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BASELINE TRAUMA SYMPTOMS: RESIDENTIAL AND NON-RESIDENTIAL
SURVIVORS OF INTIMATE PARTNER VIOLENCE

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the Faculty of the Department of Psychology
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By
Brooke Regina Jacobs

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BASELINE TRAUMA SYMPTOMS: RESIDENTIAL AND NON-RESIDENTIAL
SURVIVORS OF INTIMATE PARTNER VIOLENCE

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Intimate Partner Violence (IPV) is a preventable public health problem that's literature has documented the clinical presentations of those who have experienced IPV. These presentations include what is generally consistent with post-traumatic stress disorder, as well as a wide range of other symptoms including different medical comorbidities, defensiveness, difficulties in self-regulation, externalizing behavior, difficulties in relationships, withdrawal, and somatic preoccupations. These presentations are typically assumed to be symptoms of IPV but some argue that some of these, such as insecure attachment or trauma exposure, may be precursors to experiencing IPV. This has been discussed with great caution to avoid victim blaming, while still attempting to identify if certain characteristics could increase one's likelihood of experiencing IPV. Treatment approaches have attempted to respond to several of these differing symptoms with evidenced-based practices such as prolonged-exposure therapy, cognitive-processing therapy, stress inoculation training, eye-movement desensitization and reprocessing, and medication therapy.

This project reviewed how victims of IPV present to IPV service providers as those needing residential reprieve from IPV or those who are suffering from IPV but are not at immediate risk. Results from this study concluded that those who require these residential services experience higher levels of attachment difficulties, specifically rejection sensitivity, displayed level of mental distress, and traumatic symptomology than

those who are seeking non-residential IPV services. The traumatic symptomology that was higher specifically identified tension reduction behaviors, suicidality, somatization, sexual disturbances, and impaired self-reference.

Chapter I: Introduction

Public health is a topic that may not be a salient issue in the day-to-day lives of many Americans. It is when this topic directly affects ourselves or our loved ones that it typically gains our attention. There is currently a serious public health problem that affects millions of Americans and fortunately this problem is preventable. When we think of public health concerns most of us can quickly recall issues including cancer, antibiotic resistance, Zika, or tobacco use. But, when our interactions with other individuals lead to experiencing violence and fear, it becomes a concern for the overall wellbeing of our population, which is a public health concern.

The Centers for Disease Control and Prevention (CDC) defines an intimate partner as an individual engaged a relationship that is close and personal in nature, which can be characterized by the following: “emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, familiarity and knowledge about each other’s lives” (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 11). This type of relationship is a desire of most post-pubescent individuals. It is when this relationship is unhealthy and dangerous that it becomes the public health issue that is changing the lives of millions. This topic was previously labeled as domestic violence but a shift in semantics now identifies “physical violence, sexual violence, stalking, or psychological aggression (including coercive acts) by a current or former intimate partner” as intimate partner violence (IPV) (Breiding et al., 2015, p. 11). Throughout this paper the terms domestic violence and IPV will be used interchangeably. This term and definition is one that evolves with research and knowledge, with the most recent change

in the definition of IPV being the addition of stalking (Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens, 2011).

To begin to recognize the impact on our nation we need to look at the numbers of those effected. Most recent statistics (2015), provided by the National Coalition Against Domestic Violence (NCADV), explains that in one year 10 million women and men are physically abused by an intimate partner. This equates to an average of nearly 20 individuals per minute in our country. It is important to remember that physical violence is only one aspect of IPV along with stalking, sexual violence, and psychological aggression. Typically, in one day more than 20,000 phone calls are placed to domestic violence hotlines across the nation (National Coalition Against Domestic Violence, 2015). This is a significant, preventable issue for the United States (Black et al., 2011).

History, Funding, and Data of IPV Programs.

In a pursuit to decrease the occurrences of IPV and hopefully one day eradicate the issues brought on by IPV, coalitions have been formed, laws have been passed, programs have been developed and millions of dollars have been used to support the cause. Specifically, in the United States, there have been three major federal acts of legislation that have led to the development and funding of domestic violence shelters and outreach/non-residential programs.

In 1984, Congress passed, and President Reagan signed into law, the Victims of Crime Act (VOCA). VOCA established the Crime Victims Fund to assist and compensate victims and/or survivors of crime. Several streams of revenue flow into the Crime Victims Fund including: federal criminal fines, forfeited bonds, forfeiture of profits from criminal activity, additional special assessments, and donations by private

parties. These funds are then distributed to states through grants. It is specified how the funds can be utilized through the individual states. Victim services are typically provided through services of domestic violence shelters or other domestic violence service providers (National Coalition Against Domestic Violence, 2015).

Also in 1984, Congress created The Family Violence Prevention and Services Act (FVPSA) as part of the Child Abuse Amendments. This act is a primary source of federal funding for domestic violence direct service providers and is reauthorized every five years (Jordan, 2014). These funds are also distributed through the use of grants. Approximately 70% of the funds are dispersed to states with the other going directly to resource centers or state domestic violence coalitions (National Coalition Against Domestic Violence, 2015). The money received by each state is then directed to service providers which can include shelters and non-residential programs. Programs funded through FVPSA provide direct services to over 1.3 million victims each year (National Coalition Against Domestic Violence, 2015).

Ten years later in 1994 the Violence Against Women Act (VAWA) was passed by Congress. This act is formally known as Title IV of the Violent Crime Control and Law Enforcement Act (Jordan, 2014). The purpose of this Act is to increase an overall change in societal views toward violence against women and to decrease violence by supporting comprehensive, effective, and cost-saving responses to domestic violence, sexual assault, dating violence, and stalking. VAWA provides states and communities tools to help victims based on local and statewide needs and priorities (National Coalition Against Domestic Violence, 2019). This act allowed for new programs to be formed with the assistance of grant money that assisted law enforcement in this cause and assist in the

development of legal changes that were in line with the cause. Since the implementation of VAWA, intimate partner violence against women has declined by 72% (National Coalition Against Domestic Violence, 2015).

To date, the act has been reauthorized three times, but in 2018 VAWA expired. In order to continue assisting victims, the act must be reauthorized by Congress; currently, the House of Representatives has passed the reauthorization of the bill and the Senate must approve prior to signing the bill into law. The current bill up for reauthorization attempts to incorporate best practices to lessen the economic impact of IPV by breaking down barriers to housing and employment. It aims to do this through: prohibiting those with a history of violence from accessing firearms; improving criminal justice responses for tribal jurisdictions; mandating all sexual interactions between law enforcement officials and individuals in their custody be considered nonconsensual; ensure culturally competent responses to victims of gender-based violence; and general investments toward research and development to reduce and prevent violence (National Coalition against Domestic Violence, 2019).

Current Study

Although there have been significant strides made to reduce this public health issue, the gaps in research regarding risk factors of IPV victimization are significant. While it is a topic that should be approached with caution, much can be gained by recognizing contributing factors that may put one at risk of experiencing IPV. Furthermore, it is important to identify if there are differences between those who are experiencing an active threat of IPV and those who have a history of IPV in their past, even recent past. The purpose of this study is to identify if survivors of IPV differ in their

clinical presentation and needs based on whether or not they require emergency shelter services. More specifically, it aims to identify if individuals actively fleeing domestic violence may benefit from being identified as a special population of IPV victims. Both groups have experienced IPV but does a survivor experiencing the immediate safety risk differ significantly from one who is safe to maintain residence in the community? This study aims to provide a foundation of research to be built upon to identify if differing treatments for the two groups would be beneficial. It is shown that there is a gap in the research. Very little research has been done regarding the effects of non-residential or outreach IPV clinical services (DePrince, Labus, Belknap, Buckingham, Gover, 2012).

One report indicated that the burden of sexual violence, stalking, and IPV is not distributed evenly in the U.S. population (Breiding, Smith, Basile, Walters, Chen, & Merrick, 2014). Additional research is needed in order to better understand the role of individual characteristics including the interaction of substance abuse, psychopathologies, and personality disorders, as well as the context and changes in aggression over time (Capaldi & Kim, 2007; Kelly & Johnson, 2008). Although categories might overlap and the actual numbers within each are uncertain, such efforts remain helpful to understand IPV and should guide intervention strategies with the best chance of success (Buzawa & Buzawa, 2013).

The importance of reducing the negative impact on mental health after IPV has more importance than just the face value of improving mental health. It has been identified that the mental health symptoms following interpersonal trauma are associated with a risk for future victimization (Cattaneo & Goodman, 2005; Classen, Paresh, & Aggarwal, 2005; Iverson, Gradus, Resick, Sucak, Smith, & Monson, 2011; Messman-

Moore & Long, 2003). The programs that receive the federal and state money to service those affected by IPV must identify the need for mental health services on top of victim advocacy, financial counseling, legal advocacy, and housing support. Currently, the national and commonwealth service providers do not collect data regarding mental health services provided to survivors of IPV who are served by these domestic violence agencies. Data collection and interpretation will be useful in providing justification for mental health services to be provided at grant funded agencies.

The present study aimed to determine the potential differences between victims of IPV seeking residential and non-residential services, using a real world clinical sample of adults presenting for services from a domestic violence service provider. Specifically, do survivors of IPV enrolled in a residential program differ from those receiving non-residential services differ in level of attachment security, traumatic symptomology, and displayed level of mental distress? These variables were be measured by the use of two assessment tools, TSI- 2 and BSI, commonly used to quantify such symptoms. The hypotheses were as follows:

Hypothesis 1. There will be relationship between the Trauma Symptom Inventory's (TSI-2) Insecure Attachment Scale, Rejections Sensitivity Subscale, and Relational Avoidance Subscale and the mode of service required by the participant. Specifically, those receiving residential services will score significantly higher on all three scales than those in non-residential services.

