are, however, increasing, with 63% of women in 2005 stating they had not reported the most recent physical assault by their partner, compared with 74% of women in 1996 (ABS, 2007). In Australia, women with physical and cognitive disabilities are known to be at particularly high risk of victimisation (Brownridge, 2006), as are Aboriginal and Torres Strait Islander (Mouzos & Makkai, 2004) women aged 25 - 34 (ABS, 2007), and women from lower socio-economic groups (ABS, 2007).
The duration of a violent intimate relationship has been estimated to be, on average, over ten years (Pill, 2010; Sarasua & Zubizarreta, 2000), with violence often beginning during dating or in the first years of cohabitation (Sarasua & Zubizarreta, 2000; Xochimitl Tlamani, 2004). Typically, a violent intimate relationship will begin with subtle psychological violence (such as the perpetrator controlling decisions and information; Corsi, 1994), with physical violence becoming increasingly frequent and serious over time (Gelles & Pedrick-Cornell, 1990; Vargas Núñez, Pozos Gutiérrez, & López Parra, 2008). Partner violence does not discontinue when a woman becomes pregnant but may escalate (ABS, 2006) and can result in the death of the mother or foetus (Campbell, 2002). Furthermore, one in four women report experiencing violence from an abusive partner while temporarily separated, and one in five women report being stalked after separation from a violence partner (ABS, 2007).

In this thesis the term IPV is used to refer exclusively to male-perpetrated violence against a female partner. IPV researchers often refer to partner violence in this manner as the majority of partner violence that results in serious health and other consequences is that which is committed by men against their female partners (Henwood, 2000). Around 60 - 70 women are killed each year in Australia by a current or former partner (Chan & Payne, 2013) with 78% of all murders committed by an intimate partner in 2007-08 in Australia perpetrated against women (Virueda & Payne, 2010). Women are most likely to experience IPV in their home by their current or former partner, while in contrast, men are most likely to experience violence in a place of recreation by a male stranger (Australia’s National Research Organisation for Women’s Safety [ANROWS], 2014). In effect, the biggest risk
factor for becoming a victim of domestic violence is being a woman (National Council to Reduce Violence against Women and their Children, 2009b).

There is no single cause of intimate partner violence, and it can be best understood as the result of a range of individual, family, community, and societal factors interacting (ANROWS, 2014). Domestic violence awareness and prevention messages are becoming more prominent in the Australian discourse (Special Taskforce on Domestic and Family Violence in Queensland, 2015), as national and state initiatives to reduce the violence increase. Currently, there are a number of major Government initiated inquiries taking place around Australia. These include the Special Taskforce on Domestic and Family Violence in Queensland, South Australia’s Inquiry into Domestic Violence, Tasmania’s Domestic Violence Action Plan, and Victoria's Royal Commission into Family Violence. As the National Council to Reduce Violence against Women and their Children (2009b) identified, there is a clear need in Australia to improve policy and community responses to domestic violence, as enshrined in the National Plan to Reduce Violence against Women and their Children 2012-2022.

This National Plan has led to a number of initiatives to provide a nationally consistent framework for efforts to reduce such violence, such as the establishment of Australia’s National Research Organisation for Women’s Safety (ANROWS) and the Foundation to Prevent Violence against Women and their Children (ANROWS, 2014). The 2013 National Community Attitudes towards Violence Against Women Survey (NCAS), designed to monitor the National Plan, reported some encouraging results around change in Australian attitudes. Compared to 1995, more Australians now recognise that violence against women also includes non-physical behaviours, and most people are aware that IPV is against the law and usually perpetrated by men
However, the NCAS identified there were also areas of concern. More than half of those surveyed, for example, believed that a woman could leave a violent relationship if she really wanted to, and that women fabricate cases of IPV to improve their family law case. This suggests that there is still significant need for change to prevent violence against women, and that this effort must involve strategies led by individuals, organisations, and communities (VicHealth, 2014).

The Senate Inquiry into Domestic Violence in Australia delivered its final report in August 2015. The Senate Inquiry identified the importance of providing adequate long-term support for victims of domestic violence, and a need to provide stability and ongoing, comprehensive support. Currently, support is focused on crisis, and often support ceases when families are “stable”, and “this is when families need support the most” (Finance and Public Administration References Committee, 2015, p. 131). The Senate Inquiry identified multiple areas for development to make a difference in rates of domestic violence, three of which are directly related to this thesis: (1) understanding the causes and effects of domestic violence; (2) effective data collection to ensure programs and policies for women, their children and men are evidence-based; and (3) providing long term support to victims of domestic and family violence. This thesis thus seeks to effectively collect data about the effects of domestic violence, with an aim to better understand the long term support needs of women who experience IPV.

In their submission to the Senate Inquiry the Australian Psychological Society (APS) state that a range of prevention, early intervention, and tertiary level responses are needed to prevent and address domestic violence (APS, 2014). The APS further state that a lack of understanding about abusive relationships (which can include the women themselves) and a lack of supportive services when women seek help, may
contribute to the violence, or impede recovery. This thesis focuses on tertiary level responses and the mental health treatment that IPV victims may need, with particular reference to trauma responses, to support their recovery and remain safe from further intimate partner violence. This research thus seeks not to pathologise the women, but to progress the clinical understanding of normal responses to IPV.

The Impact of Intimate Partner Violence

Whilst the social and physical costs of IPV experienced by women have been well documented, there is increasing awareness that victimisation is strongly associated with a wide range of negative mental health symptoms (Hegarty, 2011). Further, an emerging literature identifies that intimate partner violence represents a special case of trauma (Ulloa, Hammett, Guzman, & Hokoda, 2015) given that IPV is an ongoing event that often occurs over an extended period of time (Lawrence & Bradbury, 2007). The social and financial, physical, and psychological impacts of IPV are, however, considered first in this overview of what is known about the impact of IPV.

Social and Financial

The social costs of violence against women are extremely high. They include the direct costs of services to treat and support abused women and their children and bring perpetrators to justice, and indirect costs such as those associated with lost employment and productivity and human pain and suffering (United Nations, 2006). A report by the National Council to Reduce Violence against Women and their Children (2009a) estimated that violence against women and their children, both domestic and non-domestic sexual assault, cost the Australian economy AUD 13.6
billion in 2009, and this is estimated to rise to AUD 15.6 billion by 2021-2022 (if the National Plan of Action is not implemented). The single greatest contributor to this cost (AUD 3.7 billion) relates to the pain, suffering and premature death of adult female domestic violence survivors. Of this, over half of the costs have been linked to depression and anxiety.

**Physical**

Beyond the social and financial costs, the association between IPV and adverse physical health has been well documented (Campbell, 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Ellsberg, Jansen, Heise, Watts, & García-Moreno, 2008; Lacey, McPerson, Samuel, Sears, & Head, 2013). In Australia, for example, between 1989 and 1998 female IPV survivors were five times more likely than male IPV victims to be killed by an intimate partner, report fearing for their lives, and require medical attention or hospitalisation (Mouzos, 1999). In a review of the literature, Campbell (2002) found that the largest physical health difference between abused and non-abused women was gynaecological problems, such as sexually-transmitted diseases, vaginal bleeding or infection, genital irritation, pain on intercourse, chronic pelvic pain, and urinary-tract infections. Campbell (2002) further reported that IPV survivors were more likely to have been injured in the head, face, neck, thorax, breasts, and abdomen than women injured in other ways. Additionally, victims experience chronic pain (e.g., headaches, back pain), recurring central nervous system symptoms (e.g., fainting and seizures), blows to the head resulting in loss of consciousness, gastrointestinal symptoms (e.g., loss of appetite, eating disorders) and disorders (e.g., irritable bowel syndrome) associated with
chronic stress, and cardiac symptoms (e.g., hypertension and chest pain). Disturbed sleep has also been associated with IPV (Woods, Hall, Campbell, & Angott, 2008).

IPV is the leading contributor to death, disability, and illness in Victorian women aged 15 to 44 making it the largest known contributor to preventable disease burden for that population (VicHealth, 2004). For women of all ages, IPV accounts for 3% of the total death, disease and injury burden; this contribution increases to 8% for women aged 18-44 years of age (Vos et al., 2006).

**Psychological**

There is increasing evidence that IPV is strongly associated with adverse mental health (Hegarty, 2011), including anxiety, depression, suicide, and tobacco and alcohol use (Lacey et al., 2013; VicHealth, 2004). A recent systematic review and meta-analysis found that there is a high prevalence of IPV among women across all diagnostic categories of mental health disorder (Trevillion, Oram, Feder, & Howard, 2012). The review found that there is a high prevalence and increased possibility of IPV among women who experience depressive disorders, anxiety disorders, and posttraumatic stress disorder, compared to women without mental health disorders (Trevillion et al., 2012). In Australia, IPV is the leading contributor to death, disability, and illness in women aged 15-44 years old. Within this child-bearing-age population, poor mental health contributes 73% and substance abuse 22% to the disease burden attributed to IPV (VicHealth, 2004), highlighting the need for more research and mental health professionals’ involvement with victims.

A meta-analytic review of studies that have investigated the impact of IPV on mental health disorders by Golding (1999) found that IPV survivors are 3 times more likely to suffer depression, 3.5 times more likely to be at risk of suicide, 4 times more
likely to suffer posttraumatic stress symptoms, 5.5 times more likely to misuse illicit or licit drugs, and 6 times more likely to misuse alcohol than women who have not experienced IPV. Similarly, analyses of the World Health Organization multi-country survey found that women who reported IPV at least once in their life displayed significantly more emotional distress, suicidal thoughts, and suicidal attempts than non-abused women (Ellsberg et al., 2008). A systematic review and meta-analysis of longitudinal studies published before 2013 found that IPV increases the odds of depressive symptoms and suicide attempts among women (Devries et al., 2013), and that, even after adjusting for probable common mental health disorders, IPV is one of the most consistent risk factors for suicide attempts (Devries et al., 2011).

Survivors of partner violence are more likely than non-abused women to report heavy drinking or binge drinking (Bonomi et al., 2006) and to abuse and depend on drugs and/or alcohol (Tolman & Rosen, 2001). Other mental health issues such as somatisation, dissociation, and phobias have also been observed (WHO, 2000). However, perhaps the most significant mental health issue reported by IPV survivors is posttraumatic stress disorder (PTSD), with international research showing that between 31% and 84% of IPV survivors meet the criteria for this diagnosis (see Jones, Hughes, & Unterstaller, 2001). The limited Australian research on this topic to date suggests that nearly half (45 to 49%) of IPV survivors will meet the diagnostic criteria for PTSD (Mertin & Mohr, 2000; Roberts, Lawrence, Williams, & Raphael, 1998). It is these traumatic responses to IPV that are the focus of the current investigation.

An emerging diagnostic disorder is Complex Post-Traumatic Stress Disorder (Complex PTSD), which encompasses the core criteria of PTSD and other alterations
in emotion regulation, dissociation, somatic distress, and identity and relational
disturbance (Courtois & Ford, 2009). Many of the aforementioned adverse
psychological responses are consistent with Complex PTSD features and associated
problems such as substance abuse and increased risk of suicide thoughts and
attempts. Complex PTSD is defined in detail in Chapter 2, along with commonly
experienced symptoms, support for the construct, and its particular relevance to IPV.

**Types of Intimate Partner Violence**

Intimate partner violence has historically been understood from a
heterosexual and male perpetrated context. This conceptualisation of IPV has
broadened in past years to consider different patterns of control within relationships.
Johnson’s (2007) typology of IPV, for example, identifies three types of IPV;
intimate terrorism, violent resistance, and situational couple violence. Intimate
terrorism is the violence to which feminist theories typically refer, in which one
partner attempts to take control of their partner by using violence and other coercive
control tactics. This type of violence can be used by either men or women in
heterosexual or same-sex relationships, but is thought to be most common in
heterosexual relationships in which the male partner is the perpetrator of the violence
(Johnson, Leone, & Xu, 2014). Violent resistance occurs when the victim of
intimate terrorism responds to the coercive controlling violence of their partner with
violence themselves; it is typically used by females in heterosexual relationships
(Johnson & Farraro, 2000). Situational couple violence occurs in the context of
specific conflicts that turn into arguments, escalating into violence. Johnson (2006)
argues that it is roughly gender symmetric, and is probably as likely to occur in
same-sex and in heterosexual relationships.
Intimate terrorism is primarily, but not exclusively male-perpetrated, with data demonstrating that this type of IPV involves a wider array of violence acts, is more frequent, and leads to more injuries and psychological distress, than situational couple violence (Johnson, 2006, 2008). It is this particular type of IPV that is the focus of this investigation.

**Responses to Intimate Partner Violence**

Prevention and intervention efforts related to IPV have, over time, been developed across various contexts including the criminal justice system, the psychotherapeutic community, and the women’s movement. An historical review of interventions for IPV in the United States of America (Barner & Carney, 2011), for example, demonstrates how the justice system has progressed by instating laws prohibiting spousal violence, how the psychotherapeutic community has changed from victim-focused to perpetrator-focused IPV interventions, and how the women’s movement has moved from a victim advocacy perspective to one that is concerned with the development of coordinated community responses. With regard to treatment, the review found that behavioural intervention programs, as part of the larger paradigm of coordinated community response, have been shown to lack empirical support, and there is inconclusive data on the effectiveness of mandated (for perpetrators) or supported treatment modalities (Barner & Carney, 2011).

A review of programs which typically focuses on the provision of advocacy and counselling to assist victims to leave abusive partners (e.g., domestic violence shelters, prenatal clinics, and police-social service outreach programs) by Stover, Meadows, and Kaufman (2009) did, however, find that post-shelter support and advocacy approaches have short-term impacts on subsequent violence, although their
effect on victims’ psychological symptoms following the abuse was not evaluated. Eckhardt et al. (2013) more recently reported that brief (<3 hours of contact) victim interventions (such as those that occur in medical contexts such as in an emergency room) can lead to the increased use of safety behaviours. Longer term interventions for IPV victims such as extended counselling, therapeutic, and advocacy programs, also lead to enhanced well-being and quality of life, and the limited research on supportive group interactions appears to demonstrate a measurable positive impact on social support and emotional distress, although there is relatively little research literature on the outcomes of therapeutic and advocacy interventions for IPV victims.

Research has demonstrated that women’s engagement with, and remaining within, treatment is negatively affected by IPV (Galvani, 2006). In addition to managing mental health difficulties, IPV victims may also be faced with additional stressors related to the partner violence, which can also act as barriers to disclose IPV when in contact with psychiatric services (Rose et al., 2011). These may include the threat or fear of further IPV, isolation and lack of support, coping with the loss or failure of the relationship, their children’s wellbeing, disruptions for their children or employment, and legal processes (Rose et al., 2011).

It is known that women experiencing IPV frequently attend family practice with mental and physical difficulties (Hegarty, 2006), and they generally have poor mental health and quality of life (Campbell, 2002). In addition to using health care services, IPV victims report using medication, but that they use specialist domestic violence services infrequently (Hegarty et al., 2013). A primary care sample of IPV victims identified that women who experience severe combined physical, emotional, and sexual abuse are more like to report poorer mental health and quality of life, than women who experience other types of abuse (Hegarty et al., 2013). This was found
despite that these women were more likely to attend mental health and specialist services, have a safety plan, and be asked by their doctor about safety. This illustrates a need for targeted and specialised treatment for women who experience severe, combined IPV, to improve quality of life and functioning.

Trials of two trauma-specific cognitive behavioural therapy approaches have been reported; *Cognitive Trauma Therapy for Battered Women* (CTT-BW; Kubany, Hill, & Owens, 2003; Kubany et al., 2004) which targets women with PTSD who have ended their abusive relationship, and *Helping to Overcome PTSD through Empowerment* (HOPE; Johnson, Zlotnick, & Perez, 2011) which addresses more acute needs and concerns of IPV victims in shelters. Both CTT-BW trials demonstrated significant reductions in PTSD diagnosis, depressive symptoms, and trauma-related guilt following treatment, with results maintained at 6-month follow-up. Findings from the HOPE trial (Johnson et al., 2011) were mixed, with those who received at least five sessions reporting lower levels of some categories of PTSD symptoms. A final CBT trial found that exposure to memories of trauma led to reductions in some PTSD symptoms (Crespo & Arinero, 2010).

A systematic review of trauma-focused interventions for domestic violence survivors by Warshaw, Sullivan, and Rivera (2013) identified only 9 studies that met the criteria for treatment that was non-pharmacological, trauma-based, specifically focused on adult survivors of IPV, and included control groups. These articles were all included in the aforementioned Eckhardt et al. (2013) review, with the exception of one study (by Gilbert et al., 2006). Warshaw et al.’s review highlights just how little is known about which evidence-based trauma treatment modalities are most applicable to IPV survivors, especially given that most studies do not consider ongoing trauma. Warshaw et al. do, however, make the important observation that
while partner abuse may lead to mental health problems such as PTSD and depression, some responses are not pathological, but appropriate responses to ongoing danger. For example, although an “exaggerated” startle response may be a manifestation of previous abuse, it may equally be viewed as a rational response that protects the woman from further harm. Similarly, passivity may be a manifestation of abuse or an intentional strategy to avoid or minimise further violence (Warshaw et al., 2013).

Consequently, even trauma-focused treatments such as cognitive therapy may not be effective, accessible, or even desired by IPV survivors, as they fail to address ongoing issues faced by the survivor. For example, while exposure therapy aims to make a prior traumatic event lose its power through repeated recall of the event, this may escalate rather than decrease when threat is present. At the time of treatment, IPV survivors may also be dealing with child care responsibilities, the legal system, financial independence and stability, and coping with the abuser claiming they are mentally unfit to care for their children or as a reason for further abuse or threats.

As will be explored in Chapter 2, treatments for PTSD and trauma-related depression were principally originally created to address single-incident trauma (e.g. sexual assault) or multiple traumatic experiences that occur in the past, such as during combat. They do not take into account long-term, recurrent interpersonal trauma such as IPV, or that survivors often experience multiple types of trauma. This further suggests that there is a need for basic research documenting the trauma experiences of IPV survivors.
Chapter Summary

This chapter has described some of the key concepts of intimate partner violence against women and underscored its social, physical, psychological impacts. It highlights the mental health issues that are commonly associated with IPV, and introduces the idea that it is important to consider trauma and traumatic symptoms if effective and appropriate services for victims of IPV are to be developed. A review of interventions for IPV victims highlights the paucity of research literature on the treatment of trauma-related symptoms. The next chapter will critically review current knowledge about the relationship between trauma and IPV.
Chapter 2
Trauma and Intimate Partner Violence

Posttraumatic Stress Disorder

Survivors of intimate partner violence (IPV) are at particular risk of developing posttraumatic stress disorder (PTSD; Dutton, 2009; Silva, McFarlane, Soeken, Parker, & Reel, 1997), a recognised psychiatric disorder which can be understood as a ‘normal’ reaction to ‘abnormal’ events (Jones et al., 2001). The original criteria for PTSD diagnosis, introduced in the third edition of the DSM (DSM-III; American Psychiatric Association [APA], 1980), were developed from observations and interviews with male Vietnam War veterans (Courtois, 2008; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) and women with a history of sexual abuse (Mooren & Stofsel, 2015). It was noted that the traumatic experiences associated with childhood abuse, adult rape, and war experiences all appeared to produce a similar set of symptoms (van der Kolk, 1996). At the time, PTSD created an organised framework for understanding how mental health is shaped by life events, whilst recognising that symptoms are a response to real experiences that overwhelm one’s capacity to cope. It allowed individuals to make sense of what they were going through instead of feeling “crazy” and forsaken, as it provided validation and legitimisation for their distress (van der Kolk & McFarlane, 1996) and has since provided a useful basis for the assessment and treatment for those displaying trauma symptoms (Conner, 2005; Mertin & Mohr, 2000).

The core criteria of PTSD symptoms, as defined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders - 4th Edition - Text Revised (DSM-IV-TR; APA, 2000), make reference to three distinct sets of symptoms: intrusion, numbing/avoidance, and hyperarousal. Symptoms of intrusion can include
intrusive memories, distressing dreams, or flashbacks of the event.

Numbing/avoidance symptoms involve the afflicted person persistently avoiding internal (e.g., thoughts, feelings) and external (e.g., people, places) reminders of the event, and experiencing numbing of general responsiveness, such as feelings of detachment (inability, or a choice not to, connect with others) or inability to recall important aspects of the trauma. Additionally, hyperarousal refers to persistent symptoms of increased arousal such as difficulty falling or staying asleep, difficulty concentrating, hypervigilance, or having an increased startle reflex.

In the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, published in May 2013, PTSD was listed in the new cluster of disorders known as “Trauma- and Stressor-Related Disorders” and four clusters of symptoms are described: intrusion, avoidance, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. The intrusion cluster includes additional possible intrusive symptoms, while the avoidance cluster continues to refer to the avoidance of internal and external reminders of the event. Negative alterations in cognitions and mood associated with the traumatic event include symptoms such as: an inability to remember important aspects of the traumatic event; persistent and exaggerated negative beliefs about oneself, others, or the world; or feelings of detachment or estrangement from others. This cluster of features was added to deal with the cognitive changes victims reveal. The final cluster, labelled alterations in arousal and reactivity, remains similar to the aforementioned hyperarousal cluster of symptoms in DSM-IV-TR.

The research presented in this thesis was designed, commenced, and data collection largely completed before DSM-5 was published. Therefore, the *core PTSD*
symptom criteria presented in DSM-IV-TR is the criteria to which this thesis principally refers.

**Complex Posttraumatic Stress Disorder**

Since the inclusion of PTSD in DSM-III, many have postulated that the criteria do not adequately address the negative psychological impact experienced by survivors of chronic, escalating, and/or severe interpersonal trauma experienced either in childhood or throughout a person’s life (e.g., Courtois, 2008; Herman, 1997; Mechanic, 2004; van der Kolk, 1996; van der Kolk et al., 2005). It has been established that the effects of prolonged trauma include affect dysregulation, aggression against self and others, dissociation symptoms, somatization, and character pathology (van der Kolk et al., 2005). The combination of a diagnosis of PTSD with other DSM-IV-TR Axis I and II disorders, Axis III medical conditions, and Axis IV psychosocial and environment problems, may be a simple solution to account for the array and complexity of symptoms experienced after trauma, however, existing diagnoses (including those in DSM-5) do not account for, nor offer guidance for the treatment of, the constellation of such symptoms (Ford & Courtois, 2009).

The concept of Complex Posttraumatic Stress Disorder (Complex PTSD; Herman, 1992) was proposed to account for these symptoms. Complex PTSD symptoms are primarily associated with emotion regulation, dissociation, somatic distress, and identity and relational disturbance (Courtois & Ford, 2009). According to Herman (1992, 1997), individuals who suffer from the complex sequelae of chronic trauma commonly risk being misdiagnosed as having personality disorders, which may lead to stigmatisation and reduced access to appropriate treatment
services. The concept of Complex PTSD thus proposes that prolonged, interpersonal trauma leads to a complex array of symptoms, characteristic personality changes, and a vulnerability to repeated harm by both self and others. Herman (1992) proposes that in contrast to the circumscribed traumatic event, prolonged, repeated trauma occurs without a discrete beginning or ending.

After being involved with the care and treatment of school children who were held hostage for several days on a school bus, Terr (1991) distinguished between type I and type II traumatic events. Terr defined type I events as a single shocking event, while type II events are prolonged and multiple trauma events. While type I events appear to place a person at greater risk for developing PTSD, type II events have been associated with more complicated and multifaceted trauma symptoms (Mooren & Stofsel, 2015), such as those that potentially result when the perpetrator and receiver of violence are in prolonged contact. Coercive control over a prolonged period of time can, it is suggested, lead to a complex constellation of observable mental health symptoms that transcend the intrusive, avoidant, and hyperarousal symptoms of PTSD.

Herman (1992, 1997) identified three broad areas of disturbance which move beyond those defined by the core features of PTSD, including more complex symptoms, characteristic personality changes, and a vulnerability to repeated harm by both self and others. Herman (1992) proposes that the consequences of prolonged victimisation include:

1. Symptomatic sequelae. Multiplicity of symptoms including somatisation, dissociation, and affective changes such as protracted depression.
(2) **Characterological sequelae.**

a) Changes in relationship to others and the perpetrator: The perpetrator uses violence and threats of violence to induce terror, decrease a sense of autonomy, isolate, and destroy emotional ties to others of the receiver of violence, leading the individual to depend on the perpetrator for basic survival and emotional needs.

b) Changes in identity: The receiver of chronic violence may lose her sense of self or develop a malignant sense of self as contaminated, guilty or evil.

(3) **Repetition of harm.** In PTSD repetitive phenomena may take the form of intrusive memories or somato-sensory reliving experiences. However, after prolonged and repeated trauma, survivors’ repetitive phenomena are not simple re-enactments or reliving experiences, but rather, take a disguised symptomatic or characterological form including self-inflicted harm or harm at the hand of others. The risk of IPV doubles for survivors of childhood abuse, with witnessing IPV as a child or being sexually abused as a child increasing the risk of subsequent marriage to an IPV perpetrator.

Independently from Herman’s (1992; 1997) conceptualisation of Complex PTSD, another group of researchers have also created a list of symptoms repeatedly described in the literature by individuals who have been exposed to prolonged and extreme interpersonal trauma (Pelcovitz, et al., 1997). These, along with the symptoms identified by Herman, can be described in terms of seven categories which are listed below (adapted from Courtois, 2008; Herman, 1997; Pelcovitz, et al., 1997; van der Kolk et al., 2005).
(1) *Alterations in regulation of affect and impulses.* Includes all methods used for emotional regulation and self-soothing, including substance abuse, self-harming behaviours, excessive risk taking, or compulsive or inhibited sexuality. The individual may display persistent dysphoria, chronic suicidal preoccupation, and difficulty modulating anger.

(2) *Alterations in attention or consciousness.* Includes amnesia (cannot remember incidents or experiences), dissociative episodes (severe disconnection with oneself) and depersonalisation (feeling that one’s body is unreal, includes out-of-body experiences, and thoughts and feelings seem unreal or do not belong to oneself), different to those included in the DSM criteria for PTSD, incorporating findings that dissociation tends to be associated with prolonged, severe interpersonal abuse such as that which occurs during childhood.

(3) *Alterations in self-perception.* Includes a chronic sense of guilt and responsibility, feelings of shame, a belief that nobody can understand, and minimising self-worth.

(4) *Alterations in perception of the perpetrator.* Includes adopting disordered beliefs of the perpetrator, idealising, or being preoccupied with hurting the perpetrator.

(5) *Alterations in regulations with others.* Includes not being able to trust or feel intimate with others. The receiver of violence learns people are self-serving, use whatever means necessary to get what they want. This may result in further abuse, or abusing others.
(6) *Somatisation &/or medical problems.* Includes direct or indirect consequences of violence such as chronic pain, digestive, cardiopulmonary, sexual, or conversion symptoms.

(7) *Alterations in systems of meaning.* Includes a sense of despair and hopelessness that the situation will not stop, and the individual may lose previously sustaining beliefs.

Further analysis of complex posttraumatic stress disorder led to the removal of the cluster relating to alterations in perception of the perpetrator (Pelcovitz et al., 1997). The potential diagnosis arising from the remaining criteria was termed ‘disorders of extreme stress, not otherwise specified’ (DESNOS; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). The DESNOS criteria were used to create the *Structured Interview for Disorders of Extreme Stress* (SIDES, Pelcovitz et al., 1997) and, in part, to investigate the impact of chronic trauma during the development of DSM-IV. During the DSM-IV Field Trial investigating DESNOS, it was found that DESNOS rarely occurs without PTSD (van der Kolk et al., 2005). DESNOS is rare in the general population, 1 to 3% in the USA, but does appear to be particularly correlated with interpersonal violence and childhood traumatisation (Mooren & Stofsel, 2015).

A decision was made to not list DESNOS as a separate diagnosis in DSM-IV, but instead to provide this diagnostic option under “associated and descriptive features” of PTSD (APA, 2000, p. 465). This section of the DSM-IV-TR is, however, vague and offers no diagnostic features; it is about half a page in length, has been described as more of an afterthought to the main diagnosis of PTSD (De Vries, 2008), and is rarely used by professionals (van der Kolk et al., 2005). As a result, the
core PTSD symptoms are often referred to as ‘simple PTSD’, and the more complex constellation of symptoms are referred to as ‘complex posttraumatic stress disorder’ or simply ‘complex trauma’ (Mooren & Stofsel, 2015). Table 1 compares PTSD and Complex PTSD¹.

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¹ As noted above, this research was largely undertaken before the DSM-5 was published, therefore DSM-IV criteria are referred to.
Table 1.  

