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Intimate Partner Violence Typology, Self-Blame, Depression and PTSD Among Homeless Women

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INTIMATE PARTNER VIOLENCE

TYPOLOGY, SELF-BLAME, DEPRESSION AND

PTSD AMONG HOMELESS WOMEN

by
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ABSTRACT

Intimate relationships involving one partner controlling another, as in the type of intimate partner violence (IPV) called intimate terrorism (IT), have been associated with more negative outcomes than aggressive relationships without controlling behaviours, called situational couple violence (SCV; Johnson & Leone, 2005). Attributions of self-blame for victimization have also previously been examined for their ability to predict negative outcomes. The current study examines self-blame and IPV type as predictors of posttraumatic stress disorder (PTSD) and depression. Twenty-four women residing in a homeless shelter completed questionnaires assessing IPV, self-blame, depression, and PTSD. Victims of IT reported higher characterological self-blame than victims of SCV. PTSD symptoms were significantly predicted by IPV type, but not self-blame. Self-blame and IPV type did not significantly predict depression. PTSD and depression among homeless IPV female victims appear to arise through different mechanisms, and IPV type is important for determining who is most at risk for PTSD.

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CHAPTER I

Introduction

Definition and Prevalence of IPV

Intimate partner violence (IPV), is defined as any act of violence that is perpetrated against one's intimate partner or one's former intimate partner, whether it is in the context of a dating relationship or a marriage. The term has been broadened from domestic violence to account for previously unexamined rates of violent acts among couples who are not legally married (Dutton, 2006). Current definitions of IPV include not only physical acts of violence such as hitting, punching, and shoving one's partner, but psychological and sexual acts as well. Examples of psychological abuse include using derogatory names for one's partner and making threats. It is more recently that sexual abuse has been included under the domain of IPV. Sexual abuse occurs when one partner forces another to engage in a sexual act that he or she does not wish to engage in. According to the Centers for Disease Control and Prevention (2008), lifetime prevalence rates of IPV in European and Western countries fall between 26% and 74%. More specifically, according to the 2004 General Social Survey, a large-scale survey conducted by the Canadian government, 653,000 women and 546,000 men were self-reported victims of violence at the hands of their current or previous spouse during the past five years, representing 7% of women and 6% of men (Mihorean, 2005). The most severe acts of violence were more often reported by women (23%) than by men (15%; Mihorean, 2005). Amongst those who experienced violence, 54% indicated that the violence occurred on more than one occasion (Mihorean, 2005). The most recent survey of the Canadian population found that 40,200 incidents of abuse amongst couples who were

either legally married or in a common-law relationship were reported to police (Taylor-Butts, 2009). Amongst those victims, 83% were female. These figures indicate that less than 30% of violent incidents are actually reported to police (Mihorean, 2005).

Consequences of IPV Victimization

Physical Health Consequences

Victims of IPV have been found to exhibit many negative consequences of their victimization. Firstly, when physical violence is involved, injuries often occur. These physical injuries can range in severity from cuts and bruises to concussions, miscarriages, and even death (Campbell, 2002; Resick, 2004). According to the 2004 General Social Survey, 44% of women reported being injured as a result of partner violence, compared to 19% of men (Mihorean, 2005). Moreover, up to one-third of the injuries obtained due to IPV were serious enough to result in medical care being sought (Mihorean, 2005). Additionally, 65 people died at the hands of their spouse in Canada in 2007, with four times as many of the victims being female (Ogrodnik, 2009).

Mental Health Consequences

The effects of IPV are not only physical, as IPV also has a negative impact on the psychological health of the victim. The most common mental disorders associated with IPV are depression and posttraumatic stress disorder (PTSD; Campbell, 2002; Resick, 2004). Rates of PTSD among IPV victims have been found to vary between 31-84%. A meta-analysis of studies examining the mental health consequences of IPV conducted by Golding (1999) found that 47.6% of physically abused women currently residing in a domestic abuse shelter suffered from depression, 17.9% from suicidality, 63.8% from PTSD, 18.5% from alcohol abuse, and 8.9% from drug abuse. Other psychological

conditions associated with IPV include attention-deficit/hyperactivity disorder and eating disorders (Ackard & Neumark-Sztainer, 2002; Briscoe-Smith & Hinshaw, 2006). Even in the case of psychological abuse without physical violence, depression is commonly experienced (Vaeth, Ramisetty-Mikler, & Caetano, 2010). In fact, there has been some support for the idea that psychological abuse might be a better predictor of mental disorders than physical abuse (Dutton, Goodman, & Bennett, 1999; Taft, Murphy, King, Dedeyne, & Musser, 2005). Some studies have suggested that the instances of exposure to abuse likely function to create a cumulative impact on mental health (Dougall, Heberman, Delahanty, Inslicht, & Baum, 2000). Additionally there has been some research that suggests that even after the abusive relationship ends, psychological distress either remains constant or even increases (Andrews & Brown, 1988; Kemp, Green, Hovanitz, & Rawlings, 1995; Lerner & Kennedy, 2000).

Homelessness and IPV

Prevalence and Definition

One population that exhibits especially high rates of mental illness is the homeless. The 2006 Canadian census identified 19,630 homeless people living in Canada, 8,500 of whom resided in Ontario (Statistics Canada, 2006). One study found that 6% of homeless people in Toronto had schizophrenia (Frankish, Hwang & Quantz, 2005). Lifetime prevalence of affective disorders amongst the homeless has been found to range from 20-40% (Frankish, Hwang & Quantz, 2005).

The definition of a person who is homeless is someone who does not have regular access to a conventional residence (Rossi, Wright, Fisher, & Willis, 1987), though there is some disagreement over the specifics (e.g., individuals who are temporarily sharing a

residence, or residing in a vehicle). Rossi, Wright, Fisher, and Willis (1987) propose that homelessness falls on a continuum ranging from those who own a property to those who are living on the street, with those who have access to unstable, temporary housing in the middle. In their study, they examined a population that they termed "literal homeless" as individuals residing in a shelter or on the street at the time of their study. Alternatively, Frankish, Hwang, and Quantz (2005) refer to individuals either residing in a shelter or outdoors as being "absolutely homeless".

Regardless of the variation in definitions, researchers agree that homeless people face many challenges. Goodman, Saxe, and Harvey (1991) propose that the experience of being homeless is traumatic. According to their theory, the transition from having a home to no longer having a home can in itself be traumatic, in that the loss of one's home produces great stress, as well as a disruption in routine. Further trauma can result from the actual experience of being homeless, in that there is a loss of security when one does not have one's own space, as well as a loss of personal control when one must abide by shelter rules and schedules. Goodman et al. also argue that there is often a reduction in social support that occurs when someone becomes homeless, which may exacerbate trauma symptoms.

Homelessness and Victimization

One of the most serious consequences of being homeless is the loss of safety associated with not having one's own home. A study that took place in Toronto found that in the previous year 46% of homeless women reported being assaulted, and 43% reported experiencing sexual harassment or assault (Ambrosio, Baker, Crowe, & Hardill, 1992). Twenty-one percent of the women in the same sample reported being raped at

least once in that one year period. Differences in the characteristics of assaults have been found between homeless and housed women. A study by Stermac and Paradis (2001) that also took place in Toronto found that homeless women were more often assaulted by a stranger than housed women were. Also, assaults against homeless women were more violent and were more likely to include more than one sexual act (Stermac & Paradis, 2001). Homeless women reported significantly higher rates of sexual and physical abuse in both childhood and in adulthood compared to housed women (Stermac & Paradis, 2001). Homeless women have been shown to experience more instances of IPV victimization than the general population as well. The reason for this may be because they have high rates of two risk factors that have been found to be associated with IPV: childhood maltreatment and low income.

Childhood maltreatment is a term that has traditionally been comprised of four subtypes: physical abuse, neglect, sexual abuse, and emotional abuse (Edleson, 1999). All four of the subtypes have detrimental effects on the psychological well-being of its victims, including symptoms of PTSD and depression (McLeer et al., 1998). Studies have found a large overlap among those who have experienced childhood maltreatment and IPV. According to review studies of clinical samples, 30-60% of victims of IPV were victims of maltreatment in childhood (Appel & Holden, 1998; Edleson, 1999). Many studies have also found childhood maltreatment to be predictive of IPV victimization in adulthood, as well as in adolescence (Cyr, McDuff, & Wright, 2006; Tyler, Melander, & Noel, 2009). Not only is childhood maltreatment predictive of experiencing IPV, but it also amplifies IPV's negative consequences. Studies have found that victims of both childhood maltreatment and IPV experience greater negative effects than victims of only

one of the two forms of victimization (Chiodo, Leschied, Whitehead, & Hurley, 2008; Herrenkohl & Herrenkohl, 2007; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008).

Another risk factor that has consistently been associated with IPV victimization is low SES (Hotaling & Sugarman, 1986; Cunradi, Caetano, & Schafer, 2002). SES has typically been comprised of income, highest level of education completed, and occupational status (Liberatos, Link, & Kelsey, 1988). A study by Cunradi, Caetano, and Schafer (2002) found that income was the strongest predictor of IPV in their model which included the other two indicators of SES, as well as alcohol use and impulsivity.

Homeless women are likely to have both of the risk factors described above. According to a study by Tyler and Cauce (2002), 51% of female homeless adolescents reported being a victim of physical abuse in childhood, and 44% reported being sexually abused as a child. Similarly, of a sample of homeless youth in New York, 60% reported experiencing physical abuse, 42% emotional abuse, 48% neglect, and 21% sexual abuse in childhood (Powers, Eckenrode, & Jaklitsch, 1990). Economic reasons for homelessness include loss of a job, declining income, and eviction due to an inability to pay rent (Tessler, Rosenheck, & Gamache, 2001).

Despite the overwhelming evidence that homeless women are a subgroup of the population that are at particular risk for experiencing IPV, surprisingly little research has been conducted on the IPV experiences of these women. A study by Tyler, Melander, and Noel (2009) that investigated prevalence rates of IPV among homeless people found that 69% reported having been victimized by a partner, and 65% reported having victimized a partner. The same study found that three-quarters of the violence was bidirectional. Also,

being victimized by one's partner was associated with more severe substance use and higher levels of PTSD, but not depressive symptoms. Despite the efforts of some researchers to fill the void in the research on homelessness and IPV, this remains an understudied population.

Causes of IPV

Feminist Theory of Partner Violence

While the debilitating effects of IPV have been well-established, less clear is the explanation for why IPV occurs. Although there are far too many contributing factors to discuss each one here (for a review please refer to Dutton, 2006), two main theories have been proposed to explain the occurrence of intimate partner violence. According to feminist theories of partner violence, IPV occurs because Western society is based on a patriarchal system, one in which men are raised to believe that they are superior to women, and as a result, many men do whatever they must to exert dominance over their female partners (Kurz, 1989). As such, according to feminist theories, IPV is perpetrated by men against women, and almost never the reverse. Connell's (1987) theory of gender and power argues that the imbalance in power between the genders that exists on a societal level plays out in the interpersonal relationships between men and women. Since it is instilled in men that they are supposed to be more powerful in the world compared to women, they try to maintain that amount of power in all situations, sometimes resorting to physical violence to do so. Multiple studies have found support for the link between power imbalances and incidents of IPV (Kim & Emery, 2003; Pence & Paymar, 1993; Smith, 1990). Additionally, a qualitative analysis by Anderson and Umberson (2001) of 33 males either court-mandated or self-referred to a domestic violence agency showed

that male perpetrators self-report that one of the main reasons for their use of violence was to control their partner.

Feminist theories have also been supported largely by data collected from public aid agencies. Multiple studies have indicated that almost all cases of IPV reported to police, as well as almost all users of domestic abuse shelters are female (Fields & Kirchner, 1978; Gaquin, 1977). For example, Kincaid (1982) analyzed 337 family court files in Ontario and found that there were 17 times as many female victims as male victims. Further support for this theory has been largely based on qualitative reports from women who were in such relationships, usually collected from samples of women living in domestic violence shelters. These accounts often contained common references to the controlling behaviours of men. These behaviours included threatening to harm the woman's children or pets and convincing the woman that any violence directed at her was her own fault (Dobash & Dobash, 1979). In relationships characterized by control, the violence often escalated in severity across time and incidents (Johnson, 1995; Pagelow, 1981).

Family Violence Theory of Partner Violence

Feminist theories of IPV have long been contrasted with the family violence theory. The family violence theory is based on evidence from wide-scale national surveys indicating that women are not the only ones who are experiencing violence at the hands of their partners, but that men are victimized by their partners as well—and often in equal numbers as women (e.g., Straus & Gelles, 1990). For example, a study by Straus and Gelles (1990) that used data from the 1975 National Family Violence Survey found that 12.1% of men and 11.6% of women used violence against their partners. The use of

severe violence was symmetric as well, with 3.8% of men and 4.6% of women reporting its use. These figures were replicated in an analysis of the 1985 version of the same survey (Straus & Gelles, 1990). Similar studies have been conducted in Canada with comparable findings (Kwong & Bartholemew, 1998; Kwong, Bartholemew & Dutton, 1999). A meta-analysis by Archer (2000) also indicated that among large-scale survey samples, IPV was symmetric between men and women. Findings such as these led Steinmetz (1978) to conclude that violence perpetrated by women against men is a serious societal issue that had gone unnoticed. She coined the term "battered husband syndrome" to describe these male victims of abuse. With this new identification of victims came lobbying for the institution of public policy to provide services to the victimized men. Not surprisingly, these attempts were met with intense criticism from feminists who argued that funding to shelters for women would be lessened in order to fund shelters for men (Adams, Jackson, & Lauby, 1988; Dobash, Dobash, Wilson, & Daly, 1992).

Advocates of the family violence theory argued that the reason that rates of police-reported IPV and shelter usage indicated that IPV was experienced almost solely by women was because of the same gender role paradigm that the feminists argue for, coupled with the lack of acceptance of female-perpetrated violence (Dutton, 2006). Men in our society are socialized to believe that they should be able to take care of themselves without outside help, and therefore would be less likely to use public aid services. This assertion has been supported by research examining police responses to female-against-male perpetration indicating that often the reports were not taken seriously, with female perpetrators rarely being charged (Henning & Renauer, 2005). Proponents of feminist

theories argue that even though equivalent rates of violence have been found in large samples, these samples are not representative of the most severe cases, and that the violence used by women against men is self-defence (Walker, 2000).

Johnson's IPV Typology

The two prevailing perspectives of feminist theories and family violence theory remained in opposition to each other until the last decade when the two views were reconciled into one encompassing theory of IPV that accounted for the seemingly contrasting evidence. Michael Johnson (1995) argued that the differing findings from shelters and wide-scale general surveys were a result of a bias in data collection inherent in the two samples. The bias in shelter data is proposed to be due to the use of a help-seeking population. Those who seek help are more likely to be the victims of severe violence, and therefore are unlikely to be representative of the entire victimized population, in which one would expect a range of severity. In contrast, there exists a nonrespondent bias in large surveys, such that those who are abused or are more severely abusive towards their partner would be unlikely to agree to answer questions about violence. As well, victims who are being controlled by their partner are unlikely to agree to answer such questions out of fear of their partner finding out. In the case of general surveys then, there is likely an undersampling of those who experience severe violence. Johnson proposed that the two methods of sampling were likely tapping two different types of victims of IPV. He argued that their victimization experiences represent two qualitatively different phenomena and went on to explain the ways in which the two types of IPV differed. The main distinguishing feature between Johnson's two IPV types is

either the existence or nonexistence of attempts at controlling one's partner through tactics of coercive control.

The Role of Coercive Control

Coercive control refers to a pattern of behaviours aimed at exerting power over another individual, and once the desired level of control has been achieved, displaying it (Stark, 2007). As is depicted in the power and control wheel created by Pence and Paymar (1993) as part of the Duluth Domestic Abuse Intervention Project (see Figure 1), the exertion of control is carried out through multiple means, of which physical violence is only a part.

Figure 1

Power and Control Wheel

Adapted from Pence & Paymar (1993)

For instance, coercive control often involves attempts to isolate the victim from their friends or family as a way of maintaining control, as well as limiting victims' financial resources either by not permitting the victim to work or by confiscating money the victim earns. The use of threats either against the victim or the victim's children is also a common example of coercive control. Moreover, it acts as a barrier against leaving the relationship. Emotional abuse is yet another common tactic used in asserting dominance, whereby the victim is made to feel incompetent, worthless, and as if the victim would be nothing without the abuser. The function of coercive control is to control the victim and to undermine the victim's ability to leave the relationship.

Intimate Terrorism

Johnson referred to the type of IPV that is high in coercive control as intimate terrorism (IT). IT involves a pattern of violence almost always exerted by a man against a woman and that is usually severe. However, Johnson argues that even though there are differences in the severity and gender distribution between IT and SCV, it is actually high levels of coercive control that is the main characteristic of this type of IPV. IT arises from the man's need to always be in control of his partner, and involves multiple tactics in addition to physical violence. This type of violence is relatively frequent and escalates over time. Previously, victims of IPV who experienced repeated abuse at the hands of their partner while under their partner's control were referred to as "battered women" in the literature, showing the severe and repeated nature of the victimization experience (Walker, 2000).