Hypothesis 2. TSI-2 clinical scale profiles for those requiring residential services will be significantly higher than the scale profiles for those seeking non-residential

services. These higher scores will be representative of client who seek residential services having a higher report of traumatic symptomology.

Hypothesis 3. There will be a significant difference in the BSI's Global Severity Index of victims of IPV requiring residential services as compared to those who require non-residential services. Suspecting that clients in residential services would score higher on the GSI scale, indicating higher displayed levels of mental distress.

Hypotheses 1 and 3 will be evaluated by the use of *t*-test to identify if the two groups present differently for each of the variables: Insecure Attachment Scale, Rejection Sensitivity Subscale, and Relational Avoidance Subscale, and Global Severity Index. Hypothesis 2 will utilize a multivariate analysis of variance (MANOVA) to identify if the 12 clinical scales of the TSI-2 vary mode of service.

The following paper will be organized by chapters in an attempt to provide a streamlined overview of applicable literature that supports the research questions, overall method of the research project, results of the data analyses, and discussion of how the project offers information for service providers and clinicians. Appendices are attached for ease to review the materials utilized in the study as well as the references for supporting literature.

Chapter II: Review of the Literature

The literature identified in the current section will provide a clear understanding of why the three variables of attachment level, traumatic symptomology, and mental distress were chosen to compare between the two groups. An overview of reactions to IPV, treatment approaches for victims of IPV, and the most recent information regarding creating a typology of victims of IPV will be discussed. Due to the current study being conducted in Kentucky, a specific review of how Kentucky responds to victims of IPV through service providers will be noted.

The individuals served in each of these programs across the nation are facing an array of challenges. When we use the term IPV it can be easy to forget scope of the term. The sexual violence aspect of IPV includes rape by an intimate partner. Of the rapes that occur in the U.S., approximately 47% of female and 45% of male victims were raped by someone they knew. From these, 45% of female and 29% of males were raped by an intimate partner (National Coalition Against Domestic Violence, 2015). With the addition of stalking to the definition of IPV, the occurrences have been tracked. It was found that 61 % of the 9.3 million female and 44% of the 5.1 million male victims of stalking reported being stalked by a former or current intimate partner. Another devastating outcome of IPV can include homicide. It is reported that 40% of female murders in the U.S. are murder by an intimate partner (National Coalition Against Domestic Violence, 2015).

While these are some of the physical and sexual demonstrations of IPV, psychological aggression is another arm of IPV that has significant effects on victims. This type of abuse can increase the trauma that comes with physical and sexual abuse

(O’Leary & Mairuo, 2001). Multiple studies have demonstrated that psychological abuse alone, independent of other types of abuse, leads to long-term negative effects on the mental health of the victim (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Golding, 1999; Lee & Hadeed, 2009; O’Leary & Mairuo, 2001). This abuse can take many different forms, but subtle psychological abuse has been found to prove more harmful than either overt psychological abuse or direct aggression (O’Leary & Mairuo, 2001). This more indirect form of psychological abuse may introduce certain behaviors or be the absence of specific behavior. For example, abusers may withhold emotional availability or withdraw in a passive-aggressive manner (O’Leary & Mairuo, 2001). Overall, victims of psychological abuse often experience depression, PTSD, suicidal ideation, low self-esteem, and difficulty trusting others (O’Leary & Mairuo, 2001).

Reactions to IPV

With the different types of abuse and multitude of situations in which IPV may occur, there are several possible symptoms of IPV including emotional responses, difficulties in relationships, behavioral outcomes, and the impact on others besides the direct victim. The effects of some symptoms that have been reported to be a result of experiencing IPV include defensiveness, withdrawal, depressive symptoms, difficulties in self-regulation and affect regulation for instance high levels of anger, self-impairment, dissociation, externalizing behavior, intrusive experiences, somatic preoccupation, sexual disturbance and suicidal tendencies (Briere, 2011; Fonagy & Target, 2002; Finkelhor, Ormrod, Turner, & Hamby, 2005).

Affective reactions. The costs of experiencing any or all modes of IPV can include psychological effects that last years after the violence has ended, resulting in a

chronic issue for victims (Campbell & Soeken, 1999; Zlotnick, Johson, & Kohn, 2006). While ongoing abuse and violence can induce feelings of shock, disbelief, confusion, terror, isolation, and despair, and can undermine a person's sense of self (Messman-Moore & Long, 2003).

There is an overwhelming complex nature to the symptoms of IPV due to the many forms of IPV and many other compounding variables. There are some known potential psychological effects of IPV. Consequences of IPV can lead to long-term symptoms of PTSD, depression, anxiety, lowered self-esteem, and a diminished sense of self-efficacy (Cascardi et al. 1992; Perez, Johnson, & Wright, 2012; Stets and Straus 1990; Sutherland, Bybee, & Sullivan, 2002). More research is needed on treating PTSD and co-morbid disorders such as depression, anxiety, substance abuse, personality disorders and psychosis which can escalate the severity of the individual's symptoms of PTSD (DeAngelis, 2008).

PTSD is one of the responses most often identified as a result of experiencing IPV. It has been identified that 31-84% of IPV survivors experience PTSD and it is estimated that depression is second to PTSD as an outcome for 48% of IPV survivors (Golding, 1999). Complexity comes when looking at the different disorders and symptoms as they are closely related. For instance, survivors who develop depression are also at risk for PTSD, as depression has been found to significantly relate to the development of PTSD (Cascardi, O'Leary, & Schlee, 1999; Stein & Kennedy, 2001).

Victimization can also lead to many symptoms that are not necessarily specific to PTSD. Research with the general population has found strong associations between IPV and depression (Beydoun et al., 2012; Heim & Nemeroff, 2001; Lee & Hadeed, 2009).

Specifically, researchers discovered up to a three-fold increased likelihood for major depressive disorder and up to a two-fold increase in depressive symptoms for female victims of IPV (Beydoun et al., 2012; Devries et al., 2013; Trevillion, Oram, Feder, & Howard, 2012). Other mood disturbances such as anxiety and anger have been linked to IPV (Gilboa-Schechtman & Foa, 2001, Heim & Nemeroff, 2001). A victim of IPV may also experience reduced affective regulation capacities (Briere & Rickards, 2007; van der Kolk, McFarlane, Weisaeth, 1996; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). Emotional dysregulation is identified as the inability to cope with heightened levels of emotions.

Relational difficulties. There are a number of concepts including interpersonal difficulties, social support, intimacy dysfunction, relational capacity, attachment, relational functioning, and quality of relationships that appear in the literature regarding aspects of the social phenomena associated with trauma (Matlack, 2010). Trauma can influence a victim's sense of self and lead to identity disturbances as an unwanted outcome (Peppard, 2008). Identity disturbance is included as a criterion for multiple mental health diagnoses as described by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013). Therefore, individuals who experience IPV are at risk of experiencing identity disturbance along with mood, anxiety, and psychotic disorders (Briere & Rickards, 2007; Cole & Putnam, 1992).

Interpersonal problems refer to the difficulties individuals encounter in establishing and maintaining interpersonal relationships in general (Matlack, 2010). Several studies have identified that the experience of trauma can lead the individual to display chronic interpersonal difficulties (Office of the Surgeon General, 2001; Pietrzak,

Goldstein, Malley, Johnson, & Southwick, 2009). Researchers have also identified that attachment disorganization can be experienced by victims of trauma, specifically they may display insecure attachment styles (Brennan, Clark, & Shaver, 1998; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008; Watson, 2007). Attachment disruption and trauma may derail the development of an integrated self as well as creating difficulties in forming and maintaining healthy relationships (Matlack, 2010).

Behavioral manifestations. The effects of IPV have manifested in behavioral outcomes including maladaptive coping strategies such as self-harm, substance use, and impulsive sexual behaviors (Briere & Gill, 1998; Wright, Foran, Wood, Eckford, & McGurk, 2012). Some of these behaviors may be classified as tension reduction or externalization activities including bulimic eating, impulsive aggression, and self-mutilation (Breier & Gil, 1998; Zlotnick et al., 2007). One symptom of trauma that is almost unanimous with the definition of trauma is dissociation. The definition of dissociation as "disruption of the usually integrated functions of consciousness, memory, identity, or perception of the environment" (APA, 1994, p. 477) or a state of consciousness that results in reduced awareness of environmental events (Foa, Keene, & Freidman, 2000). Howell explained that the best definition of trauma may be an "event that causes dissociation" (2008, p. 109). The DSM-5 notes that dissociative disorders are frequently identified after trauma is experienced (APA, 2015). Research supports that traumatic memories are at their nature dissociated and are initially stored as separate sensory information without a consistent storyline with the memory (van der Kolk & Fisler, 1995).

Another factor to consider in the experience of trauma is the correlation with substance abuse (Ouimette & Brown, 2003). Many studies have been conducted regarding the connection between the two but causality is unable to be determined due to the retrospective nature of the studies (Herman, 1997). Evidence has been provided to support that the brain itself is changed by traumatic events (Anda et al., 2006; Gaskill & Perry, 2012), and victims of trauma use substances to provide a numbing effect or dissociate from the experience (Najavits, Hamilton, Miller, Griffin, Welsh, & Vargo, 2014).