Comparison of DSM-IV-TR (2000) Posttraumatic Stress Disorder (PTSD) and Complex Posttraumatic Stress Disorder (Complex PTSD) Features

<table>
<thead>
<tr>
<th>PTSD</th>
<th>Complex PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Exposure to traumatic event that involved possible death or serious injury, or threat to physical integrity. Person’s response involved intense fear, helplessness, or horror.</td>
<td>(1) Alterations in regulation of affect and impulses.</td>
</tr>
<tr>
<td>(B) The traumatic incident is persistently re-experienced.</td>
<td>(2) Alterations in attention or consciousness.</td>
</tr>
<tr>
<td>(C) Persistent avoidance of stimuli associated with the traumatic event and numbing of general responsiveness.</td>
<td>(3) Alterations in self-perception.</td>
</tr>
<tr>
<td>(D) Persistent symptoms of increased arousal.</td>
<td>(4) Alterations in relations with others.</td>
</tr>
<tr>
<td>(E) More than one month of symptom duration.</td>
<td>(5) Somatisation and/or medical problems.</td>
</tr>
<tr>
<td>(F) Symptoms cause clinically significant distress or impairment in social, occupational, or other important functioning.</td>
<td>(6) Alterations in systems of meaning.</td>
</tr>
</tbody>
</table>

Note. PTSD diagnostic criteria obtained from DSM-IV-TR (American Psychiatric Association, 2000); Complex PTSD diagnostic criteria obtained from van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005).
The complex trauma terminology of DESNOS and Complex PTSD are often used interchangeably, as will be the case in this thesis, and will specifically refer to the six alterations explored by Pelcovitz et al. (1997). Although the validity of DESNOS has not been fully established (see Mooren & Stofsel, 2015) and there can be poor reliability when applying DESNOS criteria (Beltran & Silove, 1999), a number of studies have found participant symptoms to be highly reflective of DESNOS criteria after interpersonal trauma (e.g., Ford, Stockton, Kaltman, & Green, 2006). The criteria for DESNOS, and slight variations, consistently appear in the literature for complex trauma symptoms, albeit most commonly under the titles of Complex PTSD or complex trauma (see Cloitre et al., 2011 for example). It is this criteria and constellation of symptoms to which this thesis relates. Although Complex PTSD is not included in the current DSM, there continues to be a push from many researchers and clinicians for it to be recognised in its own right because current trauma diagnoses do not adequately capture many people’s response to their trauma experience or reflect their impairment. Of importance, the phenomenological differences between Complex PTSD and PTSD have important treatment implications (van der Kolk et al., 2005), and these are discussed below.

In contrast to the DSM-IV-TR, the International Classification of Diseases (ICD-10) issued by the World Health Organisation (WHO, 2007) does provide a diagnostic category entitled “Enduring Personality Changes after Catastrophic Experience” (EPCACE). The disorder is characterised by a hostile and distrustful attitude toward the world, social isolation, alienation, chronic sense of threat, and feelings of hopelessness or emptiness. PTSD may precede this personality change, however it has been suggested that this diagnosis does not completely address the symptoms associated with some chronic interpersonal violence (Ebert & Dyck,
The proposed diagnosis criteria for Complex PTSD for ICD-11 combines core PTSD symptoms with three clusters of intra- and interpersonal symptoms (Maercker et al., 2013). It includes the re-experiencing, avoidance, and sense of threat symptoms (similar to the three corresponding DSM-5 criteria) of the proposed PTSD criteria for ICD-11, and it additionally includes symptoms relating to emotion regulation (anger, hurt feelings), negative self-concept (worthlessness, guilt), and interpersonal problems (not close to others, feel disconnected; Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014).

Previous attempts to systematically classify complex trauma symptoms, namely DESNOS and EPCACE, have not led to a stable diagnostic construct for adults who experience often chronic and multifaceted trauma events and consequential changes in their daily functioning. What is evident throughout the literature is that the term “complex trauma” is often adopted by both researchers and practitioners, and comprises a coherent cluster of traumatic reactions to multiple and chronic violence. Common to all definitions of complex trauma symptomology are issues associated with emotion regulation, attention and concentration, identity, trust, and functioning within relationships.

Mooren and Stofsel (2015) propose that complex trauma lies somewhere at the point between (simple) trauma and personality disorders, such that personality development is regarded as dynamic, layered, and a lifelong process. They provide a practice-based working definition of complex trauma which they base on theoretical
constructs and clinical experience. The authors put forward that the essence of complex trauma symptoms is those trauma symptoms associated with PTSD combined with alterations in cognition, affect, personality, relationships, and a variety of physical complaints. This essence is also proposed by other researchers (e.g., Courtois & Ford, 2009; Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005).

Support for the Complex Posttraumatic Stress Disorder Construct

There is growing empirical support for the relevance of the Complex PTSD construct for survivors of interpersonal violence. Results from the DSM field trial demonstrated that Complex PTSD is specific to trauma, as it was rarely found among non-trauma exposed survivors (Pelcovitz et al., 1997). Complex PTSD symptoms have been observed in incarcerated women (Mahoney, 2006), incarcerated men (Scoboria, Ford, Lin, & Frisman, 2008), combat veterans (Newman, Orsillo, Herman, Niles, & Litz, 1995), war-zone military veterans (Ford, 1999), outpatients attending a substance abuse treatment clinic who had a trauma history (Scoboria et al., 2008), victims of political trauma in Ireland (Dorahy et al., 2009), victims of war or mass violence in Algeria, Ethiopia or Gaza (de Jong, Komproe, Spinazzola, van der Kolk, & Van Ommeren, 2005), survivors of childhood sexual abuse (Dickinson, deGruy, Dickinson, & Candib, 1998; Ford et al., 2006; McLean & Gallop, 2003; Pelcovitz et al., 1997; Roth et al., 1997; Zlotnick et al., 1996), and adult survivors of physical and sexual abuse, including that which is perpetrated in IPV (Cloitre et al., 2009; Roth et al., 1997).

Research demonstrates Complex PTSD to be inversely related to the age of onset of first trauma, with individuals who experienced trauma in early life more
likely to experience Complex PTSD symptoms rather than only PTSD symptoms (van der Kolk et al., 2005). In addition, individuals with a history of violence who meet both Complex PTSD and PTSD criteria display greater dissociative symptoms than those with PTSD only (Zucker, Spinazzola, Blaustein, & van der Kolk, 2006), and women with a history of childhood sexual abuse are significantly more at risk of Complex PTSD symptoms than those who have experienced completed or attempted rape (Dickinson et al., 1998). This finding is to be expected given that childhood sexual abuse can take place over time when the child has an ongoing relationship with the perpetrator (as is the case in IPV). In contrast, rape is often a discrete traumatic event and the perpetrator and survivor do not typically have ongoing contact (Herman, 1997).

Combined physical, psychological and sexual IPV have a cumulative effect on PTSD (Pico-Alfonso et al., 2006; Silva et al., 1997), depression (Hegarty, Gunn, Chondros, & Small, 2004; Pico-Alfonso et al., 2006), anxiety symptoms, and suicide attempts (Pico-Alfonso et al., 2006). Multiple trauma experiences, such as childhood abuse and adult abuse, result in a greater risk of PTSD symptoms and many other types of psychiatric disorders (Jones et al., 2001; Roberts et al., 1998; Silva et al., 1997), with those with higher rates of PTSD reporting greater levels of mental health issues and psychological distress (Mertin & Mohr, 2000) such as those addressed by Complex PTSD. The associated literature on mental health issues and multiple types of IPV and trauma further indicates that those who experience more than one type of trauma experience heightened mental health issues, many of which are adequately addressed by the Complex PTSD construct.

A large number of studies on Complex PTSD have focussed on trauma in childhood and adolescence and subsequent emotional development. A review of
research establishing the nature of Complex PTSD identified survivors of torture in adult life experience such symptoms, despite no history of childhood trauma (McDonnell, Robjant, & Katona, 2013). The authors argue that comparative research is required between developmental trauma and chronic, interpersonal trauma in adulthood, as this may establish clinically relevant subtypes of Complex PTSD.

Cloitre et al. (2014) cites three studies that have found evidence supporting the validity of the distinct PTSD and complex PTSD diagnostic criteria proposed for ICD-11. Additionally, Cloitre et al. (2014) present research which supports the construct of Complex PTSD as distinguishable from both PTSD and Borderline Personality Disorder (BPD), providing some clarification for the debate that Complex PTSD is distinct from BPD comorbid with PTSD. Similarly, a review of clinical and scientific findings regarding Complex PTSD, PTSD, and BPD demonstrated that although there was an overlap of Complex PTSD with BPD (and with PTSD), it was unjustified to conceptualise Complex PTSD as a replacement for, or subtype of, BPD (Ford & Courtois, 2014). The authors concluded that an empirically-based differentiated view of these three constructs is important for the progression of clinical practice and scientific research among traumatised adults (Ford & Courtois, 2014).

Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder among Intimate Partner Violence survivors

Jones et al. (2001) report that rates of PTSD for IPV survivors range from 31 to 84% depending on sample characteristics, IPV severity, IPV chronicity, and history of interpersonal violence (among other factors). For example, they found that those who had multiple victimisation experiences (childhood abuse, particularly
sexual abuse, and adult sexual abuse) were at greater risk of PTSD symptoms and many other types of psychiatric disorders. A meta-analysis of the findings of 11 individual studies by Golding (1999) found the weighted mean prevalence of PTSD among IPV survivors was 64%. A recent exploratory study in Lebanon using a community snowball sampling method found that 97% of women who had experienced physical IPV endorsed core PTSD symptoms (Khadra, Wehbe, Fiola, Skaff, & Nehme, 2015).

The chronicity of trauma symptoms among IPV survivors can continue well after separation from the abusive partner. Within a community sample, between 44 and 66% of women with a history of IPV, who had separated from the abusive partner for an average of 9 years, continued to report PTSD symptoms (Woods, 2000). Past research has established that IPV victims who experience higher frequencies and more severe (more life threatening) abuse are more likely to report PTSD symptoms (Houskamp & Foy, 1991). Recent research indicates that PTSD symptom severity may be associated with recent partner abuse (Khadra et al., 2015) or recent interpersonal trauma (Forbes et al., 2012), and the prevalence of PTSD symptoms may be more dependent upon the recency of IPV rather than the setting in which an IPV victim is assessed. Given that the effects of psychological abuse can be equally (Jones et al., 2001), or even more profound (Follingstad, Rutledge, Berg, Hause, & Polek, 1990), than physical abuse, and ongoing psychological abuse from a previous partner is common for IPV survivors, recent psychological abuse may be a key factor in predicting PTSD symptoms.

A review of international literature of community-based and non-psychiatric healthcare surveys demonstrated that among women reporting PTSD, 61% reported experiencing IPV (Trevillion et al., 2012). In the first research of its kind
(Nathanson, Shorey, Tirone, & Rhatigan, 2012), clinically administered diagnostic interviews explored mental health disorders among a non-shelter community sample of 94 women who had experienced IPV. Co-occurrence of mental health disorders was common, most women met diagnostic criteria for a mental health disorder, and PTSD was the most common disorder, with 57% meeting criteria. In England, among 260 domestic violence service users, 70% reported severe abuse, and 77% self-reported above the optimum threshold of symptoms to identify PTSD (Ferrari et al., 2014).

In Australia there have been relatively few investigations of PTSD among IPV survivors. A review in September 2015 of MEDLINE, PsycINFO, and the Cochrane Library identified only two relevant studies using a set of pre-defined key search terms (including combinations of intimate partner violence and/or domestic violence, posttraumatic stress disorder, posttrauma*, Australia, trauma symptoms, prevalence, NOT children, NOT perpetrat*). The first, by Mertin and Mohr (2000), involved 100 women recruited from various domestic violence shelters in Adelaide. This study utilised the Posttraumatic Stress Disorder Interview Schedule, a face-to-face interview, and found that 45 out of the 100 women met criteria for a PTSD diagnosis, and that all women displayed at least some symptoms of PTSD. Those women meeting PTSD criteria experienced significantly higher levels of anxiety and depression than those that did not meet criteria. The second study, by Roberts et al. (1998), included women who identified as IPV victims and included a measure of PTSD, however, the sample also included non IPV victims and specific results for IPV victims alone were not reported. Among 335 women leaving a hospital’s emergency department in Brisbane who had been in an intimate relationship in their lifetime, Roberts et al. found 48% disclosed a lifetime history of IPV, with this group
receiving significantly more psychiatric diagnoses than those who reported no IPV. Women who reported IPV but no childhood abuse were significantly more likely to be diagnosed with phobias, depression, dysthymia and anxiety, than those with no IPV exposure. For those with IPV and childhood abuse, there was an additional effect for somatisation, harmful alcohol consumption and drug dependence.

Although interpersonal childhood abuse has repeatedly been associated with Complex PTSD (Cloitre et al., 2009), little consideration has been given to the link between IPV and Complex PTSD (Torres et al., 2013). To date only two published investigations in English have explored the applicability of the Complex PTSD construct to symptoms experienced by IPV survivors (De Vries, 2008; Leahy, 2008). Leahy (2008) conducted a longitudinal study involving a community sample of IPV survivors in which Complex PTSD symptoms were compared between those with differing levels of IPV. It was reported that those who had experienced even moderate levels of IPV were at risk of affective and behavioural dysregulation that transcends core PTSD, and that their symptoms were better accounted for by Complex PTSD. However, core PTSD symptoms were not assessed and, as such, it is not possible to know if these women would have met PTSD criteria either in isolation or with Complex PTSD. In the second study, De Vries (2008) found that 2 of 3 women attending a battered women’s shelter met at least one Complex PTSD criterion although, only 5% met all Complex PTSD criteria. This compares with the 58% who met the diagnostic criteria for PTSD. These somewhat conflicting findings highlight the need for more research into the prevalence of Complex PTSD in this population.

De Vries (2008) cites a third relevant study by Teegen and Schriefer (2002) in Germany which found that, of 71 participants, 58% met PTSD criteria, and an
additional 27% met Complex PTSD criteria. Those who were diagnosed with Complex PTSD also displayed higher PTSD scores. Unfortunately, this study is written in German and a published English version is not available. Courtois (2008) also refers to a conference paper by Pelcovitz and Kaplan (1995) which appears relevant, although a published version was not located.

**Characteristics of Intimate Partner Violence Affecting Complex Posttraumatic Stress Disorder**

Overall, trauma theories suggest a link exists between IPV and Complex PTSD (Herman 1992, 1997; Walker, 1979, 2009). However, not all women have the same experience of IPV and there is evidence that different types of IPV can affect mental health differently; women who experience a combination of psychological, physical, and sexual IPV most likely to experience impaired mental health (Ruiz-Pérez & Plazaola-Castaño, 2005). Therefore, different exposure to violence may also differentially influence the development of Complex PTSD symptoms (Leahy, 2008) although in her original formulation Herman (1992, 1997) did not explain how specific configurations of violence may vary and contribute to different levels or patterns of Complex PTSD symptoms among women who experience IPV (Leahy, 2008). Of the two published studies that have explored Complex PTSD among IPV survivors, only one examines the characteristics of IPV as they relate to Complex PTSD; Leahy (2008) found that Complex PTSD was associated with greater levels of IPV traumatisation, regardless of the specific indicator of abuse, be it IPV frequency, IPV severity, threats of violence, physical IPV or sexual IPV. Sexual IPV did not demonstrate greater specificity for Complex PTSD symptoms compared to threats and physical IPV as predicted. Leahy explains this by stating that Herman (1992,
Roth et al. (1997) found that prolonged exposure of an interpersonal stressor increased the risk of Complex PTSD symptoms. There is also some support for the idea that frequency of lifetime sexual violence and Complex PTSD are associated, as early-onset of violence has been shown to significantly increase Complex PTSD symptoms (McLean & Gallop, 2003). A third study by van der Kolk et al. (2005), using data from the DSM-IV field trial, found that duration of lifetime physical and sexual violence was significantly correlated with Complex PTSD symptoms and that early-age of onset itself does not increase risk for Complex PTSD, but rather that longer duration of violence is typical for those who experienced violence at a younger age. Severity of violence among women who have histories of childhood and/or adult sexual abuse is also positively related to Complex PTSD, with childhood severity almost paralleling severity of Complex PTSD symptoms (Dickinson et al., 1998). An analysis of lifetime trauma indicated that there is an overall additive effect of the contribution of cumulative trauma, or multiple types of experiences of trauma, to symptom complexity in Complex PTSD (Cloitre et al., 2009).

This literature suggests, albeit tentatively, that more severe violence from a known perpetrator which is experienced over a longer duration will increase the risk of Complex PTSD symptoms developing, with the relationship between IPV and Complex PTSD severity mediated by childhood abuse. This supports Herman’s (1992) notion that Complex PTSD can result from a relationship of coercive control which develops over time, and ultimately leads to an increased risk of mental health
issues such as Complex PTSD. Additionally, experiencing at least one type of IPV appears to be associated with greater mental health problems, which also increase with number of violence types experienced.

Re-victimisation and Complex Posttraumatic Stress Disorder

This section discusses the extent to which re-victimisation is relatively common among survivors of interpersonal violence, including intimate partner violence, and the bidirectional effects of adverse mental health and re-victimisation. It is widely acknowledged that a large proportion of IPV survivors are repeatedly abused by the same perpetrator (Walby & Allen, 2004) and that characteristics of both members of the couple will influence the risk of IPV (Kras, 2011; Moffitt, Robins, & Caspi, 2001). There has been limited consideration, however, of how the psychological difficulties of IPV survivors might influence re-victimisation (Cattaneo & Goodman, 2005), perhaps because of the obvious dangers of implicitly blaming the victim rather than the perpetrator of violence (Kuijpers, van der Knaap, & Lodewijks, 2011). However, the identification of controllable factors for re-victimisation potentially empowers those who often report feeling hopelessness about their current situation (Walker, 2009). Therefore, this section focuses on the influence that complex trauma symptoms reported by IPV survivors may have on IPV re-victimisation.

Individuals who experience interpersonal trauma frequently experience further interpersonal trauma, or re-victimisation, at some point in their life, either at the hands of the original perpetrator or by a new perpetrator. Re-victimisation has been shown to occur across cultures (Chan, 2011), sexual orientation (Balsam, Lehavot & Beadnell, 2011), ages (Noll, Horowitz, Bonanno, Trickett, & Putnam,
The largest body of research in this area has focussed on childhood abuse, suggesting that interpersonal abuse can significantly increase the risk of future abuse. For example, a literature review of 90 empirical studies on sexual re-victimisation conducted by Classen, Palesh, and Aggarwal (2005) and a 15 year prospective study with individuals who experienced childhood abuse by Barnes, Noll, Putnam and Trickett (2009) found that, for those who experience childhood abuse, the risk for sexual or physical adult abuse is twice that than for women not abused in their childhood. Additionally, a 30 year prospective study showed that experiencing any type of childhood abuse places an individual at greater risk for lifetime re-victimisation compared to those that do not experience child abuse (Widom, Czaja, & Dutton, 2008).

A 15-year prospective study of survivors of childhood sexual abuse provided evidence that interpersonal re-victimisation is related to greater risk of experiencing IPV (West et al., 2000). In this study, those who additionally experienced adulthood violence were significantly more at risk of experiencing IPV than those who did not experience adult violence. A cross-sectional study by Coid et al. (2001) also found that women who experienced either physical or sexual childhood abuse were at equal risk for future IPV. In a recent longitudinal study, it was found that different types of childhood trauma lead to varying interpersonal relationship trajectories, both of which can lead to re-victimisation in adulthood in the form of IPV (Valdez, Lim, & Lilly, 2013).

Re-victimisation appears to be a potent risk factor for adult mental health problems (Classen et al., 2005). For example, those who experience both child and adult violence report greater mental health issues such as depression (Kimerling et
TRAUMA RESPONSES TO IPV

al., 2007; Virkler, 2006), anxiety (Kimerling et al., 2007), posttraumatic stress disorder (Campbell, Greeson, Bybee, & Raja, 2008; Kimerling, et al., 2007; Noll, et al., 2003; Ullman, Najdowski, & Filipas, 2009), dissociation (Noll et al., 2003), sexually permissive attitudes or risky behaviour (Miner, Flitter, & Robinson, 2005; Noll et al., 2003), alcohol use (Balsam et al., 2011), self-harm behaviours (Balsam et al., 2011; Noll et al., 2003), or suicidality (Balsam, et al., 2011; Lau & Kristensen, 2010), than those who experience child-only or adult-only violence. These symptoms can be explained and understood as a response to multiple traumatic incidents rather than a constellation of pathological disorders. One study that directly assessed the relationship between complex posttraumatic stress disorder and childhood abuse found that, compared to those with no abuse history, women had who experienced early traumatisation reported multiple Complex PTSD symptoms (Zlotnick et al., 1996).

Research suggests that compared with the general population, people with severe mental health issues face 12 times the risk of any type of violent victimisation (Teplin, McClelland, Abram, & Weiner, 2005). Due to poor mental health, women may be at greater risk of IPV due to an increased likelihood of being in unsafe relationships and environments (McHugo et al., 2005). More severe PTSD symptoms have been shown to increase the risk of psychological IPV at an 18-month follow-up (Bell, Cattaneo, Goodman, & Dutton, 2008), while PTSD symptom severity predicted future IPV beyond the effects of previous interpersonal violence experiences and other environmental factors (such as social support) in another study by Perez and Johnson (2008). Specifically, the numbing constellation of PTSD symptoms either solely predicts intimate partner re-victimisation among IPV survivors at 1-year follow-up (Krause, Kaltman, Goodman, & Dutton, 2006; Ullman...
et al., 2009) or is significantly related to re-victimisation (Root, 2008), compared to intrusive, avoidance, and hyperarousal symptoms.

Therefore, there appears to be a somewhat cyclical or bidirectional process of re-victimisation and adverse mental health; re-victimisation may lead to poor mental health, while poor mental health itself may lead to future violence. In a longitudinal study exploring the relationship between IPV experience and depressive symptoms, it was found that this relationship is bidirectional (Devries et al., 2013). That is, women who report depressive symptoms were more likely to subsequently experience IPV, and women who experience IPV are more likely to experience depression symptoms.

Kuijpers et al. (2011) conducted a systemic review of prospective studies investigating the influence that IPV survivors have on future IPV. These authors identified 15 studies for inclusion and utilised them to assess a model of women’s influence on IPV proposed by Foa, Cascardi, Zoeliner, and Feeny (2000). Foa and colleagues developed two models; one that focuses on psychological factors and the other on environmental factors. The psychological model identifies three key factors in repeat IPV: severity and frequency of prior partner violence, the woman’s psychological difficulties, and the protective factor of the woman’s resilience. Foa et al. hypothesise that IPV and psychological difficulties interact in a vicious cycle whereby IPV causes psychological difficulties that, in turn, put women at greater risk of re-victimisation, a theory which is supported by the research presented above.

The study by Kuijpers et al. (2011) only identified 7 investigations relevant to the key factor of psychological difficulties, demonstrating a paucity of prospective studies on this topic. The only prospective data on psychological difficulties included PTSD, depression, and substance abuse. Compared to the multiplicity of mental
health issues that IPV survivors report, the studies constitute a small aspect of the overall adverse mental health reported by these women. The results indicated that PTSD and substance abuse may predict future partner abuse, but that depression does not, which is converse to the findings on depression by Devries et al. (2013).

Kuijpers et al. (2011) do indicate that many of the studies in their review used different variables for re-victimisation and given the small number of studies, methodological differences may have impacted the study outcomes. Additionally, each trauma symptom was analysed separately, despite one study reporting on two mental health issues and another on all three. Given that survivors of interpersonal violence often report experiencing multiple symptoms simultaneously, which is related to greater psychological distress (Mertin & Mohr, 2000), it is expected that combined symptoms would have a more predictive effect on re-victimisation, than each mental health issue separately. That is, more complex trauma symptoms may more adequately predict re-victimisation than fewer, or less complex, symptoms. Many of the studies included in the review by Kuijpers et al. (2011) used binary measures for the psychological difficulties assessed, which is a limitation that may have confounded the support for psychological difficulties as a predictor of future partner abuse.

**Treatment for Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder**

A Cochrane review of psychological treatment of post-traumatic stress disorder (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013) identified various treatment options for PTSD among adults who experience traumatic stress symptoms for three months or longer. Individual trauma-focused cognitive behavioural therapy
(TFCBT) and eye movement desensitisation and reprocessing (EMDR) are currently the recommended treatments of choice, and there is also support for the efficacy of individual non-TFCBT and group TFCBT in the treatment of chronic PTSD in adults. Other non-trauma-focused psychological therapies, such as non-directive counselling and psychodynamic therapy, did not reduce symptoms as significantly. The review concluded that psychological treatments can reduce traumatic stress symptoms among individuals with PTSD, and that trauma focused treatments are more effective than non-trauma focused treatments. There was insufficient evidence to determine if psychological treatment is harmful for people with PTSD, however the authors note that participant drop-out is an important issue. There was considerable heterogeneity among the types of trauma experienced by the participants, of which long-term or ongoing interpersonal violence was not listed. Finally, due to the significant heterogeneity between the studies in the review, the authors stressed the need for caution in interpreting their results.

The International Society for Traumatic Stress Studies have published practice guidelines for effective treatments for PTSD based on DSM-IV-TR diagnostic criteria, which include guidelines for therapy with both children and adults (Foa, Keane, Friedman, & Cohen, 2009). The guidelines include acute interventions, CBT, psychopharmacology, EMDR, group therapy, psychodynamic therapy, hypnosis, couple and family therapy, art therapies, and a guideline for treating PTSD and comorbid disorders. The construct of PTSD is based upon the notion that a person is experiencing trauma symptoms as a reaction to a past event, and that despite the passing of such threat, the individual continues to respond as though the threat remains. Given that it is well established that IPV is an ongoing phenomenon, may continue for years post relationship cessation, and that partner
femicide is highest post separation, IPV survivors continue to face real danger. Their hyperarousal reactions are survival-based reactions, rather than symptomatic responses to past danger, under presently safe conditions (Mechanic, 2004).

As psychotherapeutic interventions for PTSD aim to reduce fear and corresponding hyperarousal symptoms and target maladaptive beliefs about fear and safety (Foa et al., 2009), such strategies are not appropriate for women facing harm from a current or previous partner, and often fail to remedy the needs of IPV victims (Kwan, 2009). Current, empirically validated PTSD treatments are not appropriate for individuals facing the threat of ongoing danger (Foa et al., 2009), such as in IPV, which leaves a considerable gap in the treatment options available for PTSD interventions for IPV victims (Mechanic, 2004). It is therefore important to reconceptualise the nature of trauma reactions in the context of IPV, and to develop therapeutic strategies that allow women to manage symptoms in the face of continued harassment and threat of further violence (Mechanic, 2004).

The differences between Complex PTSD and PTSD have some important treatment implications (Bryant, 2010; van der Kolk et al., 2005). It has been demonstrated, for example, that “blanket” PTSD treatment for survivors of interpersonal violence who meet Complex PTSD criteria, even those that meet PTSD criteria, can be problematic and lead to re-traumatisation (Chu, 2011; Zlotnick, 1997), and that typical treatment techniques such as exposure therapy may in fact be harmful for this population (Courtois, 2008). The diagnosis of PTSD focuses on the memory of particular experiences, therefore implying that treatment focuses on the impact of specific past events and the processing of specific traumatic memories. In contrast, Complex PTSD symptoms such as loss of emotion regulation, dissociation and interpersonal problems, may be the first priority for treatment because they cause
more functional impairment than the PTSD symptoms (Briere & Spinazzola, 2005; Ford et al., 2005; Pearlman & Courtois, 2005).

Additionally, in the context of IPV and its serial and escalating nature, as the construct of PTSD (in both DSM-IV and DSM-5) fails to adequately conceptualise the nature of some trauma responses, it thereby offers little direction for therapeutic intervention (Mechanic, 2004). Moreover, as is the case with IPV, there is often no concrete beginning or end to the violence, nor a single stand-out traumatic event, which makes treatment that focuses on discrete, identifiable traumatic events often inapplicable to IPV survivors. It is therefore particularly important to establish whether IPV survivors display Complex PTSD symptoms, with or without PTSD, to ensure that appropriate and effective treatment can be offered.

While trauma-focused cognitive-behavioural treatment (TFCBT) has been demonstrated to be an effective form of therapy for PTSD (Bisson & Andrew, 2007) there are indications that it is not sufficient for DESNOS populations. Studies on CBT treatment for Complex PTSD display fairly high dropout rates, participants are symptomatic and exhibit poor levels of functioning after treatment, few participants are able to complete the studies, and some individuals prematurely terminate treatment due to significant increases in symptomatology (see Luxenberg, Spinazzola, Hidalgo, Hunt, & van der Kolk, 2001). Further, a meta-analytic review by Stover et al. (2009) reveals a lack of research evidence for the broad, long-term effectiveness of many of the most common treatments provided for victims of IPV.

Despite research in both community and clinical samples demonstrating the Complex PTSD symptom constellation can occur after chronic, repeated interpersonal violence (van der Kolk et al., 2005), there has been limited systematic investigation of its presence, clinical significance, and associated treatment
implications (Cloitre, 2011). Nonetheless, over the past decade and a half there has been advance in psychotherapy with the development of evidence-informed treatment models which address Complex PTSD (Herman, 2009). Of principal importance is the development of a trusting and collaborative treatment relationship; forming a therapeutic alliance with a client with a history of prolonged, interpersonal violence may be more successful if the clinician understands that the client believes their relationship may be another setup for betrayal, or the client may engage the therapist in relational reenactments (Herman, 2009).

Current psychotherapy approaches for complex trauma commonly use a tripartite model, as proposed by Herman (1997), for recovery. The stages include: (1) establishment of safety and empowerment of the survivor; (2) the survivor tells the story of, and processes, the trauma; and (3) there is repair and reconnection with social connections. These stages are not rigid, acknowledging the trauma and its consequences in the first stage may begin the process of meaning making, however, it is considered important that early in recovery there is no form of “exposure” therapy (Herman, 2009). Coming to terms with the past trauma must occur after there is a somewhat secure base in the present (Herman, 1997). Comprehensive reviews and explanations of three-phase treatment model options can be found in Courtois and Ford (2009) and Mooren and Stofsel (2015).

