

Psychological and psychophysiological reactions to personal violation

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I declare that this is my own work and that the contribution of others has been duly acknowledged.

A handwritten signature in cursive script, reading "Washington", is positioned above a horizontal line.

Amy. L. Washington

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Amy. L Washington

12th June, 2009.

Abstract

Acts of personal violation, whether they be physical, emotional or sexual in nature, can occur independently or co-exist (Basile, Arias, Desai, & Thompson, 2004; Garcia-Linares et al., 2005; Matud, 2005). Personal violation constitutes any act of harm or desecration of an individual that is inappropriate, usually forceful, abusive and disrespectful. Personal violation is often a humiliating and demeaning experience affecting dignity and integrity (Charney & Russell, 1994).

The experience of violation and traumatic abuse are influenced by several factors: pre-trauma factors such as personality, previous experiences and coping resources (Carlson & Dutton, 2003); peri-trauma factors such as the duration, nature, context and severity of the abusive experience (Lauterbach & Vrana, 2001); and post-trauma factors such as symptom persistence and severity, post-trauma experiences and individual coping strategies (Memon & Wright, 2000; Schurr, Friedman & Bernardy, 2002). Previous research has shown that several of these factors can prolong the negative consequences associated with a traumatic event, yet no one factor can consistently account for symptom severity (Garcia-Linares et al., 2005).

One common traumatic outcome is the development of posttraumatic stress symptoms such as avoidance, intrusions and hypervigilance. In order for Posttraumatic Stress Disorder (PTSD) to be diagnosed, the individual must have been confronted with a traumatic event that was outside the range of normal experience and one that caused the individual to perceive possible threat to life or

physical integrity (American Psychiatric Association, APA, 2000). Many experiences of personal violation (i.e., emotional abuse, sexual harassment) do not meet this specific criterion, yet symptoms of posttraumatic stress are still evident in those who experience these forms of personal violation (Pico-Alfonso et al., 2006), suggesting that traumatic experience is strongly influenced by the subjective experience of the victim (O'Hare, Sherrer, & Shen, 2006).

The following study examined the experiences of four groups of individuals who had been victims of personal violation within either a working or personal relationship. Personal experiences of sexual abuse, physical abuse, emotional abuse and sexual harassment were examined in relation to pre-trauma, peri-trauma and posttraumatic factors in order to determine if there are different traumatic outcomes for each of the groups.

Study one examined pre-trauma factors such as prior victimisation, personality and psychological traits and coping resources. The results indicated that prior victimisation was common in those who had experienced adult sexual abuse, and across the groups there was evidence of dependent, histrionic and depressive personality traits. The commonly reported finding of borderline traits in victims of abuse (Landecker, 1992; Modestin, Furrer, & Malti, 2005; Westen et al., 1990) was not supported, yet poor coping was still evidenced.

Study two examined the psychophysiological reactions to acts of personal violation through the measures of heart rate, respiration and a range of psychological measures. The results indicated the process of

psychophysiological responding to traumatic events was the same regardless of the type of abuse, with all groups showing similar levels of arousal, stage by stage in response to imagery scripts of personalized events. However, visual analogue scales indicated that whereas psychophysiological responding was similar, psychologically the groups responded differently on measures of anger, violation, anxiety, reality, control and fear.

Study three examined posttraumatic stress reactions for each of the groups as well as coping strategies used post-trauma. Obsessive-compulsive, anxious and depressive symptoms in participants were evident post-trauma, and there was evidence of a trend for PTSD symptomology in the sexual abuse group only. Generally, the results showed that all groups had evidence of traumatic stress responses, with avoidance symptoms being particularly evident for the sexual abuse group. Use of poor coping strategies was evidenced across groups.

Overall, it was concluded that posttraumatic stress reactions to different forms of personal violation are fundamentally similar, but the different forms of abuse may vary with regard to peri-traumatic reactions. This considered, psychological responses to different forms of personal violation were found to be very different between groups. Violation, in particular was evident at varying degrees across the groups, and the results indicated that a sense of violation does not resolve after an abusive experience. This demonstrates the traumatic nature of personal violation, making the long term negative consequences of abuse understandable. Pre-traumatic factors such as good coping resources were not found to be beneficial for participants post-trauma, as the traumatic experience

seems to overwhelm victims and prevents them from using adaptive coping strategies.

This research has implications for diagnostic and therapeutic outcomes. Even though abusive acts such as sexual harassment and emotional abuse may not fit diagnostic criteria for a traumatic event, the results of the present study indicate that all forms of personal violation investigated in this study are traumatic in nature when viewed from the victim's perspective.

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In memory of Lolly....who never left my side and always sat by my feet when I worked...