Suicidal thoughts and behaviors have a clear relationship with PTSD regardless of the type of trauma experienced (Panagioti, Gooding, & Tarrier, 2009). The relationship found between trauma and suicidality are not only present when victims experience PTSD but it is this connection seems to have a significant amount of supporting evidenced. The development of PTSD after trauma is the main predictor of suicidality; one study identified suicidal ideation was four times higher in trauma victims with at least four symptoms of PTSD than trauma survivors who did not report traumatic symptoms (Marshall, Olfson, Hellman, Blanco, Guardino, & Struening, 2001). Victims of trauma with PTSD were found to have greater rates of suicidal ideation and suicide attempts when compared to no lifetime trauma experienced or those who experienced trauma but did not meet criteria for PTSD (LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015). Specifically, if the individual is experiencing depression and symptoms of PTSD the risk for suicidality increases, as well as the presence of feelings of hopelessness, defeat, or entrapment (Panagioti, Gooding, & Tarrier, 2009). Also, the amount of traumas experienced increases suicidality in that each additional trauma

increases suicidal ideation by 20% and rate of suicidal attempts by almost 40% (LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015)

Physical manifestations. The physical abuse that occurs within IPV can be devastating. On average within the United States, almost 20 people are physically abused by an intimate partner every minute (National Coalition Against Domestic Violence, 2015). Within one year, this sums up to more than ten million individuals experiencing the physical violence aspect of IPV. While an average of one out of three women and one out of four men have been victims of IPV physical violence, one out of four women and one out of seven men have been severely physically injured by an intimate partner within their lifetime (National Coalition Against Domestic Violence, 2015).

Other than the physical effects of physical violence that can occur in IPV, victims may develop somatic symptomology to accompany or displace the emotional pain that comes from the IPV (Kendall-Tackett, Williams, & Finkelhor, 1993). Either medically unexplained symptoms such as dizziness, tinnitus, and blurry vision can occur or victims may experience a range of medical conditions (Gupta, 2013). Frequent medical co-morbidities with PTSD have included hypertension, cardiovascular disease, respiratory disorders, chronic pain, and sleep disorders (Gupta, 2013). More so, there is evidence that PTSD is associated with premature onset of physical health concerns, including those listed above, to cognitive decline, and even premature death (Wolf, 2016). These are typically identified as age-related conditions, supporting the hypothesis that stress of PTSD symptoms is associated with premature aging (Wolf, 2016).

Other victim types. It is also important to note that it is not only the intimate partner who suffers the effects of IPV. A study of homicides occurring in cases of IPV

discovered that 20% of the murder victims were not the intimate partner, but rather relatives, friends, neighbors, persons intervening, law enforcement responders, or bystanders (Smith, Fowler, & Niolon, 2014). It is known that violence in the home may precipitate more violence within and outside of the home (Felitti & Anda, 2010). Other individuals who suffer from the exposure to IPV include the children involved, which can distort the lives and minds of the children (Widom & Maxfield, 2001). The prevalence is shocking as one in 15 children are exposed to IPV each year in the U.S. and 90% of these children witness the violence directly (Hamby, Finkelhor, Turner, & Ormrod, 2011).

Typology of Victims

There has been a significant amount of effort behind identifying any characteristics that are linked to someone perpetrating violence against others, specifically IPV. The most common factors discussed when attempting to predict the likelihood of someone engaging in IPV are attachment styles, history of trauma, and personality organization. While most research has been conducted to analyze male perpetrators, recently female perpetrators have been examined as well. One analysis found that female IPV offenders reported less attachment security, more trauma-related symptoms, and more personality psychopathology than non-offender clinical comparison women (Goldenson, Geffner, Foster, & Clipson, 2007). Specifically, the personality characteristics were consistent with antisocial, borderline, and dependent scales on personality assessments.

Attachment theorists suggest that attachment types can help explain perpetrated IPV (Dutton, Saunders, Starzomski, & Bartholomew, 1994). This theory has been utilized as a developmental framework for understanding different characteristics of relationship

distress within the context of adult romantic relationships (Carnelley, Pietromonaco, & Jaffe, 1994; Dutton, Saunders, Starzomski, & Bartholomew, 1994). Insecure attachment has also been linked with PTSD (Dutton, Saunders, Starzomski, & Bartholomew, 1994). It is suggested that early exposure to IPV and experiences of abuse can create a social learning experience that increase one's chances of perpetrating IPV against others. Finally, Dutton and colleagues termed the "abusive personality" as extensive PTSD symptoms, high separation anxiety, high anger, and symptoms of borderline personality disorder (Dutton, Saunders, Starzomski, & Bartholomew, 1994). Overall, it has been identified that male IPV offenders have significantly more personality psychopathological as compared to males who had no history of perpetrating IPV (Carnelley, Pietromonaco, & Jaffe, 1994; Dutton, Saunders, Starzomski, & Bartholomew, 1994). While personality, attachment, and trauma-related patterns all contribute to the behavior of IPV offenders, it is important to remember the possibility of alternative causal pathways (Goldenson, Geffner, Foster, & Clipson, 2007).

While there has been a significant amount of research conducted on the effects of experiencing IPV, there is also some research surrounding factors that may increase the likelihood of an individual being subjected to IPV. The focus of most IPV research regarding typology has been on the typology of a perpetrators rather than that of a victim (Cattaneo & Goodman, 2005). Research surrounding risk factors for IPV victimization suggests that attachment style, trauma exposure, and personality organization are also significant in the victim as well as the perpetrator (Carnelley, Pietromonaco, & Jaffe, 1994; Cattaneo & Goodman, 2005). The reason for this one sided research may be due to a fear of victim blaming, which is a legitimate concern. While this topic should be

handled with care, it is important to identify potential factors that can be recognized and can be used to reduce the risk of individuals experiencing IPV (Dutton, 2009; Noll, 2005).

For ease of communication, potential risk factors for IPV have been categorized into institutional, community, interpersonal, and individual aspects. Institutional or policy factors can include laws protecting women, awareness of laws, and enforcement of laws surrounding IPV (Shauman, Ibrahim, Gupta, Hausman, O'Brien, & Paranjape, 2014). Community issues that may lead increased IPV incidents included social norms around women and neighborhood poverty. Interpersonal factors are marital conflict, poverty, substance use, and family violence. While individual aspects are age, mental health status, impulsivity, history of abuse, substance use, and homelessness (Shauman, et al, 2014). These personal, individual factors are the aspects that are difficult to analyze without victim blaming.

There have been other aspects that show consistency in IPV situations. The role of economic factors as a risk for IPV has also been explored. Research showed women with male partners who experienced two or more periods of unemployment were almost three times as likely to be victims of IPV when compared to women with partners who remained employed (Fox, Benson, DeMaris, & Van Wyk, 2004). Violence may inhibit a victim's ability to escape or establish financial autonomy. Victims often lack feelings of social efficacy, as well as the knowledge and economic resources needed to leave an abusive relationship (Renzetti, 2009).

One group reviewed the effects of providing outreach services to female victims of IPV identified in the court system (Gondolf, 1998). The outcome of the outreach

project noted that there may be some different types of victims who would then need differing services based on their type. The largest group involves the women who are simply difficult to reach. They may be in transition, in hiding, or fearful of their partner. Another group of women are those who refuse services because they do not perceive a need for them. They appear to be relatively self-sufficient or prefer to cope on their own. Many victims may, moreover, simply not see counseling as what they need most. They may most need income, housing, employment, childcare, or a safe neighborhood. A third relatively small group are those who are interested in additional services. They are concerned about emotional impacts, legal complications, and children's needs beyond coping with physical abuse (Gondolf, 1998).

It is argued that there is also a typology of an individual in an intimate relationship with the perpetrator. Some researchers argue that for research to be conducted on IPV that it is necessary to identify the specifics of the violence that is occurring. Johnson's typology explains that IPV can be defined at a deeper level; specifying if it is intimate terrorism, violent resistance, or situational couple violence (Johnson, 2008). Situational couple violence is often described by both parties enacting violence on the other. This can be an argument that escalates into a violent, aggressive situation. Intimate terrorism involves physical and sexual violence combined with nonviolent control tactics that may include psychological aggression, confinement tactics, or economic abuse. Violent resistance is when victims of intimate terrorism react in violence with a defensive motive (Johnson, 2008). While Johnson's typology provides more information regarding typology and types of IPV, it does not provide an explanation of the possibility of risk factors for IPV victimization.

Evidenced Based Treatment of Trauma Symptoms

As previously discussed, there is not a guaranteed response to trauma. The complexity of the trauma as well as many other factors can affect the symptoms that are experienced following the trauma. Typically, PTSD and Acute Stress Disorder are on the short list of considerations in the case conceptualization of trauma victims. For succinctness and efficiency, the treatments for these two disorders will be discussed while knowing they are not all encompassing of the resulting symptoms of trauma.

Prolonged-exposure therapy is cognitive-behavioral intervention designed specifically for the treatment of PTSD (DeAngelis, 2008). The treatment consists of requesting and assisting a client in re-experiencing a traumatic event, in a controlled fashion. The re-experiencing can be done through accessing the memories and engaging with identified triggers. This is practiced in order for the clients to eventually regain mastery of their thoughts and feelings that are associated with the event (DeAngelis, 2008). The therapy is a structured attempt to decrease clients' patterns of avoidance by having them gradually and repetitively evaluating circumstances to understand in current reality they are safe to return participating in life as they choose (DeAngelis, 2008). To overcome the disproportionate distress and anxiety that is a typical outcome of experiencing a traumatic event, this technique allows patients to approach feared and avoided memories and stimuli that are related to their trauma in a safe place (Ruzek, Eftekhari, Rosen, Crowley, Kuhn, Foa, Hembree, & Karlin, 2014). Drawing from PTSD best practices, the APA-initiated Center for Deployment Psychology includes training for exposure therapy for health professionals who are or will be treating returning specific military veterans (DeAngelis, 2008).