Courtois and Ford (2009) present an array of individual, couple, systems, and group therapies which integrate treatment models that combine techniques and skills from a range of biopsychosocial approaches, which are integrated into the three-phase treatment model. They present treatment options which may target particular symptoms identified in assessment, such as attachment and self-regulation dysfunction, which may enhance psychotherapy effectiveness and efficiency. They
also highlight the complexity of assessment and treatment of complex trauma symptoms, and additional considerations such as the need for the therapist to be aware and manage their own reactions and potential vicarious traumatisation.

Mooren and Stofsel (2015) present goals and approaches for each of the three treatment phases, such as control and relaxation techniques, and regulating trauma symptom during phase 1. They present general aspects and specific techniques of trauma processing, such as cognitive and narrative therapies, in phase 2, and address reintegration in phase 3.

As noted earlier, Complex PTSD appears to be inversely related to the age of onset of first trauma. It is known that the developing brain may be affected by adverse experiences in childhood resulting in survival-based neural pathway adaptations, whereby the brain may become engrossed in automatic scanning to identify and escape danger (Perry, 2009). This unconscious, adapted, scanning can alter and dysregulate two core psychological processes particularly relevant in Complex PTSD; emotion regulation and information processing (Ford, 2005). Research into neurobiological and developmental impacts and their clinical implications in relation to complex trauma are progressing, and have been integrated into the tripartite recovery model (see Ford, 2009).

Structured treatments for Complex PTSD are relatively new compared to other trauma-focused treatments, and continue to be developed (see Courtois 2008; Courtois & Ford, 2009) and assessed (e.g., Cloitre et al., 2011). Cloitre et al. (2009), for example, investigated a phase-based skills-to-exposure treatment for a population with a history of chronic and early-life trauma, and found that initial emotion-regulation-augmented CBT lead to greater treatment gains and fewer dropouts than normal CBT. Sensory integration treatment combined with psychotherapy improved
symptom outcome over psychotherapy alone in the treatment of Complex PTSD among adults with childhood abuse histories (Kaiser, Gillette, & Spinazzola, 2010).

As psychotherapy for adults with Complex PTSD is widely practiced but still in the early stages of clinical and scientific validation (Courtois, Ford, & Cloitre, 2009), the International Society for Traumatic Stress Studies (ISTSS) conducted an expert clinician survey to aid in the development of best practice guidelines (Cloitre et al., 2011). Areas of consensus and disagreement regarding the most appropriate treatment approaches and interventions for Complex PTSD were rated in a survey of 25 Complex PTSD experts and 25 PTSD experts. For this survey, Complex PTSD was defined as including DSM-IV-TR PTSD symptoms, in addition to the Complex PTSD symptoms mentioned in Table 1 (although alterations 3 and 6 have seemingly been combined into one domain relating to belief systems).

The majority of experts endorsed a phase-based therapy as most appropriate, with interventions tailored to specific symptom sets. The importance of selecting a treatment approach specific to the predominance of a particular presenting problem was identified. The most commonly endorsed techniques were emotion regulation interventions and education about trauma. Also repeatedly mentioned techniques used to match specific symptoms were cognitive restructuring, narration of trauma memory, anxiety and stress management, and interpersonal skills. Although a specific timeline for treatment was not agreed upon by the experts, responses suggested treatment for Complex PTSD needed to be longer than that for PTSD as there was consensus that life stressors and poor social supports were the greatest relapse factors, and their presence may necessitate longer treatment time (Cloitre et al., 2011).
In 2012 the Complex Trauma Task Force provided the ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in adults (Cloitre et al., 2012). Their definition of Complex PTSD is the aforesaid ISTSS definition. The recommended treatment model is the aforementioned sequential treatment model with three distinct phases; safety, stabilisation and skills strengthening; the review and reappraisal of trauma memories; and then transition from therapy to engagement in community life, by strengthening safe and supportive relationships and networks. The Task Force identify nine published studies supporting treatment for Complex PTSD, however all studies required participants to have experienced childhood abuse, with no identified studies including adult-onset complex trauma experiences. Experts considered 12 months to be a reasonable length of treatment time for Phase 1 and 2 combined, with Phase 3 tapering off over a further 6-12 months. During the processing of trauma (Phase 2) relapses are planned and expected, with clients returning to Phase 1 to re-consolidate skills before continuing with trauma processing. The Task Force highlight that some individuals may need longer than the estimated 12-month period, and given the continuing risk of exposure to trauma and life stressors, and severe impairment Complex PTSD presents, several years of treatment may be necessary, and/or intermittently over the individual’s lifetime.

**Chapter Summary**

This chapter has explained intimate partner violence as a traumatic experience and reviewed evidence that a large constellation of mental health symptoms is related to that violence. Past research and clinical reports have concentrated on PTSD to explain symptoms associated with IPV however the many symptoms that IPV survivors experience are not adequately addressed by the core
PTSD criteria. Complex posttraumatic stress disorder provides a formulation for explaining the predictable consequences of prolonged and severe interpersonal violence that often occurs in IPV. This chapter further identified IPV as a risk factor for future partner abuse, focusing on the psychological difficulties experienced by IPV survivors as a specific risk factor. It presented a rationale that the experience of traumatic symptoms may predict re-victimisation, and that Complex PTSD may be a more useful concept than simple PTSD to explain the mechanisms by which psychological difficulties can be associated with further partner abuse. Current research relating to treatment for PTSD and Complex PTSD were reviewed, along with an overview of current trends and guidelines for psychotherapy.
Chapter 3
The First Investigation

Rationale

The rationale for this study is based on the following literature (see above):

1. Violence by an intimate partner is one of the most common forms of violence against women (World Health Organisation [WHO], 2009). Up to one in three Australian women who have ever had an intimate partner will suffer intimate partner violence (IPV) at some point in their lifetime (Mouzos & Makkai, 2004). The cost of partner violence is multifaceted with social, physical, and psychological costs ranging right through from the individual to the broader community. In Australia, IPV is the leading contributor to death, disability, and illness in Victorian women aged 15 to 44 making it the largest known contributor to preventable disease burden for that population (VicHealth, 2004).

2. Mental health issues have been identified as a key health outcome of IPV that contribute to the disease burden, including but not limited to, anxiety, depression, suicide, illicit and licit drug use, and posttraumatic stress symptoms (Golding, 1999; VicHealth, 2004). Posttraumatic stress disorder has been demonstrated to be the most significant mental health issue reported by IPV survivors in the USA (Jones, Hughes, & Unterstaller, 2001) and, in Australia, the limited research that has been conducted has concluded that almost half of IPV survivors meet PTSD diagnostic criteria (Mertin & Mohr, 2000; Roberts et al., 1998). Jones et al. (2001) report that rates of PTSD for IPV survivors range from 31 to 84% depending on sample characteristics, IPV severity, IPV chronicity, and history of interpersonal violence (among other factors).
example, they found that those who had multiple victimisation experiences (childhood abuse, particularly sexual abuse, and adult sexual abuse) were at greater risk of PTSD symptoms and many other types of psychiatric disorders. Combined physical, psychological and sexual IPV display a cumulative effect on PTSD, depression, anxiety symptoms, and suicide attempts (Hegarty et al., 2004; Pico-Alfonso et al., 2006; Silva et al., 1997). Those with higher rates of PTSD have reported greater levels of mental health issues and psychological distress (Mertin & Mohr, 2000), such as those addressed by Complex PTSD.

3. An analysis of lifetime trauma by Cloitre et al. (2009) has indicated that there is an overall additive effect of the contribution of cumulative trauma, or multiple types of experiences of trauma, to symptom complexity in Complex PTSD. Therefore, the associated literature on mental health issues and multiple types of IPV and trauma indicate that those that experience more than one type of trauma experience heightened mental health issues, many of which are adequately addressed by the Complex PTSD construct.

4. No published Australian study to date has explored the prevalence of complex trauma symptoms among IPV survivors, or PTSD among a non-domestic violence shelter population.

5. As explained in Chapter 2, the differences between Complex PTSD and PTSD have important treatment implications (Bryant, 2010; van der Kolk et al., 2005). “Blanket” PTSD treatment for survivors of interpersonal violence who meet Complex PTSD criteria, even those that meet PTSD criteria, can be problematic
and lead to re-traumatisation (Chu, 2011; Zlotnick, 1997), and that typical
 treatment techniques such as exposure therapy may in fact be harmful for this
 population (Courtois, 2008). This highlights the importance of identifying the
 range of mental health issues IPV survivors’ experience. The Complex PTSD
 construct has been most clearly and structurally addressed by the DESNOS
 symptom criteria.

 The current investigation aims to examine the prevalence of both
 posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder
 (Complex PTSD) among a sample of women attending an Australian community-
 based domestic violence centre, post separation from an abusive partner. The limited
 previous research into IPV victims’ symptoms within Australia has been conducted
 in acute settings, such as hospitals or shelters, and has not examined the applicability
 of the complex posttraumatic stress disorder concept to IPV victims who attend a
 community support and advocacy service. This investigation additionally seeks to
 expand understanding of IPV in relation to trauma symptoms by exploring how
 particular characteristics of intimate partner violence may relate to trauma symptoms
 among these victims. Specifically, the project will address the following research
 questions:

 1) What proportion of female intimate partner violence survivors within a
 community-based domestic violence centre are likely to meet the criteria for a
diagnosis of: a) posttraumatic stress disorder; and b) complex posttraumatic
 stress disorder?

 2) What is the correlation between trauma symptoms and intimate partner violence
 chronicity and severity?
3) Are those who experience more severe and chronic IPV more likely to meet Complex PTSD and PTSD diagnoses than those with less severe or shorter histories of IPV?

**Method**

**Participants**

Participants were 59 English-speaking women aged 18 years or older who represented a sample of women receiving services from a domestic violence community centre within an Australian Significant Urban Area (ABS, 2012). Their ages ranged from 24 to 58 years ($X = 37.93$ years, $SD = 7.48$), and all had experienced intimate partner violence from a male at some point in their lifetime. Approximately 300 women were considered and reviewed for inclusion in the study by the domestic violence (DV) centre. Issues relating to duty of care by the DV centre was the foremost criterion for exclusion. For example, women were invited to participate if they had an established relationship with the centre, were assessed to have the emotional capacity to complete the process, and the centre felt confident participation in the study would not lead to re-traumatisation.

Only those assessed by the domestic violence centre and deemed at “low risk” for imminent future intimate partner violence were invited to participate. It was decided, after consulting with the service, that those who were at higher risk of imminent IPV may be placed in too great a danger should their abusive (previous) partner discover their participation in the study, or that they had contacted a domestic violence centre. Information on the domestic violence centre’s *Safety and Risk Assessment* is provided in Appendix E. It is important to note, the very nature of IPV risk is a fluctuating dynamic, and therefore great care was taken in selecting the
women who were approached to participate. Those who had poor literacy skills or
who were pregnant were also excluded as the study required participants to complete
the study online in written form, and pregnant women were also deemed “high risk”.
The domestic violence centre approached 120 women to participate in this study,
therefore, 61 women declined to participate.

The socio-demographic characteristics of the participants are reported in
Table 2. Close to two-thirds identified as Australian or New Zealander, more than
two-thirds had a TAFE or university education level, and the majority (86%) did not
have an intimate partner at the time of participating in the study. Overall, the
participants were generally representative of the DV centre’s clientele in terms of
age, education, and ethno-culture. The questions used to collect demographic
information are provided in Appendix F.
Table 2.

Socio-demographic Characteristics of Study 1 Participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-identified Cultural Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian/New Zealander</td>
<td>38</td>
<td>64.41</td>
</tr>
<tr>
<td>Aboriginal/Maori</td>
<td>3</td>
<td>5.08</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>20.34</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
<td>10.17</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
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<td>1.69</td>
</tr>
<tr>
<td>High school</td>
<td>17</td>
<td>28.81</td>
</tr>
<tr>
<td>TAFE</td>
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<td>45.76</td>
</tr>
<tr>
<td>University</td>
<td>14</td>
<td>23.73</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Single</td>
<td>18</td>
<td>30.51</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>32</td>
<td>54.24</td>
</tr>
<tr>
<td>Married/Partnered</td>
<td>8</td>
<td>13.56</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>1.69</td>
</tr>
</tbody>
</table>

*Note. N = 59.*

**Procedure**

The World Health Organisation’s recommendations for research on domestic violence of women (WHO, 2001) informed the ethical and safety standard for the
procedure and the study was approved by the Deakin University Human Research Ethics Unit (DUHREC; see Appendix A).

Participants were recruited between November 2012 and July 2013 inclusive. They were initially approached by the domestic violence centre (verbally, by phone, or in-person at the centre) and invited to read a Plain Language Statement (see Appendix D) describing the aims of the research and the parameters that governed participation. Before commencing the study all women gave their written, informed consent. They were then asked to complete the questionnaire (see below) on a computer at the domestic violence centre, however, due to safety and practical issues such as work and childcare, some asked to complete the study outside the centre. Further approval was gained by DUHREC (see Appendix B) for participants to complete the questionnaires online.

Those who completed the questionnaire at the DV centre were assisted by a worker who was experienced in working with IPV victims and able to offer face-to-face support (if needed) during or after participation. Those who completed the questionnaires online were asked to do so during office hours and offered telephone or in-person support. Participants were asked to indicate if they wished to be contacted by the DV centre if they experienced any distress following participation. Finally, participants were asked if they would be interested in participating in a second study should they meet certain criteria.

**Measures**

The measures used in the study are described in the order in which they were administered.
The Posttraumatic Stress Disorder Checklist: Civilian Version (PCL-C; Weathers, Litz, Huska, & Keane, 1994) is a 17-item self-report questionnaire rated on a 5-point Likert scale ranging from 1 (“Not at all”) to 5 (“Extremely”). Questions refer to stressful experiences within the previous month, and example questions include: “Avoiding activities or situations because they remind you of the stressful experience?” and “Feeling distant or cut off from other people?” PCL-C scores can also be used to indicate whether an individual meets clinical threshold for DSM-IV symptom criteria, and is likely to meet a diagnosis of PTSD, with symptoms rated “moderately” or above (responses 3-5) counted as present, and must be present for at least 1 B item (questions 1-5), 3 C items (questions 6-12), and at least 2 D items (questions 13-17). The scale has been shown to have good internal reliability (α = .94) and retest reliability after a 2-week interval (r = .66; Conybeare, Behar, Soloman, Newman, & Borkovec, 2012) and good convergent and discriminant validities (Conybeare et al., 2012; Ruggiero et al., 2003). In the current study, the internal reliability of the PCL-C was .89. The PCL-C can be found in Appendix G.

The Self-Report Instrument for Disorders of Extreme Stress (SIDES-SR; van der Kolk, 2002) is a 45-item self-report questionnaire which purports to measure: (a) baseline severity of complex posttraumatic stress disorder (Complex PTSD or DESNOS); (b) baseline severity of each of the six individual symptom clusters; and (c) symptom change over time. It was used in this study to identify those participants who self-report experiencing significant symptoms of complex trauma.

The SIDES-SR is an adaptation of the SIDES which is the structured interview for Complex PTSD which has good interrater reliability, internal consistency, predictive validity, and construct validity across various clinical
populations and cultures (see Briere & Spinazzola, 2009 for a review). SIDES was designed to convey Complex PTSD symptoms in an understandable manner to responders constructed on client feedback and scale reliability estimates (Luxenberg, Spinazzola, & van der Kolk, 2001). The subscale “Alterations in Perception of the Perpetrator” was removed from the original SIDES as a requirement for diagnosis due to a low reliability coefficient (.53), with the six remaining symptom alpha coefficients ranging from .76 to .90 and a total Complex PTSD diagnosis reliability coefficient of .96 (Pelcovitz et al., 1997).

Respondents are asked to answer either “Yes” or “No” to each of the 45 statements about the lifetime and current presence or absence of each of the symptoms delineated in the Complex PTSD diagnosis. Example items include: “I have the feeling that I basically have no influence on what happens to me in my life” and “I have trouble trusting people”. If they indicate “Yes” they are further asked to indicate the extent to which the difficulty has been bothersome over the previous month. Answers range from 0 (“None; not at all”) to 3, with “3” indicating a severe level of distress or behaviour for the indicated difficulty. All questions pertaining to how bothersome the difficulty has been over the previous month additionally include a “Not applicable” option. Threshold criteria for each subscale (alteration) vary, with three of the six items requiring endorsement of more than one symptom to meet life alteration endorsement. If the responder endorses criteria that indicates they currently experience an alteration, their current symptom severity is further calculated. The possible range of scores is 0 – 3 for any one of the six alterations, with a score of 2 or above considered clinically significant by the scale creators. A total score of 4 or over is used in this study to indicate the likely presence of significant complex trauma symptomatology. This reflects an overall clinical severity experienced by the
participants equal to a minimum of at least two of the six life alterations defined by the complex trauma symptom clusters. Psychometric testing on the SIDES-SR (see Luxenberg et al., 2001) has demonstrated a high rate of internal consistency for both the full scale (α = .93), and five subscales (α = .74 to .82). The lower internal consistency of the Somatisation subscale (α = .68) suggests the scores on this subscale should be interpreted with caution. In the current study, the internal reliability was .86. Information on the SIDES-SR can be found in Appendix H.

The Abusive Behaviour Inventory (ABI; Shepard & Campbell, 1992) is a 29-item self-report questionnaire with two subscales that measure the frequency of physical (12 items) and psychological (17 items) abusive behaviours. It was used in this study to measure the severity of intimate partner abuse. It uses a 5-point Likert-type scale to measure the frequency of the abusive behaviours during a 6-month period, ranging from 1 (“Never”) to 5 (“Very frequently”). Sample items include: “Pushed, grabbed, or shoved you” and “Used your children to threaten you (example: said you would lose custody; said he would leave town with the children)”. Possible responses range from 1 (“Never”) to 4 (“Very often”). There are two subscales: psychological abuse (16 items) and physical abuse (12 items). The mean score of each subscale is computed by summing the values of the items and dividing by the applicable number of items, thereby there is a maximum score of 3 for each of the subscales.

The original ABI for women was a 30-item questionnaire, however the scale creators, Shepard and Campbell (1992), removed item 21 from the scale due to low response rate and a negative correlation with the total scale. Additionally, after assessing for factor validity, items 6, 20, and 24 were changed from the
psychological subscale to the physical subscale. Final reliability, or alpha
coefficients, on the physical abuse subscale ranged from .80 to .92, and on the
psychological abuse subscale the alpha coefficients ranged from .76 to .91. This scale
has evidence of convergent, discriminant, criterion, and factorial validity (Shepard &
Campbell, 1992).

There are different versions for males and females (which are identical except
for the use of pronouns to focus on the use of abusive behaviour by men only. For
example, women would read a question asking how often their partner had “kicked
you”, as opposed to the male version which would read how often they had “kicked
her”) (Shepard & Campbell, 1992). The female version of the ABI was used in this
study with the removal of item 10 “Put you on an allowance” as the factorial validity
was low for both subscales in a study by Shepard and Campbell (1992). The wording
of five questions (items 1, 4, 6, 18, and 26) was minimally changed to simplify the
language. Three more questions were added to the ABI directly relating to sexual
abuse which were inserted at random points in the inventory (to create item numbers
5, 10, and 16), leading to a total of 31 items. In the current study, the internal
reliability was .93. The mean score of the sexual abuse subscale gives a maximum
score of three, equal to that of the other two subscales.

As this study was concerned with lifetime IPV history, the original
instructions were adapted to ask the participants to respond to the questions in
reference to their lifetime, not the previous 6 months. The Abusive Behaviour
Inventory was used to measure abuse severity by measuring psychological, physical,
and sexual abuse, and aggregating the three subscale scores for a total severity score.
That is, a total abuse severity score was calculated by summing the values for each of
the three subscales, with a maximum score of 9. Total scores of 1 – 3 indicate
moderate IPV, 4 – 6 high IPV, and 7 – 9 severe IPV. The ABI can be found in Appendix I.

*IPV History.* Participants were asked to indicate if they were currently in a relationship ("Yes" or "No"), and if “Yes”, if they were currently experiencing intimate partner violence. They were asked by how many intimate partners they had experienced physical, emotional, sexual, or financial abuse. For each partner they indicated had abused them, they were further asked to indicate the length of abuse in years and months, what year the abuse started, ended, or if the abuse was currently ongoing, and the frequency of the abuse they experienced by that partner. Frequency was indicated by selecting one of the four options; rarely, sometimes, often, very often. The questions used to collect information on IPV history can be found in Appendix J.

*Data Screening and Cleaning*

One participant did not complete the socio-demographic questions and part of the SIDES-SR, and another did not complete the ABI and part of the SIDES-SR. A Missing Value Analysis (MVA) was conducted to ascertain the amount and pattern of missing data for each of the scales. This showed that data was missing ‘completely at random’, indicating that there was no systematic pattern contributing to missing values (McKnight, McKnight, Sidani, & Figueredo, 2007). As a result, missing data were imputed through replacement by the series mean for variables with only one missing datum point (socio-demographics and IPV years) and regression estimates for variables with more than one missing datum point but less than 5% total missing
data (ABI and SIDES-SR) (Tabachnick & Fidel, 2007). The participant with no responses for the ABI was excluded from all corresponding analyses.

The distribution of scores for each of the variables was then checked (Field, 2009). A normal distribution was found for total ABI score and psychological ABI subscale score, while physical ABI subscale score (Shapiro-Wilk = .011), sexual ABI subscale score (Shapiro-Wilk = .003), and total IPV years (Shapiro-Wilk = .004) were not normally distributed. The Levene statistic showed that the total ABI score met the assumption of homogeneity of variance, while total years of IPV violated the assumption. Accordingly, non-parametric statistical methods were used in the subsequent analyses involving total IPV years and ABI subscales.

**Results**

Analyses were performed using Statistical Package for the Social Sciences (SPSS) Version 22.0 and Excel 2013.

**Descriptive Statistics**

On average, women in the study reported that they had experienced 11.94 years of lifetime IPV ($SD = 8.25$, range 2 months – 42 years), from an average 1.81 violent partners ($SD = 1.51$, range 1 – 6). All women reported having experienced psychological abuse, 97% reported physical abuse, and 86% reported sexual abuse. The total mean scores for the three subscales of abuse; psychological, physical and sexual, are reported in Figure 1. The aggregated score (range 0 – 9) indicates that higher scores reflect more severe levels of abuse in all three domains measured. It can be seen that the majority of participants (85%) score a total between of 2 – 6 on the ABI, with 9% of women higher still. Almost two thirds (62%) had a total score
of 4 or higher, demonstrating they had experienced ‘high’ to ‘severe’ levels of lifetime intimate partner abuse.

**Figure 1.** Total Mean ABI Scores.
Scores taken from the Abusive Behaviour Inventory with range 0 – 9; higher ranges indicate higher lifetime severity levels of various violence types. Total scores are the aggregation of equally weighted mean scores for psychological, physical, and sexual abuse subscales. $N = 58$. ABI = Abusive Behaviour Inventory.

Figures 2, 3, and 4, respectively, demonstrate the mean subscale scores for lifetime psychological, physical, and sexual partner abuse. Figure 2 shows that the majority of participants reported experiencing ‘high’ (52%) to ‘severe’ (43%) psychological partner abuse in their lifetime. Figure 3 shows that all but two participants reported physical abuse. Fifty-two percent of participants reported ‘moderate’ lifetime partner physical abuse, 36% reported ‘high’ levels, and 9% reported ‘severe’ levels of physical abuse. Figure 4 shows that only 9 of the 58 participants reported no sexual partner abuse. Around a third reported a ‘moderate’ (34%) or ‘high’ (36%) lifetime sexual abuse history, while 14% reported having experienced ‘severe’ intimate partner sexual abuse in their lifetime.
Figure 2. Mean Psychological ABI Scores.
Scores taken from the Abusive Behaviour Inventory with range 0 – 3; higher ranges indicate higher lifetime severity levels of psychological violence. N = 58. ABI = Abusive Behaviour Inventory.

Figure 3. Mean Physical ABI Scores.
Scores taken from the Abusive Behaviour Inventory with range 0 – 3; higher ranges indicate higher lifetime severity levels of physical violence. N = 58. ABI = Abusive Behaviour Inventory.
Figure 4. Mean Sexual ABI Scores.
Scores taken from the Abusive Behaviour Inventory with range 0 – 3; higher ranges indicate higher lifetime severity levels of sexual violence. \( N = 58. \) ABI = Abusive Behaviour Inventory.

**Trauma Symptom Prevalence**

The first research question concerns the proportion of female intimate partner violence survivors, within a community-based domestic violence centre, who meet the criteria for a diagnosis of: a) posttraumatic stress disorder; and/or b) complex posttraumatic stress disorder.

*Research question 1a: What proportion of female intimate partner violence survivors within a community-based domestic violence centre are likely to meet the criteria for a diagnosis of posttraumatic stress disorder?*

More than two-thirds (68%) of the 59 participants endorsed above clinical threshold levels which indicate the likely presence of DSM-IV-TR (2000) posttraumatic stress disorder, as assessed by their scores on the self-report measure
of trauma symptomatology, the PCL-C. Another quarter (24%) of participants met the clinical threshold for at least one of the symptom sets of PTSD, and only 8% reported no clinical levels of any of the three PTSD symptom sets.

Research question 1b: What proportion of female intimate partner violence survivors within a community-based domestic violence centre are likely to meet the criteria for a diagnosis of complex posttraumatic stress disorder?

The majority (80%) of participants reported clinical threshold levels of at least one significant alteration of complex posttraumatic stress disorder (Complex PTSD) as assessed by the SIDES-SR. Four of the 59 women, or 7%, endorsed threshold levels for items measuring all six alterations, with 28% of the women endorsing threshold levels for items measuring four or more alterations. This is illustrated in Figure 5.

Figure 5. Number of Complex Posttraumatic Stress Disorder Criteria Endorsed by Participants. Results calculated from SIDES-SR. CPTSD = Complex Posttraumatic Stress Disorder.
Figure 6 shows the percentage of women who endorsed threshold levels for each of the six Complex PTSD criterion. The most common symptom, endorsed by 54% of participants, was an *alteration in relationships with others*, with nearly all (92%) reporting an inability to trust others. The next most common presentation was an *alteration in self-perception* (with 46% of women meeting this criterion). Participants reported a sense of permanent damage in their self-perception (69%), a belief that nobody can understand them (68%), and a chronic sense of guilt (64%). Forty-four percent of women endorsed threshold levels for criteria for *alterations in attention or consciousness*, with 51% of women reporting that they experienced transient dissociative episodes and depersonalisation.

Thirty-six percent of the participants reported a high number of medical problems and an array of physical symptoms. Within the alterations in regulation of affect and impulses criterion, nearly two thirds (63%) reported difficulty in affect regulation, and the same percentage noted difficulty in modulating sexual involvement or being preoccupied with sexual involvement, whether that be avoidance or otherwise. Finally, within the alterations in systems of meaning criterion, 69% reported feelings of despair or hopelessness, and 63% reported a loss of previously sustaining beliefs.
Relationship between Trauma History and Symptoms

The second and third research questions relate to the hypothesis that those women with more severe and longer histories of victimisation will experience greater trauma symptoms. IPV severity was calculated by summing the mean scores of the three ABI subscales (see Figure 1). IPV chronicity was measured by the total number of years that a participant had experienced IPV from all abusive partners. Although a diagnosis requires a clinical interview to assess if all DSM diagnostic criteria are met, for the purposes of these research questions, a diagnosis of PTSD or Complex PTSD was defined by meeting the relevant scale threshold levels. PTSD was defined by the three core symptoms of a DSM-IV-TR diagnosis, and a diagnosis of Complex PTSD was indicated by the participant meeting all 6 alteration criteria. The author
acknowledges that meeting the scale threshold levels only indicates if an individual is likely to meet diagnostic criteria, and that it is possible that an individual who meets clinical threshold on a scale may not meet diagnostic criteria after further clinical interview and assessment.

**IPV Chronicity**

*Research question 2a: What is the correlation between trauma symptoms and intimate partner violence chronicity?*

A Spearman correlation was computed between the total number of years a woman had experienced IPV and the number of PTSD symptoms reported. A small positive correlation was found \((r = .27, p = .04)\), indicating that women who experienced more years of partner abuse also experienced more posttraumatic stress disorder symptoms. A non-significant correlation was found \((r = .15, p = .26)\) between the total number of years a woman had experienced IPV and the number of Complex PTSD alterations. This indicates that the number of complex posttraumatic stress disorder alterations and the number of IPV years the participants had experienced are not strongly associated.