Two different approaches have been taken to examine this need for control as it exists in IT. One is based on a compensatory model in which attempts to control one's partner

arise when the perpetrator feels like they have lost control in some other area of their life, and they attempt to compensate for it by increasing control in a different area of their life (Stets, 1993). The other line of research focuses on individual differences in character that would make someone more likely to strive for high relationship control (Stets, 1993). Compared to women with no violent experiences in the past year, IT victims had poorer overall health, greater psychological distress and were more likely to receive government funding (Leone, Johnson, Cohan, & Lloyd, 2004).

Situational Couple Violence

The second type of IPV Johnson described was situational couple violence (SCV). This type is similar to the violence referred to by the family violence perspective that was derived from evidence from large-scale surveys. In this case, violence occurs when one partner feels they have lost control of a conflict situation and attempts to get it back. The violence does not reflect a general need to be in control of the partner; as a result, neither partner uses more general tactics of coercive control, but rather a situation-specific need for control. This type of violence is usually mild in severity and fairly infrequent. It also occurs equally between the genders and is unlikely to escalate over time.

Theory Revisions

Since his seminal 1995 paper, Johnson added two other types of IPV to his taxonomy (2000). Violent Resistance (VR) is a type of IPV that is similar to IT in that one partner is both controlling and violent, but in this case, the other partner uses violence as well, but not coercive control. The VR partner is almost always female and the violence that she perpetrates is usually seen as a self-defence reaction to the violence of her partner. The final type added by Johnson is Mutual Violent Control (MVC). MVC is a pattern of

behaviour in which both partners are controlling of each other and are both violent. This type is generally rare; it is estimated to occur in approximately 1% of cases (Johnson, 2001). Due to the low rates of these two types of IPV as well as the difficulty of measuring the VR type, the current study will focus on IT and SCV only.

Research Findings on Johnson's Typology

Since the publication of Johnson's theory delineating these two typologies, studies have begun to appear in the IPV literature testing the existence and utility of this typological distinction. Using the statistical method of cluster analysis, Johnson (1999) was able to show that relationships that involved IPV were best fit by a two-cluster solution, in which one cluster was high on measures of coercive control and the other cluster low on coercive control. This study also found that among those in the IT cluster, 97% of perpetrators were male and of those in the SCV cluster, 56% of perpetrators were male. This finding supports Johnson's assertion that IT is mainly male-perpetrated, whereas the gender balance in SCV is basically symmetrical. Additionally, in the IT group, the median number of violent incidents was 58, compared to 14 in the SCV group. Violence was also found to have escalated amongst IT couples in76% of cases, compared to 28% of the SCV couples. These findings were all in line with Johnson's theory-based predictions. Graham-Kevan and Archer (2003) set out to replicate Johnson's findings and extend them further where possible. Using two separate samples from England, one from a shelter and one consisting of university students, they also found that a two-cluster solution best fit the data, with one cluster high on control variables and the other cluster low. In their sample, 49% of couples were classified as nonviolent, 11% fell under the IT category, 6% fell into Violent Resistance, 3% Mutual Violent Control, and 28%

Situational Couple Violence (n.b.: they referred to the SCV group as Common Couple Violence). IT involved more acts of physical violence, as well as more of a likelihood of escalation. A further study of 563 low-income minority women by Leone et al. (2004) identified three clusters instead of two. One cluster involved high levels of psychological abuse and verbal threats consistent with IT, one with low levels of verbal abuse, coercion and threats consistent with SCV, and the third one was characterized by high levels of verbal abuse and coercion but not threats. A few theories were proposed to explain the existence of this third group, including methodological and population differences between this study and Graham-Kevan and Archer's (2003) study. Additional explanations posited by Leone et al. (2004) included the possibility that once the victim is under the control of their partner, threats are no longer needed and therefore cease, or that the threats of some perpetrators may be ineffective in that they are not credible, and therefore perpetrators may rely on other control tactics and not use threats, creating this third group.

A study by Macmillan and Gartner (1999) using latent structure analysis also determined that there were three types of perpetrators of IPV, two of them corresponding to SCV and one to IT. Additionally, they found that women were more likely to experience coercive control if they had been in the relationship for a shorter time, if their partner drank heavily, if their mother was abused, if their household income was low, and when they or their parents had little education. Frye, Manganello, Campbell, Walton-Moss, and Wilt (2007) found that at least one general control tactic was used by 69% of victims of physical abuse interviewed from a large telephone sample. However, only 10% experienced the combination of control tactics, violence escalation, and injury (a pattern

consistent with IT), a figure comparable to IT prevalence rates established from previous studies. Frye and colleagues (2007), identified a number of perpetrator factors that distinguished IT from SCV, including the perpetrator having been arrested for a domestic violence offense, violence escalation in the last year, having access to a firearm, partner perpetrating 10 or more assaults in the past two years, the partner being the one to initiate the worst episode in the past two years, and the occurrence of fewer injuries for the victim, as well as the perpetrator having threatened or attempted suicide and being in poor mental health. The fact that a pattern of more frequent violence but fewer injuries was found among IT was interpreted to mean that the perpetrator may learn how to control the force of the violence. The victim characteristic found to be associated with IT was lower income. Consistent with the belief that IT stems from patriarchal values in which men have the right to control women, it has been found that IT perpetrators advocate significantly more misogynistic beliefs than perpetrators of SCV, whose beliefs do not differ significantly from men who have never been violent against their partners (Holtzworth-Munroe, Rehman, & Herron, 2000).

The consequences of IPV have been found to differ between the two types as well. Leone and colleagues (2004) found that victims of IT, compared to victims of SCV, had more injuries and missed more work. Specifically, the victims of IT were 2.5 times more likely to be injured than victims of SCV, even after controlling for severity of the violence. In analyzing data from the National Violence Against Women Survey, Johnson and Leone (2005) found that victims of IT experienced more frequent and more severe violence than victims of SCV, with 99% of SCV victims having experienced no violence in the past 12 months, compared to 78% of IT victims. Another difference was that IT

victims reported significantly more symptoms of PTSD than did victims of SCV. In terms of depression, victims of both SCV and IT scored higher on depression than those who had experienced no violence, but they were not significantly different from each other. Victims of IT were also more likely to use painkillers than SCV victims, even when controlling for severity of violence. The finding that both minor and severe injuries were more likely to occur among IT than SCV victims has been replicated (Graham-Kevan & Archer, 2003).

Anderson (2008) set out to determine whether using Johnson's typology was a better predictor of negative outcomes from IPV than a measure of violence severity. Violence severity proved to be a slightly more effective predictor of injury from violence than typology. However, typology was a slightly better predictor of PTSD symptoms than severity, though both were significant independent predictors of PTSD. When considering depression, Anderson's results suggested that violence severity and typology were equally effective in explaining depression. Specifically, as the amount of control placed on the victim increased, violence severity did not impact rates of depression. This was found to be due to a ceiling effect in that victims of IT already displayed such high rates of depression that the existence of violence was irrelevant. These findings imply that a high level of control (as is indicative of IT) is associated with negative health outcomes, even when physical violence is not present. The findings suggests that another group of victims may exist—one that experiences coercive control, but no physical violence, and who may be suffering the same negative consequence of IPV as the other groups (Stark, 2007).

While most of the research has supported Johnson's typology, it has not gone without some criticism. Dutton (2006) argues that while the IT group may exist, it is very small (around 3% of the population). Despite his acknowledgement that the IT exists (albeit in small numbers), he still refers to Johnson's typology as "Johnson's false dichotomy of patriarchical terrorism vs. common couple violence" (Dutton, p. 124). Dutton also cites the work of Laroche (1999), who examined data that not only looked at rates of violence inflicted by men against women, but the opposite as well. Following his analysis, Laroche concluded that there was a group of matriarchal terrorists who represent about 4% of the population and who displayed the same pattern of coercive control against their male partners—a group who has gone unstudied.

Alternate Typologies

Johnson's IT/SCV distinction is not the first IPV typology that has been theorized. Holtzworth-Munroe and Stuart (1994) described three types of IPV perpetrators. One of these types was labelled as family-only. The violence perpetrated by this type of batterer is fairly mild and does not usually involve psychological or sexual abuse. Johnson draws parallels between the family-only batterer and the SCV perpetrator, suggesting that they represent the same phenomenon (Johnson & Ferraro, 2000). He believes that the other two types, "generally-violent-antisocial", in which the perpetrator is sociopathic and whose violence is not contained to the family unit, and the "dysphoric-borderline" type in which the batterer uses violence exclusively against their partner because they are fearful of losing them, are both forms of IT. An "abusive personality" has been proposed that seems to be in line with the characteristics of intimate terrorists (Dutton, 1998). These individuals display outbursts of anger, a tendency to project blame onto their partners,

and generally only direct their rage toward their partners. There are high rates of personality disorders amongst them, particularly borderline personality disorder (Dutton, 1994). Not surprisingly, there has been a lot of evidence indicating that male perpetrators of IPV have more anger than nonperpetrators (Dutton, 1995; Maiuro, Cahn, & Vitaliano, 1986).

Self-Blame

Attributions and Learned Helplessness

A number of theories have arisen to explain what happens between an experience of victimization and the emergence of psychopathology. One such theory has focused on attributions that individuals make for why an event occurs. Attribution style is a cross-context disposition to explain events in a certain way. Attribution style has been found to be a valid construct at the moderate or general level, to be consistent across contexts, and to have shown adequate divergent and convergent validity (Anderson, Jennings, & Arnoult, 1988). One main aspect of the process of forming attributions is determining causality, or whether one's own or another's behaviours led to a certain outcome. According to Forsterling (1992), the reactions that individuals have following events are governed largely by the causes that individuals attribute to the event. The exploration of causality began to take off with the work of Rotter (1966), who proposed causality as one-dimensional, either internal to the individual or external. He labelled this dimension "locus of control". Weiner (1974) proposed a second dimension, that of stability. Here, outcomes could be either stable or unstable, in that they may be specific to one time point, or likely to continue into the future. Later, Weiner added a third dimension of causality, controllability (Weiner, 1979). Abramson, Seligman, and Teasdale (1978)

proposed that instead of a third dimension of controllability, globality was more suitable. This dimension ranged from global to specific, a global attribution being made if the individual believes that the cause of negative events is consistent across different contexts.

Studies using animals have shown that when exposed to a negative stimulus, animals initially do everything that they can to avoid the negative outcome. After some time of trying to escape the stimulus and failing to do so, the animals eventually give up and stop trying, even when a way to prevent the negative outcome appears (Maier & Seligman, 1976). Based on this repeated observation, it was concluded that once an animal learns that something is uncontrollable, it stops trying to change it. The learned helplessness theory proposes that the perceived uncontrollability of a negative outcome gives rise to feelings of depression (Seligman, 1975). The reformulated learned helplessness theory expands on the previous theory, adding that depression arises when a negative outcome is determined to be caused by internal (caused by the individual), stable (consistent across time), and global (consistent across contexts) factors (Abramson et al., 1978). The link between learned helplessness and negative affect has been repeatedly demonstrated in humans (Frazier & Schauben, 1994; Greening, Stoppelbein, & Doctor, 2002; Griffith, 1977; Roth & Kubal, 1975). It has even been shown that feelings of powerlessness are a stronger predictor of depression than physical violence (Campbell, Sullivan, & Davidson, 1995). Additionally, a study by Filson, Ulloa, Runfola, and Hokoda (2010) found that powerlessness mediated the relationship between IPV and depression, providing additional support for the learned helplessness model.

Since victims of IPV, particularly those who would be described as victims of IT often experience repeated, uncontrollable incidents of abuse, learned helplessness could help explain high rates of depression among this population (Walker, 2000). The repeated instances of violence experienced by these victims may lead them to believe that they are powerless to stop the violence, and therefore they may stop trying. In a sample of battered women, a learned helplessness attribution style was predictive of depression and PTSD symptoms in that victims with a learned helplessness attribution style exhibited more severe symptoms of both depression and PTSD than those without this attribution style (Palker-Corell & Marcus, 2004). However, in a comparison between battered women and those without a history of IPV, no differences were found in attribution style. That is to say that women who were victims of IPV did not display more learned helplessness attributions than nonvictims. Launius and Lindquist (1988) showed that battered women were less likely to persist in a problem-solving task, which they took as an indicator of learned helplessness in the women. They did not, however, find differences in locus of control between battered and nonbattered women. Overall, there has been consistent support for learned helplessness predicting psychopathology, but very little empirical support for a learned helplessness attribution style among battered women.

Definition of Self-Blame

This lack of expected findings has led some researchers to believe that perhaps causality is not the most important construct that should be studied, choosing instead to focus on attributions of blame. Causality, responsibility, and blame have often been confused in the literature. Responsibility, in addition to a causal link, requires a determination of accountability that often involves a moral judgement. For example, in

the case of someone underage who commits a crime, the parents may not have caused the crime to happen, but they are nonetheless considered accountable or responsible for the actions of their child. Once someone is deemed to be at least partly responsible for an outcome, then it can be determined whether they are also to blame. According to Shaver (1985), attributions of causality presuppose attributions of responsibility, which presuppose attributions of blame. Firstly, a person must be determined to be either the only cause or one of multiple causes of an event. The event can be either an act that produces a negative event or an act that prevents a positive event from occurring. If a person is found to have played a causal role, then there are four dimensions in addition to causality that are used to determine if they are responsible as well. The first of these dimensions is coercion. This asks the question of whether the individual was forced to cause the event due to a situation that they could not control. An example of this would be someone who commits a crime while they are held up at gun-point. If coercion appears to be the sole reason an act was committed, that person would not be deemed responsible. The second dimension is whether the individual had knowledge of the action they were doing. Awareness that an individual did not know what they were doing is not always sufficient to remove responsibility from that person. If the knowledge that is missing is considered something that the individual should have known, then an attribution of responsibility can still be made. The third dimension is intentionality. This refers to whether the outcome produced by the individual's actions was what the individual intended by their action. The final dimension is the appreciation of the moral implications of their actions. This is different from the knowledge dimension in that it

does not involve a judgement of whether the action would produce a certain outcome, but instead hinges on whether the individual is aware that that outcome is not morally correct.

Once it is determined that an individual is responsible, the assessment of whether they are to blame is simpler. A person would be determined to be to blame so long as there are no sufficient justifications or excuses for their behaviour or its outcome. One of the main features that distinguish blame from causality is its effect on emotions. An attribution of causality is not sufficient to alter affect, whereas blame does give rise to an affective response (Wollert & Rowley, 1987). Common affective responses include shame and guilt (McGee, Wolfe, & Olson, 2001; Shaver & Drown, 1986). Shame has been conceptualized as an emotion that comes from the perception of being inadequate that is global in nature, and that derives from one's self-evaluation as one who transgressed morally (Blum, 2008). In contrast, guilt involves feelings of remorse that are not global, but instead are an emotional reaction to a specific behaviour or transgression (Blum, 2008). Shame-proneness has been found to correlate with a learned helplessness attribution style (Tangney, Wagner, & Gramzow, 1992).

Some studies have attempted to determine how common it is for victims to blame themselves for the victimization experience. McGee et al. (2001) found that victims rarely considered themselves to be mainly responsible or to blame for their victimization. It should be noted that this study actually assessed responsibility and self-blame together. In another study, Cascardi and O'Leary (1992) found that only 12% of women recruited from a domestic violence shelter reported blaming themselves. In contrast, using a community sample, Andrews and Brewin (1990) found that 53% reported blaming themselves. The methodological differences such as the different types of samples and

definitions of self-blame could account for the large range in the prevalence of self-blame across studies.

Self-Blame amongst Homeless Victims of IPV

A search of the literature revealed only one study that examined self-blame attributions amongst victims of IPV who were homeless. Tucker, Wenzel, Straus, Ryan, and Golinelli (2005) conducted structured interviews on history of IPV victimization with 172 female victims of IPV, some of whom were living in a homeless shelter and some of whom were living in low-cost housing. The authors also conducted more in-depth interviews on participants' most violent incidents with a subset of 41 of the victims. During the initial structured interview, the majority of victims recruited from both settings (i.e., homeless shelters and low-cost housing) attributed blame first to the perpetrator, then to themselves, and lastly to their living environment. Consensus between the two groups was not, however, replicated during the in-depth interviews. Whereas women living in low-cost housing attributed blame solely to the perpetrator 65% of the time, to both themselves and the perpetrator 20% of the time, and to themselves 0% of the time, 57% of the women living in shelters attributed blame solely to themselves, 19% attributed blame solely to the perpetrator, and 14% attributed blame to both themselves and to the perpetrator. Two main reasons shelter victims gave for blaming themselves was that they had remained in the relationships and that they had used substances. Given that only one study has examined self-blame amongst homeless victims of IPV in the literature to date, additional research is needed on this topic.

Consequences of Self-Blame

Within the victimization research, emphasis has been placed on the consequences of blaming oneself as opposed to blaming the perpetrator for the victimization. One study that compared self-blame attributions across types of maltreatment found that among victims of neglect 18% of the variance in internalizing disorders (such as depression) was accounted for by blame attributions, amongst victims of family violence 25% of the variance in internalizing disorders was accounted for, and among victims of sexual abuse 46% of the variance in internalizing disorders was explained (McGee et al., 2001).