Another form of cognitive-behavioral therapy used to treat PTSD is cognitive-processing therapy. Initially the therapy was developed by psychologist Patricia A. Resick, PhD, director of the women's health sciences division of the National Center for PTSD, to treat rape victims and was later identified as a functional technique to treat PTSD (DeAngelis, 2008). Similar to prolonged exposure, there is an exposure piece to the treatment approach but the main emphasis is placed on developing cognitive strategies to address the invalid thinking that is present.

Stress-inoculation training is another form of cognitive-behavioral therapy that is fundamentally different from the previously mentioned therapies. Prolonged-exposure and cognitive-processing protocols both require clients to disclose details of their trauma and are therefore emotionally demanding (Mott, Mondragon, Hundt, Beason-Smith, Grady, & Teng, 2014). Stress-inoculation training can be seen as less intrusive as the clients are taught to manage and reduce anxiety through breathing, muscle relaxation, positive self-talk, and other techniques (DeAngelis, 2008). Similarly, cognitive restructuring, cognitive therapy, and different combinations of the afore mentioned treatments have been identified as appropriate to address PTSD (Bryant et al., 2008).

Another PTSD focused therapy technique that has been gaining attention is eye-movement desensitization and reprocessing (EMDR). The clinician provides an external stimulus through bilateral stimulation; this is typically done through asking the client to visually track the clinician's hand back and forth or the clinician may tap on the client's knees (DeAngelis, 2008). This is done while the client recalling a traumatic experience. It is hypothesized that EMDR allows for the facilitation of recalling and processing memories that are traumatic and bring an adaptive solution (Maxfield & Hyer, 2002). The

solution is desensitization of emotional distress, reformulation of associated cognitions, and physiological arousal reduction. It has not been fully clear how the process of EMDR reduces symptoms of PTSD, and, for that reason, it's somewhat controversial, though the therapy is supported by research (DeAngelis, 2008).

Finally, medications have also shown benefits with regard to reducing experienced symptomology of PTSD, specifically selective serotonin reuptake inhibitors. Two specific medications, paroxetine (Paxil) and sertraline (Zoloft), have been approved by the Food and Drug Administration for use in PTSD (DeAngelis, 2008). The guidelines provided by the Food and Drug Administration also note that other medications may be useful in treating PTSD as well, particularly when the person has additional disorders such as depression, anxiety, or psychosis (DeAngelis, 2008).

These treatment approaches are utilized for several types of IPV victims. Trauma treatment has been specialized for other groups of survivors of IPV such as: males, pregnant, low socio-economic status, substance abuse, African American, Hispanic, members of the lesbian, gay, bisexual, transgendered, and queer community, immigrants, and those who experience guilt as a result of IPV (Christiansson, 2013). These approaches incorporate different tools that typically adjust aspects of the therapeutic relationship between therapist and client. Other approaches include providing psychoeducation regarding the effects of IPV within the specific group (Christiansson, 2013).

Kentucky's History of IPV

While the previously mentioned federal legislation acts were passed to assist the country's development of services provided to IPV victims, the Commonwealth of

Kentucky was working reforming legislation around women's rights. Starting in the late 1960's, a shift was seen in Kentucky law that had its successes and failures (Jordan, 2014). Initially, the Kentucky Commission on Women was developed to report and review women's status across the state. Throughout the next decade, bills were passed that allowed women to enter into contracts without the signature of a husband, required data collection of domestic violence occurrences, enforced mandatory reporting in spouse abuse cases, allowed women to be served alcoholic beverages in bars, and the Adult Protection Act was expanded to protect spouses instead of just vulnerable adults (Jordan, 2014).

Kentucky's first "Spouse Abuse Center" was opened in Louisville in 1977 and by 1980 there were six different programs serving and providing shelter to women and their children who were fleeing domestic violence (Jordan, 2014). The Commonwealth continued their support of spouse abuse centers in the 1980's by passing state funding. In 1981, the Kentucky Domestic Violence Association was developed by the staff of the spouse abuse centers. They had a goal to include all domestic violence programs in Kentucky and provide mutual support, information, share resources, coordinate programming and necessary services (Jordan, 2014). Overall, they aimed to be a united front in advocating for changes in state laws to assist victims of domestic violence and their families. This association is now known as the Kentucky Coalition Against Domestic Violence (KCADV).

A total of \$686,000 was allocated to shelters in 1982 (Jordan, 2014). Soon after the Commonwealth began reforming their mental health system to line up with research and legislative changes. Specifically, they developed the Sexual and Domestic Violence

Program as well as the Office of Victims Advocacy. A position within the governor's office titled liaison for family violence prevention was developed. Kentucky's Domestic Violence and Abuse Act followed which allowed for victims to obtain protection against further violence and abuse, expand the ability of the law enforcement to respond and intervene in domestic violence and abuse situations, and provide for the collection of data including incidents of domestic violence and abuse (Jordan, 2014).

In response to the information gathered and voices heard, Kentucky moved to expand spouse abuse centers in 1986. This resolution explained that approximately 6.3 million men and women were "beaten by spouses" annually across the nation (Jordan, 2014). Specifically, it argued that Kentucky was not equipped to provide for these individuals as shelters were not available in all regions of the Commonwealth and current shelters were forced to turn away victims on a daily basis. This sparked the network of domestic violence programs offered across Kentucky today. Legislation in Kentucky continues to adapt including providing protective orders for stalking victims, the notification of victims when respondents to protective orders attempt to purchase firearms, and the development of the Office of Women's Physical and Mental Health (Jordan, 2014).

Today, KCADV administers over nine million dollars in funds, both state and federal, throughout the 15 domestic violence programs in the Commonwealth. The coalition helped pass legislation that increased resources for victims as well as legal concerns such as: addressing warrantless arrest, emergency protective orders, and the recognition of both marital rape and dating violence (Jordan, 2014). The group's efforts have also led to formal data collection, allowing for the need of programing to be

identified accurately. In Kentucky's 2015-2016 fiscal year 2,071 women, 28 men, and 1,506 children were admitted into residential domestic violence shelters (Kentucky Coalition Against Domestic Violence, 2016). While the non-residential, outpatient new participants included 16,871 women, 1,343 men, 400 children, and 79 "adult other/unknown." All of these numbers are unduplicated numbers, representing individuals served (Kentucky Coalition Against Domestic Violence, 2016).

Across the commonwealth of Kentucky, the 15 domestic violence service providers assist survivors by assessing their needs and immediate safety risk to help determine if the individual would most benefit from residential or non-residential services. One of the ways a person's safety risk is assessed by the use of a lethality assessment tool that was initially developed by the Maryland Network Against Domestic Violence. This tool requests the individual to answer 11 yes/no questions regarding the perpetrator including use of weapons, access to weapons, threats of violence, suicidality, use of choking, controlling behaviors, employment, and having children not in common. The assessment is scored as highly lethal if the victim answers "yes" to at least one of the three high lethality questions or "yes" to at least four of the other eight questions. The service providers help inform those seeking help of the lethality of certain behaviors and safety plan with the individual. These services are voluntary as KCADV provides clear directive that all services should be client directed (KCADV, 2016). Ultimately, a mutual decision is made between the service provider and the client to determine which mode of service would be most beneficial to the client. It is important to note that once individuals become a client of a service provider it does not mean that the person is no longer in the

active IPV relationship. It is not uncommon for the IPV to continue after the connection with the service provider has been made.

For the current study, the clinical records from one of the commonwealth's services providers were be utilized to assist in filling the current gap in the research about how victims of IPV can clinically present, specifically if there is a difference in the presentation of those seeking residential services and those seeking non-residential services. While the research has been discussed on how clients can present after experiencing IPV, including depression, interpersonal difficulties, trauma exposure, attachment concerns, substance abuse, and general mental distress, it is unknown if these are responses to IPV or a typology of a victim of IPV. This research provides a basis for further research to guide the clinical treatment of the two different groups and presentations as well as adds to the literature of how individuals present after experiencing IPV.

Chapter III: Method

In an attempt to answer the question if victims of IPV enrolled in a residential program differ from those receiving non-residential services differ in level of attachment security, traumatic symptomology, and displayed level of mental distress, the following method and procedure was implemented. This chapter will describe how data were collected and analyzed to provide further information on the overall clinical presentations of those who have experienced IPV and if it can be stated that those needing residential services are presenting with a significant amount more distress, traumatic symptomology, and disrupted attachment than those needing the narrower case management assistance of non-residential services.

Participants

Participant data were collected from the records of clients who presented at a domestic violence crisis center in Kentucky. This agency provides emergency shelter and non-residential services to domestic violence survivors and their children. In the 2015-2016 fiscal year, this center provided shelter to approximately 150 families and outreach services to an estimated 550 families. The organization offers many services including, but not limited to: 24-hour crisis line, 24-hour emergency shelter, relocation services, support groups, financial assistance, transportation, micro-loan programs, housing stabilization, and mental health support. The mental health support is encompassed by the clinical department at this crisis center and the files from this department are ones that were utilized in this study. Clients are offered clinical services in a voluntary manner in which the client's access to other services, including shelter, are not affected by the decision to participate or not in the clinical services.