*Research question 3a: Are those who experience more chronic victimisation more likely to meet Complex PTSD and PTSD diagnoses?*

Mann-Whitney U tests were used to test for the difference in total years of IPV experienced between those who did, and did not, meet a PTSD diagnosis, and also for those who did, and did not, meet a Complex PTSD diagnosis. The women who met a PTSD diagnosis \((n = 38)\) had experienced a median number of 14.59 years of IPV, while those that did not meet a diagnosis \((n = 21)\) had a median of 8.00
years of IPV experience. This difference was statistically significant ($Z = -2.00, p = .04$), indicating that as the years of IPV increase, so too does the likelihood that a woman will meet the criteria for a PTSD diagnosis. As only 3 of the 59 participants met all 6 Complex PTSD criteria for a Complex PTSD diagnosis, this research question was not able to be statistically addressed. A post-hoc Mann-Whitney U test was used to examine any difference in IPV years between those who met at least one Complex PTSD criterion ($n = 47$) and those who did not ($n = 12$). No statistical difference between the two groups was found ($Z = -1.12, p = .26$).

**IPV Severity**

*Research question 2b: What is the correlation between trauma symptoms and intimate partner violence severity?*

The severity of IPV (total mean ABI score; see Figure 1) and number of PTSD symptoms were not correlated ($r = .08, p = .54$). Nor was there an association between IPV severity and Complex PTSD alterations ($r = .14, p = .28$).

A post-hoc Spearman correlation was computed between each of the ABI subscale scores (see Figure 2, Figure 3, and Figure 4) and the three PTSD symptoms, in addition to the six Complex PTSD alterations. No statistically significant differences were observed for any of the subscale scores in their relationship with the number of PTSD symptoms reported, or the number of Complex PTSD alterations reported. Statistics for these analyses are reported in Table 3.
Table 3.

The relationship between ABI subscale scores and PTSD and Complex PTSD symptoms

<table>
<thead>
<tr>
<th>ABI subscale</th>
<th>PTSD symptoms</th>
<th>Complex PTSD symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spearman’s rho</td>
<td>p value</td>
</tr>
<tr>
<td>Psychological</td>
<td>.197</td>
<td>.139</td>
</tr>
<tr>
<td>Physical</td>
<td>-.155</td>
<td>.244</td>
</tr>
<tr>
<td>Sexual</td>
<td>.104</td>
<td>.437</td>
</tr>
</tbody>
</table>

Note. N = 58. ABI subscales range 0 – 3. PTSD symptoms range 0 – 3. Complex PTSD symptoms range 0 – 6.

Research question 3b: Are those who experience more severe victimisation more likely to meet Complex PTSD and PTSD diagnoses?

A two-sample independent t-test revealed no significant difference ($t(56) = -.35$, $p = .73$) in total severity scores between those who met the criteria for a PTSD diagnosis ($n = 38$), and those who did not ($n = 21$). Complex PTSD diagnosis was not calculated due to insufficient statistical power.

Mann-Whitney U tests were used to examine differences in severity of psychological, physical, and sexual IPV between those who met a PTSD diagnosis ($n = 38$), and those who did not ($n = 21$). Statistically significant differences were not observed for psychological severity ($Z = -1.55$, $p = .12$), physical severity ($Z = -1.22$, $p = .22$), or sexual severity ($Z = -0.33$, $p = .74$). Again, Complex PTSD diagnosis was not considered due to insufficient statistical power.

These findings are discussed in Chapter 5.
Chapter 4
The Second Investigation

Rationale

The published literature on mental health issues and multiple types of IPV and trauma indicates that those who experience more than one type of trauma will be more likely to experience mental health issues. For example, there is evidence that combined physical, psychological and sexual IPV has a cumulative effect on the development of PTSD (Pico-Alfonso et al., 2006; Silva et al., 1997). However, the findings of Study 1 suggest that severity of IPV is not directly related to the presence of trauma symptoms, although IPV chronicity does appear to be associated with the presence of PTSD symptoms (but not Complex PTSD). Thus, although these findings are preliminary, it appears that while many IPV victims experience trauma symptoms that are better explained by Complex PTSD than PTSD alone, the lifelong chronicity and severity of the intimate partner violence that they have experienced may not be as clearly associated with increased complex trauma alterations as might be expected. This suggests a clear need for further investigation into understanding the development and effects of Complex PTSD among IPV victims. The aim of this study is to understand more about how trauma symptoms may influence further or ongoing violence, based on the notion that previous traumatic reactions will influence the impact of ongoing violence.

It is well-established that characteristics of both members of the couple will influence the risk of IPV occurring (Kras, 2011; Moffitt et al., 2001), and identifying factors for re-victimisation, such as traumatic responses, potentially allows the IPV survivor to better understand those risk and protective factors that they themselves can influence, thereby empowering those who often report feeling hopelessness about their current situation (Walker, 2009). This study was conceptualised in light
of evidence that more severe PTSD symptoms have been shown to increase the risk of psychological IPV (Bell et al., 2008), while PTSD symptom severity predicts future IPV beyond the effects of previous interpersonal violence experiences and other environmental factors such as social support (Perez & Johnson, 2008). The focus is on Complex PTSD alterations given that their effect on IPV has not been well researched, and that the most common symptom, numbing, has been shown to either solely predict intimate partner re-victimisation among IPV survivors at 1-year follow-up (Krause et al., 2006; Ullman et al., 2009) or be significantly related to re-victimisation (Root, 2008). Numbing, and its more severe form of dissociation, are symptoms of the Complex PTSD alteration, changes in attention and concentration, indicating that Complex PTSD may affect future IPV. Therefore, it would appear that repeated interpersonal violence not only increases risk for mental health issues developing, but also that mental health issues increase the risk of ongoing intimate partner violence.

This somewhat cyclical or bidirectional process of re-victimisation and adverse mental health has not been considered in any depth in the IPV literature although Foa et al.’s (2000) psychological model identifies three key factors in repeat IPV: severity and frequency of prior partner violence; the woman’s psychological difficulties; and the protective factor of the woman’s resilience. The association between mental health and IPV is, of course, unlikely to be simple or linear given that the chronicity of trauma symptoms among IPV survivors can continue well after separation from the abusive partner. This suggests that mental health issues may place an IPV victim at risk of further abuse despite no longer being in a relationship with the perpetrator. For example, Woods (2000) found between 44 and 66% of women with a history of IPV, who had separated from the abusive partner for an
average of 9 years, continued to report PTSD symptoms. Other studies have demonstrated that women can themselves predict re-assault, sometimes better than risk assessments (Heckert & Gondolf, 2004), and that these predictions are associated with each new cue from the perpetrator’s erratic moods and behaviour, substance abuse, employment status, and abuse towards themselves and others (Cattaneo, Bell, Goodman, & Dutton, 2007). It would therefore appear that the ability to accurately appraise a situation and assess future violence is likely to be influenced by a victim’s own mental health (Nicholls, Pritchard, Reeves, & Hilterman, 2013).

This study utilises a qualitative research methodology. Qualitative research allows for the women to make sense, explain, and expand on their experience of trauma, allowing a better understanding of this phenomenon by taking into account that the only common factor among women who experience intimate partner violence is the experience of abuse. This uniqueness may also include the possibility that IPV victims experience trauma symptoms for years after the abuse stops, or seek trauma treatment whilst remaining at risk and under threat from the perpetrator.

The main aim of this study was to explore, through victims’ narratives, the risk and safety factors associated with trauma symptoms of future IPV, among women who report experiencing multiple Complex PTSD alterations. A further aim was to identify unique treatment needs among IPV victims experiencing trauma symptoms, who commonly experience threats and harassment from their abusive ex-partner, whilst seeking mental health support. The phenomenon, or research question, that is explored in this study is: how may the victim’s trauma symptoms play a factor in their risk of, or safety from, future intimate partner violence?
Method

Participants

Participants had all completed Study 1 and were identified as meeting a minimum of three Complex PTSD alterations, as determined by their responses in Study 1. Participants were 9 English-speaking women aged 18 years or older who were receiving services from an Australian Significant Urban Area domestic violence community centre. Their ages ranged from 29 to 58 years ($X = 44.56$ years, $SD = 8.82$ years), they had experienced an average 20.03 years ($SD = 10.33$ years) of intimate partner violence, ranging from 5.67 to 42.00 years, and had experienced violence from 1 to 5 partners ($X = 2.33$ years, $SD = 1.32$ years). All of the participants reported experiencing psychological and physical IPV, and 8 of the 9 women reported experiencing sexual IPV. At the time of participation in the study, none of the women were in an intimate relationship. All of the participants had completed high school or TAFE, listed themselves as single, separated, or divorced, and 8 of the 9 participants identified as Australian with the other participant identifying herself as ‘other’. All participants met the criteria for DSM-IV posttraumatic stress disorder and the criteria for 3 to 6 complex posttraumatic stress disorder (Complex PTSD) alterations.

Procedure

The procedure, study methods, findings, analysis and interpretations of Study 2 were guided by the Consolidated Criteria for Reporting Qualitative Research (Tong, Sainbury, & Craig, 2007) which is a 32-item checklist for interviews and focus groups. The checklist includes three domains: research team and reflexivity; study design; and data analysis and reporting. It can be found in Appendix K. Ethics
approval was gained by the Deakin University Human Research Ethics Unit (DUHREC; see Appendix A). An amendment was further approved by DUHREC (Appendix C) as some participants were willing to participate in a telephone interview, but not a focus group.

All participants were asked in Study 1 to indicate if they would be willing to be approached by the researchers to participate in a further study, should they meet certain criteria as based on their response in Study 1. Only those that indicated “Yes”, included their contact details, were deemed to remain a “low-risk” participant by the domestic violence community centre, and met a minimum criterion of three Complex PTSD alterations, were approached (by a community centre staff member). A total of 20 women received a verbal invitation and explanation of Study 2, and asked if they would be willing to be contacted by the researcher. A total of 11 agreed. Eight women subsequently agreed to participant in a focus group, and three women agreed to have a one-on-one phone interview.

Two focus groups, with four women in each, were conducted. The researcher directed the focus groups with a psychologist from the community centre, known to all the participants, also present should any of the participants need additional support during, or after. Each focus group was only audio recorded for safety reasons; a 4-directional microphone was placed in the middle of focus groups or next to the phone. Groups lasted approximately 2.5 hours, with each participant reading the Plain Language Statement and signing a Consent Form at the beginning. Confidentiality parameters were carefully explained, including that they were welcome to use as alias should they desire. All participants chose to use their first name, but not their surname. They received a $50 voucher at the conclusion of the interview by way of reimbursement for expenses associated with participation.
Two of the three women who had agreed to a phone interview were not able to be further contacted. The final person completed the phone interview, with the interview taking the same format as the focus groups. Verbal consent was gained from the participant at the beginning of the interview and a hard copy of the Consent Form was mailed to the participant to complete and return, along with a $50 voucher. The audio recorded interview lasted 50 minutes.

The psychologist from the community centre called the women from the focus groups to follow up on the interviews and offer support if needed. Three of the eight women said that they wanted to talk further with the student researcher, either to express ideas they did not share during the interviews or to share further thoughts after having some time to reflect post focus groups. These women were contacted via phone and after verbally consenting to the phone call being recorded, continued to be interviewed one-on-one for 16, 17, and 57 minutes respectively.

**Materials**

Focus groups and individual interviews discussed and expanded on the following three questions:

1) Can you tell us about how your thoughts and behaviours have helped, or help, to keep you safe from partner violence?

2) What role do you think your thoughts and behaviours play in putting you at risk of partner violence?

3) Can you tell us how domestic violence services have been helpful, and could improve to be more helpful, in keeping you safe from future partner violence?
Analytical Framework

Qualitative research is interested in understanding how people make sense of their world and the experiences they have in the world (Merriam, 2009). Major traditional types of qualitative research include phenomenological analysis, ethnographic analysis, grounded theory, narrative analysis, discourse analysis, and critical social research (Merriam, 2009; Willig, 2013). Previously thematic analysis was seen as underpinning most other methods of qualitative data analysis, however, in recent years it has been recognised as a research method in its own right (Braun & Clarke, 2006; Joffe, 2012). With the exception of critical social research, which seeks to go beyond studying and understanding society to critiquing and changing it, the above analytic approaches can all be considered interpretive. That is, they aim to understand the phenomenon and the participants’ associated meaning. Therefore, there are some underlying assumptions that run across these six approaches, most simply exemplified by basic qualitative research (Merriam, 2009).

The underlying premise of basic qualitative research is constructionism, whose central characteristic is the idea that individuals construct reality in interaction with their social world. Basic qualitative research is therefore focused upon how people construct their world, interpret their experiences, and what meaning they give those experiences (Merriam, 2009). Beyond these underlying assumptions, the six mentioned interpretative approaches differ in their theoretical and epistemological frameworks. A brief overview of these interpretative approaches follow. This overview signals the most appropriate analysis for the current study, given the main aim is to explore the phenomenon of the relationship between the victim’s trauma symptoms and intimate partner violence. The overview identifies a thematic analysis
with a phenomenological epistemology and relativist ontology as the most suitable methodology.

**Phenomenological Analysis**

Phenomenology focuses on the world as it is experienced by people within particular contexts and at a particular time, and does not consider objects and events as separate from a person’s experience of them (Willig, 2013). Therefore, the appearance of an object or event as a phenomenon varies depending on the perceiver and their location, context, judgements, wishes, aims and past experiences. This variance is referred to as intentionality, and indicates that the self and world are necessarily combined components for meaning to occur. Hence, phenomenology considers perception to always be intentional, and therefore constitutive of experience itself (Willig, 2013).

The phenomenological method includes three phases of contemplation (Willig, 2013). Firstly, *epoché* which requires assumptions and judgements to be put aside. It may be conceded that few researchers would claim that a true epoché state is possible, therefore the researcher attempts to bracket their presuppositions and biases. Secondly, *phenomenological reduction* in which the constituents of the experience of the phenomenon are identified, that is, the ‘what’ is identified. Finally, *imaginative variation* which focuses on the ‘how’ of the phenomenon and involves the identification of the conditions associated with the phenomenon such that its experience is possible. The integration of the ‘what’ and ‘how’ allow an understanding of the essence of the phenomenon (see Willig, 2013).

In recent years, phenomenological methods have become more common in psychology research, particularly, interpretative phenomenological analysis (Smith,
Interpretative phenomenological analysis (IPA) aims to gain insight into another individual’s thoughts and beliefs about the phenomenon that is being investigated. IPA recognises the central role of the researcher in making sense of the participants’ experience, while the participant too is trying to make sense of their personal and social world (Smith, 2004).

Although the epistemological position of IPA appears to be an appropriate framework for the current study, it is important to note, while Smith (2004) explains that IPA has been developed as an approach committed to the detailed exploration of personal experience, it was not designed for focus groups and has infrequently been used for such. Smith explains to approach focus group analysis using IPA the researcher must explore for both group patterns and dynamics, and idiographic accounts. As group patterns and dynamics are not a focus of the current research aim and questions, another method was deemed more appropriate.

*Ethnographic Analysis*

Ethnography focuses on human society and culture whereby a phenomenon is understood through the lens of culture, and the result of ethnographic research is cultural description (Willig, 2013). Data collection includes the immersion of the researcher as a participant observer, and includes a lengthy and intimate study in a particular social setting.

*Grounded Theory*

Like IPA, grounded theory (seeks to describe patterns across qualitative data and is theoretically bounded (Braun & Clarke, 2006). This methodology was designed to allow the development of new, contextualised theories. It merges the
process of data collection and analysis and attempts to ‘ground’ the analysis in the
data, by way of theoretical saturation which is when no new themes emerge. This
methodology requires an initial research question to identify a phenomenon, and the
question can change and become progressively focussed throughout the process
(Willig, 2013).

**Narrative Analysis**

Narratives, also known as “stories”, can be considered as the most natural
form of “sense making” (Jonassen & Hernandez-Serrano, 2002). Narrative analysis
uses stories as data, particularly first-person accounts of an experience whereby the
experience is told from the beginning to the end. This methodology emphasises the
interpretation and context of written text of the story (Willig, 2013).

**Discourse Analysis**

This studies what people do with language and the emphasis of this
methodology is what people or cultures achieve through language (Wetherell, 1998).
Therefore, discourse analysis may examine how participants use language and to
what effect, such as in order to negotiate and manage social interactions. This
methodology does not seek to understand a psychological phenomenon but rather
how the phenomenon is constituted in talk (Willig, 2013).

**Thematic Analysis**

As aforementioned, thematic analysis is a widely used qualitative analytic
method, and has more recently been considered as a method in its own right (Braun
& Clarke, 2006). It has been used recently within the IPV literature to better
understand the narrative of IPV survivors, and the meaning they give to interpersonal victimisation (Lim, Valdez, & Lilly, 2015). It is not tied to a particular theoretical or epistemological position, therefore it provides a flexible and useful method to deliver a rich and complex account of data. Braun and Clarke (2006) and Joffe (2012) outline a guide to completing thematic analysis, and stress the importance of the researcher clearly stating their assumptions, such as their epistemological and ontological ethos. This type of method produces themes which capture and make sense of the meaning given to the studied phenomenon. Therefore, the knowledge acquired from thematic analysis is dependent upon the nature of the research question, and the epistemological implications of the formulation of the research question and data collection (Willig, 2013).

As the aim of Study 2 was not to describe culture, create a theory, emphasise the full “story” and context of IPV, or to examine how participants use language and to what effect, respectively, ethnographic analysis, grounded theory, narrative analysis, and discourse analysis were all considered to be inappropriate methodologies for the current research, along with IPA. Thematic analysis was therefore reasoned to allow exploration of the current study’s aim and research questions. Thereby, the epistemological and ontological positions need to be explicitly stated for this study. A phenomenological position is taken, which encompasses, like IPA, an attempt to gain insight into another individual’s thoughts and beliefs about the phenomenon that is being investigated. Additionally, it recognises the central role of the researcher in making sense of the participants’ experience, while the participant too is trying to make sense of their personal and social world (Smith, 2004). The ontological position taken in this study is relativist. This indicates a stance whereby truth or reality is constructed by humans and situated
within an historical moment and social context. It further acknowledges that multiple meanings may exist within the same data, dependent upon the perception of the viewer. Given this ethos, a positioning statement is indispensable.

**Positioning Statement**

One characteristic that has been identified as key to understanding the nature of qualitative research is that the researcher is the primary instrument of data collection and analysis (Merriam, 2009). As understanding is the goal of qualitative research, humans, who are able to be immediately responsive and adaptive, are fundamental. The researcher can process and clarify information immediately, check for interpretation accuracy, explore unanticipated responses, and expand understanding through verbal and non-verbal communication (Merriam, 2009).

Research of this kind therefore presents human factors that will impact the manner in which data is collected and analysed (Corbin & Strauss, 2008). It is important to identify and monitor potential researcher biases and preconceptions, and as to how they may shape the collection and interpretation of data. Additionally, a specific technique of IPA is epoché which is the process of the researcher attempting to remove or at least become aware of prejudices or assumptions, such that they endeavour to see the experience for itself (Willig, 2013). A positioning statement of the student researcher is provided in order to offer some context of her background and potential assumptions, and how they may have impacted upon the framing of the research.

The current research project forms a partial requirement for a Doctorate of Clinical Psychology for the principal researcher, Natalie Pill. Natalie’s interest in domestic violence and trauma stems largely from volunteer work she completed
while living in Mexico. There she worked as a psychological support staff member within a public centre for women, providing mental health support, assisting and observing individual and group therapy about a range of topics. What was notable for Natalie was that the only consistent factor among the many women she worked with was that they had experienced family violence, particularly partner violence. In this role Natalie also helped initiate and run community groups in low socio-economic and underprivileged areas within Mexico City, with the premise of educating and supporting people in aspects such as self-esteem. Again notably, after sometime, the topic of domestic violence would emerge from the participants; this occurred both within the women’s centre and in community groups. Natalie was also struck by the normalising effect of group settings around partner violence, and by the empowering and enlightening effect that education of IPV, and a greater understanding of their own experience, ensued.

Natalie then completed a Master’s of Arts (Clinical Psychology) and her research explored mental health symptoms among female survivors of partner violence. That research was principally quantitative, however impromptu feedback from the participants after completing the study served as a rich and highly meaningful research medium. It gave insight into the women’s past and current experience, that which the quantitative method had not permitted.

Within the Master’s degree, Natalie also completed clinical placement. Although fluent, Spanish is not Natalie’s native language, therefore she would often seek clarification from her clients for their meaning and interpretation of the language which they used. Natalie found that despite knowing the translated terms, the pursuit for clarification often lead the clients to explain quite a different and detailed meaning to that which they had summarised in a mere word. Natalie has
found that seeking similar clarification with clients who speak her native language produces the same result, highlighting the importance of personal meaning construction, interpretation, and communication. This clinical and research experience served as a catalyst for further interest into the symptoms that IPV survivors experience, and how the survivors make sense of, and understand, their experiences and their world.

Natalie has four years of clinical experience and many years teaching and facilitating groups among both clinical and non-clinical populations. The age of group participants has ranged from early primary school age through to older adults in their 70’s.

Analytic Process

The analytic process was based upon a thematic analysis method with a phenomenological epistemology and relativist ontology. Audio interviews were first transcribed verbatim by the researcher, or de-identified and transcribed verbatim by a transcription company. De-identified transcripts were then imported into NVivo 10 (QSR International), a software package that assists with the storage, management, and analysis of qualitative data. The principal researcher familiarised herself with the data by listening to the audio recordings a number of times, and reading and re-reading the transcripts. The researcher developed some ideas about the nature of the data and its relevance to the research questions during this initial stage of analysis.

The qualitative process of data analysis was principally guided by Braun and Clarke (2008), with further instruction taken from Alhojailan (2012), Fereday and Muir-Cochrane (2006), Joffe (2012), and Willig (2013). The researcher analysed the entire data set by initially coding with an inductive approach, at a semantic and then
interpretative level, to ascertain the predominant themes of the focus groups and individual interviews. Data was then approached with a theoretical thematic approach, at a latent or interpretative level, to provide a detailed analysis of the data, specific to the three study questions. The emergence of themes was discussed during both the inductive and deductive approaches between the researcher and principal supervisor.

**Results**

**Inductive Approach**

Twenty-three codes were created to classify the individual themes discussed across the focus groups and interviews. One code identified instances and situations where the women described trauma symptoms, or the researcher noted evidence of trauma symptoms within the interview. For example, at times throughout the interviews women would lose track of what they were saying mid-sentence, or draw a blank on the topic of conversation. They confirmed that this occurred often, had occurred for a long time, and demonstrates the second Complex PTSD alteration; alterations in attention or consciousness. The remaining 22 nodes represented three major categories, with each major category relating to partner violence and trauma symptoms. One category pertains to the past and primarily includes multiple factors related to why the women remained in the abusive relationship. Two categories pertain to ongoing and future safety and risk of partner violence. Within each of these categories, internal and external subcategories were identified, with the ongoing and future internal safety and risk factors being the focus of this study.

Within the past category, the internal factors included learned thoughts and behaviours from childhood and within the abusive relationship; empathy for others
and the perpetrator; and family values such as “a child needs his father”. External factors included a lack of resources or lack of opportunity to access resources to help facilitate the victim’s exit from the abusive relationship, and a lack of understanding from those around them, such as family and close friends. Table 4 lists these factors.

Table 4.

<table>
<thead>
<tr>
<th>Past Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal factors</strong></td>
</tr>
<tr>
<td>Childhood violence &amp; relationships</td>
</tr>
<tr>
<td>Understanding others</td>
</tr>
<tr>
<td>Family values</td>
</tr>
<tr>
<td><strong>External factors</strong></td>
</tr>
<tr>
<td>Lack of understanding</td>
</tr>
<tr>
<td>Lack of resources</td>
</tr>
</tbody>
</table>

Within the ongoing and future safety category many internal factors were identified, with some crossing over into external factors, such as connecting with support services. Some of the internal factors included trauma symptoms and related cognitions and behaviours which potentially protect them from further violence, education and enlightenment about partner violence, ownership of their own healing process, connecting with other women who had experienced partner abuse, and resilience. The external factors included helpful experiences with others in the court system or with police. It is also comprised of ideas the women proposed for recovery from IPV, and some improvements for domestic violence services. Table 5 lists these factors.
The internal factors within the ongoing and future risk category highlight the trauma symptoms and related cognitions and behaviours which put the women at risk of further violence. It similarly includes unsuccessful treatment, which also crosses over into external factors and includes interaction with others who advocate for inappropriate psychotropic medicine. External factors relate to the ongoing violence that this group of women uniquely face whilst coping with trauma symptoms, and legal management. This includes negative experiences with police and court proceedings with the perpetrator, which can be an ongoing traumatic experience in itself. Table 6 lists these factors.
Table 6.

**Ongoing and Future Risk Category**

<table>
<thead>
<tr>
<th>Internal factors</th>
<th>External factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of ignoring and numbing</td>
<td>Legal and police experiences</td>
</tr>
<tr>
<td>Risk of adaptive or changed behaviour</td>
<td>Ongoing violence and risk</td>
</tr>
<tr>
<td>Risk from symptoms</td>
<td></td>
</tr>
<tr>
<td>Unsuccessful treatment</td>
<td></td>
</tr>
</tbody>
</table>

**Deductive Approach**

The deductive approach identified four themes associated with trauma symptoms and how they play a factor in the women’s risk or safety from intimate partner violence. The questions that were posed in the interviews directly related to identification of future safety and risk. However, when the women were asked these questions, they were largely unable to discuss in the future tense how their trauma symptoms may lead to risk or safety. They were, however, able to identify past and present effects of symptoms, and associated reactions of those symptoms, on their safety and risk. Consequently, the results present discourse from the women in relation to trauma symptoms on past, present, and future risk and safety of intimate partner violence.

Three of the four themes highlight both risk and safety factors for IPV, while the fourth theme indicates only a protective factor. The first of the identified themes was trauma symptoms themselves, which highlights how some symptoms serve to protect, and also place at risk, the victim. The second and third themes relate to trauma symptom associated behaviour and cognition changes, further highlighting both risk and protective factors. These two themes are entitled: understanding and
adapting to intimate partner violence, and treatment. The fourth theme is resilience, which was a consistent factor identified within the safety factors of the other three themes. It was identified as a separate theme as it clearly served as a protective factor in its association to trauma symptoms, and was not dependent of any other singular theme. The four themes, along with risk and safety factors, are displayed in Figure 7.

Figure 7. Thematic map for Study 2.
Indicates the three themes which represent the safety and risk factors for future intimate partner violence, associated with trauma symptoms.
**Theme 1: Trauma Symptoms**

The effect of trauma symptoms on risk and safety from intimate partner violence is highlighted in this theme. Complex trauma symptoms, a lack of trust of others and numbing, can serve as both a protective and risk factor for the women. Hypervigilance, a PTSD symptom, is described in a chronic form amongst the women, and indicates a mechanism by which the women maintain physical safety from their abusive ex-partners who continue to threaten and emotionally abuse them. The most discussed and prevalent trauma symptom which serves as a risk factor is numbing, a PTSD symptom, which is one aspect of the Complex PTSD alteration, alterations in attention or consciousness. The PTSD symptom of numbing in the DSM-IV relates to experiencing numbing of general responsiveness, such as feelings of detachment or inability to recall important aspects of the trauma. The alteration of attention or consciousness in Complex PTSD includes amnesia, dissociative episodes and depersonalisation. While there is some crossover of symptoms between the two, such as an inability to recall experiences or a feeling of disconnection, the symptoms of the Complex PTSD alteration are considered more severe than numbing.

The other five complex trauma alterations were identified as also putting the women at risk of IPV. Figure 8 illustrates the risk and safety factors associated with trauma symptoms.
Figure 8. Thematic map for Theme 1. Thematic map indicating the protective and risk factors for future violence associated with trauma symptoms.

Safety Factors – Trauma Symptoms and Alterations

Most protective of the trauma symptoms were hypervigilance and not trusting others. Continually knowing where their ex-partner is makes the women feel safer. They all discussed that after many violent encounters, they knew what reaction was most likely to protect them, and that if they did not know where the partner was, or what his mood was, then they did not know how best to react. Not trusting others was a major factor for all women, and they discussed not trusting anyone. It is discussed below as a safety factor as it screens potential future violent partners, but it also creates and maintains isolation from people who can serve as a support system. Women also spoke of times when depersonalisation protected them from further abuse, and that sometimes anxiety was what made them move. The safety factors related to trauma symptoms are comprised of both Complex PTSD symptoms and other trauma-related symptoms.
Complex PTSD Symptoms

Lack of Trust

There was a unanimous approach to trusting others, and that included a conscious decision by the women not to.

“Well I don’t trust.

Trust is huge.

Trust is my...

Trust is huge, yeah.

I’m pretty much the same. Trust. Isolation. I’ve isolated myself, can’t go out...

That protects me from sort of interacting with other people that might hurt me.

Barriers.

Yeah, I’ve built these walls and they now stay there.”

However, it also demonstrated the isolation it can cause, even when people are trying to be supportive. The following was one woman referring to a conversation she had with a friend about the domestic violence centre within which the interviews took place. The location of the centre is confidential, for the women’s protection.

“I said, yeah I’ve got to go to [the domestic violence centre] and I explained to her, and she goes, well do you want me to come with you? And I said, no you can’t. And she goes, well I can meet you afterwards. I said, I still can’t do that. She was there for me if I
need her and she’s a phone call away but I just, yeah, kept it a secret.”

Depersonalisation

Women discussed how experiencing interpersonal violence at any age had taught them that sometimes feeling and acting numb to the violence led to protecting them, and that depersonalisation had occurred during times of assault. This included within their intimate partners’ relationships, and one woman explained how she had learned it from experiencing parental abuse as a child.