The learned helplessness model argues that blaming oneself (which is an off-shoot of attributing causality to the self) would result in negative outcomes. The idea of high self-blame being predictive of psychological distress has been shown in a number of studies. One study found that self-blame attributions following childhood sexual abuse mediated the relationship between the victimization and symptoms of internalizing disorders in that self-blame was predictive of negative outcomes (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996). These results were replicated while controlling for factors such as age, gender, and characteristics of the sexual abuse experience (Feiring, Taska, & Lewis, 1998). Another study found that victims of childhood sexual abuse who blamed themselves had the most symptoms of psychopathology followed by victims who blamed fate, and lastly by those who blamed the perpetrator (Feinauer & Stuart, 1996). However, Cascardi and O'Leary (1992) did not find an association between self-blame and depression when domestic violence victims were asked about aggressive incidents that occurred in the beginning of their relationship. Self-blame for violent incidents in general, though, was nearly significant in the prediction of depressive symptoms. Cascardi and O'Leary hypothesized that this might have been because women who blame

themselves in general may have a more stable self-blaming attribution style which would be more likely to result in psychological distress.

In contrast to the expectation of learned helplessness theory, others have argued that blaming oneself should serve an adaptive function based on the implications for controllability of one's future behaviours. If a negative event is deemed to be caused by something over which one has control (such as one's own actions), it is possible that it could be prevented in the future. In contrast, if one does not feel like they have any control over the situation, it may seem inevitable that it will happen again. A number of studies have demonstrated positive outcomes as being associated with self-blame (Bulman & Wortman, 1977; Koss, Figueredo & Prince, 2002). These studies support the idea of self-blame as being related to future controllability, and in turn, being adaptive.

A review of the literature examining attributions of causality following a broad range of negative events, of which IPV was not included, found that amongst 76% of the studies they reviewed, no association was found between causal attributions and psychological distress markers (Hall, French, & Marteau, 2003). Twenty-one percent of the studies found that naming oneself as the cause resulted in poor outcomes (Hall et al., 2003). Those who expressed self-blame in general were 5.2 times more likely to have a poor outcome. It was proposed that the large variation in findings in the studies included in the review was due to factors such as low power, outcome measure used, and the method used to elicit the attributions (Hall et al., 2003).

Characterological vs. Behavioural Self-Blame

The conflicting findings in the literature about the effect of self-blame on psychological health have led to attempts to reconcile the two theories. Both the learned

helplessness model and the model that sees self-blame as an adaptive process are centered around the notion of control, although they come at it from two different perspectives. The learned helplessness model argues that self-blame is maladaptive in that one cannot change who one is, and that individuals therefore come to believe that negative events will likely repeat. According to this model, victims of repeated abuse perceive that they have no control over their victimization experiences, and therefore believe that the violence is bound to repeat. In contrast, the model that argues that blaming oneself is adaptive in that if one considers oneself to be the cause of previous abuse, one can always change one's future behaviours to prevent future negative events; thus a sense of control is indeed present and comforting. In light of these conflicting, yet seemingly logical hypotheses, Janoff-Bulman (1979) proposed that dichotomizing self-blame into two constructs rather than one might account for the discrepancy in theories and findings. Janoff-Bulman proposes that self-blame can be either characterological or behavioural in nature. She hypothesized that blaming one's character would result in psychological distress because one's character is not easily changeable. Therefore, characterological self-blame would be associated with lack of controllability and be maladaptive. Beliefs about characterological self-blame are related to one's self-esteem. People who see some deficit in their character large enough to attribute a negative event to it will likely also have low self-esteem. In their study of 33 women seeking assistance from a domestic violence organization, Cascardi and O'Leary (1992) did indeed find that women who tended to blame themselves for the violence in their relationships also tended to rate themselves as lower in self-esteem. Hence, characterological self-blame can be seen as a context-specific manifestation of low self-esteem. In contrast, according to this line of

reasoning, behavioural self-blame would be adaptive, as one's behaviours are readily controllable. From this perspective, future negative events would be seen as avoidable. Behavioural self-blame would thus reflect an internal, yet unstable attribution, and would therefore be adaptive for victims of negative events (Anderson, Miller, Riger, Dill, & Sedikides, 1994).

The existence of two subsets of self-blame has been supported by the findings of a factor analyses. A study by Breitenbacher (2006) found that blame amongst victims of sexual assault was best subdivided into five factors: perpetrator blame, character self-blame, situational factors or chance, behavioural self-blame, and societal blame. The emergence of both the characterological and behavioural self-blame factors supports Janoff-Bulman's distinction.

Many of the previous conflicting findings have been reinvestigated in light of the theoretical distinction between characterological and behavioural self-blame, particularly the role that each has in predicting negative outcomes (such as psychological distress) following a negative experience. A recent study that examined experiences of sexual victimization found that characterological self-blame was the only variable that could significantly predict psychological distress (Breitenbacher, 2006). In Breitenbacher's study, characterological self-blame was moderately correlated with behavioural self-blame (r = .43), and characterological self-blame increased as violence frequency increased. Using a sample of battered women, O'Neill and Kerig (2000) found that characterological self-blame was correlated with depression, interpersonal sensitivity, and obsessive-compulsivity. Perceived control was negatively related to those same outcomes. The relation between violence and psychopathology was also mediated by

characterological self-blame. These findings support the hypothesis that characterological self-blame is predictive of psychological distress. These authors also found that there were significant differences in self-blame attributions among women who were still in the abusive relationship and those that no longer were, with those still in the relationship having higher self-blame. This indicates that whether the woman is still in a relationship is a factor that must be taken into consideration in future studies (O'Neill & Kerig, 2000).

Despite the support that the link between characterological self-blame and psychological distress has received, not every study has replicated these findings. Cascardi and O'Leary (1992) did not find any difference in depressive symptoms as a result of characterological or behavioural self-blame. A literature review, however, found that a victim who blamed their own character was 7.2 times more likely to experience a poorer outcome (Hall et al., 2003). Based on their review and the findings from the majority of the studies on characterological self-blame, the authors concluded that "there can be little doubt that characterological self-blame is associated with poorer outcomes" (Hall et al., p. 527).

In contrast to the consistent findings on the negative consequences of characterological self-blame, research on behavioural self-blame has produced less consistent results. Some research has shown that behavioural self-blame has been associated with either positive outcomes, or at least less negative outcomes. A study by Anderson et al. (1994) of 680 students from a large mid-western university, for instance, found that a general attributional tendency to blame one's behaviour was associated with lower rates of depression and loneliness. Similarly, a study that investigated individuals who had received a diagnosis of a life-threatening illness found behavioural self-blame to

be adaptive (Turnquist, Harvey, & Andersen, 1988). Such findings are consistent with the theoretical rational that behavioural self-blame for specific events would be associated with better adjustment. However, the majority of research actually shows the opposite. O'Neill and Kerig (2000) found that behavioural self-blame, like characterological self blame, correlated positively with depression, interpersonal sensitivity, and obsessive-compulsivity among a sample of IPV victims. In this same study, behavioural self-blame also mediated the relation between violence and psychopathology. O'Neill and Kerig hypothesized that the reason behavioural self-blame was not adaptive in this sample was that perhaps the distinction between the two types of blame is not made by these women, or that the repeated nature of the violence may differentiate this population from women who are victims of crimes that usually involve only one incident, such as rape. Janoff-Bulman (1979) argued that findings for behavioural self-blame may not be as strong as for characterological self-blame because while it is possible to blame one's behaviour and not view it as a reflection on one's character, it is far more difficult to blame one's character without seeing one's behaviours as an offshoot of that. Therefore the negative associations of blaming one's character may dilute the benefits of blaming one's behaviours. A review by Hall et al. (2003) found only five studies that showed a negative relation between behavioural self-blame and psychological distress. Of the five, only one found the relation to be mediated by future controllability (Winkel, Denkers, & Vrij, 1994). Overall, based on their review, Hall and colleagues (2003) did not find any significant association between behavioural self-blame and outcome. These authors argue that inconsistent findings may be the result of definitional problems involving the concepts of blame, responsibility, and causality.

Purpose of the Current Study

The current study was the first to examine self-blame attributions while taking into account Johnson's typology of IPV. As such, its main goal was to bring some clarity to the mixed findings in the research on self-blame and its association with depression and PTSD. The present study was also the first to investigate the role of coercive control in the IPV experiences of homeless women. It asked victims of IPV currently residing in a homeless women shelter to answer questions about the amount of coercive control in their relationship, both characterological and behavioural self blame attributions regarding their IPV experiences, and symptoms of depression and PTSD. Differences in self-blame attributions were examined between women in the intimate terrorist (IT) group and women in the situational couple violence (SCV) group. Additionally, two regression models were tested to predict PTSD and depression from IPV type and self-blame. A number of variables that were previously identified in the literature to be associated with IPV outcomes, and could therefore confound the analyses, were controlled for. These variables included childhood maltreatment and income (please refer to *Homelessness and Victimization* section for theoretical rationale). The specific research questions that will be addressed include the following:

a) Will the breakdown of homeless victims of IPV who experience IT compared to SCV be similar to the breakdown found in studies of the general population or domestic violence shelters?
b) Will there be differences in the amount of characterological self-blame reported by victims of IT and SCV?

c) Will there be differences in the amount of characterological self-blame reported by victims of IT and SCV?

d) Which combination of IPV typology and self-blame attributions will best be able to predict ratings of posttraumatic stress disorder (PTSD)?

e) Which combination of IPV typology and self-blame attributions will best be able to predict ratings of depression?

Hypotheses

Based on the literature review presented above, the following hypotheses were tested to better understand the relation between IPV typology, self-blame, depression, and PTSD. No hypothesis was proposed about whether rates of IT versus SCV among homeless victims of IPV were comparable to rates among women in the general population or those seen in a domestic violence shelter as this research question is exploratory given that there is no previous research on which to base such a prediction.

Hypothesis 1

Because two of the persistent means of attaining coercive control are telling the victim that they are responsible for the abuse and emotional abuse tactics such as making her think she is a bad person, it is hypothesized that women who are victims of IT will display more characterological self-blame compared to victims of SCV (Pence & Paymer, 1993).

Hypothesis 2

Because SCV is context specific, it is hypothesized that women who are victims of SCV will display more behavioural self-blame compared to victims of IT (Johnson, 1995).

Hypothesis 3

The combination of self-blame attributions (both characterological and behavioural) and IPV typology will significantly predict depression. Specifically, there will be an interaction such that victims of IT with high levels of characterological self-blame and behavioural self-blame will experience the most symptoms of PTSD.

Hypothesis 4

It is also expected that the combination of self-blame attributions (both characterological and behavioural) and IPV typology will significantly predict depression. Specifically, victims of IT with high levels of characterological self-blame and behavioural self-blame will experience the highest levels of symptoms of depression.

CHAPTER II

Method

Participants

Twenty-four women temporarily residing at an agency that provides short-term shelter for homeless women in Windsor, Ontario participated in this study. Participants ranged in age from 19-58 with a mean age of 36.95 (*SD* = 11.02) years. The majority of the sample was Caucasian (67%) and heterosexual (71%). The women most often reported having less than a high school education (46%) as well as an annual income below $9,999 (50%). With one exception, the rest of the women (46%) reported an annual income of $10,000-$19,999.

Of the 24 participants, only two had symptoms of depression in the minimal range (as evidenced by Beck Depression Inventory-II scores below 14), four had symptoms in the mild range, and two had symptoms in the moderate range. The remaining 16 women (75%) fell above the clinical cut-off for severe depression (Beck, 1996). All but three of the participants met criteria for a PTSD diagnosis according to the criteria set forth by Weathers, Litz, Herman, Huska, and Keane (1993).

Participants were asked to report on the most recent relationship in which a partner was verbally or physically abusive toward them. The majority of the women were no longer in that relationship (92%). The average relationship duration was six years and three months. The majority of the participants had been cohabitating with but had not married the aggressive partners (54%). Participants most frequently reported that the violence occurred three times per week (33%), followed by every day (21%). The majority of participants reported having had at least one other previous dating

relationship that involved physical abuse (63%), as well as at least one relationship that involved psychological abuse (88%). Most of the participants had previously sought services from a domestic violence agency (58%) and a mental health agency (58%). As well, the majority of participants reported currently taking medication for a psychiatric problem (54%). Table 1 contains a detailed breakdown of the sample characteristics as indicated on the demographics questionnaire.

Table 1

Demographic Information

Variable	Number	%
Ethnicity (*N* = 24)		
African American	2	8.3
Aboriginal	1	4.2
Caucasian	16	66.7
Other	5	20.8
Religion (*N* = 24)		
Protestant Christian	6	25.0
Roman Catholic	4	16.7
Evangelical Christian	1	4.2
Jewish	2	8.3
Muslim	1	4.2
Other	10	41.7
Sexual Orientation (*N* = 24)		
Heterosexual	17	70.8
Bisexual	5	20.8
Other	2	8.3
Family Income (*N* = 24)		
Under $9,999	12	50.0
$10,000 to $19,999	11	45.8
$30,000 to $39,999	1	4.2
Education Level (*N* = 24)		
Less than high school	11	45.8
High school graduate	4	16.7
College	5	20.8
Bachelor's degree	2	8.3
PhD.	1	4.2
Other	1	4.2
Relationship Status (*N* = 24)		
Current	2	8.3
Past	22	91.7
Relationship Length (*N* = 22)		
Less than 1 year	6	27.3
One to five years	10	46.0
Six or more years	6	27.3

(continued)

Variable	Number	%
Status During Relationship (*N* = 23)		
Married	6	25.0
Cohabitating	13	54.2
Neither	4	16.7
Time Between First and Last Violent Incident (*N* = 23)		
Less than a month	4	16.7
1-3 months	4	16.7
3-6 months	5	20.8
6-12 months	2	8.3
More than a year	8	33.3
Frequency of Violence (*N* = 24)		
Every day	5	20.8
Three times per week	8	33.3
Once per week	3	12.5
One to two times per month	3	12.5
Once every three months	2	8.3
Once every six months	2	8.3
Once per year	1	4.2
Attempt to End Relationship (*N* = 24)		
Once	3	12.5
Two to four times	7	29.2
Five or more times	10	41.7
Never	4	16.7
Previous Physical IPV (*N* = 24)		
Yes	15	62.5
No	9	37.5
Previous Psychological IPV (*N* = 24)		
Yes	21	87.5
No	3	12.5
Received Services from Domestic Violence Shelter (*N* = 24)		
Yes	14	58.3
No	10	41.7
Received Psychological Services (*N* = 24)		
Yes	14	58.3
No	10	41.7
Currently on Medication (*N* = 24)		
Yes	13	54.2
No	11	45.8

Participant Recruitment

Participant recruitment occurred at a short-term shelter (with a maximum length of stay of two weeks) for homeless women. The shelter houses up to eleven women at a time. Its primary focus is on providing temporary shelter rather than therapeutic intervention. Residents are aided in locating a place to live following discharge.

Recruitment occurred weekly during the house meeting that is mandatory for all residents of the recruitment site. At the end of each meeting, a brief description of the study was given, and the women were told to approach project staff after the meeting if they had any questions about the study or if they were interested in participating. There were two criteria for inclusion in the study: having been a victim of at least one act of IPV (physical or psychological) in their lifetime, and being over the age of 18. In exchange for their participation, the women received a $5 gift card to Tim Hortons (a large coffee shop chain). Due to privacy issues, data were not collected on the number of women who attended the house meetings (and were therefore aware of the study), nor the percentage of the women attending the meetings who met the inclusion criteria but opted not to participate.

Measures

Basic demographics (Appendix A). The demographic questionnaire consisted of 19 questions and inquired about participants' age, highest level of education attained, ethnic identity, sexual orientation, religion, and yearly income. Additionally, the women were asked a number of questions about their last physically or psychologically abusive relationship, such as its length, the frequency of violence, and whether they had ever attempted to end the relationship. Participants were also asked whether they were

currently taking medication for a mental illness and whether they had sought psychological help or help from an organization for domestic violence.

Physical aggression. The Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to collect information on the frequency of IPV within respondents' dating or marital relationships. The scale asks about experiences of victimization as well as perpetration. Respondents rated on a scale of 0 (*never*) - 6 (*more than 20 times*) how many times the event occurred in the past year. The CTS2 consists of five subscales, corresponding to Injury (6 items; e.g., "Had a broken bone from a fight with a partner"), Psychological Aggression (8 items; e.g., "Insulted or swore at my partner"), Sexual Coercion (7 items; e.g., "Used threats to make my partner have sex"), Physical Assault (12 items; e.g., "Choked my partner"), and Negotiation (6 items; e.g., "Suggested a compromise to a disagreement"). The scores on the Physical Assault and Injury scales were summed and were used as measures of physical violence frequency and IPV severity, respectively. The internal consistency of the physical assault subscale has been reported to be .86 in past studies (Straus et al., 1996). This scale has also demonstrated convergent and divergent validity (Straus et al., 1996). In the current sample, the internal consistency ratings for the physical assault and injury subscales were .93 and .87, respectively.