The focus of this research was geared toward adults, therefore, no records from children were used for this study. Records of individuals over the age of 18 years who presented to the domestic crisis center, voluntarily agreed to receive clinical services, and completed the Brief Symptom Inventory (BSI) and Trauma Symptom Inventory-2 (TSI-2) measures between the years of 2017 and 2019 were used for this research. Following approval from the Institutional Review Board at Western Kentucky University, data collection began in the fall of 2019 and continued until 120 data points were obtained. At the time collection began, the data was archival. The BSI and TSI-2 profiles were assessed for validity and only those determined to be valid were included. Only records from clients who signed a form approving the use of their files to be analyzed for research purposes were considered and the clients' assessment forms and scores, as well as demographic data are kept in the clients' files.

The client's clinical presentation upon seeking services helps determine which method of service delivery is best suited to meet the participant's needs. In order to receive shelter, the client must be fleeing a domestic violence situation and deemed at immediate risk of danger. Some of these clients are homeless, with nowhere else to flee, but others may need to leave their own home due to the safety risk. Clients are offered outreach services if they are not in immediate risk but have still experienced IPV and need assistance to overcome the many effects of this experience. The client's status as noted in the client's file, either shelter/residential ($n = 59$) or outreach/non-residential ($n = 61$), at the time of the assessments determined participant's group status within the study. Thus, 120 participants (119 females, 1 male) were included in the final sample.

Materials

Brief Symptom Inventory. The BSI is a self-report questionnaire which collectively provides an overview of an individual's symptoms and their intensity at a specific point in time (Derogatis, 1993). It is a validated shortened form of its parent instrument, the 90-item Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1994). It is standardized for use in the clinical assessment of individuals 13 years of age and older, with a required reading level of sixth grade. Most individuals are able to complete the 53 questions included on the BSI within eight to ten minutes. A short introduction and period of instruction of approximately two to five minutes are mandatory for test validity (Derogatis, 1993). Test-takers are instructed to choose one answer of the five choices of responses: not at all, a little bit, moderately, quite a bit, and extremely. The instructions include reading the test form directions, "Please, read each [item] carefully, and blacken the circle that best describes how much that problem has distressed or bothered you during the past 7 days including today" (Derogatis, 1993, p. 6). The respondent is also to have access to the administrator for questions or concerns.

It covers nine symptom dimensions: Somatization, Obsessive Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism (Derogatis, 1993). Three Global Indices are calculated: Global Severity Index, Positive Symptoms Distress Index, and Positive Symptom Total; they measure current or past level of symptomology, intensity of symptoms, and number of reported symptoms, respectively (Derogatis, 1993). A description of these scales and global indices can be found in Appendix A. An 85-page administration, scoring, and procedures manual provides information on scale development, norms, reliability and

validity, along with administration, scoring and guidelines for interpretation and profile configurations.

The reliability, validity, and utility of the BSI instrument have been tested in more than 400 research studies (Derogatis, 1993). Internal consistency reliability for the nine clinical domains are reported as ranging from .71 to .85 and has been supported in several other independent studies (Aroian, & Patsdaugher, 1989; Croog et al 1986; Derogatis, 1993). The internal consistency for the Global Severity Index has a Cronbach's alpha reported as .96 (Mohammadkhani, Dobson, Amiri, & Ghafari, 2010). Test-retest reliability for the nine symptom dimensions ranges from .68 to .91 and for the three Global Indices from .87 (Positive Symptoms Distress Index) to .90 (Global Severity Index). Validity correlations between the BSI and MMPI ranged from .30 to .72 with the most relevant correlations averaging about .50 (Conoley & Kramer, 1989 in Derogatis, 1993). The norms for the BSI is also gender-keyed; providing separate norms for males and females (Derogatis, 1993). Therefore, the scorer should identify the norm group that best represents the test-taker by selecting norm group (adult psychiatric outpatient, adult nonpatient, adult psychiatric inpatient, and adolescent nonpatient) and gender.

Transformed scores which are based on a comparison to a normative reference sample, known as *T*-scores, are used to express the scales. The raw scores of the nine scales and three global indices are converted to *T*-scores. The BSI used normative groups including psychiatric patients, medical patients, and individuals in the community who are not currently patients (Derogatis, 1993). Separate norms for adolescents, college students, and elderly have also been published. The *T*-score has a mean of 50 and a standard deviation of 10 T (Derogatis, 1993). This identifies that if an individual has a *T*-

score greater than 50 on scale, he or she has endorsed items that represent a specific construct to a greater degree than what is typical in the general population. The profile also provides the percentile that corresponds to the *T*-score for both the community and clinical comparison groups. Typically, a score of 60*T* would identify that the test-taker lies at approximately the 84th percentile in terms of experiencing symptoms and problems related to the specific construct (Derogatis, 1993). A score of 70*T* represents the 96th percentile for most scales.

While most researchers agree that the BSI is an appropriate measure of general psychopathology and psychological distress, the Global Severity Index helps quantify an individual's severity-of-illness and provides a single composite score for the most sensitive single indicator of distress (Derogatis, 1993; Skeem, Schubert, Odgers, Mulvey, Gardner & Lidz, 2006). This score is essentially the mean of all of the subscale scores. Reliability for the Global Severity Index is reported as .95 (Derogatis & Melisaratos, 1983). It is a single composite score, which has a cut off of 63 or greater to determine if an individual is at greater risk of psychological distress (Derogatis, 1993). The variable of mental distress was operationalized by the *T* score of the GSI. Consistent with the areas identified as possible predictors or outcomes of IPV within the literature, it is expected that the Global Severity Index will differentiate between the two groups.

Trauma Symptom Inventory 2. The TSI-2 is a widely used test of trauma-related symptoms and behaviors; it specifically evaluates acute and chronic posttraumatic symptomatology (Briere, 2011). This 136 item self-report measure typically takes an individual 20 to 30 minutes to complete. The accompanying manual provides instructions to be read verbatim or paraphrased to the test-taker. The instructions ask the client to

complete the answer sheet by responding to the questions in the item booklet. It is instructed that the individual rates how often an event has happened in the past six months with the choices of: 0 = never, 1 = only rarely, 2 = sometimes, 3 = often (Briere, 2011). The TSI-2 is for individuals 18 years of age and older, with a required fifth-grade reading level, and it transfers raw scores into *T* scores which have corresponding percentiles. The *T* scores have a mean of 50 and a standard deviation of 10. *T* scores ranging from 60 to 64 are considered “problematic” and those at or above 65 reflect “clinically elevated” symptom endorsement (Briere, 2011).

In total, the inventory has two validity scales, 12 clinical scales, 12 subscales, and four factors; a detailed description of these can be found in Appendix B. The TSI-2 utilizes scales and corresponding subscales but, the scales are not independent and therefore relationships among them should be considered (Briere, 2011). The TSI-2 identifies four factors in which scales are grouped to represent these larger constructs. The four factors include: Posttraumatic Stress (TRAUMA), Self-Disturbance (SELF), Externalization (EXT), and Somatization (SOMA); Appendix B provides what scales are included in each factor as well as descriptions of each. The TSI-2’s two validity scales, which are included to measure the test taker’s response style, are designed to determine whether a person is likely to deny or underreport symptoms (Response Level Scale), or to over-report symptoms related to trauma (Atypical Response Scale) (Briere, 2011).

The TSI-2 was standardized and validated on adults in the general United States population. Score conversion tables are provided within the professional manual that correspond to groups based on age and sex (e.g., females ages 18-54) (Briere, 2011). The standardization sample consisted of 678 adults between the ages of 18 and 90 and was

determined to represent the US population on areas including: sex, race/ethnicity, age, education level, and geographic region. During development, the TSI-2 was examined for reliability and validity in several populations including university students, incarcerated women, and a clinical sample. The clinical sample had four groups represented: individuals with a diagnosis of borderline personality disorder, combat veterans, survivors of domestic violence, and survivors of sexual abuse (Briere, 2011).

It is important to note why each of the clinical scales were utilized in the study, rather than just the TRAUMA factor and its scales. The previously discussed literature provides documentation of a wide variety of symptoms that are associated with interpersonal victimization but are not necessarily specified within diagnostic criteria of PTSD. A non-exhaustive list includes: mood disturbance, chronic interpersonal difficulties, suicidality, substance abuse, and somatization. While the TRAUMA factor represents symptoms or associated features of PTSD along with dissociative symptoms associated with Acute Stress Disorder, it is not fully representative of symptoms related to trauma. The range of symptomatology assessed by the TSI-2 is important because research has demonstrated victims of trauma most likely present with a variety of symptoms. Therefore, it seems necessary to analyze each of the scales on the TSI-2 in order to fully examine the differences in traumatic symptomology. The 12 clinical scales of the TSI-2 were analyzed to answer the research question regarding traumatic symptomology.

A more thorough discussion of the Insecure Attachment scale and its two subscales are included due to these three being variables within the current study as an objective measurement of attachment difficulties. The Insecure Attachment scale loads

onto the SELF factor. This scale helps identifies concerns and behaviors that are associated with early relational losses, parental maltreatment or inaccessibility; this includes abuse and/or neglect, insufficient empathic attunement, and frightening or frightened behavior (Briere, 2011). These early negative experiences with attachment figures often lead to later fears, ambivalence, interpersonal insecurity, or avoidance in close relationships (Bolwby, 1988). Individuals who display elevated scores on this scale may describe problems in forming or maintaining stable, positive connections with others and often either greatly fear abandonment and rejection in relationships or avoid relationships all together (Briere, 2011).

Individuals may endorse items that represent significant interpersonal difficulties or dissatisfactions, while others may report they attempt to avoid such distress by maintaining considerable emotional distance from others (Briere, 2011). These two forms of interpersonal dysfunction, averting close relationships and anxiety toward rejection or abandonment are measured by the two subscales of the Insecure Attachment scale: Relational Avoidance and Rejection Sensitivity. In many cases, one of these two subscales will be endorsed considerably more than the other (Briere, 2011). When both subscales are elevated simultaneously, there may be an ambivalent or disorganized attachment style displayed by the test-taker.