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Appendix I:

Questionnaires for Study

CHAPTER ONE
INTRODUCTION AND OVERVIEW

“We were arguing again... I felt so exhausted and sick of the fights. I told him that I did not want to argue anymore. I kept telling myself just to put up with it.....I told myself that I just had to live with it for the present time. I got into bed feeling angry and irritated with him. We continued to fight after we got into bed. He kept trying to prove a point but I did not agree with him. He told me that I was not fit to be his wife or to share his bed. He got out of bed, came around to my side of the bed and pulled me onto the floor. I was frightened. He then proceeded to drag me across the room and into the bathroom. He shoved me down onto the cold tiles and told me to sleep there. He threatened me and told me that I HAD to spend the night there or else. He refused to give me a blanket. He shut the bathroom door. I heard him walk back to the bed and get back under the covers. I was laying there, on the cold tiles.....no blanket, it was freezing. I felt so angry and full of hate. I remember lying there and despising him for the way he treated me.”

- Victim of physical abuse

1.1 Introduction to the investigation

Personal violation and violence within relationships encompasses a range of behaviours including psychological, physical and sexual abuse. It can be perpetrated by partners or former partners, family members, household members and within other close relationships such as working relationships (Goodyear-Smith & Laidlaw, 1999). Physical abuse, sexual abuse, emotional abuse and sexual harassment occur in close relationships. They represent violations of the

rights of the victims (Frazier, 2000). Therefore, throughout this thesis they will be referred to as acts of personal violation.

The experience of these types of violation can be acute or chronic. Acute events would be defined by their sudden onset and limited duration. These forms of personal violation would be considered to be chronic when they occur as part of an ongoing behavioural pattern by the perpetrator and are characteristic of the perpetrator-victim interaction pattern (Roberts, 2006). Physical and sexual abuse are acts of violence that can be either isolated or recurring. In intimate relationships, these types of abuse typically follow a cycle of violence, illustrated by a series of violent episodes that increase in both severity and frequency (Berlinger, 2004). Fear associated with abuse in intimate relationships may be linked to the anticipation of future abuse. It has often been reported that a woman assaulted by an intimate partner may experience greater levels of posttraumatic stress symptoms than if she were assaulted by a stranger (Frieze & Brown, 1989).

Different psychological and physical outcomes have been linked with repetitive and single incident abuse (Tubman, Montgomery, Gil, & Wagner, 2004). For those who have experienced single incident assaults, there is an easier transition to a 'survivor' identity and, hence, greater psychological growth and resilience (Collins, 1995). For those who have experienced repetitive abusive behaviours, the negative consequences of such behaviours are more likely to be experienced by the victim leading to the development of attachment difficulties and learned helplessness (Pakieser, Lenaghan, & Muelleman, 1999).

In addition to the pattern of abuse, severity of abuse may vary. There has been much debate in relation to individual reactions to various types of abuse and the factors that influence symptom severity (e.g., Maercker, Beauducel & Schutswohl, 2000). Factors such as culture and sex have frequently been cited as influencing factors, namely, that women are more vulnerable to physical and psychological injury as a result of domestic abuse (Gavranidou & Rosner, 2003). In terms of violence occurring within personal relationships, females tend to report higher rates of psychological abuse than males. There is consensus that the experience of abuse is essentially different between the sexes. It has been proposed that this is due to situational variables. Romito and Grassi (2007) reported that women experience greater negative consequences of abusive behaviours than do men due to the fact that they are exposed to more severe, repetitive and terrorizing violence.

Physical abuse involves causing physical pain or injury (Hegarty, Hindmarsh, & Gilles, 2000). In some instances, the mere threat of physical harm is enough to provoke a stress reaction. Sexual abuse is unwanted sexual behaviour occurring within relationships (Karmen, 2007). Sexual harassment is unwanted sexual attention, they may or may not include the actual occurrence of a sexually abusive event. Sexual harassment generally occurs outside of intimate relationships but commonly occurs within working and academic environments where contact is frequent and, to a large extent, inescapable (Kelley & Parsons, 2000). Emotional abuse, once known as 'mental cruelty, is the process of psychological maltreatment which may involve the use of intimidation, threats,

humiliation and degradation and may include the threat of physical violence (Semple, 2001).

Other types of abuse that can occur in an intimate relationship include economic abuse through the deprivation of basic necessities or income and social abuse which includes deprivation of liberty and enforcement of social isolation (Hegarty et al., 2000). These types of abuse can be distinguished from emotional abuse although they are also incorporated into some definitions of emotional abuse (Walker, 1984). Emotional abuse commonly accompanies other forms of abuse and is often found to be more prevalent and destructive (Egeland, Sroufe, & Erickson, 1983; Fitzner & Drummond, 1997).