Childhood Maltreatment. The Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994) is a 28-item self-report measure of experiences of abuse and neglect in childhood. Each item on the measure describes an event that could have occurred during childhood, and the participant must rate on a scale of 0 (*never true*) to 5 (*very often true*) whether the event had occurred in their childhood. An example of an item on this

questionnaire is “people in my family didn’t seem to know or care what I was doing”. The CTQ contains five subscales: emotional abuse, physical abuse, sexual abuse, physical neglect, and emotional neglect. The scores given for each item were added together to form an overall rating of the frequency of childhood maltreatment experiences. This scale has been shown to have acceptable reliability, with alpha coefficients for each subscale ranging from .70-.93 among a sample of Canadian students (Paivio & Cramer, 2004). Test-retest reliabilities ranged from .66-.94 in the same sample. According to Paivio (2001), the CTQ demonstrated good convergent validity with measures of post-trauma distress. In this study, the CTQ had acceptable reliability, with an alpha coefficient of .82.

Coercive Control. The Revised Controlling Behaviours Scale (CBS-R; Graham-Kevan & Archer, 2005) was used to measure coercive control tactics. This rating scale consists of 24 nonphysical behaviours often used to obtain control over one’s partner. Five additional items apply only to respondents who have children. On a scale of 0 (*never*) to 4 (*always*), the respondent first rates how often they acted that way toward their partner in the past year (i.e., perpetration), then rates how often their partner acted that way towards them in the past year (i.e., victimization). This scale can be used to obtain a total coercive control score or it can be divided into five subscales, corresponding to economic abuse, coercion and threats, intimidation, emotional abuse, and isolation. Internal consistency for the total scale was found to be .87 amongst a sample of undergraduate students (Graham-Kevan & Archer, 2005). In order to conserve power, in the current study only the total score of the items assessing victimization were summed to obtain a total coercive control score. The five items that apply only to

respondents who have children were not included in the total score to avoid artificially inflating the scores of respondents with children compared to those without. Internal consistency for the total scale was .88 in the current sample. Although the CBS-R provides a continuous score of controlling behaviour, per Johnson's (2008) recommendation, scores were dichotomized to establish typology membership into intimate terrorism versus situational couple violence.

Self-Blame. The Behavioural and Characterological Self-Blame Scale is a 12-item scale that measures characterological and behavioural self-blame for IPV victimization (O'Neill & Kerig, 2000). Each item states a possible source of blame for the victimization and the respondent rated on a scale of 1 (*strongly disagree*) to 6 (*strongly agree*) how much they blamed the violence on that reason. Each item corresponds to either characterological self-blame (i.e., "The abuse happened because of the kind of person I am") or behavioural self-blame (i.e., "My partner abused me because of something I did"), with six items to assess each. Scores for the items that correspond to each type of self-blame were summed independently to attain an overall characterological self-blame score and an overall behavioural self-blame score. Internal consistency for the characterological self-blame scale has been found to be .78, and internal consistency for the behavioural self-blame scale has been found to be .71 (O'Neill & Kerig, 2000). In the current sample, though, internal consistency for characterological self-blame was .67, and behavioural self-blame was .55.

Posttraumatic Stress Disorder (Appendix B). The PTSD Checklist, Civilian Version (PCL-C) created by Weathers et al. (1993) of the National Centre for PTSD consists of 17 self-report questions pertaining to the diagnostic criteria for PTSD as

outlined in the fourth edition of the *Diagnostic and Statistical Manual* (*DSM-IV*; American Psychiatric Association, 1994). It is available in the public domain. Each item represents a common symptom of PTSD and respondents rate on a scale ranging from 1 (*not at all*) to 5 (*extremely*) how much they have been bothered by that symptom in the past month. Scores for each item were summed to determine an overall score of PTSD severity, ranging from 17-85. This scale does not require that the respondent refer to a single event when responding, but can refer to a series of traumatic events, as is likely relevant to victims of IPV. This measure is used often in trauma research, as it correlates highly with other commonly-used PTSD measures and diverges appropriately from measures of other disorders, such as depression (Briere, 2004). The civilian version of this scale that has respondents answer with one specific event in mind (PCL-S) has shown internal consistency of .94 among a sample of sexual assault victims and victims of motor vehicle accidents (Blanchard, Jones-Alexander, Buckley & Forneris, 1996). Using a sample of respondents who experienced diverse traumatic events, the measure showed an internal consistency of .86 and test-restest reliability of .80 (Ventureyra, Yao, Cottraux, Note, & De May-Guillard, 2002). Finally, using a sample of undergraduate students reporting a variety of traumatic experiences, Ruggiero, Del Ben, Scotti and Rabalais (2003) reported an alpha of .94 and test-retest reliability of .92 for immediate retests, .88 one week later, and .68 two weeks later. Internal consistency for the current sample was .92.

Depression. The Beck Depression Inventory-II (BDI-II; Beck, 1996), a self-report measure of depressive symptoms, is the most commonly used measure in studies of depression (Beck, Rush, Shaw, & Emery, 1979). It consists of 21 items, each making

reference to a symptom of depression with the respondent required to choose among four statements for each item that best fits their experience. Scores were summed across all items, with higher scores applied to statements that reflect greater symptom severity. Two of the items contain seven options; thus total scores range from 0 - 63. The BDI–II exhibits an internal consistency of .92 among outpatients and .93 among university students and a one-week test-retest correlation of .92 (Beck & Steer, 1984). A study examining depression among victims of IPV found the BDI-II to have an internal consistency of .94 (Palker-Corell & Marcus, 2004). In the present sample, the internal consistency was .91.

Procedure

Once participants expressed interest in participating, they were taken to a separate room and were given the letter of information (Appendix C) that detailed all of the potential risks and benefits of participating in the study, as well as information about the confidential manner with which their data would be treated. The researcher reviewed the letter orally while participants followed along. Once the participants indicated that they were still interested in participating, they were given the packet of measures and were told where they could find the researcher if they had any questions. The women were then left alone in the room to complete the measures while the researcher waited outside. Two women who participated in the study did not consider themselves literate enough to complete the survey; therefore, the researcher read aloud each of the items on the questionnaire.

The basic demographics questionnaire was always administered first and then the remaining questionnaires were presented in a counterbalanced order to control for order

effects. The questionnaires that were completed were the Revised Conflict Tactics Scale (Straus et al., 1996), the Childhood Trauma Questionnaire (Bernstein et al., 1994), the Revised Controlling Behaviours Scale (Graham-Kevan & Archer, 2005), the Behavioural and Characterological Self-Blame Scale (O'Neill & Kerig, 2000), The PTSD Checklist, Civilian Version (Weathers et al., 1993), and the Beck Depression Inventory-II (Beck, 1996). As a final exercise, participants were asked to think of a recent situation that made them feel good, and to write about it (Appendix D). This was done to reduce any negative affect that may have arisen from answering the previous questionnaires. Once the questionnaires were completed, participants handed their questionnaires back to the researcher who placed them in a sealed envelope. The participant then received their gift card, and the researcher reviewed the debriefing form (Appendix E) which explained the purpose of the study and provided participants with a list of community centers that offer a variety of forms of supportive help (Appendix F). The researcher also checked in emotionally with participants to ensure that the women were not experiencing any emotional distress from having completed the questionnaires.

CHAPTER III

Results

Preliminary Analyses

Data Integrity/Missing Data

I used SPSS 19.0 to conduct all analyses. I examined the ranges for each variable to ensure that all entered values were possible. Three percent of data was found to be missing. A missing value analysis was run on the dataset to determine whether data were missing at random. Little's MCAR test was significant, $\chi^2(3859) = 32322.17$, $p < .001$, indicating that data were not missing at random (NMAR). According to Tabachnick and Fidell (2007), if data that are NMAR are not handled appropriately, generalizability of the results obtained would likely be compromised. Due to the small sample size, deletion of cases due to missing data was not a viable option. Because multiple imputation makes no assumptions about whether data are missing randomly and because it is currently considered the best method of handling missing data, multiple imputation was selected as the most appropriate method of replacing missing values (Tabachnick & Fidell, 2007).

According to Tabachnick and Fidell (2007), multiple imputation is a multi-step procedure that derives a regression equation for estimating the missing values. Then, the distribution of the variable with missing data is estimated using a subsample of cases with no data missing on that variable. Next, based on that distribution, random samples are taken from the dataset to estimate new values to replace the missing values. More than one new dataset is then created with values for previously missing data points imputed, depending on the number of imputations specified. According to Rubin (1996), it is typically not useful to use more than five imputations; therefore, five imputations were

used. Because the five datasets must be analyzed separately, SPSS combines certain parameters (such as *t* values and means) into one pooled result. There are certain parameters that SPSS does not have the capability to combine; therefore, for those parameters (such as standard deviations and *F* values), ranges of parameters across imputations were reported.

Outliers

To determine whether outliers were present, each residual was converted to a standardized residual with a mean of 0 and a standard deviation of 1. Only one problematic standardized residual was found. Nevertheless, further analysis revealed that it was not an influential outlier (i.e., it did not exceed cut-offs associated with Cook's distance, Mahalanobis distance, or leverage values). Finally, inclusion or removal of the potential outlier did not affect the model parameters. As such, the case was included in all analyses.

Assumptions of Multiple Regression

Data were also checked for the assumptions of normally distributed errors and homoscedasticity. Scatterplots of standardized residuals versus predicted values did not have any systematic pattern or clustering, demonstrating that the errors were normally distributed. Additionally, residuals appeared to be constant at each level of the predictors, indicating that the assumption of homoscedasticity was met. The scatterplot of the residuals also appeared to be rectangular rather than curved, indicating that the assumption of linearity was also met. Further evidence of linearity was seen by the histogram of standardized residuals which followed the normal curve, and the normal probability plot of the data followed a straight line. Multicollinearity was not an issue in

the data given that none of the variables correlated above 0.8. Finally, the error terms were found to be independent as indicated by Durbin-Watson values which fell within the range of 1-3. Based on the assumptions above having been met, it can be assumed that the results of this study are accurate for this sample and generalizable to the population of interest.

Cluster Analysis

In order to determine whether participants belonged in the intimate terrorism or situational couple violence groups according to Johnson's (1995) typology of IPV, the continuous measure of coercive control (The Revised Controlling Behaviours Scale) needed to be dichotomized, as no specific cut-point has yet been established to optimally distinguish between the two types. This study used a k-means cluster analysis with a two-cluster solution to determine how best to dichotomize the groups. The cut-off point chosen was the score that provided the best fit between the cluster solution and the scale. Participants were then coded to reflect the group to which they belonged. For the two cases in which a participant was classified into a different group depending on the imputation dataset used, participants were classified into the group that they were assigned to most often across imputations. Ten participants (42%) were classified into the first cluster, which represented the SCV group, with low scores on the CBS-R (M = 43.38, SD = 9.91-10.23). Fourteen participants (58%) were classified into the second group, which represented the IT group, with high scores on the CBS-R (M = 76.04, SD = 8.39-9.24). Table 2 shows the means and standard deviations for all questionnaires for each group as well as overall means and standard deviations for each questionnaire. A t test found that the two groups differed significantly on the CBS-R, t (85619) = -8.34, p <

.001. This method of scale dichotomization has been recommended by Johnson (2008) while further research on this and other control scales is being conducted.

Table 2

Descriptive Statistics for Each Measure Across Imputations by Group Membership

	SCV (n = 10)		IT (n = 14)		Total (N = 24)	
Measures	*M*	*SD*	*M*	*SD*	*M*	*SD*
CTS2						
Physical Assault						
Imputation 1	54.78	50.57	77.60	87.93	69.04	75.65
Imputation 2	55.00	50.18	77.33	87.78	68.96	75.42
Imputation 3	54.78	50.30	77.40	88.07	68.92	75.67
Imputation 4	53.11	50.41	77.80	88.13	68.54	75.90
Imputation 5	54.89	50.21	78.20	88.38	69.46	75.92
Injury						
Imputation 1	3.22	8.20	14.33	21.17	10.17	18.07
Imputation 2	3.56	8.11	14.33	21.03	10.29	17.90
Imputation 3	3.56	8.11	14.47	21.39	10.38	18.18
Imputation 4	3.56	8.11	14.73	21.44	10.54	18.26
Imputation 5	3.22	8.20	14.60	21.34	10.33	18.23
Sexual Coercion						
Imputation 1	19.33	27.07	63.47	52.46	46.92	49.06
Imputation 2	19.22	26.77	62.27	52.91	46.13	49.05
Imputation 3	19.11	26.47	62.07	52.91	45.96	48.98
Imputation 4	19.11	26.47	62.80	52.69	46.42	49.00
Imputation 5	19.22	26.77	62.33	53.16	46.17	49.23
SBS						
Characterological Self-Blame						
Imputation 1	12.89	6.60	16.26	6.54	14.99	6.63
Imputation 2	12.89	6.60	16.07	6.34	14.88	6.49
Imputation 3	12.89	6.60	16.16	6.43	14.94	6.56
Imputation 4	12.89	6.60	16.23	6.51	14.98	6.61
Imputation 5	12.89	6.60	16.22	6.49	14.97	6.60
Behavioural Self-Blame						
All Imputations	17.44	6.93	16.20	5.52	16.67	5.97
CTQ						
Imputation 1	70.78	13.05	79.57	18.99	76.27	17.23
Imputation 2	70.43	13.31	79.21	19.08	75.92	17.38
Imputation 3	70.61	13.17	79.60	19.13	76.23	17.40
Imputation 4	70.67	13.13	79.17	19.34	75.98	17.48
Imputation 5	70.51	13.25	79.20	19.04	75.94	17.33
PCL-C						
Imputation 1	43.93	13.04	66.02	10.27	57.74	15.58
Imputation 2	43.93	13.03	66.18	10.16	57.84	15.59
Imputation 3	43.70	13.02	66.11	10.16	57.70	15.64
Imputation 4	43.68	13.00	65.97	10.48	57.62	15.72
Imputation 5	43.16	13.25	65.93	10.30	57.39	15.89

(continued)

	SCV (n = 9)		IT (n = 15)		Total (n = 24)	
Measures	*M*	*SD*	*M*	*SD*	*M*	*SD*
BDI-II						
Imputation 1	26.48	11.47	34.70	13.66	31.62	13.26
Imputation 2	25.01	11.41	34.70	13.66	31.06	13.48
Imputation 3	25.08	11.30	34.70	13.66	31.09	13.44
Imputation 4	25.13	11.46	34.70	13.66	31.11	13.48
Imputation 5	25.51	11.26	34.70	13.66	31.25	13.35

Note. CTS2 = Revised Conflict Tactics Scale (Straus et al., 1996). CTQ = Childhood Trauma Questionnaire (Bernstein et al., 1994). SBS = The Behavioural and Characterological Self-Blame Scale (O'Neill & Kerig, 2000). PCL-C = PTSD Checklist, Civilian Version (Weathers et al., 1993). BDI = Beck Depression Inventory-II (Beck, 1996).

Main Analyses

Covariates

Bivariate correlations between each item on the demographic questionnaire and the outcome variables were examined to determine which demographic variables should be controlled for. Correlations between each predictor and criterion variable can be seen in Table 3. Childhood maltreatment, income, highest level of education attained, relationship status (married, cohabitating, or neither), and receipt of psychological services were all found to correlate significantly with characterological self-blame, the dependent variable in the first analysis. For the sake of parsimony, a regression model using all of the potential predictors was run and then the output was examined to determine which predictors significantly contributed to the model, as recommended by Field (2009). All of the potential covariates were significant with the exception of highest level of education attained. Therefore, childhood maltreatment, income, relationship status, and receipt of psychological services were used as covariates in the prediction of characterological self-blame in the first analysis. No demographic variables were found to correlate with behavioural self-blame; therefore no covariates were used in the second analysis. Use of medication for a psychological disorder correlated significantly with PTSD, and was therefore controlled for in the third analysis. None of the demographic variables were found to correlate significantly with depression; therefore no covariates were used in the last analysis.

Table 3

Summary of Intercorrelations between Covariates, Outcome, and Predictor Variables

Variables	1	2	3	4	5	6	7	8	9	10	11
1. Maltreatment	-										
2. Income	.32	-									
3. Highest Education	.08	.34	-								
4. Relationship Status	-.07	-.36	-.43*	-							
5. Psychological Services	-.55**	-.70***	-.36	.52*	-						
6. Medication	-.13	-.05	-.10	-.27	.24	-					
7. IPV Type	.25	-.21	.30	.20	-.04	-.32	-				
8.Characterological Self-Blame	.45*	.48*	.57**	-.53**	-.48*	.22	.25	-			
9. Behavioural Self-Blame	.00	.21	-.12	-.38	-.14	.32	-.10	.37	-		
10. PTSD	.29	-.16	.20	.28	-.09	-.59**	.71***	.15	-.08	-	
11. Depression	.16	-.17	-.13	.05	.02	-.33	.34	.07	.21	.69***	-

Note. *$p < .05$. **$p < .01$, ***$p < .001$.