Demographics. Along with the *T* scores from the above mentioned measures, demographic information was collected from the information form within the participant's file. The specific demographics collected include: age, gender, race, relationship status, education level, employment status, dates the assessments were given, and mode of service (non-residential/residential) at the time of the assessment. The

agency allows individuals to categorize his or her race into one of the eight options: white, black, Asian, Hispanic, Native American, Pacific Islander, multiracial, and other. Relationship status selections are listed as: single, married, divorced, separated, widowed, or unknown. Employment status has four choices: unemployed, part-time employment, full-time employment, or student. Education is determined by the highest level of education completed and is broken into classifications: less than ninth grade, tenth grade, eleventh grade, high school diploma, general education diploma (GED), some college, associate's degree, bachelor's degree, or graduate degree.

Procedure

Participants' data were gathered from client files at the domestic violence crisis center discussed within the afore mentioned section. Only data from clients who signed an informed consent form prior to having the BSI and TSI-2 administered giving specific permission for the information in their files to be utilized for research purposes were used. The information collected from participant files included: age, gender, race, relationship status, education level, employment status, dates the assessments were given, type of service (outpatient/residential) at the time of the assessment, BSI, and TSI-2 *T* scores. The BSI and TSI-2 were hand-scored by the assigned clinician at the domestic crisis center. This assigned clinician met the professional requirements to administer, score, and interpret the TSI-2 and BSI as outlined by the corresponding manual. Since the data was collected from previously existing files, the clients did not undergo any special treatment for the completion of this study. The database of collected data does not contain any identifiable information to ensure the confidentiality of all participant data.

The validity of the TSI-2 was analyzed, for the purposes of this study, any data associated with invalid profile of the TSI-2 were excluded from the analysis. A TSI-2 profile was considered invalid if there is an identified raw score of 15 on the Atypical Response scale and/or a Response Level scale with a *T*-score above 75 (Briere, 2011). The *T*-scores for the Insecure Attachment scale, Relational Avoidance subscale, and Rejection Sensitivity subscale were collected from the TSI-2 to measure attachment security. The GSI *T*-score from the BSI was collected and analyzed to assess the level of mental health distress. The *T*-scores from the 12 clinical scales on the TSI-2 were used to measure the level of traumatic symptomology.

Data Analysis

Initially, demographic profiles were created for each group, residential and non-residential. This was done by utilizing a *t*-test to identify if there were any significant age differences between the groups and Chi square analyses were used to demonstrate if there were any significant differences between other demographics including: gender, race, education level, relationship status, or employment status. Within the study, the independent variable was the group identification, either residential or non-residential, while overall three different constructs were measured by several dependent variables. The dependent constructs are level of attachment security, traumatic symptomology, and displayed level of mental health distress. The software used to conduct the proposed analyses was IBM's Statistical Package for the Social Science (SPSS) Statistics 24.

For the purpose of this proposed study, the following hypotheses (stated in null form) were tested:

The following hypotheses addressed research question one:

1. There will be no relationship between the TSI-2's Insecure Attachment scale and the mode of service required by the participant.
2. There will be no relationship between the TSI-2's Rejection Sensitivity subscale and the mode of service required by the participant.
3. There will be no relationship between the TSI-2's Relational Avoidance subscale and the mode of service required by the participant.

The following hypothesis addressed research question two:

1. There will be no differences in the TSI-2 clinical scales of victims of IPV requiring residential services as compared to those who require non-residential services.

The following hypotheses addressed research question three:

1. There will be no differences in the Global Severity Index of victims of IPV requiring residential services as compared to those who require non-residential services.

An independent samples *t*-test was selected as the statistical method to assess for group differences with regard to the three hypotheses addressing the first research question and the one hypothesis addressing research question three. Four separate independent *t*-tests were conducted, one for each of the dependent variables (Insecure Attachment scale, Rejection Sensitivity subscale, Relational Avoidance subscale, and Global Severity Index). This test was chosen because the two groups are independent of each other and the means of these two groups were compared in order to determine if there was statistical evidence that the two means were different.

Due to the large number of dependent variables created by the TSI-2 (12 clinical scales), a MANOVA was the statistical method used to assess the group differences identified in the hypothesis to address research question two. If determined necessary by the presence of statistical significance at the collective level, the means are compared on each dependent variable to examine the differences in each of the independent variables. The dependent variables consist of the clinical scales of the assessment (TSI-2).

Overall, these methods and analyses assisted in the purpose of this study to identify if the individuals who seek residential services present differently clinically than those who request non-residential services. It was the goal to provide evidence that while both groups will present with symptoms of trauma, clinical distress, and attachment difficulties, it seems that those seeking residential services due to an immediate safety concern will present with more clinically significant symptoms; potentially, benefitting from a different treatment approach. With further studies, perhaps identifying if this may be a typology for victims of IPV.

Chapter IV: Results

This chapter will provide an overview of the findings extrapolated from the previously discussed statistical analyses used to test the hypotheses. The outcomes from *t*-tests used to identify the difference between the two groups on attachment presentations and level of displayed mental distress will be presented, as well as the MANOVA results to identify the traumatic symptomology differences. Initially, analyses were conducted to identify if the two groups differed on general demographic presentations. To recap, these participants were seeking services from a domestic violence service provider and agreed to participate in clinical services through this agency. These services are voluntary as the agency endorses a client led service approach.

Overall, the final sample included 120 participants (119 females, 1 male). The demographics for the participants are located in Table 1. Participants' ages ranged from 19 to 75 years old ($M = 39.57$ years, $SD = 11.39$), with the majority reporting Caucasian ethnicity ($n = 106$). Participants identified their relationship status as single ($n = 44$), married ($n = 44$), divorced ($n = 19$), separated ($n = 9$), widowed ($n = 3$), or unknown ($n = 1$). The majority of participants indicated unemployment at the time of the assessment ($n = 61$), followed by employed full time ($n = 42$), employed part time ($n = 11$), and students ($n = 6$). Participants' educations varied from not completing high school nor obtaining a GED ($n = 18$), to high school or GED ($n = 30$), some college ($n = 36$), and college degree ($n = 28$).

An independent *t*-test identified ages were equally distributed between residential ($M = 41.20$ years, $SD = 11.19$) and non-residential ($M = 37.98$ years, $SD = 11.46$), with ($t(118) = .01, p = 0.90$). While chi square analyses were used to demonstrate if there were

any significant differences between other demographics including: gender, race, education level, relationship status, employment status as shown in Table 1. These frequencies were significantly differed by race $\chi^2 (4, n = 120) = 11.28, p = .024$, education $\chi^2 (9, n = 120) = 24.99, p = .003$, and employment $\chi^2 (3, n = 120) = 26.39, p < .001$; while relationship status and gender were equally distributed between the two groups, respectively, $\chi^2 (5, n = 120) = 4.37, p = .497$, $\chi^2 (5, n = 120) = 2.17, p = .307$

It can be seen that the two groups were not significantly different in age or relationship status while they differed significantly on race, education, and employment. These findings may ultimately speak to a difference in the socio-economic status between the two groups. This could lead one to infer that those who are employed with a higher education may have greater means to increase their safety, outside of seeking residential services, than those who are unemployed and have less formal education. Another theory could be that more lethal IPV interferes with employment and education of the victim. The specifics of how the groups differed on these demographics can be viewed by looking at reported frequencies in Table 1.

Table 1

Demographics by Mode of Service.

Variables	Residential (<i>n</i> = 59)	Non-residential (<i>n</i> = 61)	Total (<i>n</i> = 120)	<i>p</i> value
Gender				
Male	1	0	1	.307
Female	58	61	119	
Education				
<9 th	8	0	8	.003*
10 th	1	2	3	
11 th	6	1	7	
HS Diploma	12	10	22	
GED	6	2	8	
Some College	14	22	36	
Associate	4	6	10	
Bachelor	3	2	5	
Graduate	0	2	2	
Unknown	5	3	8	
Relationship				
Single	26	18	44	.497
Married	18	26	44	
Divorced	9	10	19	
Separated	5	4	8	
Widowed	1	2	3	
Unknown	0	1	1	
Race				
Caucasian	48	58	116	.024*
Black	10	1	1	
Asian	0	1	1	
Multiracial	1	0	1	
Other	0	1	1	
Employment				
Unemployed	44	17	61	<.001*
Part-Time	3	8	11	
Full-Time	10	32	42	
Student	2	4	6	

Note. *Indicates significant difference between the groups, Chi Square $p < .10$.

Within the project, the dependent constructs were compared by group identification, residential or non-residential. These constructs were operationalized by the assigned assessment tool and scales. Four separate independent *t*-tests were conducted to assess the group difference on the *T*-scores of the Insecure Attachment scale, Rejection Sensitivity subscale, Relational Avoidance subscale, and Global Severity Index.

Using an alpha level of .10, the independent-samples *t*-tests were first conducted to evaluate whether participants' insecurities regarding close relationships with others differed significantly based on mode of service. The attachment styles were addressed through a separate research question due to the amount of literature identifying attachment disturbances as a common symptom of or precursor to experiencing IPV. Hence, the TSI-2's scale of Insecure Attachment; and the two subscales of Insecure Attachment, Relational Avoidance, and Rejection Sensitivity were reviewed. This allowed the inspection of attachment styles between the two groups at a closer level. Table 2 identifies the means and standard deviations for each of the scales by the mode of service. The means of the three attachment scales noted in Table 2 also identify that none of the scale or subscale means are above the cutoff score of 65 to indicate clinical significance on the TSI-2 for either group.