“See I learnt that as a kid, from a parent, but pretty much my sister got belted the poo poos out of, let’s say, I didn’t even know how to say that nicely. I couldn’t run because it would have been worse for me so I had to stand there and cop it, so I learnt to freeze and become numb, that was pretty much--I’m invisible, I’m a tree you can’t see me…

The freeze response, yeah.

Yeah, pretty much.

If I don’t move it’s not happening.

I’m over six foot and I’ve got more than a metre around the arse but you can’t see me, I’m invisible…”
Other Trauma Related Symptoms

Hypervigilance

Participants talked about the need to know where their abusive ex-partner was and what they were doing, in order for them to know if they might be in danger. They explained that when they hear nothing from, or about, the ex-partner they feel most at risk, because they are not sure when the partner may reappear and attempt to hurt them. It was safer for the women to be constantly scanning their environment, and to explicitly know where their ex-partner was.

“...once I stopped all contact things got a lot worse and then I found myself checking Facebook, even though I de-friended him, just to see what he was up to, just so I knew if I was in danger.”

One participant spoke of a time post-separation from her ex-partner, but still living under the same roof, and how she let him know she was watching him, in order to protect herself. The following occurred after the woman denied his sexual proposal and he said to her, “I could just rape you, you know. I could”.

“...so I started getting the little thing out and putting it behind the door so he couldn’t come in and things like that, so it protected me, because he may have - and he knew what I was doing, I said that, I was making sure he knew what I was doing...”

Anxiety

Many of the women experience, or have experienced, anxiety and depression. They spoke about the necessity to use the anxiety when they felt it, in order to get moving, and to get things done. The anxiety allows them to focus on their safety, and some admitted that the anxiety was due to fear for their safety, relating back to the
first point of this sub-theme; hypervigilance and being motivated to stay safe. Women spoke of a roller-coaster experience through waves of anxiety and depression and the need for insight in order to capitalise their current mental health state.

“...you know you’re going into numb land or whatever it is, so you’ve got to like, “Hold on, hold on, right, so focus, right now what’s happening, what’s going on?”

I do that too, when the anxiety’s there, because for me I have anxiety and depression and I know that when I’m really anxious and I get it, that’s actually when I get things done, yeah.

Yeah, but I know that that’s the only time I’ve got to do stuff because once I hit the depression I won’t do anything, and so that in a way kick starts—I think that’s a protective factor, because that’s when I’m doing stuff. So, the symptom of anxiety actually helps me get anything done.

-Yeah, mine’s all done out of fear, mind you, it’s still out of fear so it’s not...

-Motivation by fear, not a problem!

Yeah, we’re used to that.”

Risk Factors - Complex Trauma Alterations

These risk factors highlight the potential effect the six alterations, which define complex post-traumatic stress disorder, may have on a woman’s risk for IPV.
The second alteration, alterations in attention or consciousness, was particularly salient in the interviews, with distinct Complex PTSD symptoms apparent, along with a consistent crossover with the theme of numbing. The women described numbing to the violence and the world around them, and how this led them to experience more severe symptoms such as depersonalisation and dissociation. The women’s discourse commonly termed alteration in attention or consciousness symptoms as numbing, and for these women symptoms of numbing and dissociation/depersonalisation was simply a continuum of severity for the same response to violence. As such, examples of numbing have been included in this section under the umbrella term of alteration in attention or consciousness; the women commonly described both types of symptoms interchangeably. Risk associated with the five other complex trauma alterations were also mentioned by the women, with alterations in self-perception another salient change in the women’s thinking and behaviour. This theme includes two factors: alterations in attention or consciousness; numbing, and other complex trauma alterations.

*Alterations in Attention or Consciousness*

Experiences of dissociation or depersonalisation were discussed, along with reactions that felt out of character for the women.

> You get impulsive sometimes. I’m just thinking of the effects of what the numbness, you know, is. Sometimes you feel like you’re outside of yourself.

Moments and periods of amnesia were discussed among the women, a symptom of alterations in attention and consciousness.
“When all this happened to me and disbelief hit him, shock and numbness happened for me that I actually do not remember my move for two months of a year, I have no idea how I got my kids back, how I moved, how we even functioned. And I want a bit of it back so I know what was going on.”

The women also spoke of the risk of feeling closed off from others or becoming cold to others, including their children. Beyond alterations in attention and consciousness, this also indicates the fourth Complex PTSD alteration; alterations in regulation of others.

“Yes I really feel I’m probably cold with my little guy sometimes, because you just put up with the shit for so long, and the problem is my son talks to me how he did ... and sometimes I think God, you know, have I just become a really numb, cold ass, I mean sometimes I just think God I really should go and give him a cuddle ... I think you just kind of...

You do, you close off...you get emotionally numb.

You do, everybody’s still waiting for me to get angry or breakdown and cry and I haven’t done either. Continually numb.”

Going numb during physical violence in order to protect oneself, can also lead to the perpetrator reacting with more violence.

“I mean I know of points where I was in the middle of being hit and go numb so that you don’t feel that pain but because there’s not a reaction from you those hits get worse.”
Due to the level of violence the women had experienced from their ex-partner, they were less likely to identify new threats of violence or gauge the severity of new violence, post-separation. Below is the story of one survivor whose neighbour’s behaviour escalated in threats. She did not identify danger, and her family eventually convinced her to move. Her sense of distance and depersonalisation from the incident was apparent whilst she gave her story; indication of an alteration in consciousness is evident.

“I just wasn’t reacting to it and no one, my family said, ‘You don’t realise how serious this person is’. And I’m going, ‘Is that all you can do?! Oh, come on!’

Exactly, because you’ve been with somebody worse.

And I’m going, ‘Is that all you can do?’ And they go, ‘This is really serious, you’ve got to get the police involved, he’s setting fire, he’s jumping the fence and waving swords at you’, and you just go, ‘Come on!’...

... And that’s being numb, is that I couldn’t relate to how dangerous this guy was. And I’d completely forgotten until just now.

So sometimes you become passive, very passive.

And that’s numb; I completely have forgotten how dangerous... I just forgot about this because that’s why I had to move, see that’s what it’s like. I’m numb, I forget, but that’s why I moved to my new place where I am now... I even forgot why I moved house.”
Numbing

Feelings of numbness or immunity towards the abuse and signs of potential abuse led to further violence from their ex-partner. The following passage gives insight into how emotional numbing and depersonalisation affects a victimised woman in her daily life, with the ongoing threat of violence in her relationship. It highlights how not just surviving the abuse, but surviving the day, is at the centre of her thoughts and behaviours. Further, it exemplifies the routine and normality the abuse can take within a relationship, when a woman feels numb.

“When you become numb everything becomes, it makes things, you just go this is my normal, this is the routine, it’s going to happen this, it’s going to happen like this. And that’s what being numb is all about is that today’s going to be okay, this is like this it’s numb, I’m going to be ready for this, I’m going to be ready for this, okay I’ve got to be ready for this, I’ve got to be ready for this, and that’s just numbness of just okay morning I’m going to expect this, I’m going to expect this, I’m going to expect that and numb to whoa it’s a lovely day out there I think I might go and do something. I’ve just got to do this, I’ve got to do this, got to do this, got to do this, got to do this. And that’s for me it was numbing is that there was no emotional high, low, no expectations of what, oh are we going to go to the park? Numb, numb, no, no, no. It’s just absolutely, and being numb with it is the same thing or going through the motions, when you’re going through motions you don’t have any feelings, because you just go I’ve got to do this, got to do this, got to do this, got to do this, I hope you survive, I hope I’ve got the beer there
The women spoke of numbness in reaction to the partner violence, in order to protect themselves. Not being able to read the perpetrator’s signals or mood could lead to shutting down and experiencing a general numbing in responsiveness, as they did not know what else to do. One woman explained how she would shut down and feel numb when she could not “figure out what was going on that day, for him, or that minute”. Asked if she believed that response put her at risk, she responded:

“Oh definitely, he would make the assumption that obviously I wasn’t paying attention or picking up or doing whatever he thought or whatever, whatever. Sometimes I find that people that want power tend to escalate the behaviour so that they get attention, so if you’re not behaving the way you should then, ‘Well we’ll damn well find a way to make you listen or behave or respond or something’. Yeah.”

Another woman spoke of the risk involved with becoming numb, particularly detached, over time, and that usual reactions associated with protecting herself were diminished.

“I’m sure when you’re numb you’d probably miss signs maybe like you’d be that numb or tired that you’d miss that sign that I shouldn’t have argued back that day.”

Becoming numb in responsiveness can lead to feeling one is immune to the abuse, leading to greater risk.
“When you get like that you just tend to cop more and put up with more because you just kind of throw the towel in. You’re immune to it; you’re so used to it.

Yeah it becomes the normal.”

The women discussed whether or not the numbness protects them, and there was a general agreement that it does not. They identified that the numbness leads to an inability to focus or get organised, “wastes your life”, and prolongs the abusive relationship because “you just put up with it”. Numbness also causes them to have difficulty with memory, which they indicated puts them at risk, not only in day to day activities, but also in terms of remembering what life is like without partner violence. The numbness can also lead to questioning one’s judgement, both during the abusive relationship and post-separation. One woman spoke of her experience in the court system, when she gave written evidence of her ex-partner’s threats and abuse, and the defending lawyers tried to demonstrate that none of her evidence was true.

“You question your judgement.... And I started to believe, I’m starting to think I, I thought, why is it? Were you too numb for long, did you imagine it?”

Other Complex Trauma Alterations

This section focusses on complex trauma alterations, and demonstrates how the five remaining alterations may put IPV survivors at risk of partner violence.
Alterations in Regulation of Affect and Impulses

Women reported various changes in affect and impulses, such as passivity and anger. One woman notes that she has lately been prone to impulsive anger whilst driving, and recognises that it puts her at risk.

“But even actually road raging, I mean I sometimes have to pull myself back and think, ‘Hey hang on, if you carry on like that what if he has a go back at you, this guy?’”

Another woman talks about her various coping mechanisms over the years, and that she currently drinks more than is recommended, just so the day ends.

“I just wish you could get work, get away from that eye in the back of your head ... I’ve got to shut down. And I admit I drink too much now. I drink probably three glasses because I just want to...

Sleep.

No, I just want to get the day over.”

Alterations in Self-perception

The alteration in self-perception among the women was a prominent topic of discussion. They all reported self-doubt and negative self-talk, low self-esteem, low confidence, and a lack of confidence in their judgement. Many of the women had grown up being told by their family the same negative things about their worth, as what their abusive partners had told them. Other people’s beliefs had become their own, and were most prominent when they were at their most vulnerable.

“No self-worth, no belief in myself, doubting...

Self-doubt, that’s the one.
...you’re not good enough, you’re a useless piece of shit.

You’re never going to...

You don’t deserve...

Especially if you get taught that as a kid as well.

Yeah, I’ve got a lot of this stuff that was said, and I say it now, it’s my self-talk now when I’m not healthy ... I resort back to the old ways, ‘Oh, you’re stupid, you’re an idiot, not good enough. Don’t do it you’re going to fail, don’t even try.’”

The effect of constant emotional abuse and belittling is the belief that others are correct in their evaluation of their worth.

“I would say my feelings of not being worthy, which is my lack of self-esteem and confidence. So, when someone’s saying to me, ‘No one’s ever going to love you, no one else will ever have you,’ I believe that.”

Another effect is a lack of confidence in judgement, including “gut instinct”, which may inhibit women to act upon instinct which would otherwise serve to protect her.

“You question your gut instinct because you’ve been through like a washing machine, you don’t even know if you have an instinct anymore, if you’re using your right judgment.”

Due to numbness as a reaction to the violence, the women discussed a loss of identity and an alteration in self-perception.
“I loved cooking but he turned me off it, I friggin hated it.

Yeah and that’s the numbing experience.

You know, always loved it.

The numbing of becoming not knowing who you are.

Yeah, you just become whatever.”

Alterations in Relation with Others

The most prevalent symptoms in the alteration in relation with others was isolation and a lack of trust in others. The lack of trust in others was a salient symptom and included those whom the women felt they should have been able to rely on, such as the police.

“I used to have a really high perception of police too so my judgment that’s what I’m getting at, is I don’t trust the police now through these experiences through DVO.”

The effect of not trusting anyone also exacerbated the women’s isolation, thereby this protective factor may place them at greater risk of partner violence.

“I absolutely trust no one else. I want to be socially active or involved with people, so I’ve got to develop a bit of trust. So as much as I’ve protected myself, I’ve alienated myself as well because I just can’t give myself away that way.”

The recognition of not trusting others and being isolated has led one woman, at the advice of her family, to attempt to reconnect with others, particularly men, in a
manner which puts her at risk of abuse. She spoke of going out to night clubs, drinking large amounts of alcohol, and having sexual encounters with new acquaintances.

“But then again I thought maybe I should just try and learn by having one night stands. <laughs>”

One woman spoke about how her lack of trust in others, and consequential isolation led to her beginning another relationship with her abusive ex-partner. In a series of events occurring over Christmas, when support services were closed, she was feeling lonely and highly isolated and she called her abusive ex-partner. She discussed how this led to them beginning the relationship again, which became violent, in addition to the consequences on her self-perception, and how this compounds her position to not trust others.

“I don't trust anybody and I have difficulty forming friendships. I either overreact or underreact to things. I had a situation... [my ex-partner and I] got back together for about a month and of course the abuse started again and then the guilt and shame associated with my actions just compounded my sense of self and so I have to be really vigilant.” 

Somatisation and/or Medical Problems

The women spoke about the direct physical effects of the violence, and also the long-term, chronic medical issues which they attributed to the violence and chronic hypervigilance.
"I was just saying that over awareness of everything, I think it can put, I just think it can put you at risk because of your health, because it runs you down, it wears you out.

That’s your risk, your health."

They also spoke about the detriment to their health, and that they experienced life-long medical issues due to the stress of IPV.

“I’ve just been put on blood pressure medication for life, because I get that worked up. ... I don’t know how many tablets I take probably seven a day, you know, for different things then you think well your kidneys or your liver’s going to go because of them, always in some cycle."

**Change in Systems of Meaning**

One change the women voiced was the idea of what a family is, to them. Previously they had an ideal that a child should have both their mother and father present, however over time, as discussed in theme 2 safety factors, they now considered that ideal was not absolute and should not occur if a parent is abusive and teaches poor ideals to the child. The consequence of this change in such a major ideal was to question other systems of meaning in their life, thereby leading them to question themselves and what they believe. One consequence was a change in their approach to the world, from once being positive, to negative, and a belief that the change was permanent. One woman relayed a recent conversation she had had with a friend.
“She said, ‘When I met you, and it was about 16 years ago...you were a very positive person’. So it changes who you are. It just changes who you are.

Of course it does, it’s baggage. I don’t think you ever get back to normal.

No.”

Theme 2: Understanding and Adapting to Partner Violence

Both cognitive and behavioural adaptations as a response to intimate partner violence are highlighted in theme 2. Three safety factors were identified which indicate a shift in cognitive appraisal of the survivor’s situation, intimate partner violence, and the perpetrator of abuse. Three risk factors were identified which demonstrate changes in the women’s behaviour in order to try to protect themselves. According to the women, their protective measures and adaptations towards the perpetrator and those around them can result in greater risk of IPV. Figure 9 illustrates the risk and safety factors associated with trauma symptoms, in relation to understanding and adapting to partner violence.
Figure 9. Thematic map for Theme 2.
Thematic map indicating the protective and risk factors for future violence associated with understanding and adapting to partner violence.

**Safety Factors - Understanding Intimate Partner Violence**

These safety factors highlight how understanding abuse and the cycle of violence is an important aspect of maintaining safety. As women learn more about partner violence, they become increasingly able to identify when they, or their children, witness and experience further abuse. This serves to reinforce their theoretical knowledge and motivates them to remain out of the abusive relationship. There are three safety factors related to theme 2: knowledge enlightenment, violence acknowledgement, and opinions on the perpetrator.
Knowledge Enlightenment

This safety factor refers to the education the women have sought out or received about partner violence, such as the cycle of violence and normalisation of their experience. This education can lead to lessening of shame and guilt, improvement in empowerment, and identity of signs of further manipulation and abuse. Information about the law and court proceedings is also important in the process of women learning how to further protect themselves. Learning what intimate partner violence is, is crucial for a woman to identify her relationship as such.

“I’ve been out of it but I haven’t been out of it for a long time. I never ever really knew I was in it. I was married in ’94; I wanted to be out three months later.”

Knowledge about these aspects may help facilitate a woman to leave an abusive relationship, however it is not sufficient alone to keep a woman from returning to a relationship, or starting another, with an abusive partner.

“I was re-entering an abusive relationship, and I knew better, and I didn’t want to be, and I didn’t understand why I went back to it ... It was like I had to go through that process of what was going on before I could make that decision ... I was aware that if I re-entered the relationship I was saying that I deserved to be abused. That’s what someone said to me, they said if you re-enter the relationship it’s like saying, ‘You do deserve this’, and you deserve better. So then I still went back to it knowing that.”
Within the process of education about violence, women often experience more violence. With more knowledge and experience, they become better able to identify the elements of partner violence, along with a greater awareness of themselves within the cycle of violence, gradually decreasing their risk. It is an ongoing process continuing from when they begin learning about violence, to present day.

“I just realised how ingrained it was and once I realised just how ingrained it was, I could let go, I was able to let go as I thought if I don’t want to end up like my mum I can’t keep going back ... I was aware of it before, my last boyfriend too.

But you’re more aware now.

Yeah, I think I’m more aware of myself, and my own behaviours and reactions towards things. That’s what I’m more aware of now.”

Another woman commented on her improving ability to remove herself from an abusive relationship.

“I got involved with honestly another idiot, <laughter> and it only lasted for three months, thank God. But I’m getting better at it now, two years, and the next one was three months.”

Another woman discussed how groups focussing on violent relationships and healing had fostered enlightenment of herself, her relationship, and allowed her to feel closure of that relationship.
“[I] only got my closure just the last couple months, like coming to the groups here, and just listening and participating in a group it really got me out and thinking ... I could not have done it without the groups here. It’s taught me a lot about myself as well, and made me realise where I was wrong, where things went wrong.”

Finally, this knowledge enlightenment and greater awareness of the effects of intimate partner violence on themselves and their family helps the women make sense of their trauma symptoms. It also allows for a sense of normalisation, with many women commenting that once they understood their symptoms in the context of partner violence, they felt “normal” and pleased to have confirmation that they were “not crazy”. The challenge, they felt, was for this type of information to be disseminated to the wider public.

“I think the lack of knowledge and awareness, particularly with domestic violence, and the symptoms is, for me, a really scary thing. Because I started to think I was about to be put into involuntary treatment.”

Violence Acknowledgement

Part of the initial stages of the healing process outlined below in the sub-theme “healing ownership” is the realisation that their intimate partner violence needs to be acknowledged. Once a woman is more aware of what partner violence is, admitting its existence is crucial to healing. This includes acknowledgement that the violence is not the victim’s fault, they “did not ask to be abused”, and that the victim does not need to, nor should she, hide that she was, or is being, abused. It also
includes acknowledgement about violence in their past, such as witnessing or experiencing parental abuse, and identifying patterns of violence. Acknowledging these aspects was a clear necessity the women discussed in the early stages of healing, and in order for them to move forward with their lives.

“If you don’t acknowledge it and say this is happening, this happened, this is the reality, what can I do for me?

I spent many years hiding stuff and I realised years ago that was going nowhere.

Doesn’t do any good.

No. And I was impacting others with my behaviour because of it.”

Acknowledging the intimate partner violence with their children was highlighted as an important factor for decreasing the chance of intergenerational partner abuse. One woman who experienced and witnessed family violence resolutely and successfully taught her daughter that partner violence was not acceptable. Another woman who also witnessed parental partner violence and has come to realise she learned to accept abusive relationships in her childhood, commented on the importance of acknowledging and communicating about the violence.

“That’s really good that you’ve taught her, I think. You’ve acknowledged it and my mother never could, we can’t talk about it.

We never talk about anything.”
Opinions on the Perpetrator

With greater knowledge and time, the women’s opinions about the perpetrator change, due to his past and current behaviour to both her and their children, including ongoing abuse to children. The women commented on learning and understanding about several aspects of the perpetrator’s personality, and the depth of their desire to control. The past and current effects of partner violence on the children was a strong motivator to remove themselves, and remain out of, the abusive relationship.

Two women spoke of exploring information about personality types and discovering that diagnostic criteria for Narcissist Personality Disorder described their abusive partners. This highlights the pattern of behaviour that they were exposed to, such as a high sense of self-importance and entitlement, a preoccupation with power, and interpersonal exploitation. One woman looked up the definition after her abusive partner called her a narcissist because she wanted to know what it meant, and after years of emotional abuse and feeling vulnerable, she was concerned that, “Maybe I was”.

“I was looking it up and then I went through, and I was like, “Oh my God, I just found him, it’s him; he’s the narcissist.”

Other women described their respective opinions upon reflection of what abusive men are like, and their time with them. This included an acknowledgement that perpetrators can be so determined to control their partners, they disregard potential consequences.

“But like he had so much control, these people are so controlling. And at the time you’re just scared all the time. They’re emotionally
controlling, they’re physically controlling, they’re just like monsters, absolute monsters.”

“They’re bloody psychopaths and the problem is they’ve got no fear of government, coppers, whatever, they don’t care.”

After having had some education about perpetrators and self-reflection, the women expressed their current opinion on what perpetrators like to achieve; find a strong woman, control her, and break her down. This is in stark contrast to the opinions they expressed about the perpetrator’s motives, when they started dating their partner.

“A wild horse that’s beautiful and free; they just want to get it, control it and destroy its freedom, something that’s beautiful.

I bet you all four of us [here] we’re strong, we were confident, we knew who we were, and then suddenly this bastard comes along and sees this beautiful creature and then goes, ‘that’s it’.”

The impact of witnessing partner violence by their children served as an indicator for the women of what their child was learning and feeling, during the relationship. This helped to change their perspective on the violence, as they realised their partners’ behaviour was having a direct effect on their child.

“When he saw me hyperventilating after having a broken nose or something, he actually did a drawing. And there was something physical that my son had drawn of mummy lying down, after daddy had done terrible things, and it was a picture of me, and something
physical that he had seen. It was there in front of me, and that’s when I realised, ‘Holy, holy…’

Yeah, [my son] started drawing pictures of stabbing his father and stuff.”

This impact and effect on the children was also a strong motivator for the women to remain out of the abusive relationship with the father of their children. They were concerned for their children’s well-being, and how they were currently being abused and manipulated by their father. These issues concerned children who were in their late adolescence and early twenties, and also middle childhood.

“They still live with their father, who tells them he wishes they were dead. There’s holes in the walls, they live in squalor, my [17-year-old] son doesn’t go to school, they are given everything they want.”

“My ex-husband … passes on information to our eight and seven year olds to tell me stuff when he could just tell me.”

Many of the women discussed their concern that their children had learned that intimate partner violence is okay, or that certain thoughts and behaviours their ex-partner demonstrated, had been taught.

“I’ve got a really scary problem that, I’m scared that I see traits of the father in the son. He’s learnt horrible habits from his father; and his perception and opinion of women.”

“It has a knock-on effect on my kids because my daughter, she’s more likely and has accepted abuse in her relationships because
it’s what she’s seen and she’s seen society accepts that it’s okay.

And my boys who think that violence is okay.”

Another woman expressed her distress that she was currently witnessing the effect of her young children spending more time with their father. She resolved to change his visitation rights.

“Now that he has them more often I can really see the difference when I come home because he used to just have them every second fortnight, so then I didn’t really - I could still see, but now it’s getting worse.”

Risk Factors - Adaptive Behaviours

These risk factors highlight how some of the behaviours that women consciously, or unconsciously, take on in order to protect themselves, may lead them to be at greater risk of partner violence. Throughout the interviews the women spoke of chronic hypervigilance. As was discussed in safety factors due to trauma symptoms, this adaptation can be the very behaviour that keeps the women alive. However, consequences of constantly scanning their environment can be stressful for them and their children, lead to fatigue and feelings of being worn out, and potentially lead to missed signs of future violence due to the stress and exhaustion. Women also spoke of avoiding situations and people who demonstrate a lack of understanding and judgement about partner violence, and not wanting to tell others about experiencing IPV. This conscious avoidance compounds isolation, and therefore women were more unlikely to seek, or be open to receiving, support. There are three risk factors related to theme 2: protective measures, chronic hypervigilance, and active avoidance of judgement.
Protective Measures

Some women spoke of purposefully ignoring the partner violence or “playing the game” and choosing to take a submissive role in the face of violence, however the violence continued to escalate in reaction to some of these behaviours.

“...he’d yell at me, I’d make him a cup of tea, you know, do all the things, play the game. But, I told myself that no matter what, I would be submissive, I would choose to do this ... it was like a stupid game which is what I really resent and it was working on me overtime.”

The women generally agreed that some days, whilst with their partner, they would “play the game”. One woman explained her perspective on the danger of purposefully ignoring the violence.

“I reckon you’re crazy if you just ignore it, unless you’re ignoring to gain some head space it’s madness because they’re not happy unless they get attention or something, so it will escalate.”

There was an agreement among the women that they felt most at risk when they had not heard from the perpetrator, or did not know his whereabouts. In order to try to separate themselves from the perpetrator or to give themselves an emotional rest from interacting with the perpetrator, the women would actively cease contact and remove forms of possible contact. All the women confirmed this was the most likely time they felt the perpetrator was planning something, and they were likely to be hurt due to being caught off-guard and therefore lack capacity to protect themselves.
“I was also worried because I didn’t know what was going on then, at least when I was talking to him I knew what he was up to, I knew what he was thinking and what he was liable to do to me, or when he was liable to be around.”

One woman explained that being assertive in the past had led to further abuse, such that she now avoids being assertive not just with her ex-partner, but also with others.

“So even something like avoiding assertiveness behaviour, because in the past it only ever caused more abuse, so I’ve found, personally myself, avoiding being assertive in certain situations when I realise that that was just going to make things worse.”

One woman spoke about the day she permanently broke up with her husband. On her daughter’s birthday, her ex-partner was very physically violent and she told him to leave. Since then, on her daughter’s birthday she thinks about what happened, and is distressed that she was unable to focus on her daughter and the positive of the day. Such is her distress that in order to change her rumination, she has considered behaviour that would place her at great risk of future partner violence. Other women could relate to wanting to change a negative IPV association with a positive event.

“... and the scary thing was I actually did think about getting back with him and breaking up with him on a different date...

Trying to fix that. I know exactly what you mean, yeah.”
Chronic Hypervigilance

All the women spoke of chronic hypervigilance. The protective element of hypervigilance is discussed in theme 2. Given the constant and chronic nature of hypervigilance the women experience, it can lead to health issues, put stress on others, and also lead to stress and hypervigilance amongst their children. Some of the women spoke of their children’s need to know that they were safe, and the constraining knock-on effects of the hypervigilance.

“I had to pick up [my son] every day from school. I couldn’t hold a job, because I had to drop him off..."

Yeah [my son] is like that too, if I’m late, I can’t be late.

...and you’ve got to be at the gate, yeah at the gate waiting for him.”

All the women reported fatigue from constantly being hypervigilant, along with the longer term effect of the hypervigilance wearing them down. Some women discussed their concern of the consequential effect on their health, and the risk it puts them at.

“I was just saying that over awareness of everything. I think it can put, I just think it can put you at risk because of your health, because it runs you down, it wears you out.”

“But it’s just draining, you’re just so tired. That’s the thing you’re just so tired of protecting and being...”
The hypervigilance and consequential fatigue can put the women at risk of abuse from others, those that they may otherwise protect themselves from.

“Constantly scanning while I’m driving keeps me safe... But it also is exhausting and then my immune system can’t keep up and I also don't have the mental clarity to keep others away that could be abusive, yeah.”

Active Avoidance of Judgement

The women experienced feelings of being judged and vulnerable, due to both their experience of being abused, and also the trauma symptoms they experienced. The lack of understanding shown them from others, such as doctors, family, and friends, led the women to be less likely to share their story, further minimising opportunities of support from others.

“I feel like people are really judging me because a lot of things are happening where I know that’s a symptom from the stress but how do you explain that to the doctor, how do you explain that to friends?”

“...it just leaves you open for more abuse, I think, like when it comes to say, even doctors and things like that. Or other friends and stuff as well, if they see you willing to put up with stuff and then you have these symptoms...”
The women would therefore avoid situations and people who judge them and demonstrate a lack of understanding and support, further encouraging the women to withdraw and become isolated.

“I remember being upset at school one morning, and then the next minute some of them were, you know, they weren’t around as much and I’m thinking, yeah all right, okay.

You just lose so many friends.

Yeah, because people are judgmental, and DV’s a bloody...”

Having to cope with potentially stressful situations and people judging them on a daily basis leads to adaptations which further increase their isolation. They feel they need to hide their current feelings, a process which is draining, and they do not feel they can relate to others who do not experience IPV. One woman talked about the stress of the daily task of picking up her son, and interacting with other parents for a short period of time.

“It’s only lately that I’m saying, ‘Honey, Mum just can’t be bothered today mate, I’ll pick you up from the pickup zone, because I can’t be bothered talking to anybody. I can’t be putting on a happy face’.

You can’t relate to them.”