Hypothesis 1

Using an ANCOVA, I assessed whether victims of IT had significantly higher rates of characterological self-blame than victims of SCV, after controlling for childhood maltreatment, income, relationship status, and receipt of psychological services (Hypothesis 1). I conducted a hierarchical linear regression instead of a General Linear Model because SPSS was able to compute pooled estimates using the former procedure only. Childhood maltreatment, income, relationship status, and receipt of psychological services were entered in the first step of the regression followed by IPV type in the second step. The dependent variable was characterological self-blame. Maltreatment, income, relationship status, and receipt of psychological services were all significant predictors of characterological self-blame. Amount of characterological self-blame was significantly different between the two types of IPV after the covariates were controlled for, with characterological self-blame higher amongst those in the IT group (M = 16.19, SD = 6.34-6.54) than those in the SCV group (M = 12.89, SD = 6.60). The power to detect a significant effect should one exist was only .66, yet a significant effect was still found. Results of this regression can be seen in Table 4.

Table 4

Predictors of Characterological Self-Blame

Step	Variables Entered	*B*	*SE* B	*t*	*p*
1	Constant	2.45	11.18	0.22	0.83
	Maltreatment	0.16	0.08	1.99	0.05
	Income	3.19	2.13	1.50	0.14
	Relationship Status	-5.03	2.02	-2.49	0.01
	Psychological Services	3.52	3.92	0.90	0.37
2	Constant	-10.64	10.00	-1.06	0.29
	Maltreatment	0.13	0.07	1.99	0.05
	Income	5.33	1.87	2.86	0.00
	Relationship Status	-6.98	1.76	-3.97	0.00
	Psychological Services	6.68	3.34	2.00	0.05
	IPV Type	6.67	2.10	3.17	0.00

Hypothesis 2

Because there were no covariates to include in the second analysis, an independent *t* test was run to test the hypothesis that victims of IT would have significantly higher rates of behavioural self-blame than victims of SCV. Participants in the SCV group had slightly higher rates of behavioural self-blame (M = 17.44, SD = 6.93) than did victims of IT (M = 16.20, SD = 5.52), though the difference in behavioural self-blame was not statistically significant, $t(22) = 0.49$, $p = .63$. The power to detect a significant group difference if one existed was .07, which is extremely low.

Hypothesis 3

A hierarchical linear regression was conducted to determine whether PTSD symptoms could be significantly predicted from IPV type, characterological self-blame, behavioural self blame, and the interaction between those three terms after controlling for use of psychiatric medication. All predictor variables were centered around their means prior to inclusion in the model, as is recommended to reduce the chances of multicollinearity (Cohen, Cohen, West, & Aiken, 2003). When only the covariate (medication use) was used in the model, the model was significant, with F values ranging from 10.86 to 12.32 and all significance values below .01, accounting for 33-36% of the variance in PTSD (depending on the imputation). Once all variables were included in the model, the model was again significant with F values ranging from 7.80-8.33 and all significance values below .001. The complete model accounted for 68-70% of the variance in PTSD symptoms. Power was adequate at .97

Each predictor was then examined to determine whether it contributed significantly to the model. The covariate, current medication use, contributed

significantly to the model, B = -13.46, p = .004. IPV type contributed significantly to the prediction of PTSD, B = 24.13, p = .001. Characterological self-blame, behavioural self-blame, and the interaction between characterological self-blame, behavioural self-blame and IPV type did not contribute significantly to the model. See Table 5 for values of B, β, R^2, and F for change in R^2 for each imputation.

Table 5

Hierarchical Multiple Regressions Predicting PTSD from IPV Type, Characterological Self-Blame, Behavioural Self-Blame, and an Interaction Across Imputations

	Imputation 1		Imputation 2		Imputation 3		Imputation 4		Imputation 5		Pooled
Predictor	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*
Step 1											
Constant	84.44(8.06)**		84.60 (8.06)**		83.89 (8.19)**		84.18 (8.20)**		83.56(8.39)**		84.13 (8.19)**
Medication	-18.31 (5.23)*	-0.60	-18.35(5.23)*	-0.60	-17.95 (5.32)*	-0.58	-18.21 (5.32)*	-0.59	-17.94 (5.45)*	-0.58	-18.15 (5.31)*
Step 2											
Constant	88.75(10.50)**		89.54 (10.58)**		88.71 (10.64)**		88.67 (10.74)**		89.14 (10.76)**		88.96 (10.65)**
Medication	-13.71 (4.61)*	-0.45	-13.66 (4.57)*	-0.45	-13.16 (4.63) *	-0.43	-13.52 (4.70)*	-0.44	-13.23 (4.70)*	-0.42	-13.46 (4.65)*
IPV Type	23.42 (6.91)*	0.74	24.05(6.87)*	0.76	24.37(6.96)*	0.77	23.88 (7.06)*	0.75	24.93 (7.06)*	0.78	24.13 (7.00)*
Char. S-B	0.76 (0.59)	0.32	0.82 (0.62)	0.34	0.81 (0.61)	0.34	0.78 (0.61)	0.33	0.88 (0.61)	0.37	0.81 (0.61)
Behav. S-B	0.95 (0.66)	0.36	0.96 (0.65)	0.37	0.98 (0.66)	0.37	0.97 (0.67)	0.37	0.97 (0.67)	0.39	0.98 (0.67)
Interaction	-0.03 (0.02)	-0.51	-0.03 (0.02)	-0.55	-0.03 (0.02)	-0.55	-0.03 (0.02)	-0.52	-0.03 (0.02)	-0.57	-0.03 (0.02)

Note. N = 24. Char. S-B = characterological self-blame. Behav. S-B = behavioural self-blame. The interaction term represents IPV type by characterological self-blame by behavioural self-blame.

*p < .01. **p <.001.

Step 1 R^2 = .33-.36, F for Δ R^2 = 10.86- 12.32**

Step 2 R^2 = .68-.70, F for Δ R^2 = 4.80- 5.25**

Hypothesis 4

A linear regression was conducted to determine whether depression could be significantly predicted from IPV type, characterological self-blame, behavioural self blame, and the interaction between those three terms. Again, all predictor variables were centered around their means prior to inclusion in the model. Overall, the model was not significantly able to predict depression with *F* values ranging from 1.15 - 1.54 (*p*s = .23 - .36). The complete model accounted for 20 - 24% of the variance in depression symptoms. Table 6 displays the regression coefficients for the model. The power to detect a significant effect should one exist was .43, which is very low.

Table 6

Hierarchical Multiple Regressions Predicting Depression from IPV Type, Characterological Self-Blame, Behavioural Self-Blame, and an Interaction

	Imputation 1		Imputation 2		Imputation 3		Imputation 4		Imputation 5		Pooled
Predictor	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*	*β*	*B (SE)*
Constant	41.87 (11.88)		43.09 (11.92)		42.46 (11.80)		42.39 (11.76)		42.15 (11.78)		42.39(11.84)
IPV Type	15.68 (8.70)**	0.59	18.08 (8.64)**	0.66	17.72 (8.60)**	0.65	17.69 (8.60)**	0.65	17.04(8.60)**	0.63	17.24 (8.69)**
Char. S-B	0.27 (0.79)	0.14	0.41 (0.82)	0.20	0.35 (0.80)	0.17	0.32(0.78)	0.16	0.31 (0.79)	0.15	0.33(0.80)
Behav. S-B	1.27 (0.88)	0.57	1.42 (0.87)	0.63	1.39 (0.87)	0.62	1.40 (0.87)	0.62	1.35(0.87)	0.60	1.37 (0.88)
Interaction	-0.02 (0.03)	-0.56	-0.03 (0.03)	-0.65	-0.03 (0.03)	-0.62	-0.03 (0.03)	-0.61	-0.03 (0.03)	-0.59	-0.03 (0.03)

Note. $N = 24$. Char. S-B = characterological self-blame. Behav. S-B = behavioural self-blame. The interaction term represents IPV type by characterological self-blame by behavioural self-blame.
*$p < .01$. **$p < .001$.
$R^2 = .20$-$.24$

CHAPTER IV

Discussion

The purpose of the present study was to advance current knowledge on theories related to the influence of self-blame on the development or maintenance of psychopathology among homeless women who have experienced intimate partner violence. Two of the factors commonly discussed in the literature, characterological and behavioural self-blame, were examined for their ability to predict depression and PTSD. This study, which is one of the few to examine the IPV experiences of homeless women, also examined the influence of coercive control within an abusive relationship on female victims' psychological well-being. Relationships high in coercive control, referred to as intimate terrorism, have been associated with higher rates of PTSD than relationships without coercive control, referred to as situational couple violence (Johnson & Leone, 2004). The current study aimed to determine whether coercive control is important for the prediction of PTSD and depression among women with low SES.

IPV and Homelessness

The cluster analysis of women's scores on the Revised Controlling Behaviours Scale (Graham-Kevan & Archer, 2005) classified 14 women (58%) in the IT group and 10 women (42%) in the SCV group. Previous findings by Johnson (2001) found the rates of IT in a survey of the general population to be 11%, 68% in a court sample, and 79% in a domestic violence shelter. Therefore, the breakdown of the type of IPV experienced by women in the current sample was more consistent with women in a court or domestic violence shelter sample than those in the general population. In the current sample of women residing in a homeless shelter, IT, which has been previously associated with

greater injury and poorer outcome (Anderson, 2008; Johnson & Leone, 2005; Leone et al, 2004), was more common than SCV. Such findings suggest that it may be beneficial for female residents of homeless shelters to be screened for the various forms of IPV, and referred for psychological intervention as needed.

The homeless women in this study exhibited comparatively high rates of both depression and PTSD. A previous study by Campbell, Sullivan, and Davidson (1995) found that 70-85% of women living in a domestic violence shelter were at least mildly depressed and 30-55% were severely depressed. The current sample of 24 homeless victims of IPV experienced even higher rates of depression, with 75% being severely depressed. Similarly, 88% of the women in the current study met criteria for a PTSD diagnosis. The high symptom severity indicates that this population is one that is in critical need of intervention. Although the majority of the women in this sample had previously sought psychological services, 42% had not. Despite the fact that the women living in a homeless shelter may not be there solely to escape a violent home situation, if the resources are available, some programming geared to educate the women on IPV and safety-planning would be beneficial. As well, information on how to obtain psychological services at low to no cost, and emergency hotline numbers should be readily available to those in the shelter.

Given that high rates of PTSD and depression have been consistently found in homeless women (Tyler et al., 2009), it remains to be examined whether these disorders have a special impact on homeless women (compared to their nonhomeless counterparts). For example, perhaps PTSD and depression are maintaining factors of homelessness. That is, perhaps experiencing symptoms of PTSD and depression interferes with victims'

abilities to maintain employment, resulting in an inability to earn the income necessary to afford housing.

Correlates of Characterological Self-Blame

Results of the current study also indicated that characterological self-blame was associated with several demographic and distal predictors, including level of education, income, status of relationship, and childhood maltreatment, with the last three predictors being the most reliable predictors. Given that two of the three main indicators of socioeconomic status are income and education level (Liberatos et al., 1988), these findings indicate that having higher socioeconomic status appears to be related to having higher rates of characterological self-blame. A possible explanation for this finding is that characterological self-blame might require abstract reasoning, a component of critical thinking, to generalize from multiple experiences of psychological abuse to a judgement of one's character on the whole. One of the main goals of formal education is to increase students' abilities to think critically; therefore it is likely that those who have more years of education are more adept at this skill, and therefore would be better able to generalize their experiences, in this case to their detriment (Pithers, 2000).

The positive association found between childhood maltreatment and characterological self-blame was not surprising given that psychological abuse is one component of childhood maltreatment. A study by Gold (1986) also found that childhood maltreatment was related to characterological self-blame. According to Herbruck (1979), children who are maltreated are often told by their parents that they are bad and unlovable. It could be expected that after being told repeatedly that one is characterologically deficient, a child might develop an underlying belief that he or she is

in fact defective. Additionally, because victims of IPV who were also maltreated in childhood have been abused by more than one person in their lifetime, it may be harder for them to blame multiple perpetrators for the abuse. Instead, they may be more likely to blame their own character for the abuse (Andrews & Brewin, 1990).

In this study, characterological self-blame was also related to relationship status. Women married to their abusive partners displayed the highest rates of characterological self-blame, followed by women cohabiting with their partners but not married, and lastly by those who were neither married nor living with their partners. One possible explanation could be that marital status is positively related to IPV victimization. Although higher rates of IPV have consistently been reported among cohabiting couples compared to dating couples (Lane & Gwartney-Gibbs, 1985; Sigelman, Berry, & Wiles, 1984; Stets & Straus, 1990), it has typically been found that couples who cohabit but are not married have the highest rates of IPV victimization (Brownridge, 2004; Brownridge & Halli, 2002). In the current study, participants who were neither married nor cohabiting with their abusive partner reported the highest frequency and severity of IPV, and couples who were cohabiting but were not married reported the lowest incidence and severity of violence. Despite being discrepant with previous studies, the fact that couples who were neither cohabiting nor married experienced the most frequent violence could explain why characterological self-blame was lowest amongst couples who were neither cohabiting nor married. Research on attribution theory indicates that instances of behaviour that are considered to be extreme are most likely to be attributed to the actor, as they represent too great a departure from how the perceiver views themselves to attribute the behaviour to themselves (Jones & Davis, 1965; Walster, 1966). Consistent with attribution theory,

Holtzworth-Munroe (1988) argues that when violence is more severe (and therefore considered more extreme), it represents too great a threat to the victim's view of their own character, making them more likely to blame their partner. Given that less severe violence results in more self-blame amongst victims and that married participants experienced less severe violence, it is not surprising that women who were married experienced the most characterological self-blame in the current study.

Alternatively, it could be that by virtue of being in more serious relationships, married women feel that their partners love or care more deeply about them as compared to women in less serious relationships. They may therefore have trouble reconciling that a man that they believe loves them would harm them. They might instead begin to believe that there must be something wrong with their own character to make them deserving of the abuse.

Finally, the present study found, as one would expect, that having received psychological services in the past was negatively associated with characterological self-blame. This may be because those who received psychological intervention worked on reducing their characterological self-blame directly within the therapeutic intervention by learning that there is more than one way to look at things. Alternatively, therapy may work indirectly on self-blame, such as by enhancing self-esteem (Kubany, Hill, & Owens, 2003).

IPV Type and Characterological Self-Blame

Consistent with the first hypothesis, which predicted that victims of intimate terrorism would experience higher rates of characterological self-blame than victims of situational couple violence, results of the present study suggest that after controlling for

all of the covariates described above, victims of IT showed significantly higher levels of characterological self-blame than did victims of SCV. This was expected given that one component of coercive control, the distinguishing feature in Johnson's typology of IPV (Johnson 1995, 2006), is blaming the victim (Pence & Paymer, 1993). A study by Ullman (1996) found that being blamed by others for sexual assault victimization increased characterological self-blame. Extrapolating from Ullman's finding, being told by the perpetrator that you brought the violence upon yourself (as is a commonly done by perpetrators of IT) would likely increase characterological self-blame. Additionally, Briere and Runtz (1990) found that psychological attacks and criticism by a parent, as often occurs in childhood maltreatment, was associated with negative self-evaluation in adulthood. The authors attributed the association between parental criticism and negative self-evaluation to be due to the child's internalization of the criticism. Therefore, if victims of IT are repeatedly told that they brought the violence upon themselves, it is likely that the victims would internalize the message, and in turn, blame their character for the abuse. The fact that all of the women in the present study endorsed that they blamed themselves to some extent for their abuse indicates that characterological self-blame is an important construct to consider when predicting characterological self-blame and to target in interventions.

IPV Type and Behavioural Self-Blame

The second hypothesis was that behavioural self-blame would be higher amongst victims of SCV than victims of IT. Although SCV victims did not report higher levels of behavioural self-blame than IT victims, it is important to interpret this result cautiously, as the power to detect a significant difference between the groups was extremely low due

to an extremely small sample size. The relation was in the expected direction, with behavioural self-blame slightly higher amongst women who had experienced SCV. This finding is consistent with Johnson's (1995, 2006) theory, which purports that SCV is usually the result of the escalation of an argument during which both partners become violent. Given that the violence in this typology is defined as being situationally bound and not usually part of a larger pattern of incidents, one might be more likely to blame situational variables for the violence, such as one's behaviours leading up to the incident.

Prediction of PTSD

The third hypothesis was that IPV type, characterological self-blame, behavioural self-blame, and the interaction between the three would significantly predict PTSD symptoms after controlling for medication use. The model was quite effective in predicting PTSD symptoms, explaining 68% of the variance. Medication use and IPV type were both significant independent predictors of PTSD. It is not surprising that the use of psychiatric medication was negatively associated with PTSD symptoms, as more than 50% of the women were currently taking medication. Some of these medications might have been prescribed specifically to reduce their symptoms of PTSD. Thus, one would hope to have found the significant negative correlation.