Table 2

Mean and Standard Deviation of Scales as a Function of Mode of Service.

Mode	IA*		IA-RA		IA-RS*		GSI*	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
<i>Residential</i>	59.17	8.37	58.19	11.48	57.86	9.26	52.44	11.40
<i>Non-Residential</i>	55.64	10.32	55.13	10.49	54.69	10.61	48.69	11.24

Note. *n* = 120.

*Indicates significant difference between the groups, *t*-test *p* < .10.

The results indicated that the TSI-2 Insecure Attachment scores were significantly higher for residential clients than those of non-residential clients, with $t(118) = 4.71, p = .042, 95\% \text{ CI } [0.13, 6.94]$. These were significant at an alpha level of .10. When looking more closely to identify which specific aspects of attachment the groups differ, the results showed a significant difference on Rejection Sensitivity $t(118) = 1.61, p =$

0.084 but not on Relational Avoidance $t(118) = .14, p = .131$. These findings suggest that individuals who are actively seeking respite from IPV are experiencing higher levels of preoccupation with and fears about the possibility of rejection and abandonment than those who have experienced IPV in their past or are not experiencing an acute safety concern. It identifies that while the two groups have affected by IPV, they present differently on levels of insecure attachment. It seems to be the previously noted symptoms of rejection sensitivity portion of insecure attachment rather than a discomfort with and avoidance of intimacy and interdependence in relationships that create this difference.

Next, the results of another independent t -test indicated a significant difference between the two groups' levels of mental distress as measured by GSI scores $t(118) = .040, p = .072, 95\% \text{ CI } [0.34, 7.85]$, with residential participants scoring higher, as shown in Table 2. The means noted in Table 2 show, same as the attachment scales, that neither of the group means met the clinical cut off score of 63 for the GSI from the BSI. While they don't meet the cutoff, these results answer "yes" to the research question, do victims of IPV seeking residential services differ from those seeking non-residential services on the level of displayed mental distress. The GSI provides a sensitive single indicator of a respondent's distress level, combining information about numbers of symptoms and intensity of the distress and therefore, allows these results to speak to how the nature of acute cases of IPV can increase this indicator over those whose risk of IPV is less immediate.

Finally, a MANOVA was the statistical method used to assess the group differences on traumatic symptomology. At the collective level, the presence of statistical

significance indicated the appropriateness of further discrimination between the two groups. The dependent variables consisted of the 12 clinical scales of the TSI-2. These 12 clinical scales are loaded onto four factors as noted in Appendix B and the scales will be discussed as a function of the assigned factor. More closely, for the scales that identified a significant difference, the means were compared to identify which group displayed higher means.

A one-way MANOVA revealed a significant multivariate main effect for traumatic symptomology between the residential and non-residential groups, Wilks' $\lambda = 1.90$, $F(12, 106) = 1.90$, $p = .042$. Upon further examination, six of the clinical TSI-2 scales were independently significant at the .10 level. Due to only two groups being present post-hoc ANOVA's were unnecessary; the means for each of the groups were reviewed to identify which were higher. As shown in Table 3, these scales included, in order of significance: Somatic Preoccupations ($F(1,117) = 10.79$, $p = .001$, $R^2 = .08$), Sexual Disturbances ($F(1,117) = 7.46$, $p = .007$, $R^2 = .06$), Tension Reduction Behavior ($F(1,117) = 6.71$, $p = .011$, $R^2 = .05$), Suicidality ($F(1,117) = 3.69$, $p = .057$, $R^2 = .02$), Insecure Attachment ($F(1,117) = 3.96$, $p = .075$, $R^2 = .02$), and Self Reference ($F(1,117) = 3.02$, $p = .085$, $R^2 = .02$).

Table 3

Mean and Standard Deviation of Scales as a Function of Mode of Service.

Symptoms (Factor)	Residential (<i>n</i> = 59)	Non-residential (<i>n</i> = 61)	<i>F</i>	<i>p</i> -value
	<i>M</i>	<i>M</i>		
Somatic Preoccupations (SOMA)	59.07	51.54	10.79	.001*
Sexual Disturbance (EXT)	59.74	52.90	7.46	.007*
Tension Reduction (EXT)	63.19	56.77	6.70	.011*
Suicidality (EXT)	54.19	50.28	3.69	.057*
Anger (EXT)	56.38	54.85	0.57	.445
Insecure Attachment (SELF)	59.08	55.64	3.96	.049*
Impaired Self-Reference (SELF)	61.60	57.67	3.02	.085*
Depression (SELF)	60.76	58.25	1.81	.180
Intrusive Experience (TRAUMA)	64.62	62.36	1.23	.270
Dissociation (TRAUMA)	63.36	60.30	1.62	.206
Defensive Avoidance (TRAUMA)	62.78	60.07	2.36	.127
Anxious Arousal (TRAUMA)	62.10	59.77	1.57	.213

Note. *N*=120

*Indicates significant difference between the groups, MANOVA *p* < .10.

These clinical scales from the TSI-2 that are significantly different between the groups show a trend in regards to the factors on which they load. The four factors as noted in Appendix B include Self-Disturbance (SELF), Externalization (EXT), Post-Traumatic Stress (TRAUMA), and Somatization (SOMA). As depicted in Table 3, the significant scales loaded on the SOMA, EXT, and SELF factors while none of the TRAUMA scales were significantly different. This provides feedback that the groups are presenting similarly on the symptoms generally identified with Post-Traumatic Stress Disorder but it is that other symptoms that create the difference for the groups.

As previously noted in the overview of the TSI-2, the TRAUMA factor represents features of PTSD and dissociative symptoms but it is not fully representative of symptoms related to trauma. This can broadly be discussed as the residential participants experiencing symptoms of trauma outside of PTSD such as increased self-destructive or dysfunctional behaviors, reduced self-awareness, and increased somatic complaints.

Overall, the results from this study concluded that those who require these residential services experience higher levels of attachment difficulties, specifically rejection sensitivity, displayed level of mental distress, and traumatic symptomology than those who are seeking non-residential IPV services. When looking at the specific differences among the traumatic symptomology presentations, participants actively fleeing domestic violence had mean *T*-scores that were higher on the following TSI-2 clinical scales: tension reduction behaviors, suicidality, somatization, sexual disturbances, and impaired self-reference.

Chapter V: Discussion

Our public health is something to consistently strive to improve; IPV could be a public health concern that is one day eradicated. While that dream seems to be just that- a distant dream, with more information on just how IPV shows up in everyday life for those affected, we can begin to work toward evidenced-based treatments, approaches, and systems that support violent free lifestyles. This study aimed to play a small part by assisting IPV service providers in identifying the clinical presentations of two types of clients they see, residential and non-residential.

The mode of service is determined jointly by the service provider and the victim of IPV seeking services. Clients of these services are not mandated to participate but rather are voluntarily seeking respite from IPV. The parties discuss the current safety risk, by conducting a lethality assessment and interview, and reviewing the individual's access to a safe location. If the victim is in a highly lethal situation with no alternative safe place, it is typically recommended the individual utilize residential services. If the person is not at active risk of danger or is suffering the aftereffects of IPV and has safe housing, non-residential services are suggested. These screenings occur and decisions are made on a case-by-case basis to individualize services to meet the survivor's needs.

This study accessed the archival clinical data of one such service provider to determine if the clinical presentation of those participants needing residential services were significantly higher than those determined in less acute situations and receiving non-residential services. Upon studying the literature of the IPV field it was determined that the known presentations of IPV included attachment disruption, trauma exposure, and increased levels of mental distress. These constructs were chosen as the dependent

variables in the study and operationalized by the use of two common assessment tools used to monitor the baselines and progress of behavioral health clients. The TSI-2 provided the scales and subscales for the measurement of attachment; the BSI provided the global index to measure mental distress, and the TSI-2's 12 clinical scales quantified trauma exposure.

The results of *t*-tests identified that residential participants, on average, scored higher than non-residential on the Insecure Attachment scale, but when reviewing the two subscales of which it is comprised, it was determined that they only scored significantly higher on the Rejection Sensitivity subscale and not Relational Avoidance. This finding can be beneficial when working with clients receiving residential services as it may speak to what is often referred to as the "cycle of domestic violence." This cycle typically has four stages: tension building, crisis, reconciliation, and calm or honeymoon phase. This encompassing relationship style can often lead to a victim leaving and returning to the perpetrator multiple times during a relationship, as the reconciliation and calm phases can be a false promise that the violence will end. This cycle is also confirmed by the statistic provided by the National Coalition Against Domestic Violence (2015) that it takes an average of seven attempts for an individual to separate from a relationship with IPV.

With more research it may show that those who are in highly lethal relationships, may be more likely to stay in such relationships due to an overall fear of being unlovable or alone. While those who have experienced IPV but are not in active danger may be more likely to avoid romantic relationships again and distance themselves from connecting with others.

Another *t*-test presented the findings for the research question regarding the victim's general level of mental distress. This analysis also uncovered that those requiring residential services presented with higher levels of mental distress as measured by the GSI on the BSI. This finding identifies that clients who are experiencing what is defined objectively as homelessness (residing in a communal living transient shelter) due to IPV are reporting higher levels of mental distress, on average, than those who are able to identify a safe location in which to reside. While this research question seems the most theoretically plausible, the current study was able to provide statistical evidence to support this hypothesis.