A consequence of feeling unable to relate to others, being judged, and isolated is not telling others about the violence. This process is accentuated when there is a lack of support from others when seeking help or telling them about the abuse.
“He went to friends of ours after I left and told them I was a raving lunatic and they believed all the bullshit, because they never actually knew what was going on, because I was good at hiding it.”

**Theme 3: Treatment**

The protective and risk factors associated with treatment is highlighted in this theme. Four safety factors were identified which represent the women’s progression in taking ownership for their own healing, becoming connected to others and feeling connected within themselves, and managing psychotropic medication. Three risk factors were identified which indicate a lack of targeted services for their needs can lead to risk, as can poorly suited psychotherapy or psychotropic medication. Figure 10 illustrates the risk and safety factors associated with trauma symptoms, in relation to treatment.
Figure 10. Thematic map for Theme 3. Thematic map indicating the protective and risk factors for future violence associated with treatment.

Safety Factors - Moving Forward

These safety factors highlight the process of healing from the abuse and thoughts and behaviours helpful in maintaining safety. In moving forward with their lives, the women speak of owning their healing and disowning the violence that is often attributed to them, along with the blame, judgement, and labels which they feel many people afford them. This theme includes four sub-themes: healing ownership, “connecting in the inside”, connecting with others and a support system, and managing medical treatment. There are three safety factors related to theme 3: healing ownership, connection on the inside, connecting with others and support services, and managing medical treatment.
Healing Ownership

The women spoke of an ownership for their own healing and recovery, and its necessity in order to move on with their lives. As was discussed in the sub-theme “violence acknowledgement”, it includes a realisation that the partner violence needs to be acknowledged. This includes recognizing that the violence was not their fault, and ignoring those who blame them. It also comprises an ownership of educating themselves, healing themselves by self-reflection and more mindful behaviour, and a recognition that they need to be the centre of their own healing process. One woman describes returning to study to further her career in human services, a step which she believed was integral in her healing process. Other woman supported her decision and reinforced the need to focus on oneself, in order to heal.

“You've gotta heal yourself first before you can get on ... to get well you need to do what you’re doing, 'cause you won’t get well otherwise.

... So I decided I needed to heal my soul and heal myself so I could have a good life.”

Connecting on the Inside

“Connecting on the inside” was how one woman termed her process of inner healing. It speaks of mindfulness and spirituality, forgiving oneself and the perpetrator, knowledge and reflection upon violence and oneself, and freeing oneself of the past and associated emotions. It leads to an increase in empowerment and self-esteem.
One woman talked about how it was difficult that she broke up with her husband on their child’s birthday, and therefore the child’s birthday was paired with sadness. She spoke about the need to move on in her mental health, and that as she progresses, she feels more empowered.

“That was just the physical parting day. I think it’s the other stuff that’s even bigger anyway, like the emotional and the psychological stuff and once we let that go that’s way more freeing, that’s a good way ... So, now when I’ve thought about that I’ve realised that’s what I’ve got to work on now to get everything out of the way, and that’s what I’ve been doing and the more I do that the more you feel empowered.”

The same woman shared her reflective thoughts further into the interview, on the topic of connecting on the inside. She highlights the importance of forgiveness in healing, along with feeling centred and not reacting to her ex-partner’s antagonistic behaviours.

“I was thinking about what the others were saying about connecting on the inside. I think a lot of it has to do with forgiveness, forgiving myself and him. And I find the more I forgive him, and when he is being harsh towards me and I try not to reply in an angry tone, not to encourage it, and just try to be nice back to him, he eventually gives up now.

Yeah it doesn't work, doesn't get the reaction he wanted, or he needs.
Yeah, and in doing that, I'm not stressing myself out, and I'm not 
letting it worry me, and I think that is how I'm getting back.”

In talking about various treatments for trauma, and healing, the women 
discussed the need to have treatment that was individually appropriate, at the pace 
they needed, in order to heal “on the inside”.

“Yeah, I have to do it in my time and my way I feel comfortable 
with, my way.”

Beyond therapy and groups, the women spoke a lot about reading literature to 
help them understand partner violence, but also themselves and why they may think 
or behave the way they do. They listed and shared a number of books among 
themselves, and encouraged each other to read the books they had not. It exemplifies 
the broad array of materials the women are motivated to utilise, to help facilitate self-
education, reflection, and an inner healing.

“Do you feel connected on the inside?

With myself?

Yeah.

I’m getting there, I’m getting there. I’ve started to connect with 
spiritual people and lots of healing stuff.

Have you read The Road Less Travelled?

The Road Less Travelled? I’ve got it on my bookshelf actually.
Doctor Scott Peck. That was my bible that saved me. That saved me.”

Connecting on the inside is a long-term process and does not provide definitive answers or relief from abusive partners or relationships. It is a fluid process which allows the women to continue to reflect upon themselves, how they currently feel and react, and how they would like to be in the future.

“How you motivate for yourself out of love would be a real bonus and to me it’s kind of a foreign concept. Motivation by fear, not a problem!”

The following conversation between two women illustrates the ongoing reflective process the women partake in, which involves the past, present, and future. It also demonstrates the benefit of connecting with others, participating in a group with non-judgmental, encouraging women, who can identify with their situation.

“So, I still think there’s a lot of things we know in our head as common sense but knowing it in the heart might be a different story.

Yes, that’s what I was talking about before. So, I knew better, and I had that knowledge inside...

To apply, yeah.

...but it wasn’t enough, something wasn’t switching on in me, and I don’t know, is that because of the past, or was it just time?”
Connecting with Others and a Support System

Integral to moving forward with their lives was the sub-theme of connecting with others who had similarly experienced partner violence, and also connecting with a support system. Key elements included sharing their stories with others and speaking about what happened, often for the first time, and to do so without feeling judged. Meeting other victims and participating in groups allowed for identification with others, a normalisation of their experience with abuse, an importantly feeling validated that they were “not crazy”, but rather just “normal” people. Being part of, and within, a service which made them feel safe, and which offered support in legal and mental health matters was important, as was the knowledge that the service will support them in the future.

“I think the people here kept me sane.

Who kept you sane?

People here.

Oh, God yeah.”

On numerous occasions, women spoke of the importance of the groups at the domestic violence centre, particularly in communicating with women who they could identify with, and with whom they had validation that they were “normal”.

“I’m glad to hear in a way someone else has experienced something similar because I started to think there was something seriously wrong with me and it’s my personality or something.”

“The normalcy of us all, we’re all normal.”
Yes."

When asked what about the groups were specifically helpful, beyond the importantly mentioned normalisation factor, was the crucial lack of judgement the women felt.

“The knowledge, you know, and you learn so much and the main thing is that you can speak out for the first time in your life, you haven’t told people anything about yourself. You can speak out and have a voice.

Well, there’s no judgement.”

“When I shared about when I went back to him and feelings and stuff, every single other woman in the room said “I’ve been there” and it helped the identification.”

The sense of normality and non-judgment within the groups was also identified as sufficient for the women to open up and discuss their experience, with anyone who interacted with them in such as way. One woman explains how important her friend’s support was, her friend also having experienced partner violence. She explained she often felt her friend was the only one she could talk to about her abusive ex-partner and relationship, and the ongoing violence she experienced. Unfortunately, her friend was missing at the time of the interview, and the distress of her friend’s disappearance, and the loss of friendship, support, and comradery it included, was apparent.
“I could just sit there and talk about anything, you know, she was like my little sounding board and she didn’t judge me, no matter what I said to her there was no judgment.”

Another important factor was the safety that the women felt, combined with the lack of judgment, which facilitated the women’s desire and ability to share. The safety of the group also allowed the women to relax and not worry what others may be thinking, particularly if their symptoms were not understood in the general public. The women talked about often forgetting things, sometimes the topic of conversation mid-sentence. One woman describes this below, along with the benefit of the group and their understanding of their trauma symptoms.

“I’m talking having a conversation and, “I’m sorry, what was I saying?” and people are looking at me like, “Are you serious, you don’t remember what you were just saying?” and I really have a complete mental blank. Because we’re here I can remember pretty much what we’re talking about...

And you’re safe here.

...and I know I’m safe so that makes a huge difference.”

The groups and the connection with others within the groups allows for explicit education, or resulting education and enlightenment through participation in the group. The education provided on trauma symptoms within these interviews was deemed helpful, and that there should be more opportunity to learn and tell their story in a safe environment.
“Well thank you, that was really good, and I think there should be more of it. Every time I tell a piece of my story, I get something out of it. And identifying, I identified a lot with it [the trauma symptoms], what everyone else was saying too. So that's always really helpful, I find.”

The women identified the importance of their safety coming through contact with services, and that coming in contact with only one service often provided them with opportunity to be connected to more services and support systems. Many of the women explained they had come into contact with the domestic violence centre through other agencies, or through the court house. The women talked about the support the staff at the DV centre provided, particularly when attending court due to partner or family matters, when they felt highly vulnerable and anxious.

“One of these guys can sit with you in court; make you feel a bit more, you know, you've got him with his lawyer, and his bitch of a mother.”

“She [the support worker] wouldn't leave me alone in the court room. She even made sure that we stood; sat in the foyer and looked at the doorway to make sure my back wasn’t to him, that whole thing was just incredible.”

There were numerous other aspects that the women discussed which the DV centre provided and helped them in terms of their healing, connecting, and ultimately, safety. They spoke of the staff supporting them, encouraging them, and building them up.
“They try to give you more self-confidence, they try and build you up I’ve noticed that and that’s a huge thing.”

The DV centre staff also provide evidence for the women that there are people in society who have not experienced partner violence, but who are willing to listen, learn, and be non-judgmental. It provides some hope for them.

“I think knowing that there’s people that are sort of real out there that have more of an understanding, yeah.”

The stability of the DV centre and its groups was an important factor for the women. It provided routine and a weekly chance to learn about partner violence and themselves, and to connect with other women. The importance of learning about partner violence in their safety was discussed in “knowledge enlightenment”.

“Just to have that weekly group going every week ... just to learn about how to have healthy relationships and what is unhealthy and what isn’t, learning new skills and gaining knowledge on these kind of relationships and how they impact on not only myself but my children as well.”

Finally, the women’s sense of support and safety is encouraged by the openness and stability of the DV centre. They did not feel they were a burden for the centre, and knew that they could come back at any time in the future and be further supported.

“But you know if you contact these guys even if it’s six months later down the track, that you’re not going to be told, ‘Oh well, your time with us is over now.’”
Managing Medical Treatment

The primary opinion among the women was that, on the whole, psychotropic medication was unhelpful for them and their situation, even putting them in danger. This is discussed in more detail in question 2. However, there were times when some women acknowledged their benefit. Others discussed the increased safety they experienced of managing medications, by either disagreeing with others around them that they needed medication, or taking themselves off medication.

One woman, who was taking medication at the time of the interview, explained the medication was necessary for her current functioning.

“My doctors had me on post-traumatic stress disorder for the last three years, and I’m on quite a few drugs to keep my mental stability normal…it’s very flat lining your life, but it also has given me courage, which is, oh God to go out by myself, to somewhere by myself that the courage it takes is just, whoa. And once you’ve done that hurdle you just feel... But these drugs have really helped me, because the nightmares...”

One woman described how medication and counselling go “hand in hand, if you’ve got the right people”. She explained the need to “get your head to speak on a level field” and then to increase counselling and decrease medication. Another related how medication had indirectly helped her to become motivated again about her safety.

“One of the medications for my back was a mild antidepressant and all of a sudden I started coming out of this haze and starting to give a shit again, whereas before then I just copped it.”
Conversely, others spoke of times when they were told by a doctor and those around them, such as the perpetrator and family that they needed to take psychotropic medication. They were told that they did not know what was good for them. One woman explained that antidepressants made her “fuzzy and tired”. Another explained how the medication affected her and increased her risk of violence.

“That was a year and a half wasted, going on and off [the medication], the relationship was even worse, I was even more controlled because I was like a zombie and I just said yes to everything.”

Her current attitude to doctors and psychotropic medication is summarised in the following quote, and indicates for her, a safety behaviour she has assimilated into her life.

“I’ve got issues with GP’s trying to put me onto medications.”

**Risk Factors - Lack of Success**

These risk factors highlight the lack of success that the women have experienced in seeking treatment and support for themselves and particularly, their symptoms. This includes support which meets their specific needs as a victim of IPV, such as experiencing mental health symptoms whilst coping with: ongoing threats and physical danger from their ex-partner, isolation, and legal systems. Their experiences with poorly tailored psychotherapy and psychotropic medicine detrimentally affects their thoughts and behaviours, generally leading them to be less likely to seek psychotherapeutic support, or approach general practitioners or
psychiatrists when they need support. There are three risk factors related to theme 3: lack of specified support, psychotherapy, and psychotropic medication.

*Lack of Specified Support*

There was an ongoing theme throughout the interviews that there is insufficient support for women who experience intimate partner violence; that “there is not a lot of help out there”. They talked about a need for information and support in legal processes, which often take long periods of time and necessitate that they interact with their abusive ex-partner. This creates great stress on the women and can cause renewed trauma responses, or heighten mental health issues they are already experiencing. The following is an extract from an email a participant sent to the researcher shortly after the interviews were completed, highlighting the need for specialised support for IPV survivors, and the unique mental health issues and complex situations which they face.

“I have just finished a six-day family court trial. For four of those days I was in the witness stand being interrogated by my ex-partner who was self-represented. I endured and witnessed further violence and abuse from him. It took a tremendous toll on me both physically and mentally. On the night of the last day I collapsed unconscious at home and was taken by ambulance to the hospital for treatment, tests and overnight observation.

I really hope your study and paper will help prevent other women from having to experience what I have. I feel devastated by how the perpetrator of the violence, rape and abuse was legally allowed to
re-traumatise me. It has deeply affected me and my ability to function properly. My children and family are also suffering as a result of my struggling to cope."

The result of unsuccessful, and poorly targeted help leads to diminished motivation to seek further help.

“...just constantly failing to get the help I needed which made it even worse, to the point when I didn’t even want to try it again due to possible failure.”

Psychotherapy

Some of the women discussed the many years of therapy that they have received, and that years in therapy did not equate to successful, nor helpful, therapy, if the therapy was not targeted to their needs as survivors of IPV. One woman’s experience of psychotherapy was harmful, and led to her questioning herself, rather than the perpetrator or abuse.

“Eight years. And I’ve actually just been given more and more labels, rather than healing. I could see after 8 years, this isn’t getting better, it’s getting worse, and it’s not effective and I’m feeling like there is something wrong with me.”

The women discussed the blame they had experienced, and a lack of understanding about them, their situation, and intimate partner violence, in psychotherapy. One woman reported that she ceased therapy after seeing a psychiatrist for eight years due to feeling blamed for the violence and reprimanded for not doing as the psychiatrist had suggested, suggestions she felt, would have
placed her at risk, and removed the responsibility from the perpetrator for the violence. Another woman spoke of a similar experience, whereby the therapist had reprimanded the survivor for not following instructions, and also blamed her for the IPV she had experienced.

“The last person I saw was a psychoanalyst, she told me she couldn't help me with my core issues, which is what I was trying to work on, because of the decisions I had made, and the men I was in relationships with. So she couldn’t help me get out of the pattern [of IPV] ‘cos I wasn’t listening to her and I wasn’t doing what she said.”

After discussing the structure of exposure therapy and how it targets particular thoughts and behaviours associated with a traumatic event, the women discussed how exposure therapy would not be suitable for them. One woman identified some similarities with between exposure therapy and some psychoanalysis which she felt had not been successful.

“With my psychoanalysis, I felt like I was being exposed to things and opened up to stuff and then I would have to go to bed straight away every time I went home, because I was so exhausted…it didn’t work.”

Another woman explained that insight alone, is not sufficient for healing to occur.

“She was just telling me things that I already knew: I know I’m a co-dependent, I know that I’m depressed because I internalise it … and it wasn’t making a difference.”
One point which the women discussed was the need for a commonality between the techniques the psychologists presented, and the woman herself.

“I’ve seen psychologists, but it’s the sheer problem that some things that were dissimilar and they’ve told me to talk to a chair and I felt really stupid...so it didn’t work for me.”

Finally, one woman highlights the explicit issue of ongoing risk, and the management of safety, whilst seeking mental health treatment, and the need for the therapy to be tailored to such needs.

“I was getting some therapy called ACT therapy...and I found that really, really unhelpful...it just was like, how can I put this down on my lap and look at my life? It’s always there and if I put it down I’m not safe.”

**Psychotropic Medication**

A common experience for the women when they sought support from a doctor was to be told they needed psychotropic medication. They explained that sometimes going to a doctor was the only way they felt they could talk about their situation, as they were isolated from their family and friends, and did not know where else to go. They felt unheard in this situation, and that prescription was the common response when they sought help. One woman said she had seen doctors as she “just needed to talk to someone” and the responses were that she needed medication, other women agreed that was also their experience.
“And they’d just say, ‘Well, you should have some antidepressants’. That’s pretty much the story…

First port of call, yeah.

That’s the stock response.”

One risk of being prescribed medication by a doctor is the coercion that the perpetrator can elicit on the victim to take medication when she is in a vulnerable position, and may not judge taking medication to be her best option.

“I was told that I had clinical depression and that I needed to go on antidepressants. So I did that, reluctantly, because I didn’t want to, but I was told that I didn’t know what was good for me and do what he [the doctor] says. That was a year and a half wasted, going on and off [the medication], the relationship was even worse, I was even more controlled because I was like a zombie and I just said yes to everything.”

This highlights the risk for partner violence that can arise for some women taking medication. Many of the women talked about feeling “fuzzy”, numbed, and less in control whilst taking medication, particularly antidepressants. Some felt the consequences were too negative and stopped taking medication against medical advice.

“So I’ve gone to the doctors, they’ve given me antidepressants, I hate them, so I took myself off them because it made me even worse.”
One woman believes taking medication has had the opposite of its intended effect; it had made her feel worse, and increased her risk of abuse. She describes how antidepressants make her feel, and how she is more alert and self-aware without them.

“Numb and tired, and when I’m off them I can feel my feelings and I’m not exhausted all the time.”

The below conversation between two women illustrate that medication, without other supports, is not in itself sufficient to keep a woman safe from self-harm, or attempts to complete suicide. In response to ongoing threat and violence, and without sufficient support, women can decide suicide is the way to escape the abuse. One woman spoke about becoming intoxicated and driving to a cliff in order to drive off it. Another woman identified with her situation, and felt that antidepressants had been a responsible factor in her risk of suicide.

“I really identified with what you were saying about the driving off the cliff. Can I just ask, were you on the antidepressants at that time?

Yeah.

I was on antidepressants as well and I tried to kill myself, I didn’t ever want to die, I never wanted to kill myself, I knew there was hope somewhere along the line but it was after an argument with my partner at the time.”
Theme 4: Resilience

Many times the women made comments that indicated a strength to continue in the face of difficulty. They spoke about times their resilience protected them from further harm, in relation to trauma symptoms and associated adapted thoughts and behaviours, and treatment. The women’s children often motivated them to persevere, and there was resolution in their voices when they spoke about their willingness to face many challenges for their children.

Resilience as a protective factor was highlighted in association with trauma symptoms, such as isolation and thoughts of suicide. One woman discussed the difficulty of isolation, and that despite this she utilised the opportunity to educate herself about IPV. Another woman continues to build on this comment of the difficulty of isolation, and that her son inspires her to keep going with life.

“I’m at home literally by myself every night learning... And that’s hard, that’s really...

It is hard because I think if it wasn’t for [my son] I probably would have chucked the towel, plenty of times I would have, didn’t bother waking up, but I have to do it for him.”

Several of the women talked about a time when they decided that they would no longer continue on with the relationship as it was. One woman described how in order to cope with her partner’s violence, she began drinking frequently and it continued to escalate until one night she decided to get in her car and drive off a cliff. Fortunately, en route to the cliff she was pulled over by police and charged with drink-driving, after which point she decided to change, highlighting the protective factor of resilience for suicidality. Her resilience is evident as she explains how she
utilised the occurrence to seek support, and to “do something” about her partner’s violence.

“It was only at that point that I thought, I’m losing it, that’s it, I’m not going there. That was like a wake-up call for me, I can’t let him push me around anymore; I gotta get up and do something about this. So that’s when I started coming here to see some groups.”

Now, sometime after that incident, the woman is out of that relationship and continuing to educate herself and get support for the ongoing abuse. Her attitude towards the ex-partner indicates her resilience to now challenge his behaviour, highlighting a change in her cognition and behaviour to partner abuse.

“Yeah, he tells me to shut up or put up with, and just lately he said that again, and I said, ‘Well you should know that I don’t put up or shut up anymore.’”

Women also spoke about a continual effort to learn, with topics including partner violence, the court system, themselves, and about other women in an abusive relationship.

“I’ve educated myself right along the way, anything to better myself and protect my children.”

Many women indicated resilience when discussing their children, either in protecting them whilst in, or after, the violent relationship. Protecting their children was a clear motivating factor for women to continue at times, often prioritising what they believed would be best for their children. One woman discussed moving home
to where her family of origin lived, but for the sake of her children’s stability, resolved to stay.

_But then I look at them and think to go back home means to take them out of school and the only stability that they had was their school. The school has been really helpful, and the teachers, so I couldn’t take them out of school. So I thought I’ll have to go through whatever I need to so at least their life is stable. If my life is not stable that’s fine as long as theirs is._

Another woman discussed how she always considered her behaviour and its effect on her children, in relation to her ex-abusive relationship.

_“I have fought to protect my children...whatever I did I had to think of, ‘What are the repercussions for my children?’.”_

One of the women demonstrated her resilience in relation to Theme 2, by not allowing intergenerational partner violence to continue on with her daughter. She spoke of her own highly violent childhood and explained that she was resolute in educating her daughter that there was “always a better way”.

_“I decided my daughter was going to be very independent and strong, and I always taught her that there’s always a better way, “We’ll find a better way.” ... a lot of it is thoughts and attitudes, ‘What can we do? How can we do this? Find a better way, what can we do?’ ... and yeah, she’s had a pretty amazing life, so I’m really pleased with the fact that that cycle has broken and not carried on, and it won’t, it won’t with her.”_
As discussed in the treatment theme, many of the women were informed they should receive psychotropic medical, and many of them discussed the negative effects they experienced. The quote below highlights one woman’s resilience to continue with life, even when affected by medication.

“I was on antidepressants ... and I tried to kill myself, I didn’t ever want to die, I never wanted to kill myself. I knew there was hope somewhere along the line.”

Finally, highlighting the safety factor of “moving forward”, a sense of resilience and strength among all the women was shown throughout the interviews to help and honour other women, and to help the services that had helped them. They discussed that if they had money, or won money, they would donate to domestic violence services, and finance them to continue supporting other women. At the time of the interviews, one woman’s best friend, who also experienced ongoing violence from her ex-partner, was missing. Even whilst facing threats from her best friend’s ex-partner who knew the woman was helping police in the Missing Persons investigation, she wanted to do what she could to help others in a similar position.

“I’d like to raise money, I want to raise money for these guys [domestic violence centre], I want to raise money for my girlfriend, because we can’t have a bloody memorial, because we don’t know where she is, whether she’s in a hole or whatever. I would love to use her situation as a way to raise money.”
Chapter 5
Discussion

The foremost aim of this thesis was to identify the presence of trauma symptoms in female survivors of intimate partner violence in order to identify associated treatment needs. Specifically, the first study sought to identify the prevalence of self-reported symptoms of both posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (Complex PTSD) in a cohort of IPV survivors attending an Australian community domestic violence centre. A further aim was to explore the relationship between patterns of victimisation and specific trauma symptoms. The second study sought to explore, through victim narratives, the ways in which trauma symptoms, particularly those associated with complex trauma, influence the future safety of women who have experienced IPV. This study also aimed to identify the unique treatment needs of IPV victims who experience trauma symptoms in a context in which many experience ongoing threats and harassment from an abusive ex-partner.

In Study 1, a total of fifty-nine women described their experiences of intimate partner violence and subsequent reactions. More than two-thirds (68%) provided responses that suggest that they would meet the criteria for a DSM-IV-TR (2000) diagnosis of posttraumatic stress disorder, as assessed by their above clinical threshold scores on the self-report measure of trauma symptoms, the Posttraumatic Stress Disorder Checklist: Civilian Version (PCL-C; Weathers et al., 1994). This figure addresses the first aim of the current research and is broadly consistent with that reported in previous research (De Vries 2008, Golding, 1999; Jones et al., 2001; Khadra et al., 2015; Mertin & Mohr, 1998; Woods, 2000). For example, a recent English study utilising the same measure as used in this study reported that 77% of
women self-reported symptoms which indicated a likely diagnosis of PTSD (Ferrari et al., 2014). An American study involving a domestic violence community centre sample which utilised clinician led structured interviews found that 60% of women met criteria for a diagnosis of PTSD (Houskamp & Foy, 1991). Another reported that 57% met criteria (Nathanson et al., 2012). Other international studies have reported that up to 84% of IPV survivors meet PTSD criteria.

The rate of 68% reported here, however, is higher than the 45% reported in previous Australian research by Mertin and Mohr (2000), although, their study involved a clinician led interview in a domestic violence shelter setting, rather than the use of self-report measures in a specialist community service. This may be due to one of two reasons; firstly, because self-report assessment tends to inflate symptom prevalence, and secondly because women in shelters may present with a different diagnostic profile, such as acute stress. Jones et al.’s (2001) systematic research synthesis, for example, reported that prevalence rates of PTSD identified from clinician-led interviews were lower (45 - 47%) than those based on self-report (56 - 84%). This indicates, perhaps, that this study’s higher prevalence rate may be a function of the method of assessment, as well as the setting in which participants are recruited and the timing of the assessment (see Mertin & Mohr, 2000). Nonetheless, this study does provide useful comparison data for future studies involving Australian women who utilise community-based domestic violence services. This is of particular interest given evidence that PTSD symptom severity has been shown to predict future IPV beyond the effects of previous interpersonal violence experiences and other environmental factors, such as social support (Bell et al., 2008; Perez & Johnson, 2008).
This is the first Australian study to have investigated the prevalence of complex posttraumatic stress disorder in this population and addresses the first aim explored in Study 1. Based on their self-report, 4 of 59 women (7%) conveyed that they experience all six Complex PTSD alterations, which are assessed by 45 questions relating to the presence of 24 trauma symptoms. Notably, four out of five women reported they experience at least one Complex PTSD alteration, with more than a quarter endorsing items which represent four or more alterations. These results support and extend De Vries’ (2008) findings that two of three women attending a battered women’s shelter endorsed symptoms for a least one Complex PTSD alteration, with 5% endorsing clinical threshold criteria for all 6 alterations. Although the current study did not find as high a percentage of participants reporting Complex PTSD alterations as was reported by Teegen and Schriefer (2002; cited by De Vries, 2008), this study provides further evidence of the depth of trauma symptoms that are commonly experienced in this population (see also Leahy, 2008). Additionally, the most common Complex PTSD alteration, endorsed by 54% of participants, was an alteration in relationships with others, with nearly all (92%) reporting an inability to trust others. The impact of complex trauma, particularly on trusting others, has specific implications for the provision of mental health services and is discussed below.

Preliminary exploration of the relationship between trauma symptoms and patterns of intimate partner violence addressed the second aim explored in Study 1,

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2 Although Leahy (2008) used the SIDES-SR to measure symptoms of Complex PTSD among a community sample of IPV victims, rather than calculate clinical thresholds that indicate a likely presence of complex alterations, the severity of complex trauma symptoms was indicated on a continuous scale of 0–45, reflecting the 45 questions in the scale. Leahy found mean scores were 6.0 (SD = 8.5), and a range of 0 – 35 questions were endorsed. A continuous measure was also calculated for the current study in order to compare severity scores; mean scores were 18.0 (SD = 10.2), and a range of 1 – 40 questions were endorsed. This comparison indicates that the number of trauma symptoms experienced by the participants in study 1 also broadly ranged, but that collectively, the IPV victims in this study’s community sample experienced more complex trauma symptoms.
and indicated that those who had experienced more years of partner abuse also experienced more posttraumatic stress disorder symptoms and were more likely to meet PTSD diagnosis criteria than women who experienced fewer years of IPV.

Previous studies which have explored characteristics of IPV and Complex PTSD symptoms (e.g., De Vries, 2008; Leahy, 2008) did not also consider the impact of characteristics of IPV on PTSD among women who experience Complex PTSD symptoms and, as such, this is a novel finding.

As previous research has demonstrated that combined physical, psychological and sexual IPV have a cumulative effect on PTSD (Pico-Alfonso et al., 2006; Silva et al., 1997), and that increases in severity or intensity of IPV is associated with more severe PTSD symptoms (Ferrari et al., 2014; Nathanson et al., 2012; Scott, 2007), it was unexpected that no relationship between lifetime IPV severity and PTSD symptoms was identified in this study. However, the small sample size meant that further relationships between IPV severity and trauma symptoms could not be statistically explored. Of interest, however, was the observation that the women who scored highest on trauma symptoms reported either severe levels of IPV by a partner at some stage in their life or had very recently separated from a perpetrator of violence. This is consistent with recent research which have shown that exposure to recent IPV has a stronger association with mental illness than other known predictors (Ferrari et al., 2014), and that PTSD symptom severity may be associated with recent partner abuse (Khadra et al., 2015), particularly, recent psychological abuse (Mechanic, Weaver, & Resick, 2008; Nathanson et al., 2012). Therefore, the effect of IPV recency on trauma symptoms may warrant further research.