In terms of IPV type, victims of IT experienced significantly more symptoms of PTSD than victims of SCV. Previous studies have also found IPV type to be predictive of PTSD in large national U.S. samples (Anderson, 2008; Johnson & Leone, 2005). The current study extends the work of previous research by showing that the relation between IPV type and PTSD similarly exists for women from lower SES backgrounds. This finding also adds to the sparse literature on the IPV experiences of homeless women, and

demonstrates the importance of examining coercive control when predicting risk for developing PTSD among homeless women. Because it has consistently been found that victims of IT are at high risk for developing PTSD, it is important that psychological interventions are made available to these women.

No significant independent effects were found for characterological self-blame, behavioural self-blame, or the interaction between characterological self-blame, behavioural self-blame, and IPV type. Therefore, whereas being a victim of IT did significantly predict experiencing more symptoms of PTSD, characterological and behavioural self-blame did not. The fact that characterological self-blame was predictive of psychological distress in other samples but not in the current study could be because none of the previous studies included IPV type as another potential predictor (Breitenbacher, 2006; Coffey et al., 1992; Hall et al., 2003; Palker-Corell & Marcus, 2004). In the present study, self-blame did not provide any predictive ability above and beyond IPV type. Additionally, the previous studies cited above primarily used psychological distress as their outcome variable, of which symptoms of PTSD represented one component only.

The lack of association between behavioural self-blame and PTSD in the current study might have been due to measurement error associated with low reliability of the behavioural self-blame measure used in the current study ($\alpha = .55$). Results should therefore be interpreted cautiously. Alternatively, there have been mixed results regarding the impact of behavioural self-blame on psychological distress (Breitenbacher, 2006; Turnquist et al., 1988). Consistent with results of the current study, a review of the literature by Hall and colleagues (2003) failed to find a significant relation between

behavioural self-blame and psychological distress. Thus, there is some evidence to suggest that behavioural self-blame is not a strong predictor of psychological distress. As a result, clinicians and researchers should focus more attention on such variables as IPV type when identifying victims most in need of psychological intervention. In addition, behavioural and characterological self-blame should continue to be examined independently.

Prediction of Depression

The final hypothesis for the present study, that depression symptoms would be significantly predicted from IPV type, characterological self-blame, behavioural self blame, and the interaction between these three terms, was not supported. Although some research (Anderson, 2008; Prospero, 2009) has found coercive control to be positively associated with depression, other research (Johnson & Leone, 2005) has failed to find a significant difference in depression symptoms between SCV and IT groups. Although the current study did not find that IPV type was significantly associated with depression, the two variables were correlated positively (r = .32), indicating that as coercive control increased in the intimate relationship, depression symptoms increased as well. The lack of a significant correlation could be the result of low power given the small sample size.

The relation between self-blame and depression has generally been supported in the literature, albeit less consistently than the relation between PTSD and self-blame. Using the same measure of self-blame as in the current study, O'Neill and Kerig (2000) found both behavioural and characterological self-blame to be predictive of depression. Cascardi and O'Leary (1992) found depressive symptoms to be marginally significantly correlated with self-blame. Both of these studies reported correlations of approximately

.37. In the current study, there were positive, though nonsignificant, relations between characterological and behavioural self-blame and depression symptoms (r = .07 and r = .21, respectively), indicating that as characterological and behavioural self-blame increased, symptoms of depression also increased. One reason the current study was not able to significantly predict depression symptoms may have been because internal attributes represent only one third of the depressogenic trio of learned helplessness as described by Abramson et al. (1978). Therefore, without taking into account the other two dimensions (stability and globality), internal attributions may not have been able to account for a significant portion of the symptoms of depression.

It is important not to interpret the current results as indicating that self-blame and IPV type have no effect on the development of depression symptoms. While the current study did not find a significant link between self-blame, IPV type, and depression, the power to detect a significant effect in this study was fairly low due to the small sample size. Furthermore, the women in this study also experienced extremely high rates of depression symptoms, with the majority of women falling above the cut-off required for a diagnosis of severe depression. As such, depression scores were restricted in range. Therefore, there may have been a ceiling effect in depression scores that may have impeded the ability to predict depression symptoms.

Limitations of the Present Study

Although the current study is the first to examine concomitantly how two of Johnson's (1995, 2006) typologies (viz., intimate terrorism and situational couple violence) and two forms of self-blame (viz., characterological and behavioural)—as well as the interaction between these variables—are related to PTSD and depression among

homeless women who have experienced intimate partner violence, there are a few limitations to the current study that must be acknowledged. Of particular importance to this study are issues of sample size and power. Due to the difficulty of recruiting such a specialized sample, the present study consisted of 24 participants only. As a result, statistical power for many of the analyses was low. Therefore, it is possible that for some of the analyses, even if an actual effect existed, low power did not allow for its detection. Increasing the sample size for future studies would help alleviate this problem.

In terms of the methodology used in the current study, all measures used were self-report questionnaires. Although the women themselves may be the only ones who have knowledge about their experiences, there are a few drawbacks to relying only on one source for information. Firstly, all of the measures asked participants to report on their experiences retrospectively. This requires that the women accurately remember their experiences in order to report them, and at least one of the measures assessed events as far back as childhood. Secondly, all of the measures addressed difficult issues that are not often discussed openly, and that may cause the arousal of such emotions as shame and guilt. As such, the women may have attempted to reduce these feelings by responding to questions in a manner that they deemed to be more socially desirable. Therefore, it is likely that some of the participants underreported experiences of IPV, self-blame, and coercive control. Finally, all of the measures used in the current study required participant to choose between forced choice categories, limiting the amount of information and the range of scores a participant could provide. In addition, there was no room for participants to provide clarification or to explain their responses. Studies that are

longitudinal in design and that utilize interviews or open-ended questions would reduce some of these methodological flaws.

Additionally, the Revised Controlling Behaviour Scale (O'Neill & Kerig, 2000), displayed fairly low internal consistency. In our sample, the characterological self-blame scale had an alpha of .67, which is in the questionable range, and the behavioural self-blame scale had an alpha of .55, which is in the poor range. A previous study validating the measure found the internal consistency for the characterological self-blame scale to be .78, and .71 for the behavioural self-blame scale (O'Neill & Kerig, 2000). Because the two studies both used samples of women from shelters, it is unclear why there would be such a discrepancy between the alphas of these two studies. Further studies should be conducted to validate this measure in different samples.

Another limitation of this study is that it only examined two out of the four types of IPV as described by Johnson (2001). This decision was made largely due to the small sample size. Had the sample been divided into four groups rather than two, there would have been even less power to detect any significant effects. The IT and SCV groups were chosen because they are the two most common types and because they have been examined most extensively in the research literature. Given that there are no measures of coercive control that have been developed specifically to classify individuals or couples into Johnson's four types of IPV, it is imperative that future research establish a means for classifying victims into these four groups reliably.

As discussed earlier, the experience of being homeless has been suggested as a trauma in itself (Goodman et al., 1991). As well, homeless people are more likely to have been assaulted and raped than non-homeless people (Frankish et al., 2005). Although the

current study controlled for some trauma outside of IPV victimization (such as childhood maltreatment), one cannot attribute symptoms of PTSD solely to IPV experiences, as multiple traumas may have had a cumulative impact on the mental health of the participants.

The last limitation of this study concerns its generalizability. These results were derived from a sample of homeless women. Although one of the strengths of this study is that it examines IPV in a population that has been understudied, the present sample limits the findings to women with low SES who are without housing. Although there is no empirical reason to assume that the effects found in this study would differ depending on the participant's SES, these findings must nevertheless be generalized cautiously. Also, the fact that the sample only consisted of 24 women further reduces the generalizeability of the study in that these 24 women residing in one particular shelter may be fundamentally different from homeless women in another geographic area, or even women living in the same shelter who declined to participate.

It should be noted that although this study only examined the IPV experiences of women, this was done with the intention of taking a stance on the gender debate within the IPV literature. This sample was selected because of the relative methodological ease of recruiting female victims of IPV as opposed to male victims, as well as in keeping the sample comparable with those in previous studies by Johnson and colleagues (e.g., Johnson & Leone, 2005).

Strengths of the Present Study

Despite the limitations, the present study has a number of strengths. First, the present study is one of the few studies to investigate IPV amongst homeless women. A

recent study by Tyler et al. (2009) found that 69% of homeless women in their sample had been a victim of physical partner violence at some point in their lives. This alarmingly high rate indicates a need for more research to examine the IPV experiences of homeless women in order to understand the effects of the violence as well as what can be done to prevent it. Also, compared to studies of IPV that use samples of undergraduate students, the present community sample of women may be more representative of the experiences of a larger range of victims due to a wider range in age, education level, and ethnicity.

An additional strength is that the current study examined a wide range of demographic variables to determine which variables were associated with PTSD and depression, in order to control for possible confounding factors. I also controlled for childhood maltreatment when appropriate, which may have been responsible for some of the ambiguous findings in previous studies (e.g., Andrews & Brewin, 1990, Hall et al., 2003). Also, because many of the studies examining coercive control were based on large-scale surveys of the general public, the studies tended to use measures comprised of a few items only to assess each variable. The current study therefore improved upon past studies by using full measures to assess the variables of interest (viz., coercive control, self-blame, PTSD, and depression).

Finally, although there have been a number of studies on the role of coercive control in IPV, and a number of studies on self-blame, no study to date has examined these variables together. By including all of these variables in one study, it allows for the examination of how these variables work in tandem to influence the development of symptoms of PTSD and depression.

Conclusions

The present study examined the relations between self-blame, IPV typology, PTSD, and depression. Overall, this study indicates that although being a victim of intimate terrorism is associated with higher rates of characterological self-blame, the type of IPV experienced is what is important in determining who goes on to develop symptoms of PTSD. Self-blame, be it characterological or behavioural, did not provide any additional predictive power above and beyond the type of IPV in predicting PTSD symptoms. Consistent with previous findings, being a victim of intimate terrorism was predictive of experiencing more symptoms of PTSD, but not symptoms of depression (Johnson & Leone, 2005). The current study reinforced previous findings on the detrimental effects of being a victim of IT on mental health. Several main conclusions can be derived from the current study.

First, although the combination of IPV type, characterological self-blame, behavioural self-blame, and the interaction between the three terms significantly predicted PTSD, they did not significantly predict depression. This indicates that the mechanisms involved in the development of these two disorders are likely different, and that depression and PTSD should be examined separately rather than being lumped together under the general heading of psychological distress, as they have been in some previous studies (e.g., Breitenbacher, 2006; Leone et al., 2004). This is consistent with a recommendation by Greening et al. (2002), who also found differential effects for PTSD and depression in their one-year follow-up study of earthquake survivors. Greening et al. found that although depression and PTSD were both associated with attributing the earthquake to internal, stable, and global causes, this attribution style mediated the

relation between disaster exposure and depression, but not the relation between disaster exposure and PTSD. Based on these findings, the authors concluded that anxiety-related responses to trauma, such as developing symptoms of PTSD, involve different psychological mechanisms than the development of depressive symptoms. Greening et al.'s and the present study's findings together point to the need for further studies that examine PTSD and depression separately.

Second, the ability of IPV type, characterological self-blame, behavioural self-blame, and the interaction between the three terms to predict PTSD but not depression has important implications for clinical implications in addition to the implications for research. Determining what mediates the relation between the development of PTSD symptoms versus depression symptoms is important from a clinical perspective. One common method of treating victims of IPV who are no longer in the violent relationship is through cognitive therapy, in which the maladaptive cognitions of the victim are challenged and restructured (Douglas & Strom, 1988; Kubany & Watson, 2002). The cognitions that are targeted are those that would result in the greatest symptom relief if modified. In the current study, PTSD symptoms were predicted by characterological self-blame, behavioural self-blame, IPV type, and the interaction between the three, but depression symptoms were not. Therefore challenging maladaptive attributions of self-blame might be a beneficial area of focus in cognitive therapy to reduce PTSD symptoms; however, time might be better spent on other cognitive mediators for clients who present primarily with symptoms of depression (such as stable and global attributions for negative events). In short, given past and present findings it is important to not only examine PTSD and depression separately as measures of psychological

distress, but to also consider the mechanisms by which they are developed and maintained following traumatic experiences such as intimate partner violence.

Third, the current study also supports differentiating treatment for victims of IT and SCV. Victims of IT tend to experience repeated instances of both physical and psychological violence that is part of a pattern of behaviours to gain control over them. Conversely, SCV is contextually-dependent, is often mutual, and involves no attempts of partners to dominate one another (Johnson, 1995). Although the current study found that victims of IT experienced more symptoms of PTSD, victims of SCV still do experience some of these symptoms, and may therefore also present for treatment. It would not be beneficial for a client of SCV to learn about coercive control as a key component of IPV. Additionally, interventions that focus on reinstalling a sense of empowerment and control over one's one life may be of real benefit to IT victims. This type of intervention would not be a beneficial focus of therapy with a victim of SCV, however; working on patterns of communication between the couple might be more appropriate. Future research needs to examine which treatments are most effective for the two types of IPV.

Predicting risk factors for the development of psychopathology in the aftermath of traumatic events is important both from a theoretical perspective and a clinical one. In terms of theory, understanding the mechanisms that impact the presentation of certain disorders can help us better understand the disorders themselves and the factors that maintain them. Predicting psychopathology is important from a prevention stand-point, because it allows for treatment to begin even before the first symptoms emerge.

Studies investigating Johnson's typology have increased in recent years, yet many unanswered research questions remain. In order to prevent relationships of coercive

control, researchers must identify both internal and contextual factors that dispose an individual to use tactics of coercive control against a romantic partner. Also, given that the association between being a victim of IT and the development of more severe psychopathology has been replicated, researchers must now attempt to answer the question of how treatment should be tailored to meet the needs of each type of victim so that they receive optimal intervention to decrease their symptoms.

References

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49–74. doi: 10.1037/0021-843X.87.1.49

Ackard, D. M., & Neumark-Sztainer, D. (2002). Date violence and date rape among adolescents: Associations with disordered eating behaviors and psychological health. *Child Abuse and Neglect, 26*, 455-473. doi: 10.1016/S0145-2134(02)00322-8

Adams, D., Jackson, J., & Lauby, M. (1988). Family violence research: Aid or obstacle to the battered women's movement. *Response, 11*, 14-16. Retrieved from http://psycnet.apa.org/psycinfo/1989-33234-001

Ambrosio, E., D. Baker, C. Crowe and K. Hardill. The Street Health Report Toronto: Street Health, 1992.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anderson, K. L. (2008). Is partner violence worse in the context of control? *Journal of Marriage and Family, 70*, 1157-1168. doi: 10.1111/j.1741-3737.2008.00557.x

Anderson, C. A., Jennings, D. L., & Arnoult, L. H. (1988). Validity and utility of the attributional style construct at a moderate level of specificity. *Journal of Personality and Social Psychology, 55*, 979-990. doi: 10.1037/0022-3514.55.6.979

Anderson, C. A., Miller, R. S., Riger, A. L., Dill, J. C., & Sedikides, C. (1994).

Behavioral and characterological attributional styles as predictors of depression and loneliness: Review, refinement, and test. *Journal of Personality & Social Psychology, 66,* 549-558. doi: 10.1037/0022-3514.66.3.549

Anderson, K. L., & Umberson, D. (2001). Gendering violence: Masculinity and power in men's accounts of domestic violence. *Gender and Society, 15*, 358-380. doi: 10.1177/089124301015003003

Andrews, B., & Brewin, C. R. (1990). Attributions of blame for marital violence: A study of antecedents and consequences. *Journal of Marriage and the Family, 52,* 757–767. doi: 10.2307/352940

Andrews, B., & Brown, G. W. (1988). Marital violence in the community: A biographical approach. *British Journal of Psychiatry, 153,* 305-312. doi: 10.1192/bjp.153.3.305

Appel, A.E. & Holden, G.W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology, 1*2, 578-599. doi: 10.1037/0893-3200.12.4.578

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

Beck, A. T. (1996). *The Beck Depression Inventory* (2nd ed.). San Antonio, TX: Psychological Corporation.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.

Beck, A. T., & Steer, R. A. (1984). Internal consistencies of the original and revised Beck

Depression Inventory. *Journal of Clinical Psychology, 40,* 1365-1367. doi: 10.1002/1097-4679(198411)40:6<1365::AID-JCLP2270400615>3.0.CO;2-D

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychological Review, 8,* 77-100. doi: 10.1016/0272-7358(88)90050-5

Bernstein, D., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E., & Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry*, *151*, 1132–1136. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8037246

Blanchard, E.B., Jones-Alexander, J., Buckley, T.C., & Forneris, C.A. (1996). Psychometric properties of the PTSD checklist. *Behaviour Research and Therapy, 34,* 669-673. doi: 10.1016/0005-7967(96)00033-2

Blum, A. (2008). Shame and guilt, misconceptions and controversies: A critical review of the literature. *Traumatology, 14,* 91-102. doi: 10.1177/1534765608321070

Breitenbecher, K. H. (2006). The relationship among self-blame, psychological distress, and sexual victimization. *Journal of Interpersonal Violence, 21,* 597-611. doi: 10.1177/0886260506286842

Briere, J. (2004). *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement (2nd edition)*. Washington, D.C.: American Psychological Association.