Residential clients presenting with higher levels of general mental distress seems like a reasonable assumption due to them no longer having a safe physical location outside of a gated residential facility. These clients can be fearful to live in their home, attend work/school, or participate in community events due to the threat of violence or harassment. Their basic need of shelter has been removed somehow due to IPV and, therefore, it seems likely their mental distress would be higher than those who are experiencing IPV and have a safe location to live. This finding is relevant for providers to remember and fully understand the impact of declaring someone homeless due to IPV and the types of barrier this experience places in the survivor's way.

Finally, a MANOVA provided results that identified a significant difference between the two groups and their exposure to trauma. When dissecting the results, it was identified that six out of the 12 clinical TSI-2 scales were significantly higher for residential participants than non-residential. It is important to recall the wide range of symptomatology assessed by the TSI-2 due to the research demonstrating victims of

trauma will most likely present with a variety of symptoms. As previously discussed the most significant difference between the two groups on trauma symptoms was identified as somatic preoccupations. Thinking through this finding, it could be connected to the difference that was located in the demographics between the two groups as well. Those requiring residential services were generally less formally educated and had less stable employment. It is an assumption that these individuals would have more barriers to insurance and health care, presumably a barrier of transportation due to financial barriers. One potential barrier may even be the isolation and confinement factor that is a common tactic of IPV. This information could provide statistical data to service providers to utilize in their requests for funds to assist these residential clients in meeting their medical and somatic needs.

The next TSI-2 factor that was significantly different between the groups was identified by the scales in the Externalizing (EXT) factor. This factor is described as measuring the tendency to engage in dysfunctional or self-destructive behaviors when one is in distress. The scales for this factor that were significantly higher for participants in the residential group included Tension Reduction Behavior, Sexual Disturbance, and Suicidality. Anger was the one scale in this factor that was not significantly different among the modes of service. These findings can again speak to the cyclical nature of violence and, specifically, IPV. As utilizing negative coping skills, struggling with suicidal ideations, and risky sexual behaviors could all be displayed by secure individuals in unhealthy relationships if not mediated.

This information is also beneficial for the service providers who oversee the residential facilities. To understand that a person's externalizing behaviors could be a

reflection of just how dire their situation is rather than identifying the individual as problematic within a communal living situation could be the difference in effectively serving victims of IPV.

The MANOVA also identified scales comprised on Self-Disturbance (SELF) factor as significantly different between the two groups. Impaired Self Reference and Insecure Attachment were the two scales of this factor that were reported higher by those in residential services than those in non-residential. While attachment styles were previously discussed, it important to identify that that decreased self-awareness levels for residential clients is a beneficial finding. This can assist providers and funders in understanding why clients receiving these services may generally have a more negative representation of themselves and others. To utilize approaches with these clients to increase self-awareness and overall self-worth would be beneficial for the individuals' growth. Depression is a scale on the SELF factor that was not significantly different for the groups.

The scales on the last factor of the TSI-2, TRAUMA, were also not significantly different between the two modes of service. These scales included the responses typically encompassed by PTSD: Dissociation, Defensive Avoidance, Intrusive Experiences, Anxious Arousal. From the previously discussed literature, depression and PTSD are significant responses to experiencing trauma and therefore, it may be that these two groups did not differ on these symptoms due to their relentless nature on victims of trauma. One theory could be that the depression and PTSD are not a response to the lethality or acuity of the IPV, which is operationalized by the mode of service, but rather the general experience of the abuse itself.

Generally, these findings suggest that providers working with survivors of IPV should be prepared to see a difference in the presentation of those seeking residential services than those seeking non-residential services. This study lays the foundation for future research in the areas of the wide range of symptomology presented in victims of trauma. It is important to understand that an individual coming from a highly lethal situation may be experiencing an increase in the responses to trauma outside of PTSD and depression such as impaired self-reference, attachment disruption, and externalizing behaviors. This study also provides data to assist service providers in the allocation and requests for funds, as these results identify that the two groups of individuals whom they serve are presenting with significantly different symptomology and presentations.

Limitations. While this study offers information to assist service providers and clinicians, it is important to identify the limitations throughout the project. The sample utilized in the project is not representative of the population and was restricted to one Midwest domestic violence service provider's clinical department. Also the two groups of residential and non-residential were created on a case-by-case basis by domestic violence service providers and victims at the time of requesting services. Therefore, an argument could be made regarding self-selection of the groups although certain criteria are discussed when screening for mode of service, including acuity of IPV, lethality, and access to safe housing. Anecdotal evidence suggests that victims of IPV would be more likely to minimize their experiences and opt for non-residential services over residential. So it seems if there was a self-selection error within the groups it would be that those who are better suited for the residential group would chose non-residential services which would lead to a type II error. This could mean that non-residential participants who

would be incorrectly categorized could be inflating the scores of the non-residential group.

The use of archival data did not allow for any interaction with the participants to view symptomology and clinical presentation outside of the assessment scores and demographic data. While the mean scores on all of the dependent variables, significantly different or not, were higher for residential participants than the means of the non-residential group, none of the means met the cut off scores for clinical significance provided by the assessment tool manuals. Therefore, discussing the symptoms or scales as if they were overall clinically significant can be misleading. While the majority of the means were trending towards the cutoff scores, it is important for clinicians to utilize clinical judgement when formulating case conceptualization. Within clinical judgement, it can be noted that the means did not reach the cut off for clinical significance but they were higher than the mean *T*-score for each scale and therefore, not clinically insignificant. To this point, it is important to remember that the assessments discussed in this project do not provide diagnoses but rather a data point used along with clinical judgement and other assessment tools to develop diagnostic impressions.

The conclusions of this study should be tempered by another limitation of the study, the utilization of a .10 alpha level. This level was selected by the researcher as a consistent cut off level throughout the data analysis. It was chosen after consideration of the potential effects of type I error and the determination that the results would be interpreted with caution due to a higher alpha level. The alpha levels for all results are displayed within each of the three tables and the variables reaching a .05 alpha level can be clearly identified as needed.

Lastly, the limitation that affected this research project as well as most literature attempting to provide a typology for victims of IPV is the unknown timing of the symptoms discussed and the retroactive nature of the study. For instance, it is unclear if some of the symptoms within the TSI-2's SELF factor are predictors of one being exposed to IPV or results of IPV exposure. It is difficult to assess an individual's clinical presentation prior to experiencing a trauma. It has become the norm for the community to define these as symptoms of IPV out of fears of victim blaming and removing fault from those perpetrating violence but it is also beneficial to recognize the option. Another example specific to this study is that it could be suggested that the higher externalizing behaviors in residential participants is simply result of living in communal living rather than being a victim of IPV.

The overall results of this study identified a significant difference in the mode of service that a victim of IPV needs and the individual's attachment style, traumatic symptomology, and level of mental distress. It is the goal of this project to provide a baseline of research that can be replicated and used in conjunction with other projects to reduce these limitations and further the treatment for victims of IPV and even reduce overall the public health crisis that is intimate partner violence.

Chapter VI: References

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Appendix A: BSI scales with descriptions

Scale Name	# of Questions	Description
Somatization	7	Reflects concerns about perception of physical functioning and health matters
Obsessive Compulsive	6	Measures unwanted, irresistible thoughts, impulses, and actions
Interpersonal Sensitivity	4	Measures feels of personal inadequacy and comparison to others
Depression	6	Measures clinical features common to the syndrome of depression including low motivation and dysphoric mood
Anxiety	6	Measures nervousness, tension, feelings of terror, including cognitive components of apprehension
Hostility	5	A direct measure of thoughts, feelings, or actions that are characteristic of the negative affect state of anger
Phobic Anxiety	5	Reflective of a persistent fear response that is irrational or disproportionate
Paranoid Ideation	5	Measures the disordered mode of thinking that is fundamental to paranoid behavior
Psychoticism	5	Provides a continuum from mild interpersonal alienation to dramatic psychosis
Global Severity Index	53	Provides an indicator of the respondent's distress level and combines information about the number of symptoms and intensity of distress.
Positive Symptoms Distress Index	12	Provides a report of the number of symptoms the respondent reports experiencing
Positive Symptom Total	53	Provides information about the average level of distress.

Appendix B: TSI-2 Factors and Clinical Scales with descriptions

Factors	Scales	# of Items	Description
Self-Disturbance (SELF)		30	Difficulties associated with inadequate self-awareness and negative models of self and others
	Depression	10	Cognitive, affective, or somatic symptoms of depression
	Insecure Attachment	10	Difficulties or insecurities regarding close relationships
Posttraumatic Stress (TRAUMA)	Impaired Self-Reference	10	Difficulties in accessing identity, self, or self determination
		40	Posttraumatic stress and related anxiety and dissociation
	Dissociation	10	Depersonalization, derealization, detachment, amnesia, identity splits
	Defensive Avoidance	10	Avoidance of upsetting thoughts, feelings, or memories
	Intrusive Experiences	10	Reliving/intrusion symptoms of posttraumatic stress
Externalization (EXT)	Anxious Arousal	10	Anxiety and hyperarousal symptoms
		40	Tendency to engage in dysfunctional or self-destructive behaviors when distressed
	Anger	10	Angry thoughts, feelings, and behaviors.
	Tension Reduction Behavior	10	Use of external activities as ways to avoid or distract from upsetting internal states.
Somatization (SOMA)	Sexual Disturbance	10	Sexual problems and behaviors
	Suicidality	10	Suicidal thoughts and behaviors
	Somatic Preoccupations	10	Same as Somatic Preoccupations Scale
	Somatic Preoccupations	10	Somatic preoccupations and distress