There was no relationship observed between years of IPV abuse, or severity of IPV, and Complex PTSD alterations. Nevertheless, 80% of participants reported
experiencing at least one complex trauma alteration, regardless of IPV severity and chronicity. This is of particular significance and supports Leahy’s (2008) suggestion that even women who experience moderate levels of IPV are at risk of affective and behavioural dysregulation that transcends core PTSD. Given that so many of the participants reported complex trauma symptoms and alterations, it is conceivable that any experience of intimate partner violence will be sufficiently traumatic to trigger alterations in the victim’s way of thinking and behaving. It is also plausible that some types of IPV that involve prolonged entrapment (such as those described in Herman, 1997), in addition to physical, sexual, or psychological violence may be more likely to lead to Complex PTSD, rather than the simple duration or number of obvious forms of IPV. The impact of IPV is clearly a psychologically profound experience, with some research indicating that the effect of psychological IPV can be more profound than physical IPV (Follingstad et al., 1990; O’Leary, 1999).

Although preliminary, these results do not support previous research (e.g., Leahy, 2008) which suggests that Complex PTSD is associated with greater levels of IPV traumatisation, regardless of the specific indicator of abuse, such as IPV severity and chronicity. Importantly, Leahy (2008) also did not find that sexual IPV demonstrates greater association with Complex PTSD symptoms, and she argued that the predicted relative strength of sexual violence over other types of violence on Complex PTSD was essentially associated with childhood sexual violence, rather than adult sexual violence.

While Cloitre et al. (2009) found from an analysis of lifetime trauma that there is an overall additive effect of the contribution of cumulative trauma to symptom complexity in Complex PTSD, Dickinson et al. (1998) also showed that childhood sexual abuse severity paralleled the severity of Complex PTSD symptoms.
This suggests that Complex PTSD severity may be more a function of childhood trauma, rather than abuse experienced in adulthood alone. To date, there are nine published studies which target treatment of Complex PTSD symptoms among adults with a history of complex trauma (Cloitre et al., 2012). Childhood physical and/or sexual abuse was an inclusion criterion for all nine studies, indicating the salience of childhood abuse among the Complex PTSD literature. Childhood histories were not explored in this study; therefore, this is an area that warrants further research among victims of intimate partner violence. Further discussion of this opportunity for future research is discussed in the “Future Research Implications” below.

What is clear, however, is that the timing and type of maltreatment and neglect in childhood and adolescence will have an effect on adulthood behaviour (Malvoso, DelFabbro, & Day, in press). A recent systematic review of longitudinal studies of risk factors associated with domestic violence victimisation has also concluded that child and adolescent abuse are consistent predictors of DV victimisation (see Costa et al., in press). Although it is difficult to identify the causal mechanisms, developmental and early life exposures to violence and other traumas may contribute to the formation of insecure or disorganised attachment styles, which are associated with increased IPV risk (see Doumas, Pearson, Elgin, & McKinley, 2008). Such reviews highlight the potential effects an individual type of childhood abuse may have on functioning, and experiences of additional abuse, later in life. That is, they suggest that any type of partner abuse, particularly in accumulation with childhood abuse, may be associated with the experience of Complex PTSD symptoms. Given these potential effects of childhood abuse, it may be possible that alongside an accumulation effect, IPV may trigger or exacerbate Complex PTSD among a subset of women who have previously experienced childhood abuse.
In summary, the results of study 1 explored the prevalence of PTSD and Complex PTSD among female victims of IPV who receive services from a domestic violence centre, and the relationship between IPV factors and trauma symptoms. The results support and extend the limited information available on women’s mental health who have experienced IPV. They support Leahy’s (2008) suggestion that women who experience even moderate levels of IPV are at risk of affective and behavioural dysregulation that transcends core PTSD and demonstrate that many IPV victims experience trauma symptoms that are additional to PTSD symptoms and which, in part, can be accounted for by the constellation of Complex PTSD alterations.

The main aim of study 2 was to explore, through victims’ narratives, the risk and safety factors associated with trauma symptoms of future IPV, among women who report experiencing multiple Complex PTSD alterations. A further aim was to identify unique treatment needs among IPV victims experiencing trauma symptoms, who commonly experience threats and harassment from their abusive ex-partner, whilst seeking mental health support.

Nine women participated in the study, each of whom had experienced prolonged, multifaceted partner abuse, from 2-5 partners over a period of 6-42 years. At the time of participation, women were receiving support from an Australian domestic violence centre. Although they were not explicitly asked if they were experiencing ongoing abuse, most of women reported that they had experienced abuse post separation, with some continuing to experience emotional abuse, largely in the form of harassment, threats, and by manipulation through children.

Each participant reported symptoms consistent with at least three Complex PTSD alterations, as determined by their responses in Study 1. Although not an
inclusion criterion for Study 2, all of the women additionally endorsed symptoms consistent with a diagnosis of PTSD. This shows that these participants were all experiencing a number of posttraumatic symptoms, as well as various longer-term complex trauma alterations in their cognition and behaviour. This supports the suggestion of De Vries (2008) that IPV victims may experience both Complex PTSD and PTSD concurrently. Analyses of the interviews on trauma symptoms highlight the two aims of Study 2; exploration of the risk and safety factors of future IPV associated with trauma symptoms, and to identify the unique needs among IPV victims experiencing trauma symptoms. These two major areas of concern; risk of intimate partner violence and treatment are each discussed below.

**Risk of Intimate Partner Violence**

Although retrospective in nature, the analysis suggests that trauma responses to IPV may increase risk of future IPV, supporting previous research that characteristics of both members of the couple influence the risk of future IPV (Kras, 2011; Moffitt et al., 2001). Shifts in the victim’s cognitive appraisal about the perpetrator, partner violence, and needs of their children highlighted the potential for a risk factor to become a protective factor. Resilience was a common theme (among all safety factors) but was also a constant standalone protective factor against IPV and trauma symptoms. This was most clearly demonstrated for symptoms of isolation and thoughts of suicide. For example, one participant described utilising the isolation to educate herself about IPV and how to protect her son. Another participant described resilience when explaining how she was on her way to drive off a cliff and got pulled over for drink-driving, and in reaction utilised the occurrence as
“a wake-up call”, to seek support, and to “do something” about her partner’s violence.

Two of three psychological factors in the model of women’s influence on IPV proposed by Foa et al. (2000) were explored in this study; the woman’s psychological difficulties (a risk factor), and the woman’s resilience (a protective factor). Foa et al. hypothesise that IPV and psychological difficulties interact in a vicious cycle whereby IPV causes psychological difficulties that, in turn, put women at greater risk of re-victimisation, and resilience serves to protect the women in this cycle. This study offers support for this model in part; resilience was identified to protect against complex trauma symptoms, and future risk of IPV, and trauma symptoms were identified to increase risk of IPV, while IPV appeared to increase trauma symptoms.

The analysis showed that symptoms of all six Complex PTSD alterations may increase risk for intimate partner violence. It was further indicated that some trauma symptoms may also additionally serve as protective factors from intimate partner violence. The most prominent symptoms which were identified as potentially serving as both risk and protective factors were hypervigilance and not trusting others. To a lesser extent, numbing (which the women used to inclusively describe depersonalisation and dissociation) and anxiety were identified as potential protective factors, however, particularly numbing, was more likely to increase rather than reduce risk.

The most prominent Complex PTSD alteration that was associated with increased risk was the alteration of attention and consciousness, the symptoms of which are more severe responses than those encompassed by the numbing symptom of PTSD, although there is a degree of crossover. The women spoke of amnesia,
depersonalisation, and dissociation related to the IPV they had experienced, and also in relation to further instances of interpersonal violence. The women commonly termed their range of responses to the violence as “numbing”, which was used to describe more typical PTSD responses such as feelings of detachment or general numbing of responsiveness, in addition to Complex PTSD symptoms. The women often described how numbing put them at risk, but how it also led them to experience more severe alterations. As such PTSD numbing may be best conceptualised among these women as on a continuum, with the more severe end resulting in depersonalisation and dissociation.

As the numbing constellation of PTSD symptoms has been shown to solely predict intimate partner re-victimisation among IPV survivors at 1-year follow-up (Krause et al., 2006; Ullman et al., 2009) and is significantly related to re-victimisation (Root, 2008), IPV victims who experience Complex PTSD may be at heightened risk of future IPV. Women identified themselves that feelings of numbness towards the abuse and signs of abuse increased risk both during the abusive relationship and after separation. Women believed becoming numb led them to “put up with” the violence, and it additionally led to a loss of identify and poor self-perception, another alteration of Complex PTSD. Due to the level of violence the women had experienced from their ex-partner, and a sense of depersonalisation, they were less likely to identify new threats of violence or gauge the severity of new violence, post-separation.

Of all the trauma symptoms, hypervigilance was identified as the most central to maintaining safety, particularly as many participants described experiences of ongoing harassment and threat from a previous partner, post separation and even currently. The women explained they felt most at risk when they had not heard from,
or seen, the previous partner, and therefore felt the perpetrator’s behaviour was even more unpredictable and they did not know how to protect themselves from the potential future violence. This vital adaptation for safety maintenance did, however, lead to exhaustion and physical and cognitive depletion, which was itself identified to also put the women at risk. Alterations in relationship with others (lacking trust in others) was also identified by the women as a protective factor from IPV, however it was also identified as leading to isolation, a factor which increases risk of IPV (Walby & Allen, 2004).

In the focus groups and interviews, the women were largely unable to discuss or identify the effects that their trauma symptoms may have on future safety from IPV. They were better able to discuss, retrospectively, the effect of symptoms on past instances of IPV, but found it difficult to assess if their current trauma symptoms could put them at risk of future IPV. Their ability to identify possible links between their trauma symptoms and potential future IPV was improved if there was a discussion about the past experiences and how they relate to trauma symptoms, and then, relating and applying those experiences to their current situation. It may therefore follow that women with Complex PTSD find it difficult to explicitly identify how their trauma symptoms may affect risk, and may need assistance in this process.

Other studies have demonstrated that women can themselves predict re-assault, sometimes better than risk assessments (Heckert & Gondolf, 2004), and that these predictions are associated with each new cue from the perpetrator’s erratic moods and behaviour, substance abuse, employment status, and abuse towards themselves and others (Cattaneo et al., 2007). It would follow that the ability to accurately appraise a situation and assess future violence is likely to be influenced by
a victim’s own mental health (Nicholls et al., 2013), therefore the presence of Complex PTSD symptoms indicate that safety planning should incorporate an understanding of trauma. The implications of this for risk management in relation to trauma are discussed below in the Clinical Implications section.

**Treatment**

Although research into treatments adapted and developed specifically to target Complex PTSD symptoms is in its early stages, early studies have reported that they can result in improvement in PTSD symptoms in addition to improvement in Complex PTSD symptoms (Cloitre et al., 2011). Given that PTSD treatment for survivors of interpersonal violence who meet Complex PTSD criteria, including even those that also meet PTSD criteria, can be problematic and lead to re-traumatisation (Chu, 2011; Zlotnick, 1997), and that typical treatment techniques such as exposure therapy may in fact be harmful for this population (Courtois, 2008), the dual benefit of alleviating Complex PTSD and PTSD symptoms with targeted Complex PTSD treatment may be of particular relevance for IPV victims.

The ISTSS Expert Clinician Survey (Cloitre et al., 2011) found that within the sequenced approach, clinicians used interventions tailored to the most prominent symptoms, of which hypervigilance was one such symptom. Given the protective nature and salience of hypervigilance among IPV victims, it is likely that one prominent symptom of a victim who experiences Complex PTSD will be hypervigilance. The women reported that they had previously ceased psychotherapy treatment when they found it was not relevant, failed to match their needs, or required them to momentarily act like the violence did not, or does not, exist. Therefore, the identification of symptom function may require additional assessment
alongside the assessment of trauma symptoms, for IPV victims. Another symptom which appears to require an assessment of function before treatment is not trusting others, or alterations in relationship with others, as this has a clear protective factor, but can also lead to isolation.

The literature on treatment for Complex PTSD highlights that forming a therapeutic alliance with a client with a history of prolonged, interpersonal violence may be more successful if the clinician understands that the client believes their relationship may be another setup for betrayal, or the client may engage the therapist in relational reenactments (Herman, 2009). Almost all the women in study 1 reported that they lack trust in others, even those who did not meet threshold criteria that indicate the presence of PTSD or Complex PTSD. This may influence not only their decision to seek help, but also to form a therapeutic alliance with the treating clinician. This may need to be addressed at the very start of providing any service or therapy with a victim of IPV.

Guidelines for Complex PTSD indicate that psychoeducation about trauma and its effects is an essential element of phase 1 of treatment (Cloitre et al., 2012), and experts identified this approach as a first-line, or commonly used, intervention for all prominent symptoms sets (Cloitre et al., 2011). The importance of education about IPV to protect against future IPV was demonstrated in theme two safety factors, and therefore education about both IPV and potential trauma symptoms in the context of prolonged interpersonal violence may need to be incorporated into phase 1 psychoeducation for Complex PTSD for IPV victims, to improve safety and CPTSD symptoms alike. Safety factors identified in study 2 highlighted the three phase model goals for Complex PTSD: thoughts and behaviours helpful in maintaining safety and stability; the process of addressing, processing, and healing
from the abuse; and the importance of connecting with systems, particularly other women to normalise the partner abuse, reinforce their belief that they are “normal”, and understand the IPV is not their fault, and is a societal issue. This indicates that the tripartite model for IPV victims who experience Complex PTSD may be an effective treatment approach, not only decreasing trauma symptom severity, but also improving safety from future IPV.

Limitations and Future Research Implications

Although this research has several important findings, the results should be interpreted in light of the limitations of the studies. Firstly, and importantly, the results need to be replicated before generalisation can occur. The sample was a self-selecting group of women who had been identified as being at low risk of imminent intimate partner violence, who were seeking support from a unique service (a specialist community domestic violence centre). Therefore, they may not be representative of other groups of IPV survivors, such as those who remain in an abusive relationship and are at high risk of imminent abuse. Conducting research with this group does, however, present many challenges, as safety is a critical and persistent issue for victims of intimate partner violence (Breckenridge, Walden, & Flax, 2014) and should not risk being compromised by participation in research activities. Future studies which involve victims of IPV should be mindful that the traumatisation of IPV is often largely underestimated, and that even discussion of issues or situations which surround the abuse may be highly distressing for the individual.

The sample size in this study was relatively small, therefore there was low statistical power for analyses in study 1 prohibiting more sophisticated analyses to be
undertaken that could examine the interaction among variables. This would allow for better identification of the differential impact of patterns of IPV on Complex PTSD. A related limitation was that lack of data around other types of interpersonal violence. It is possible that had information about the participants’ histories of victimisation been collected, some correlation between Complex PTSD alterations and severity of lifetime violence may have been demonstrated. Therefore, in future research involving IPV victims, it may be valuable to broaden the examination of factors that are associated with Complex PTSD symptoms, particularly any history of childhood trauma. Additionally, longitudinal studies might explore if there is a recency effect for Complex PTSD due to partner violence.

The measurement of Complex PTSD poses a limitation in this study and highlights a general area for advancement in the measurement of this mental health issue. The very nature of an “alteration” in Complex PTSD means that even in a clinical interview, the clinician relies almost entirely on the client explaining profound changes in their cognition and behaviours over a potentially long period of time. The clinician is not able to directly observe clinical phenomena for a number of the alterations, and is principally reliant on a narrative over time. With the potential inclusion of Complex PTSD in ICD-11, research needs to be directed at establishing the empirical integrity of diagnostic classification and validation and refinement of psychometric assessment (Ford, 2015). One such progression may be to categorise Complex PTSD symptoms into a partial criterion, which may include the dysregulation criteria (that is, affect, somatic, and consciousness criteria) and one alteration in core beliefs (that is, self, relationships, or systems of meaning; Ford, 2015). This may provide a more reliable impression of the existence of Complex PTSD.
A further limitation is the self-report nature of the tools used. Previous studies have shown that the use of self-report measures for PTSD leads to an over reporting of symptoms (e.g., Jones et al., 2001), therefore a clinician-led interview may provide more accurate data. However, the effects of trauma (e.g., on memory and dissociation), may also mean that the SIDES-SR under-reports symptoms and increases the risk of potential misinterpretation by respondents (De Vries, 2008). Additionally, the current measure of Complex PTSD, SIDES-SR, is not well validated. It is, however, the only tool to currently measure the six-alteration definition of Complex PTSD. As the clinician-led SIDES has more validity, future studies should use this measure.

Measurement issues also affected the way in which the severity of intimate partner violence was assessed. The Abusive Behaviour Inventory (ABI) may not have completely captured the complexity of IPV severity, nor any accumulative effect from an interaction between severity and chronicity of abuse. Although the revised Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugannan, 1996) has been used extensively in research on family violence (Straus & Douglas, 2004), it does not include any emotional abuse items which is a prominent feature of IPV (Hegarty, Bush, & Sheehan, 2005). Due to this reason, its length, and its optimum use if both victim and perpetrator complete the scales, this measure was not selected for use in this study. However, the Composite Abuse Scale (Hegarty et al., 2005) does identify type and severity of abuse, although it combines various types of abuse, and cannot provide clear, nor comparable, data with extant literature. Thus the ABI was selected for it brevity, clear questions, clearly defined types of abuse, and reasonable psychometric properties. Follingstad and Bush (2014) highlight the ongoing problems with assessment specific to IPV, and difficulties with
measurement of the various types of IPV are delineated. Research into the
development of a “gold standard” instrument for IPV assessment is clearly an
important area for further investigation (Follingstad & Bush, 2014).

Clinical Implications

Based on the results of this research project, there are a number of clinical
implications which may be relevant. Of importance, these implications are
provisional for clinical practice, and need to be viewed in light of the aforementioned
limitations and opportunities for future research. In order for the posited implications
below to be more robust, future research needs to replicate and expand upon the
results of the current research. This may occur by, for example, increasing participant
numbers, screening for childhood abuse, and conducting treatment studies which
incorporate the risks and dangers to which a victim of IPV is continually exposed.

The current research demonstrated a high prevalence of trauma symptoms
among female IPV victims, and that even moderate intimate partner violence is
associated with changes in affective and behavioural functioning. Additionally, these
trauma symptoms may serve to protect, in addition to place at risk, IPV victims of
future abuse. The well documented (ABS, 2007; Chan & Payne, 2013) risk of
violence that victims continue to experience after separation is an important factor
which needs to be incorporated into any assessment or treatment plan for this
population (Eckhardt et al., 2013). Four broad areas of potential clinical relevance
are provisionally identified based on the known risk of future abuse to IPV victims,
the results of the current research, and the associated literature, which is presented
below. These four areas are; mental health assessment, trauma-informed risk
assessment, treatment for PTSD, and treatment for Complex PTSD. A synopsis of each of the areas are listed, followed by a detailed discussion.

- Mental Health Assessment - Screen for trauma symptoms among victims of IPV, due to its high prevalence, associated treatment implications, and awareness of potential effects of PTSD, Complex PTD, and IPV, on therapeutic alliance, and treatment engagement. Therefore, mental health assessments for victims of IPV should include at least one screening tool for general symptoms, and another for trauma-related disturbance (Briere & Spinazzola, 2009).

- Trauma-informed Risk Assessment - Current risk assessment practice would benefit from greater emphasis on integrating a victim’s own assessment of risk with additional risk measures (Bowen, 2011), and risk assessment should take into account the impact that trauma may have on victims of IPV, and an understanding that their appraisal of risk may be affected by trauma symptoms.

- Treatment for PTSD - The potential, or actual, ongoing partner violence experienced by victims of IPV need to be accounted for in treatment plans, particularly in relation to traditional approaches for PTSD (Warshaw et al., 2013).

- Treatment for Complex PTSD - The tripartite model, recommended in the Complex PTSD treatment guidelines (Cloitre et al., 2012), may be a particularly effective treatment approach for IPV victims who experience Complex PTSD in decreasing trauma symptom severity, and improving safety from future IPV. However, intervention should not address a symptom or alteration without initial understanding of its role in the woman’s safety.
Improvement in functioning and maintaining safety cognitions and behaviors are indicated as dual therapeutic goals for treatment for IPV victims.

**Mental Health Assessment**

The findings of this research may have implications for those who work with women who experience intimate partner violence. Firstly, the results highlight the importance of considering the prevalence of a range of trauma responses within a community sample of IPV victims. Given the high association between mental health and IPV (Hegarty, 2011), indications of either poor mental health or IPV should routinely lead to an assessment of both (Ferrari et al., 2014; Hegarty et al., 2013). This recommendation extends to when the method of treatment is couples therapy; as a high proportion of presenting problems in therapy are about relationships, there is a clinical imperative that all couples are assessed for IPV from the outset (Weiss, 2015). Due to the high proportion of family violence among Indigenous Australians (Hovane, 2015), screening for IPV and trauma symptoms may also prove to be particularly important when assessing people from such communities. This study has demonstrated that approximately two-thirds of help-seeking IPV victims in the community may experience clinically significant PTSD symptoms. As women who experience more severe IPV and report poorer mental health are more likely to engage with services (Hegarty et al., 2013), it is likely that women within the community who do seek help, are also those who experience trauma symptoms.

Briere and Spinazzola (2005; 2009) recommend that the assessment of trauma symptoms include the administration of two broad screening instruments; one for general psychological symptoms (e.g., Personality Assessment Inventory or
Minnesota Multiphasic Personality Inventory, Second Edition), and one for general trauma-related disturbance (e.g., Trauma Symptom Inventory or Structured Interview for Disorders of Extreme Stress). They further recommend that if these tests or clinical interview indicate the individual may be experiencing PTSD, a diagnostic test or structured posttraumatic interview may be used. Given the prevalence of PTSD symptoms among IPV victims, both in the literature and in this study, the standard inclusion of a PTSD screen for this population may be warranted.

There have been suggestions that elements of PTSD treatment, such as exposure therapy, for individuals with combined PTSD and Complex PTSD can be harmful for this population (Chu, 2011; Courtois, 2008). It is therefore important to screen for the presence of symptoms of both disorders before delivering this type of treatment. A further reason to screen for IPV and trauma symptoms is that symptoms of both PTSD and/or Complex PTSD can create barriers to treatment (Brush, 2000; Courtois & Ford, 2009) as can stressors associated with IPV (Rose et al., 2011), all of which demonstrate a number of initial barriers to therapeutic alliance and, initial and continued treatment engagement.

**Trauma-informed Risk Assessment**

Following disclosure of intimate partner violence, interventions may occur from a variety of service systems, such as legal, therapeutic, and welfare services, whereby responses are often coordinated distinctly (Duncan & Western, 2011). This fragmentation and disconnection has led to integrated service delivery as a specific aim of Australian responses to domestic violence, with integrated and targeted interventions recognising that victims of IPV are best supported holistically, rather than through singular service provision (Breckenridge, Rees, Valentine, & Murray,
2015). Important in this integrated approach for victims of IPV is the provision of trauma-informed care, the key elements of which are the understanding of the impact of trauma, and the organisation of service practices to account for such trauma (Quadara, 2015). Given the apparent experience of trauma among victims of IPV, this type of approach across services, appears particularly important and applicable. Additionally, at a more individual level, a core competency needed among psychologists working in domestic violence is knowledge of trauma-informed practices, to achieve recovery (O’Brien, 2015).

In a recent report published by Australia’s National Research Organisation for Women’s Safety (ANROWS) it was stated that there is increasing awareness in Australia that people seeking help from services have complex trauma histories, and that mental health and human service agencies have explicitly considered how to become “trauma-informed” to minimise the risk of individuals being retraumatised through standard operational practices (Quadara, 2015). The report also describes that those working in specialist services, such as domestic violence services, may be reluctant to engage with mental health services, sometimes due to the bio-medical view, which can result in women not receiving potentially helpful mental health interventions. Given the high prevalence of trauma symptoms among victims of IPV, and the recognised benefit of trauma-informed care (Quadara, 2015), it may be important for specialist services to explore trauma symptoms experienced by their clients, so that appropriate interventions may take place.

In a recent article published by the Australian Psychological Society for psychologists working in domestic violence (O’Brien, 2015), a number of core competencies were highlighted, one being the assessment of risk, including understanding the evidence-based factors that indicate danger. Approaches to IPV
risk assessment broadly fall into three categories: clinical, actuarial, and structure professional judgement approaches (Bowen, 2011; Kercher, Weiss, & Rufino, 2010). These respectively equate to unaided/unstructured clinical assessments, probabilistic estimates using predictor variables, and systemic assessment of a number of specified risk factors combined with an overall judgement of risk by a clinician. A review of these approaches indicated a general trend towards actuarial instruments out-performing structured professional judgement assessment (Bowen, 2011). However, a systematic review of contemporary risk assessment approaches for IPV (Nicholls et al., 2013) indicated a relatively small body of empirical evidence exists and therefore believed it was premature to recommend one preferred assessment tool over the other.

Additionally, the ability of victim appraisals of risk to predict future harm appears to be a consistently valid predictive approach, with approximately two thirds of victims correctly identifying their level of risk (Bowen, 2011). Of importance, PTSD scores did not predict inaccuracy of risk, however, when an individual was inaccurate, PTSD scores were associated with women overestimating their risk level (Bowen, 2011). Therefore, current risk assessment practice would benefit from greater emphasis on integrating a victim’s own assessment of risk with additional risk measures (Bowen, 2011), and clinicians need to have an understanding that trauma symptoms may affect risk appraisal. Combining this approach with trauma-informed care practices, risk assessment should therefore take into account the impact that trauma may have on victims of IPV, and an understanding that their appraisal of risk may be affected by trauma symptoms.
**Treatment for PTSD**

Cognitive behavioural therapy (CBT) for individuals experiencing PTSD is most efficacious (Foa et al., 2009), however IPV victims often experience other stressors, such as threat or fear of further IPV, isolation and lack of support, coping with the loss or failure of the relationship, their children’s wellbeing, disruptions for their children or employment, and legal processes (Rose et al., 2011). Cognitive trauma therapy for battered women (CCT-BW; Kubany et al, 2003) incorporates traditional CBT strategies and specific strategies for victims of IPV, and has demonstrated sustained reductions in PTSD (Kubany et al., 2004). While it appears a promising intervention for some women, it is advised as treatment only for women who are no longer in an abusive relationship, do not intend to return to the abusive relationship, have not been sexually for physically abused in the month prior to treatment commencement, and do not currently abuse alcohol or drugs (Kubany et al., 2004). Research has suggested that the effects of psychological abuse can be even more damaging than the effects of physical abuse (O’Leary, 1999) and CTT-BW does not appear to account for the common harassment and threats a victim experiences post-separation, as is not appropriate for women experiencing ongoing abuse.

Commonly, PTSD treatment is afforded in the context of the traumatic event no longer occurring. It is well established that victims of partner abuse experience continued threat, and even abuse, post separation (Campbell et al., 2008). Therefore, treatment necessarily needs to take into account the possibility of ongoing, trauma inducing, abuse occurring, whilst a woman is simultaneously seeking support for her trauma symptoms. The complexity of intimate partner violence therefore poses a unique need for specialised treatment.
The HOPE (Helping to Overcome PTSD through Empowerment) protocol (Johnson & Zlotnick, 2009) was designed for women residing in a domestic violence shelter who are at continued risk of IPV. HOPE focuses on issues relating to IPV, and deducing PTSD, however does not use exposure techniques as PTSD symptoms may represent fear responses to real threat of further IPV, and desensitisation may place women at increased risk of future violence (Johnson & Zlotnick, 2009). This treatment could be potentially modified for women not in a domestic violence shelter (Nathanson et al., 2012) and be an important treatment option for IPV victims in the community, such as those who participated in the current study. Given little is known about which evidence-based trauma treatment modalities are most applicable to IPV survivors, particularly those which take into account potential ongoing trauma (Warshaw et al., 2013), research investigating treatments such as a HOPE modification for a community sample would be an important advancement for IPV victims.

**Treatment for Complex PTSD**

The presence of Complex PTSD alterations among many IPV survivors present implications for assessment and treatment, particularly as those women who experienced more Complex PTSD symptoms, also experienced PTSD symptoms in this study. The most widely used treatment of complex trauma symptoms is the three-phase model (Courtois et al., 2009) and is the recommended model in the Complex PTSD treatment guidelines (Cloitre et al., 2012). This model is organised around the uniqueness of the individual, and treatment is planned around the specific intervention needs of that individual (Courtois et al., 2009), therefore, accurate
identification of initial treatment targets is particularly crucial (Briere & Spinazzola, 2009).

Complex PTSD Guidelines (Cloitre et al., 2012) indicate treatment requires the specific targeting of complex symptoms and alterations (in Phase 2). Results from this study indicate a necessity to be aware of the potential safety and risk factors that each alteration may create, given that the woman’s safety should always be the most important factor (Special Taskforce on Domestic and Family Violence in Queensland, 2015), and poses a unique influence on trauma therapy. Therefore, intervention should not address a symptom or alteration without initial understanding of its role in the woman’s safety. Improvement in functioning and maintaining safety cognitions and behaviours are indicated as dual therapeutic goals for treatment for IPV victims.