Briere, J. & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect, 14,* 357-364. doi:10.1016/0145-2134(90)90007-G

Briscoe-Smith, A. M., & Hinshaw, S. P. (2006). Linkages between child abuse and attention-deficit/hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse and Neglect, 30,* 1239-1255. doi: 10.1016/j.chiabu.2006.04.008

Brownridge, D.A. (2004). Understanding women's heightened risk of violence in common-law unions: Revisiting the selection and relationship hypotheses. *Violence Against Women, 10,* 626-651. doi: 10.1177/1077801204265017

Brownridge, D.A. & Halli, S.S. (2002). Understanding male partner violence against cohabiting and married women: An empirical investigation with a synthesized model. *Journal of Family violence, 17,* 341-361. doi: 10.1023/A:1020370516420

Bulman. R. J., & Wortman, C. B. (1977). Attributions of blame and coping in the "real world": Severe accident victims react to their lot. *Journal of Personality and Social Psychology, 35,* 351-363. doi: 10.1037/0022-3514.35.5.351

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

Campbell, R., Sullivan, C. M., & Davidson, W. S. (1995). Women who use domestic violence shelters: Changes in depression over time. *Psychology of Women Quarterly, 19,* 237–255. doi: 10.1111/j.1471-6402.1995.tb00290.x

Cascardi, M., & O'Leary, K. D. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence, 7*, 249-259. doi: 10.1007/BF00994617

Centers for Disease Control and Prevention. (2008). Adverse health conditions and health

risk behaviors associated with intimate partner violence—United States, 2005. *Morbidity Mortal Weekly Report, 57*, 113-117. Retrieved from http://www.medscape.com/viewarticle/570505_1

Chiodo, D., Leschied, A.W., Whitehead, P.C., & Hurley, D. (2008). Child welfare practice and policy related to the impact of children experiencing physical victimization and domestic violence. *Children and Youth Services Review, 30*, 564-574. doi:10.1016/j.childyouth.2007.11.008

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996). Mediators of the long-term impact of child sexual abuse: Perceived stigma, betrayal, powerlessness, and self-blame. *Child Abuse and Neglect, 20*, 447-455. doi: 10.1016/0145-2134(96)00019-1

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159. doi: 10.1037/0033-2909.112.1.155

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.

Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics*. Stanford, California: Stanford University Press.

Cunradi, C.B., Caetano, R., & Schafer, J. (2002). Socioeconomic predictors of intimate partner violence among White, Black, and Hispanic couples in the United States. *Journal of Family Violence, 17*, 377-389. doi: 10.1023/A:1020374617328

Cyr, M., McDuff, P., & Wright, J. (2006). Prevalence and predictors of dating violence

among adolescent female victims of child sexual abuse. *Journal of Interpersonal Violence, 21*, 1000-1017. doi: 10.1177/0886260506290201

Dobash, R. E., & Dobash, R. P. (1979). *Violence against wives*. New York: Free Press.

Dobash, R. P., Dobash, R. E., Wilson, M., & Daly, M. (1992). The myth of sexual symmetry in marital violence. *Social Problems*, 39, 71-91. doi: 10.1525/sp.1992.39.1.03x0064l

Dougall, A., Herberman, H., Delahanty, D., Inslicht, S., & Baum, A. (2000). Similarity of prior trauma exposure as a determinant of chronic stress responding to an airline disaster. *Journal of Consulting and Clinical Psychology, 68,* 290-295. doi: 10.1037/0022-006X.68.2.290

Douglas, M.A. & Strom, J. (1988). Cognitive therapy with battered women. *Journal of Rational-Emotive and Cognitive-Behaviour Therapy, 6,* 33-49. doi: 10.1007/BF01061064

Dutton, D. G. (1994). Behavioral and affective correlates of borderline personality organization in wife assaulters. *International Journal of Law and Psychiatry, 17,* 265-277. doi: 10.1016/0160-2527(94)90030-2

Dutton, D. G. (1995). Male abusiveness in intimate relationships. *Clinical Psychology Review, 15,* 567-581. doi: 10.1016/0272-7358(95)00028-N

Dutton, D. G. (1998). *The abusive personality: Violence and control in intimate relationships.* New York, New York: Guilford Press.

Dutton, D. G. (2006). *Rethinking domestic violence*. Vancouver, British Columbia: University of British Columbia Press.

Dutton, M. A., Goodman, L. A., & Bennett, L. (1999). Court-involved battered women's

responses to violence: The role of psychological, physical, and sexual abuse. *Violence and Victims,14,* 89-104. Retrieved from http://www.ingentaconnect.com/content/springer/vav/1999/00000014/00000001/art00006

Edleson, J.L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5,* 134-154. doi: 10.1177/107780129952003

Feinauer, L. L., & Stuart, D. A. (1996). Blame and resilience in women sexually abused as children. *The American Journal of Family Therapy, 24,* 31-40. doi: 10.1080/01926189508251014

Feiring, C., Taska, L., & Lewis, M. (1998). The role of shame and attributional style in children's and adolescent's adaptation to sexual abuse. *Child Maltreatment, 3,* 129–142. doi: 10.1177/1077559598003002007

Fields, M. D., & Kirchner, R. M. (1978). Battered women are still in need: A reply to Steinmetz. *Victimology,* 3, 216-226.

Filson, J., Ulloa, E., Runfola, C., & Hokoda, A. (2010). Does powerlessness explain the relationship between intimate partner violence and depression? *Journal of Interpersonal Violence, 25*, 400-415. doi: 10.1177/0886260509334401

Forsterling, F. (1992). *Antecedents and consequences of causal attributions for critical life events.* Hillsdale, NJ, England: Lawrence Erlbaum Associates, Inc.

Frankish, C.J., Hwang, S.W., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health, 96,* S23-S30. Retrieved from: http://ezproxy.uwindsor.ca/login?url=http://proquest.umi.com.ezproxy.

Frazier, P., & Schauben, L. (1994). Causal attributions and recovery from rape and other stressful life events. *Journal of Social and Clinical Psychology, 13,* 1–14. Retrieved from http://cat.inist.fr/?aModele=afficheN&cpsidt=4067925

Frieze, I. (1979). Perceptions of battered wives. In I. Frieze, D. Bar-Tal & J. S. Carroll (Eds.), *New approaches to social problems* (pp. 79-108). San Francisco: Jossey-Bass.

Frye, V., Manganello, J., Campbell, J. C., Walton-Moss, B., & Wilt, S. (2007). The distribution of and factors associated with intimate terrorism and situational couple violence among a population-based sample of urban women in the United States. *Journal of Interpersonal Violence, 21,* 1286–1313. doi: 10.1177/0886260506291658

Gaquin, D. A. (1977). Spouse abuse: Data from the National Crime Survey. *Victimology, 2,* 632-643. Retrieved from http://psycnet.apa.org/psycinfo/1979-08638-001

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14,* 99–132. doi: 10.1023/A:1022079418229

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46,* 1219-1225. doi: 10.1037/0003-066X.46.11.1219

Graham-Kevan, N., & Archer, J. (2003). Intimate terrorism and common couple violence: A test of Johnson's predictions in four British samples. *Journal of Interpersonal Violence, 18,* 1247–1270. doi: 10.1177/0886260503256656

Graham-Kevan, N., & Archer, J. (2005). Investigating three explanations of women's

relationship aggression. *Psychology of Women Quarterly, 29*, 270–277. doi: 10.1111/j.1471-6402.2005.00221.x

Greening, L., Stoppelbein, L., & Doctor, R. (2002). The mediating effects of of attributional style and event-specific attributions on postdisaster adjustment. *Cognitive Therapy and Research, 26*, 261-274. doi: 10.1023/A:1014530021675

Griffith, M. (1977). Effects of noncontingent success and failure on mood and performance. *Journal of Personality, 45*, 442-457. doi: 10.1111/j.1467-6494.1977.tb00163.x

Hall, S., French, D. P., & Marteau, T. M. (2003). Causal attributions following serious unexpected negative events: A systematic review of the literature. *Journal of Social and Clinical Psychology, 22*, 515-536. doi: 10.1521/jscp.22.5.515.22924

Henning, K., & Renauer, B. (2005). Prosecution of women arrested for domestic violence: Are they treated more leniently than men? *Violence and Victims, 20*, 361-376. doi: 10.1891/vivi.20.3.361

Herbruck, C. (1979). *Breaking the Cycle of Child Abuse*. Minneapolis: Winston Press.

Herrenkohl, T.I., & Herrenkohl, R.C. (2007). Examining the Overlap and Prediction of Multiple Forms of Child Maltreatment, Stressors, and Socioeconomic Status: A Longitudinal Analysis of Youth Outcomes. *Journal of Family Violence, 22*, 553-562. doi: 10.1007/510896-007-9107-x

Herrenkohl, T.I., Sousa, C., Tajima, E.A., Herrenkohl, R.C., & Moylan, C.A. (2008). Intersection of child abuse and children‟s exposure to domestic violence. *Trauma, Violence and Abuse, 9*, 84-99. doi: 10.1177/1524838008314797

Holtzworth-Munroe, A. (1988). Causal attributions in marital violence: Theoretical and

methodological issues. *Clinical Psychology Review, 8,* 331-344. doi:10.1016/0272-7358(88)90095-5

Holtzworth-Munroe, A., & Stuart, G. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116,* 476-497. doi: 10.1037/0033-2909.116.3.476

Holtzworth-Munroe, A., Rehman, U., & Herron, K. (2000). General and spouse-specific anger and hostility in subtypes of maritally violent men and nonviolent men. *Behavior Therapy*, *31*, 603-630. doi: 10.1016/S0005-7894(00)80034-9

Hotaling, G.T., & Sugarman, D.B. (1986). An analysis of risk markers in husband to wife violence: The current state of knowledge. *Violence and Victims, 1,* 101-124. Retrieved from http://www.ingentaconnect.com/content/springer/ vav/1986/00000001/00000002/ art00003

Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 37*, 1798-1809. doi: 10.1037/0022-3514.37.10.1798

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

Johnson, M. P. (1999, November).*Two types of violence against women in the American family: Identifying patriarchal terrorism and common couple violence*. Paper presented at the National Council on Family Relations annual meetings, Irvine, CA.

Johnson, M. P. (2001). Conflict and control: Symmetry and asymmetry in domestic

violence. In A. Booth, A. C. Crouter, & M. Clements (Eds.), *Couples in conflict* (pp. 95–104). Mahwah, NJ: Erlbaum.

Johnson, M. P., & Ferraro, K. J. (2000). Research on domestic violence in the 1990s: Making distinctions. *Journal of Marriage and the Family*, *62*, 948-963. doi: 10.1111/j.1741-3737.2000.00948.x

Johnson, M. P., & Leone, J. M. (2005). The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence Against Women Survey. *Journal of Family Issues, 26*, 322-349. doi: 10.1177/0192513X04270345

Jones, E. E., & Davis, K.. E. (1965). From acts to dispositions: The attribution process in person perception. In L. Berkowitz(Ed), *Advances in experimental social psychology*, (Vol. 2, pp. 219-266). San Diego, CA: Academic Press

Kemp, A., Green, B. L., & Hovanitz, C. (1995). Incidence and correlates of posttraumatic stress disorder in battered women: Shelter and community samples. *Journal of Interpersonal Violence, 10*, 43-55. doi: 10.1177/088626095010001003

Kim, J., & Emery, C. (2003). Marital power, conflict, norm consensus, and marital violence in a nationally representative sample of Korean couples. *Journal of Interpersonal Violence, 18*, 197-219. doi: 10.1177/0886260502238735

Kincaid, P. J. (1985). *The omitted reality: Husband-wife violence in Ontario and policy implications for education.* Concord, Ontario: Belsten Publishing Ltd.

Koss, M. P., Figueredo, A. J., & Prince, R. J. (2002). Cognitive mediation of rape's mental, physical, and social health impact: Tests of four models in cross-sectional data. *Journal of Consulting and Clinical Psychology, 70*, 926–941. doi: 10.1111/j.1471-6402.2004.00145.x

Kubani, E.S., Hill, E.E. & Owens, J.A. (2003). Cognitive trauma therapy for battered women with PTSD: Preliminary findings. *Journal of Traumatic Stress, 16,* 81-91. doi: 10.1023/A:1022019629803

Kubany, E.S. & Watson, E. B. (2002). Cognitive trauma therapy for formerly battered women with PTSD (CTT-BW): Conceptual bases and treatment outlines. *Cognitive and Behavioural Practice, 9,* 111–127. doi: 10.1016/S1077-7229(02)80005-0

Kurz, D. (1989). Social science perspectives on wife abuse: Current debates and future directions. *Gender and Society, 3,* 489-505. doi: 10.1177/089124389003004007

Kwong, M., & Bartholomew, K. (1998, August). *Gender differences in domestic violence in the city of Vancouver*. Paper presented at the 1998 Annual Convention of the American Psychological Association, San Francisco, CA.

Kwong, M. J., Bartholomew, K., & Dutton, D. G. (1999). Gender differences in patterns of relationship violence in Alberta. *Canadian Journal of Behavioral Science, 31,* 150–160. doi: 10.1037/h0087083

Lane, K.E, & Gwartney-Gibbs, P.A. (1985). Violence in the context of dating and sex. *Journal of Family Issues, 6,* 45-59. doi: 10.1177/019251385006001004

Laroche, D. (2005). *Aspects of the context and consequences of domestic violence: Situational couple violence and intimate terrorism in Canada in 1999*. Quebec City: Government of Quebec.

Launius, M. H., & Lindquist, C. U. (1988). Learned helpessness, external locus of control, and passivity in battered women. *Journal of Interpersonal Violence, 3,* 307-318. doi: 10.1177/088626088003003004

Leone, J. M., Johnson, M. P., Cohan, C. L., & Lloyd, S. E. (2004). Consequences of male partner violence for low-income minority women. *Journal of Marriage and Family, 66,* 472–490. doi: 10.1111/j.1741-3737.2004.00032.x

Lerner, C., & Kennedy, L. (2000). Stay-leave decision making in battered women: Trauma, coping, and self-efficacy. *Cognitive Therapy and Research, 24*, 215-23. doi: 10.1023/A:1005450226110

Liberatos, P., Link, B.G., & Kelsey, J.L. (1988). The measurement of social class in epidemiology. *Epidemiological Review, 10*, 87-121. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/3066632

Macmillan, R., & Gartner, R. (1999). When she brings home the bacon: Labour-force participation and the risk of spousal violence against women. *Journal of Marriage and the Family, 61,* 947-958. doi: 10.2307/354015

Maier, S. F., & Seligman, M. E. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General, 105,* 3-46. doi: 10.1037/0096-3445.105.1.3

Maiuro, R. D., Cahn, T. S., & Vitaliano, P. P. (1986). Assertiveness deficits and hostility in domestically violent men. *Violence and Victims, 1*, 279-289. Retrieved from: http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=106806

McGee, R., Wolfe, D., & Olson, J. (2001). Multiple maltreatment, attribution of blame, and adjustment among adolescents. *Development and Psychopathology, 13,* 827-846. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11771910

McLeer, S. V., Dixon, J. F., Henry, D., Ruggiero, K., Escovitz, K., Niedda, T., & Scholle,

R. (1998). Psychopathology in non-clinically referred sexually abused children. *Journal of the American Academy of Child & Adolescent Psychiatry, 37,* 1326–1333. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9847506

Mihorean, K. (2005). "Trends in self-reported spousal violence." In AuCoin, K. (ed.). *Family Violence in Canada: A Statistical Profile, 2005.* Statistics Canada Catalogue no. 85-224-XIE. Ottawa.

Miller, D. T., & Porter. C. A. (1983). Self-blame in victims of violence. *Journal of Social Issues, 39,* 139-152. doi: 10.1111/j.1540-4560.1983.tb00145.x

Ogrodnik, L. 2009. "Fact sheet- Family homicides." In *Family Violence in Canada: A Statistical Profile, 2009.* Statistics Canada Catalogue no. 85-224-X. Ottawa.

O'Neill, M. L., & Kerig, P. K. (2000). Attributions of self-blame and perceived control as moderators of adjustment in battered women. *Journal of Interpersonal Violence, 15,* 1036-1049. doi: 10.1177/088626000015010002

Pagelow, M. D. (1981). *Woman-battering: Victims and their experiences*. Beverly Hills, CA: Sage Publications, Inc.

Paivio, S. C. (2001). Stability of self-reports of child abuse and neglect before and after therapy for child abuse issues. *Child Abuse & Neglect, 25,* 1053–1068. doi:10.1016/S0145-2134(01)00256-3

Paivio, S. C., & Cramer, K. M. (2004). Factor structure and reliability of the Childhood Trauma Questionnaire in a Canadian undergraduate student sample. *Child Abuse and Neglect, 28,* 889-904. doi: 10.1016/j.chiabu.2004.01.011

Palker-Corell, A., & Marcus, D. K. (2004). Partner abuse, learned helplessness, and

trauma symptoms. *Journal of Social and Clinical Psychology, 23*, 445-462. doi: 10.1521/jscp.23.4.445.40311

Pence, E., & Paymar, M. (1993).*Education groups for men who batter: The Duluth model*. New York: Springer.

Pithers, R.T. & Soden, R. (2000). Critical thinking in education: A review. *Educational Research, 42,* 237-249. Retrieved from http://www.ingentaconnect.com/content/routledg/ rere/2000/00000042/00000003/art00001

Powers, J.L., Eckenrode, J., & Jaklitsch, B. (1990). Maltreatment among runaway and homeless youth. *Child Abuse and Neglect, 14*, 87-98. doi: 10.1016/0145-2134(90)90084-7

Prospero, M. (2009). Sex-symmetric effects of coercive behaviors on mental health?: Not exactly. *Journal of Interpersonal Violence, 24*, 128-146. doi:10.1177/0886260508315778

Resick, P. A. (2004). A suggested research agenda on treatment–outcome research for female victims of violence. *Journal of Interpersonal Violence, 19,* 1290-1295. doi: 10.1177/0886260504271339

Rossi, P.H., Wright, J.D., Fisher, G.A., & Willis, G. (1987). The urban homeless: Estimating composition and size. *Science, 235*, 1336-1341. doi: 10.1126/science.2950592

Roth, S., & Kubal, L. (1975). Effects of noncontingent reinforcement on tasks of differing importance: Facilitation and learned helplessness. *Journal of Personality and Social Psychology, 32*, 680-691. doi: 10.1037/0022-3514.32.4.680

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of

reinforcement. *Psychological Monographs: General & Applied, 80*, 1-28. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/5340840

Ruggiero, K. J., Del Ben, K., Scotti, J. R., & Rabalais, A. E. (2003). Psychometric properties of the PTSD Checklist—Civilian Version. *Journal of Traumatic Stress, 16,* 495–502.doi: 10.1023/A:1025714729117

Seligman, M. E. P. (1975). *Helplessness: On depression, development and death.* San Francisco: Freeman.

Shaver, K. G. (1985). *The attribution of blame: Causality, responsibility, and blameworthiness.* New York, New York: Springer-Verlag.

Shaver, K. G., & Drown, D. (1986). On causality, responsibility, and self-blame: A theoretical note. *Journal of Personality and Social Psychology, 50*, 697–702. doi: 10.1037/0022-3514.50.4.697

Sigelman, C.K., Berry, C.J. & Wiles, K.A. (1984). Violence in college students' dating relationships, *Journal of Applied Social Psychology, 14*, 530–548. doi:10.1111/j.1559-1816.1984.tb02258.x

Smith, M.D. (1990). Patriarchal ideology and wife beating: A test of a feminist hypothesis. *Violence and Victims, 5,* 257-273. Retrieved from http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=130045

Stark, E. (2007). *Coercive control: The entrapment of women in personal life.* New York: Oxford University Press.

Statistics Canada. 2006 Census: Analysis Series. Collective Dwellings. Ottawa, ON, 2006. Retrieved from http://www40.statcan.gc.ca/l01/cst01/famil62a-eng.htm

Steinmetz, S. K. (1977). The battered husband syndrome. *Victimology, 2*, 499-509.

Retrieved from http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=46165

Stermac, L., & Paradis, E. (2001). Homeless women and victimization: Abuse and mental health history among homeless rape survivors. *Resources for Feminist Research, 28*, 65-80. Retrieved from http://findarticles.com/p/articles/mi_hb6545/is_3-4_28/ai_n28882304/pg_7/

Stets, J. E. (1993). Control in dating relationships. *Journal of Marriage and the Family, 55*, 673-685. doi: 10.2307/353348

Stets, J.E. & Straus, M.A. (1990). The marriage license as a hitting license: A comparison of assaults in dating, cohabiting, and married couples. *Journal of Family Violence, 4*, 161-180. doi: 10.1007/BF01006627.

Stevens, J. P. (2009). *Applied multivariate statistics for the social sciences* (5th ed.). Florence, KY: Taylor & Francis.

Straus, M. A., & Gelles, R. J. (Eds.). (1990). *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families*. New Brunswick, NJ: Transaction Press.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*, 283-316. doi: 10.1177/019251396017003001

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston: Allyn and Bacon.

Taft, C. T., Murphy, C. M., King, L. A., Dedeyn, J. M., & Musser, P. H. (2005). Posttraumatic stress disorder symptomology among partners of men in treatment for

relationship abuse. *Journal of Abnormal Psychology, 114*, 259-268. doi: 10.1037/0021-843X.114.2.259

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

Taylor-Butts, A. 2009. "Fact sheet–Police-reported spousal violence in Canada". *Family Violence in Canada: A Statistical Profile, 2009*. Statistics Canada Catalogue no. 85-224-XIE. Ottawa.

Tessler, R., Rosenheck, R., & Gamache, G. (2001). Gender differences in self-reported reasons for homelessness. *Journal of Social Distress and the Homeless, 10,* 243-254. doi: 10.1023/A:1016688707698

Tucker, J., Wenzel, S., Straus, J., Ryan, G., & Golinelli, D. (2005). Experiencing interpersonal violence: Perspectives of sexually active, substance-using women living in shelters and low-income housing. *Violence Against Women, 11,* 1319-1340. doi: 10.1177/1077801205280190

Turnquist, D. C., Harvey, J. H., & Andersen, B. L. (1988). Attributions and adjustment to life-threatening illness. *British Journal of Clinical Psychology, 27*, 55-65. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/3281733

Tyler, K.A., & Cauce, A.M. (2002). Perpetrators of early physical and sexual abuse among homeless and runaway adolescents. *Child Abuse and Neglect, 26,* 1261-1274. doi: 10.1016/S0145-2134(02)00413-1

Tyler, K.A., Melander, L.A., & Noel, H.J. (2009). Bidirectional partner violence among

homeless young adults: Risk factors and outcomes. *Journal of Interpersonal Violence, 24,* 1014-1035. doi: 10.1177/0886260508319364

Ullman, S.E. (1996). Social reactions, coping strategies, and self-blame attributions in adjustment to sexual assault. *Psychology of Women Quarterly, 20,* 505-526. doi: 10.1111/j.1471-6402.1996.tb00319.x OCIAL

Vaeth, P. A. C., Ramisetty-Mikler, S., & Caetano, R. Depression among couples in the United States in the context of intimate partner violence. *Journal of Interpersonal Violence, 25,* 771-790. doi: 10.1177/0886260509336957

Ventureyra, V. A. G.,Yao, S., Cottraux, J., Note, I., & Mey-Guillard, C. D. (2002). The validation of the Posttraumatic Stress Disorder Checklist Scale in posttraumatic stress disorder and nonclinical subjects. *Psychotherapy and Psychosomatics, 71,* 47–53. doi: 10.1159/000049343

Walker, L. E. A. (2000). *The battered woman syndrome* (2nd ed.). New York: Springer.

Walster, E. (1966). Assignment of responsibility for an accident. *Journal of Personality and Social Psychology, 3,* 73-79. Retrieved from http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=1966-02829-001

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (1993, October). *The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility*. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.

Weiner, B. (1974). (Ed.). *Achievement motivation and attribution theory*. New Jersey: General Learning Press.

Weiner, B. (1979). A theory of motivation for some classroom experiences. *Journal of*

Educational Psycholology, 71, 3-25. doi: 10.1037/

Winkel, F. W., Denkers, A., & Vrij, A. (1994). The effects of attributions on crime victims' psychological readjustment. *Genetic Psychology Monographs, 120,* 145-168. Retrieved from: http://www.questia.com/googleScholar.qst?docId=95244927

Wollert, R., & Rowley, J. (1987). Concurrent and longitudinal patterns among sanctions, mood, and attributions. *Journal of Personality and Social Psychology, 53*, 608–613. doi: 10.1037/0022-3514.53.3.608

Appendix A

Demographics Questionnaire

INSTRUCTIONS: Please answer the following questions honestly by writing your answer on the blank or putting an "X" next to ONE answer for each question.

1. How old are you? _____ years old

2. What is your race? (*Check all that apply*).
   _____ African American
   _____ Aboriginal
   _____ Arab
   _____ Caucasian/White
   _____ Chinese
   _____ Filipino
   _____ Japanese
   _____ Korean
   _____ Latin American
   _____ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
   _____ Southeast Asian (e.g., Cambodian, Indonesia, Laotian, Vietnamese, etc.)
   _____ West Asian (e.g., Afghan, Iranian, etc.)
   _____ Other _____

3. What is your religious affiliation?
   _____ Protestant Christian
   _____ Roman Catholic
   _____ Evangelical Christian
   _____ Jewish
   _____ Muslim
   _____ Hindu
   _____ Buddhist
   _____ Atheist
   _____ Other

4. What is your sexual orientation?
   _____ Heterosexual
   _____ Gay/Lesbian
   _____ Bisexual
   _____ Not sure
   _____ Other (*Please specify:* _____)

5. What is your highest level of education?
   _____ Less than high school
   _____ High school graduate
   _____ Vocational/technical school
   _____ College
   _____ Bachelor's degree
   _____ Master's degree
   _____ Doctoral degree
   _____ Professional degree (e.g., MD)
   _____ Other

6. What is your family's household income? (Make your best estimate)
   _____ Under $9,999
   _____ $10,000 to $19,999
   _____ $20,000 to $29,999
   _____ $30,000 to $39,999

_____ $40,000 to $49,999
_____ $50,000 to $59,999
_____ $60,000 to $69,999
_____ $70,000 to $79,999
_____ $80,000 or more

7. Indicate which of the following applies to you.
   _____ I am currently in a relationship
   _____ I have been in a relationship in the past year, but I am not in one now
   _____ I have not been in a relationship in the past year
   _____ Prefer not to answer

The following questions refer to the relationship with your partner that prompted you to seek the services of this organization:

8. What date would you say the relationship began (use your best estimate)? __/__/____

9. What date would you say the relationship ended (use your best estimate)? __/__/____
   Note: If you are still a part of the relationship please leave this question blank.

10. Was this the last romantic relationship that you were in?
    ____ Yes
    ____ No

11. During the course of this relationship you were:
    _____ Married
    _____ Living together but not married
    _____ Not married and not living together

12. How much time passed between the first incident of physical violence and the last incident of physical violence?
    _____ Less than a month
    _____ 1-3 months
    _____3-6 Months
    _____ 6 months to a year
    _____ More than a year

13. On average, how often did violence occur?
    ____ Every day
    ____ 3 times per week
    ____ Once a week
    ____ Twice per month
    ____ Once per month
    ____ Once every 3 months
    ____ Once every 6 months
    ____ Once every year
    ____ Less than once per year

14. Did you attempt to end the relationship at any point. If yes, how many times?
    ____ Yes, once
    ____ Yes, 2-4 times
    ____ Yes, 5 or more times
    ____ No

15. Did you have any previous dating relationships that involved physical abuse?
    _____ Yes

_____ No

16. Did you have any previous dating relationships that involved psychological abuse (e.g., being called names, being made to feel worthless…)
    _____ Yes
    _____ No

17. Have you ever sought the services of an organization for domestic violence before?
    _____ Yes
    _____ No

18. Have you ever received any other kind of psychological services?
    _____ Yes
    _____ No

19. Are you currently on medication for any type of mental illness (e.g., depression, posttraumatic stress disorder…)?
    ____ Yes (please specify: _____)
    ____ No

Appendix B

The PTSD Checklist, Civilian Version (PCL-C)

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
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 from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things 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 on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

Appendix C

Letter of Information

LETTER OF INFORMATION

Title of Study: **Effects of Intimate Partner Violence Study**

You are asked to participate in a research study conducted by Amanda Levine, a graduate student at the University of Windsor, under the supervision of Dr. Patti Timmons Fritz from the Department of Psychology at the University of Windsor. The data collected from this study will be used in Amanda's MA thesis. The Research Ethics Board (REB) at the University of Windsor has reviewed and given clearance for this research study to take place.

If you have any questions or concerns about the research, please feel to contact:
Amanda Levine at levinea@uwindsor.ca
Dr. Patti Timmons Fritz at (519) 253-3000 ext. 3707 or pfritz@uwindsor.ca.

PURPOSE OF THE STUDY
This purpose of this study is to examine the effects that intimate partner violence has on its victim's mental health.

PROCEDURES
To volunteer to be in this study, you will need to fill out a series of paper-and-pencil questionnaires that will ask about your history of victimization, your emotional experiences, and your mental health.

In total, the study will take up approximately 45-60 minutes of your time.

POTENTIAL RISKS AND DISCOMFORTS
This study does not have any major risks, except that you may have some negative feelings (e.g., anxiety, sadness, embarrassment, anger) in response to some of the things that you will be asked to think about and share. However, you do not have to answer any questions that you do not want to answer, and you can stop participating in this study at any time without penalty. Should you experience any form of distress after being in this study, please either contact Amanda Levine or Dr. Patti Timmons Fritz.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY
Information obtained from this study will add to our general knowledge about what happens between an experience of intimate partner violence and the development of mental illnesses. Such information could be used to help develop prevention and treatment programs aimed at helping individuals who have been victims of intimate partner violence.

COMPENSATION FOR PARTICIPATION
You will receive a 5$ gift card from Horton's for your participation in this study.

CONFIDENTIALITY
The following steps will be taken in an effort to keep your personal information confidential in this study:

(1) Your research questionnaire package will not have any identifying information on it, but will instead be coded with a number;
(2) Your data will be stored in a secured, limited access location;
(3) Only research staff directly involved with the study will have access to your information;
(4) Your identity will not be revealed in any publication or presentation of the results of this research.

However, confidentiality cannot be guaranteed; your personal information may be disclosed if required by law. This means that there may be rare situations that require us to release personal information about you (for instance, in cases in which a judge requires such release in a lawsuit; if you tell us of your intent to harm yourself or someone else; and behaviours consistent with child abuse). In accordance with the American Psychological Association, your data (including transcriptions of your audio recordings) will be kept for 5 years.

In order to avoid a breach of confidentiality, please do not put any identifying information (such as your name or email address) on the questionnaire package.

PARTICIPATION AND WITHDRAWAL
You can decide whether or not you wish to participate in this study. You may stop participating at any time without any consequences. You may also refuse to respond to any items in the questionnaires or during the interview that you do not wish to answer and still remain in the study. The researcher may withdraw you from this research study if there are circumstances in which this would be necessary. There may be cases (e.g., certain legal situations) in which you will not be allowed to withdraw your data.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS
When this research study is finished, we will write a summary of the study results that you can access through the following website: www.uwindsor.ca/reb. (You will need to click on "Study Results: Participants/Visitors"). It is anticipated that results will be posted by September 2011. Additionally, a copy of the results will be sent to the Well-Come Centre .

SUBSEQUENT USE OF DATA
Your data may be used in subsequent studies.

RIGHTS OF RESEARCH PARTICIPANTS
You may withdraw your consent at any time and drop out of the study without penalty. If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

Appendix D

Positive Writing Task

Now think about a recent situation in your life where something happened that made you feel good about yourself. In the space below, please briefly describe this situation and how it made you feel.

Appendix E

Debrief Form

Thank you for taking the time to participate in this study. We are interested in investigating the impact of intimate partner violence on individuals' well-being, and the ways in which individuals deal with such violence. In particular, we are interested in individuals' beliefs about who is to blame for the violence and whether such blame can predict psychological well-being. Knowing this could influence treatments used with victims of intimate partner violence.

By participating in this study, you have made a significant contribution to research in this area, and have provided information that may lead to better prevention and treatment programs aimed at helping victims of intimate partner violence and at building healthy relationships.

Thank you!

Appendix F

Resource List

Sometimes when individuals have questions or problems they may not know who to talk to or where to get help. We have included a list of services that are available to individuals in your area (in addition to the Well-Come Centre). If you, a friend, or a family member have questions, would like someone to talk to, or need help with a problem, one of these resources may be able to help.

Windsor-Essex County Family YMCA 500 Victoria Ave. Windsor, ON N9A 4M8 Tel: (519) 256-7330	**Hiatus House** 250 Louis Ave. Windsor, ON N9A 1W2 Tel: (519) 252-7781
Bulimia Anorexia Nervosa Association (BANA) 2109 Ottawa Street, Suite 400 Windsor, ON N8Y 1R8 Tel: (519) 969-2112	**Sexual Assault Crisis Centre of Essex County (24 hours)** Email: sacc@wincom.net Tel: (519) 253-9667
Distress Centre of Windsor-Essex County Crisis Phone: (519) 256-5000 For persons in distress	**Amherstburg Community Services (ACS)** 400 Sandwich St. S, Unit 31 Amherstburg, ON N9V 3L4 Tel: (519) 736-5471
Belle River & District Community Information Centre Tel: (519) 728-1435	**Maryvale Adolescent & Family Services** 3640 Wells Street Windsor, ON Tel: (519) 258-0484

VITA AUCTORIS

NAME	Amanda Levine
PLACE OF BIRTH	Montreal, Quebec
YEAR OF BIRTH	1987
EDUCATION	Bialik High School, Côte Saint-Luc, QC 1999 – 2004 Dawson College, Montreal, QC 2004-2006 Concordia University, Montreal, QC 2006 – 2009 B.A. (Honours) University of Windsor, Windsor, ON 2009 – Present M.A. Clinical Psychology (candidate)