Safety factors identified in study 2 highlighted the three phase model goals for Complex PTSD: thoughts and behaviours helpful in maintaining safety and stability; the process of addressing, processing, and healing from the abuse; and the importance of connecting with systems, particularly other IPV victims. This indicates that the tripartite model for IPV victims who experience Complex PTSD may be a particularly effective treatment approach for not only decreasing trauma symptom severity, but also improving safety from future IPV.

Within Phase 1, the goal of creating and maintaining safety is a clear goal of importance for IPV victims, particularly as they potentially contend with ongoing harassment and threats (Warshaw et al., 2013) and/or other life stressors (Rose et al., 2011). The highly common symptom of a lack of trust in others and its effect on therapeutic alliance may be a prominent feature needed to be initially addressed in trauma therapy with a victim of IPV. However, given its clear role in protecting
victims, this symptom should be given careful consideration in treatment. Additionally, of importance for therapeutic alliance and ongoing engagement with a victim of IPV is, a non-judgemental approach and a safe place to tell her story, which is the focus of Phase 2. Finally, the importance of education about IPV to protect against future IPV was demonstrated in theme two safety factors, and therefore education about both IPV and potential trauma symptoms in the context of prolonged interpersonal violence appear to be important to improve safety and CPTSD symptoms alike.

Within Phase 2, the importance of having thoroughly assessed not just the complex trauma symptoms, but also the function of those symptoms, especially in relation to risk, becomes apparent. Of particular relevance for safety are the symptoms of hypervigilance and lack of trust in others. Given the protective nature and salience of hypervigilance among IPV victims, it is likely that one prominent symptom of a victim who experiences Complex PTSD will be hypervigilance. However, as hypervigilance may be a response to real threat, and desensitisation may increase risk for an IPV victim (Kubany et al., 2004), the assessment of its function is crucial. Feelings of numbing, dissociation, or depersonalisation were identified as particularly putting the woman at risk of future violence and therefore assessment and tailored treatment of this symptom warrants particular therapeutic attention for victims of IPV, particularly as numbing can predict, or is significantly related to, re-victimisation among IPV survivors (Krause et al., 2006; Root, 2008; Ullman et al., 2009).

Connection with others is an important part of healing and moving on for IPV victims, and is the focus if Phase 3. Connecting with other victims appears particularly important for IPV survivors, not just in Phase 3, but also in Phase 1 in
terms of psychoeducation and normalisation of the abuse, and also in Phase 2 with group therapy an option of the multimodality approach in the tripartite model.

**Conclusion**

Although there is still much to learn about the effects of IPV, Complex PTSD, and associated treatment needs, the current study adds to the extant empirical literature in several important ways. Specifically, it is the first known study to analyse the potential effects of Complex PTSD symptoms on risk of partner abuse among victims of intimate partner violence. It is the first study to explore Complex PTSD among an Australian sample of intimate partner violence victims, and the first to explore PTSD and Complex PTSD among an Australian population who attends a community domestic violence centre. A small number of previous studies have explored characteristics of IPV and various trauma symptoms (De Vries, 2008; Leahy, 2008), however these previous studies did not additionally address the impact of characteristics of IPV on PTSD, and only one other study has explored the impact of IPV characteristics on Complex PTSD. Additionally, it is only the second known study published in English to explore both PTSD and Complex PTSD among victims of intimate partner violence. Finally, only recently have mixed method studies begun to appear in the literature (Katerndahl, Burge, Ferrer, Becho, & Wood, 2012), and through the combination of quantitative and qualitative methods, this thesis has provided a rich picture of individual IPV dynamics.

This thesis highlights the importance of considering the prevalence of a range of trauma responses within a community sample of IPV victims, and how safety planning should incorporate an understanding of trauma. Investigation of trauma
treatment models which take into account potential ongoing victimisation and trauma, is an important direction for future research. With one in four women experiencing violence from a partner (ABS, 2007) which results in a range of mental health symptoms, and an identified need to improve policy and community responses to domestic violence (National Council to Reduce Violence against Women and their Children, 2009b), it is hoped that this thesis improves current understandings of the long term support needs of women who experience trauma symptoms and intimate partner violence.
References


Lacey, K. K., McPerson, M. D., Samuel, P. S., Sears, K. P., & Head, D. (2013). The impact of different types of intimate partner violence on the mental and physical health of women in different ethnic groups. *Journal of Interpersonal Violence, 28*(2) 359-385
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Appendix A - DUHREC Ethics Approval

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Memorandum

To: Prof Andrew Day
School of Psychology
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From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 06 August, 2012

Subject: 2012-196
Trauma Symptomology and Re-traumatisation Among Female Survivors of Intimate Partner Violence

Please quote this project number in all future communications

The application for this project was considered at the DU-HREC meeting held on 06/08/2012.

Approval has been given for Miss Natalie Emma Pill, under the supervision of Prof Andrew Day, School of Psychology, to undertake this project from 6/08/2012 to 6/08/2016.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Appendix B - DUHREC Ethics Modification 1 Approval

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Memorandum

To: Prof Andrew Day
School of Psychology

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 30 January, 2013

Subject: 2012-196

Trauma Symptomology and Re-traumatisation Among Female Survivors of Intimate Partner Violence

Please quote this project number in all future communications

The modification to this project, submitted on 21/01/2013, has been approved by the committee executive on 30/01/2013.

Approval has been given for Miss Natalie Pill, under the supervision of Prof Andrew Day, School of Psychology, to continue this project as modified to 6/08/2016.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Memorandum

To: Prof Andrew Day
School of Psychology

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 29 August, 2013

Subject: 2012-196
Trauma Symptomology and Re-traumatisation Among Female Survivors of Intimate Partner Violence

Please quote this project number in all future communications

The modification to this project, submitted on 26/08/2013 has been approved by the committee executive on 29/08/2013.

Approval has been given for Miss Natalie Emma Pill, under the supervision of Prof Andrew Day, School of Psychology, to continue this project as modified to 6/08/2016.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

• Serious or unexpected adverse effects on the participants
• Any proposed changes in the protocol, including extensions of time.
• Any events which might affect the continuing ethical acceptability of the project.
• The project is discontinued before the expected date of completion.
• Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Appendix D - Plain Language Statement

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PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Potential Participants

<table>
<thead>
<tr>
<th>Plain Language Statement</th>
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<tr>
<td>Date: 11/07/12</td>
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<tr>
<td>Full Project Title:</td>
</tr>
<tr>
<td>Trauma Symptomology and Re-traumatisation among Female Survivors of Intimate Partner Violence</td>
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<tr>
<td>Principal Researcher:</td>
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<tr>
<td>Prof Andrew Day</td>
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<tr>
<td>Student Researcher:</td>
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<tr>
<td>Natalie Pill</td>
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<tr>
<td>Associate Researcher(s):</td>
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<tr>
<td>Dr Helen Mildred</td>
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</tbody>
</table>

This document includes the Plain Language Statement (an explanation) for the two stages of this project and accompanying separate Consent Forms. Please make sure you read all the pages.

Your Consent

You are invited to take part in this research project.

Please read this Plain Language Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. This Plain Language Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project so that you can make a fully informed decision whether you would like to participate. If you agree to take part, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project. You will be given a copy of the Plain Language Statement and Consent Form to keep as a record.

Purpose

The purpose of this project is to explore the mental health treatment needs of women who experience intimate partner violence. Intimate partner violence is a specific type of domestic violence that occurs by an intimate partner such as a boyfriend/girlfriend, husband, or live-in partner.
The research project is being conducted as part of a Doctorate of Clinical Psychology at Deakin University, Melbourne.

Background

At the moment, we know relatively little about the specific mental health needs of women who experience partner violence. While there is support for those in times of crisis, we would like to find other ways to support women once they are out of a crisis period. Previous research has shown that many women experience mental health symptoms after experiencing partner violence, with many experiencing symptoms of trauma. These can include things such as: not being able to eat or sleep, feeling agitated or tired, feeling alone or disconnected from their loved ones and the world, or fearing certain places or people. Treatments have been developed for these types of symptoms, but they are often not available to those who suffer long term partner abuse. We are interested in finding out about how the experience of violence has affected women and how mental health can influence ongoing relationships, such as protecting them from future violence. We would also like to hear the views of women who currently seek services for support and hear how they think services might better help them.

Methods

This project involves two studies, however you may only be asked to take part in one, and you can decide not to participate in both studies if you do not want to.

Study 1
This will involve you answering some questions on a computer in the Domestic Violence Prevention Centre Gold Coast Inc. (DVPC) Centre. Alternatively, if you wish to participate in the study but cannot attend the centre, you may access the online questionnaires from a computer at a location of your choice (for example, a work or home computer). We will provide you with an internet address in order to access the questionnaires if you are unable to attend the centre. If possible, we ask that you do complete the questionnaires at the centre itself in order to provide immediate support should you need it, and also as a safety measure.

The questionnaires will ask you for your basic details such as your name and age. You will then be asked some questions about how you have been thinking and behaving in the past month. You will also be asked about the intimate partner abuse that you have experienced in your life, such as what types of things have happened to you and for how long. You will mostly just have to select a box that best describes your answer. Some examples of the questions you will be asked are:

Please select the answer that best describes how much you have been bothered by that problem in the past month.

a) Avoiding activities or situations because they reminded you of a stressful experience?

b) Feeling distant or cut off from other people?


Study 2
Based on the information you provide in Study 1, you may be asked to take part in Study 2. If asked to participate in Study 2, you can say no. Study 2 will involve participating in a small group, called a focus group, with other women at the DVPC. A group will include 6 to 10 women and last for about 2 hours. You will be asked about how you think your mental health affects your thoughts and behaviours related to your intimate relationships. You will also be asked about the services that you have been provided and what service support you think women who experience partner abuse need. These groups will be led by one of the researchers, Natalie Pill, who has experience in working in centres that provide services for women who experience domestic violence.

Potential Benefits and Risks to Participants

Intimate partner violence is widely recognised as a significant social issue. This project aims to increase awareness of the mental health issues surrounding the survivors of intimate partner violence. Its greater aim is to establish the treatment needs of partner violence survivors in order for more tailored services to be provided to community members.

There are no direct benefits from taking part in this research and no one will be individually identified in the research. However, participants may learn more about some of the symptoms that women who receive partner abuse commonly experience. If you identify yourself as someone who experiences high levels of traumatic stress, you may be directed to further support, with your consent. If you consent to be contacted, the researchers will contact the Director of DVPC, Amy Compton-Keen, regarding your symptoms. The Director will then contact you, to assist you in accessing appropriate services. The research will provide an opportunity for you to actively contribute to service development. The results will lead to recommendations for your service.

You will be asked to reflect on some tough times in your life, like when you experienced partner violence, and it is possible that you will find this distressing. You will also be asked to think about your recent behaviours and thoughts. As this project may be stressful, we ask that if you are pregnant you do not participate. If you do become stressed or upset, then service providers at DVPC will be available to support you, and you may ask them to direct you to further support, such as counselling. We ask that you talk with DVPC staff if you do feel distressed by this project. DVPC provide some counselling, free of charge, which may be beneficial for you if you decide to follow this option. Also, DVPC may suggest a referral for you to a GP about your symptoms to explore the option of a Mental Health Care Plan. A
Mental Health Care Plan would involve the GP referring you to a specialist mental health clinician, such as a psychologist, in order for you to be supported further. Please note that this option does have a Medicare rebate, but that the remaining amount due would be at your own expense.

Study 1
If at any point in time while filling out the questionnaires you become upset or distressed, we ask that you stop filling out the forms and take a break. Please talk to staff at the Centre if you would like to. It is then your choice to either continue with participating in the project or not. If you decide not to continue with the project there will be no problem, and any data collected from you will not be used in analyses for the research project. If you decide to discontinue with the project we ask that you complete the “Withdrawal of Consent Form” for STUDY 1 that you will find at the end of this document, so that the researchers know not to include your data in analyses.

If you are filling out the questionnaires outside of the centre we ask that you answer the questions between the hours of 9am and 4pm so that if you do become distressed you may call immediately for support. If you have any questions, queries, or feel you would like support during, or after completing, the questionnaires please call the centre immediately.

Study 2
If you become uncomfortable or upset during the group talks then you are asked to please take a break. Please talk to staff at if you would like to. If the group leader, Natalie Pill, believes that you may be feeling stressed or upset by the content of the group, she will ask you if you feel that you need a break, or if you would like to leave the group all together. She will also ask at times throughout the group talk if anyone would like a break or to leave the group. You will be free to take a break or leave the group at any point in time and there will be no consequences if you do. If after taking a break you decide that you would rather not continue in the group there will also be no problem. Please note that given these groups will be audio taped and that at times it may not be possible to identify who has spoken in the group, any input that you have before deciding to stop your participation will be included in analyses. If you decide to discontinue with Study 2 we ask that you complete the "Withdrawal of Consent Form" for STUDY 2 that you will find at the end of this document. You may decide to have your information from Study 1 removed from analyses.

Privacy and Confidentiality

Study 1
Personal results from Study 1 will remain strictly confidential and only be available to the three researchers. The data will be kept online and will only be accessible via a password that the researchers will have. Individual results will not be available. You may, however, give your permission to be contacted by the if you indicate in the questionnaires that you are experiencing high levels of trauma.
symptoms. If you do decide to be contacted you will need to provide a safe method for you to contact you. All information collected will be securely stored for six years, as according to Deakin University’s policy on research data storage.

Study 2
Individual results will not be given after Study 2. The focus groups will be audio taped in order to ensure that what is said is accurately recorded. Each participant will be asked to respect other members of the group by not identifying other participants or discussing the group outside of the meeting. Participants may choose to take part in the group by using a made-up name in order to help protect their own identity. Please note that while we ask each group member to respect and maintain the confidentiality of all other group members, confidentiality cannot be guaranteed in focus groups. The audio tapes will be transcribed by Natalie Pill, the group leader, and each participant will be given a different name in the transcript to protect identity. This transcript will only be accessible to the researchers via a password. All information collected will be securely stored for six years, as according to Deakin University’s policy on research data storage.

Under no circumstances will the identity of any participant in Study 1 or Study 2 be released in presentation or publication of the project’s results.

Results of the Project

The general results of the project will be presented in a thesis by the student researcher of this project. The results may also be published in peer reviewed journals and presented at international conferences. No participants will be identifiable in published or presented results. A short summary of the project will be provided to the Domestic Violence Prevention Centre Gold Coast Inc. Participants will be able to view the results in the centre and/or elect to have the summary sent to them. This option is available in the Consent Form.

How the Research will be Monitored

The project’s researchers regularly communicate about the project and its progression with the Director of the Domestic Violence Prevention Centre Gold Coast Inc. Any problems with the project will be monitored and discussed by the Director and the researchers throughout the entire project. Any changes to what you read in this information statement must first be approved by a stringent ethical process that maintains high levels of ethical responsibility towards participants by the researchers.

Funding

This research is funded by the Faculty of Health, Medicine, Nursing and Behavioural Sciences and the School of Psychology of Deakin University.

Reimbursement
Study 1
Participants will receive a $10 supermarket voucher.

Study 2
Participants will receive a $30 supermarket voucher.

Declarations of Interest

The members of the research team do not have any affiliation with the providers of funding or support, or a financial interest in the outcome of the research. The service provider, [service provider name], would like to know of the major findings of this project and any recommendations arising from the results.

Participation is 100% Voluntary

*If you do not wish to take part in this research you do not have to.* If you decide to participate and later change your mind, you are free to withdraw from the project at any stage, even in the middle of completing a study. Although any information obtained from you will be securely stored for six years (it is a requirement of data integrity that all data be maintained for this period), none of your information from Study 1 will be included in analyses if you withdraw from Study 1. If you withdraw after starting to participate in Study 2, as it will not be possible at times to differentiate who has been speaking in the audio recording, any input you have in the group talk before withdrawing from the research will be used in analyses. You will then have the choice to also withdraw your information from Study 1 analyses. Please see the section on “Potential Benefits and Risks to Participants” above for more information on this. Your relationship with the [Domestic Violence Prevention Centre Gold Coast Inc. and Deakin University] will not be affected in any way if you decide to participate, not to participate, or withdraw your participation at a later date.

Before you make your decision, you might have some questions. Please contact either Andrew Day or Natalie Pill, whose contacts details are below, in order for all your questions to be answered. Sign the Consent Form only after you have had a chance to ask your questions and received satisfactory answers. If you decide to withdraw from this project, please notify Andrew Day or Natalie Pill and complete and return the “Withdrawal of Consent Form” attached to this document.

Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
The ethics aspects of this research project have been approved by the Deakin University Human Research Ethics Committee.

Approval of this project has also been gained from the board of [Redacted].

Further Information, Queries or Any Problems

If you require further information, wish to withdraw your participation or if you have any problems concerning this project, you can contact:

Professor Andrew Day  
E-mail: andrew.day@deakin.edu.au  
Phone: (03) 5227 8715  
Mobile: [Redacted]  
Fax: (03) 5227 8621

Natalie Pill  
E-mail: npill@deakin.edu.au

Complaints

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au

Please quote project number [2012-196].
Name ______________________ Date __________________ Councillor ________________

RISK ASSESSMENT  LOW 1———2———3———4———5——— MEDIUM ——————————6———7———8———9——— 10 ———— HIGH

HISTORY OF DOMESTIC VIOLENCE - CURRENT AND PAST PHYSICAL & SEXUAL VIOLENCE

1. Describe the last incident of Violence or Abuse: Incident Date: __________________

2. History of abuse

   Physical: ______________________________________________________

   Emotional/Verbal: ______________________________________________

   Other Abuse: __________________________________________________

3. Has your partner's violence escalated or increased? □ NO □ YES

4. Have you ever required medical attention for injuries? □ NO □ YES

5. Has your partner ever tried to strangle you? □ NO □ YES

6. Has your partner ever threatened to kill you or your family? □ NO □ YES

7. Do you believe he is capable of carrying out the threat? □ NO □ YES

8. Has your partner ever killed or harmed a pet? □ NO □ YES

Risk Assessment Adapted from "The Duluth Accountability Audit Guide" 1998
RISK ASSESSMENT

9. Has your partner ever been sexually abusive towards you? □ NO □ YES

10. Have you ever been threatened with a weapon? □ NO □ YES

11. Do you think your partner may use a weapon against you? □ NO □ YES

12. Has your partner ever hurt your children or threatened to? □ NO □ YES

13. Do you think your partner may injure you or your children? □ NO □ YES

14. Has your partner been violent towards past partners? □ NO □ YES

15. Have they ever been charged with violent offences? □ NO □ YES

16. Is your partner jealous or obsessed with you? □ NO □ YES

17. Has your partner ever threatened suicide? □ NO □ YES

18. Has your partner ever been treated for mental health? □ NO □ YES

19. Does your partner drink excessively or use drugs? □ NO □ YES

20. Have you ever felt the need to protect your partner? □ NO □ YES

21. Do they show remorse/sadness about violence? □ NO □ YES

Risk Assessment Adapted from ‘The Duluth Accountability Audit Guide’ 1998
SARA (Safety & Risk Assessment)

Name ____________________________ Date ____________________ Counsellor ___________

RISK ASSESSMENT

LOW-1--------2--------3--------4--------5-- MEDIUM--6--------7--------8--------9--------10-- HIGH

AGGRIEVEDS PRIOR ATTEMPTS TO BE SAFE

1. Do you have a Domestic Violence Order?
   □ NO  □ YES

2. Have you separated or attempted to separate?
   □ NO  □ YES

3. What have you previously done to protect yourself?

4. Have you had contact with the Police in the past twelve months?
   □ NO  □ YES

5. Have you sought other assistance in the past twelve months?
   □ NO  □ YES

6. Do you have a supportive network of family and friends?
   □ NO  □ YES

Children

What have the children experienced directly or indirectly?

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Resides with...</th>
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</table>

Risk Assessment Adapted from 'The Duluth Accountability Audit Guide' 1998
Appendix F - Study 1 Demographic Questions

1. Name (Participants will be asked to provide own answer.)

2. Age (Options 18 – 69 provided.)

3. What is the highest level of education you have completed?
   - Primary School
   - High School
   - TAFE
   - University Educated

4. What is your current marital status?
   - Single
   - Live-in partner
   - Married
   - Separated
   - Divorced
   - Widowed
   - Partner lives separately

4. What cultural group do you identify yourself as?
   (Participants will be asked to provide own answer.)
Appendix G - Posttraumatic Stress Disorder Checklist: Civilian Version

Name: ______________________________________________________

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, and select the answer that best describes how much you have been bothered by that problem in the past month.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?

2. Repeated, disturbing dreams of a stressful experience?

3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?

4. Feeling very upset when something reminded you of a stressful experience?

5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?

6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?

7. Avoiding activities or situations because they reminded you of a stressful experience?

8. Trouble remembering important parts of a stressful experience?
9. *Loss of interest* in activities that you used to enjoy?
   

10. Feeling *distant or cut off* from other people?
   

11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?
   

12. Feeling as if your *future* will somehow be *cut short*?
   

13. Trouble *falling or staying asleep*?
   

14. Feeling *irritable* or having *angry outbursts*?
   

15. Having *difficulty concentrating*?
   

16. Being "*super-alert*" or watchful or on guard?
   

17. Feeling *jumpy* or easily startled?
   

This checklist is in the public domain, however it was adapted from: “PTSD Checklist—Civilian Version“ by F. W. Weathers, B. T. Litz, J. A. Huska, and T. M. Keane, 1994, Boston: National Center for PTSD, Behavioral Science Division.
Appendix H - Self-Report Instrument for Disorders of Extreme Stress

The Self-Report Instrument for Disorders of Extreme Stress (SIDES-SR; van der Kolk, 2002) is protected by copyright laws and hence cannot be reproduced. Copies of the instrument can be obtained by contacting the following:

Training Division Manager
The Trauma Center at JRI
1269 Beacon Street
Brookline, MA 02446
Tel: +1 (617) 232-1303 x 203

Information about the SIDES-SR is also available here:
http://www.traumacenter.org/products/instruments.php
### Appendix I - Abusive Behaviour Inventory

Here is a list of behaviours that many women report have been used by their partners or former partners. We would like you to estimate how often these behaviours occurred in your previous and/or present relationships.

CIRCLE a number for each of the items listed below to show your closest estimate of how often it has happened to you over your lifetime, whether it occurred in one or multiple relationships.

1 = NEVER  
2 = SOMETIMES  
3 = OFTEN  
4 = VERY OFTEN

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Swore, called you a name, or criticized you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Tried to keep you from doing something you wanted to do (example: going out with friends, going to meetings).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Gave you angry stares or looks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Prevented you from having money for your own use or otherwise controlled money.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>My partner made me have sex with him without a condom.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Controlled decision making himself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Threatened to hit or throw something at you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Pushed, grabbed, or shoved you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>Put down your family and friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>My partner made threats to make me have sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>Accused you of paying too much attention to someone or something else.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>Used your children to threaten you (Example: said you would lose custody; said he would leave town with the children).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>Became very upset with you because dinner, housework or the laundry was not ready when he wanted it done or the way he thought it should be done.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
14 Used a knife, gun or weapon against you. 1 2 3 4
15 Refused to do housework or childcare. 1 2 3 4
16 My partner insisted I have oral or anal sex when I did not want to. 1 2 3 4
17 Said things to scare you (example: told you something “bad” would happen; threatened to commit suicide). 1 2 3 4
18 Slapped, hit, punched, bit, pulled your hair or twisted your arm. 1 2 3 4
19 Made you do something humiliating or degrading (example: begging for forgiveness; having to ask his permission to use the car or do something). 1 2 3 4
20 Checked up on you (example: listened to your phone calls, checked the mileage on your car or called you repeatedly at work). 1 2 3 4
21 Drove recklessly when you were in the car. 1 2 3 4
22 Pressured you to have sex in a way you didn’t like or want. 1 2 3 4
23 Threatened you with a knife, gun, or other weapon. 1 2 3 4
24 Told you that you were a bad parent. 1 2 3 4
25 Stopped you or tried to stop you from going to work or school. 1 2 3 4
26 Threw something. 1 2 3 4
27 Kicked you. 1 2 3 4
28 Physically forced you to have sex. 1 2 3 4
29 Threw you around. 1 2 3 4
30 Physically attacked sexual parts of your body. 1 2 3 4
31 Choked or strangled you. 1 2 3 4

Appendix J - Intimate Partner Violence History Questions

1. Are you currently in a relationship? (Yes/No)

If yes, does your current partner abuse you in some way? (Yes/No)

2. How many intimate partners have physically, emotionally, sexually, or financially abused you? (1, 2, 3, 4, 5)

(Participants insert a number which then creates a corresponding number of options to appear. E.g. for 2 partners:)

3. Please indicate for each of those partners:

   a. **Partner 1** abused me/has abused me for approximately: ( ) Years ( ) Months
   b. Please indicate approximately when this abuse stopped ( ) Month ( ) Year ( ) On-going
   c. During the time that this partner abused you, did the abuse occur rarely, sometimes, often, very often? (Participant would select drop-down option.)

   a. **Partner 2** abused me/has abused me for approximately: ( ) Years ( ) Months
   b. Please indicate approximately when this abuse stopped ( ) Month ( ) Year ( ) On-going
   c. During the time that this partner abused you, did the abuse occur rarely, sometimes, often, very often? (Participant would select drop-down option.)
Appendix K - Consolidated Criteria for Reporting Qualitative Research

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Guide questions/description</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>Domain 1: Research team and reflexivity</strong></td>
<td></td>
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<tr>
<td></td>
<td>Personal Characteristics</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Interviewer/facilitator</td>
<td>Which author/s conducted the interview or focus group?</td>
</tr>
<tr>
<td>2.</td>
<td>Credentials</td>
<td>What were the researcher’s credentials? E.g. PhD, MD</td>
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<tr>
<td>3.</td>
<td>Occupation</td>
<td>What was their occupation at the time of the study?</td>
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<tr>
<td>4.</td>
<td>Gender</td>
<td>Was the researcher male or female?</td>
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<td>5.</td>
<td>Experience and training</td>
<td>What experience or training did the researcher have?</td>
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<td></td>
<td>Relationship with participants</td>
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<tr>
<td>6.</td>
<td>Relationship established</td>
<td>Was a relationship established prior to study commencement?</td>
</tr>
<tr>
<td>7.</td>
<td>Participant knowledge of the interviewer</td>
<td>What did the participants know about the researcher? e.g. personal goals, reasons for doing the research</td>
</tr>
<tr>
<td>8.</td>
<td>Interviewer characteristics</td>
<td>What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic</td>
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<td></td>
<td><strong>Domain 2: study design</strong></td>
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<tr>
<td>9.</td>
<td>Theoretical framework</td>
<td>What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</td>
</tr>
<tr>
<td>10.</td>
<td>Participant selection</td>
<td>How were participants selected? e.g. purpose, convenience, convenience, snowball</td>
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<td>11.</td>
<td>Method of approach</td>
<td>How were participants approached? e.g. face-to-face, telephone, mail, email</td>
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<tr>
<td>12.</td>
<td>Sample size</td>
<td>How many participants were in the study?</td>
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<tr>
<td>13.</td>
<td>Non-participation</td>
<td>How many people refused to participate or dropped out? Reasons?</td>
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<td>14.</td>
<td>Setting</td>
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<td>15.</td>
<td>Presence of non-participants</td>
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<td>16.</td>
<td>Description of sample</td>
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<td>17.</td>
<td>Data collection</td>
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<tr>
<td>18.</td>
<td>Interview guide</td>
<td>Were questions, prompts, guides provided by the authors? Was it pilot tested?</td>
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<tr>
<td>19.</td>
<td>Repeat interviews</td>
<td>Were repeat interviews carried out? If yes, how many?</td>
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<td>20.</td>
<td>Audio/visual recording</td>
<td>Did the research use audio or visual recording to collect the data?</td>
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<td>21.</td>
<td>Field notes</td>
<td>Were field notes made during and/or after the interview or focus group?</td>
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<td>22.</td>
<td>Duration</td>
<td>What was the duration of the interviews or focus group?</td>
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<td>23.</td>
<td>Data saturation</td>
<td>Was data saturation discussed?</td>
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<td><strong>Domain 3: analysis and findings</strong></td>
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<td>24.</td>
<td>Data analysis</td>
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<td>Number of data coders</td>
<td>How many data coders coded the data?</td>
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<td>26.</td>
<td>Description of the coding tree</td>
<td>Did authors provide a description of the coding tree?</td>
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<td>27.</td>
<td>Derivation of themes</td>
<td>Were themes identified in advance or derived from the data?</td>
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<td>28.</td>
<td>Software</td>
<td>What software, if applicable, was used to manage the data?</td>
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<td>29.</td>
<td>Participant checking</td>
<td>Did participants provide feedback on the findings?</td>
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<td></td>
<td>Reporting</td>
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<tr>
<td>30.</td>
<td>Quotations presented</td>
<td>Were participant quotations presented to illustrate the themes / findings? Was each quotation identified &amp; e.g. participant number</td>
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<tr>
<td>31.</td>
<td>Data and findings consistent</td>
<td>Was there consensus between the data presented and the findings?</td>
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<tr>
<td>32.</td>
<td>Clarity of major themes</td>
<td>Were major themes clearly presented in the findings?</td>
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<td>Clarity of minor themes</td>
<td>Is there a description of diverse cases or discussion of minor themes?</td>
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