The consequences of personal violation can include the development of anxiety, depression and other signs of emotional distress, physical stress symptoms, suicide attempts, alcohol and drug abuse, sleep disturbances, reduced coping and problem solving skills, loss of self esteem and confidence, social isolation, fear of starting new relationships and living in fear. The development of Posttraumatic Stress Disorder (PTSD) also has been reported among those who have experienced acts of personal violation (Hegarty et al., 2000). The development of posttraumatic stress symptoms following exposure to personal violation identifies these abusive behaviours as traumatic in nature. The ways in which these events can be understood to be traumatic stressors will be discussed later in the thesis.

Personal violation and violence between intimate partners can occur in both heterosexual and homosexual relationships. Either men or women can be the perpetrators of domestic abuse, however, statistics indicate that the majority of victims experiencing abuse in an intimate relationship are heterosexual females (Berlinger, 2004). More than a third of women who are raped or physically assaulted by a partner require medical treatment and approximately one-fifth are pregnant at the time of the abuse. There are certain individual characteristics that have been found to make an individual vulnerable to the experience of relationship violence. These factors include being under the age of 40 years, having a past history of child abuse, have undergone separation or divorce and social isolation (Hegarty et al., 2000).

Abuse can be physical, emotional or sexual in nature and abusive experiences usually include one or more of these types of violation. That is, it is unlikely that physical abuse within a relationship occurs without the experiences of emotional abuse. Despite the commonalities of different types of personal violation including their potentially traumatic nature, it is clear that there is no single, easily identifiable response to personal violation that is characteristic of all types of abuse or consistent for all victims of abuse (Garcia-Linares et al., 2005).

The extent of the problem of personal violation is apparent. Goodyear-Smith and Laidlaw (1999), in their review of the literature, stated that most studies examining relationship violence and personal violation have indicated that women sustain more injuries and are more commonly the victims of

domestic abuse than their male partners. Of course, these data are influenced by the fact that women are more likely to access support services for domestic abuse, are more likely to be identified as victims as a consequence and are also more likely to perceive domestic abusive events as serious.

Inmate partner violence against women is a particular problem in rural areas and indigenous communities. The Australian Bureau of Statistics (ABS) (2006) reported that very remote areas of Australia have the highest rates of reported domestic violence, whereas the major cities have the lowest rates. Acierno, Resnick, Kilpatrick, Saunders and Best (1999) found that women are more likely to be traumatized in relationships than men and that 62% of all assaults on women in America are perpetrated by someone known to the victim. In Australia, a 2005 survey showed that 5.8% of women had experienced domestic violence in their lives. Of this group, 4.7% reported experiencing predominantly physical violence and 1.6% reported sexual abuse. Of those experiencing sexual abuse, 21% reported that the perpetrator was a previous intimate partner and 39% a family member or friend. For physical assaults, 38% of women reported that they were assaulted by their current or former male partner (ABS, 2005). Also of interest, 61% of women who experienced domestic violence reported that they had children living in the house, and 38% of this group reported that their children had witnessed the violence. Statistics indicated an average of 129 family homicides per year, 77 of which were related to domestic disputes. In the period encompassing 2002 – 2003, the cost of domestic violence on the Australian economy was estimated to be \$8.1 billion (ABS, 2004).

Personal violation and abuse are associated with increased experiences of physical symptoms, depression, anxiety, somatisation, drug and alcohol abuse and suicide attempts, low self esteem, PTSD and self harm in the victim (Bacchus, Mezey, & Bewley, 2002; McCauley, Yurk, Jenckes, & Ford, 1998). Although these types of abuse increase a woman's need for both physical and mental health services, often victims of abuse do not seek professional help due to coercive and controlling behaviours by the perpetrators that often accompany the abuse and prevent help seeking by the victim (Scholle, Rost, & Golding, 1998). Yoshioka, Gilbert, El-Bassel and Baig-Amin (2003) suggested that there are several factors that impact upon help seeking in abused women. The major barriers to domestic violence disclosure have been reported to include fear, denial, disbelief, hope for change, social isolation and the presence of children. Many women do not feel they will be believed or helped if they disclose partner abuse (Zink et al., 2004).

Episodes of partner abuse are usually detected through medical emergency department admissions, ante-natal clinics and family medical practices. Women who have experienced partner violence commonly want to talk about their experiences but are reluctant to raise the issue and are more likely to disclose if the treating clinician/police officer is empathic and non judgmental (Hegarty, 2000). Failure to report is common following abusive experiences, particularly when the offender is known to the victim (Carcach, 1998). Older victims of domestic abuse have been reported to be more likely to disclose to

family members, particularly when they have higher levels of perceived social support (Yoshioka et al., 2003).

The consequences of abuse may differ due to the individual perceptions of the victim. Psychological outcomes are closely related to perceived individual coping skills and resources, sense of personal vulnerability and violation, these factors impact on the individual's ability to have control over aversive thoughts (Ozer & Bandura, 1990).

It is evident then that abuse in relationships and acts of personal violation are a significant social problem (Leiner et al., 2008; Roberts, 2006; Zand, 2007). Exposure to such experiences has the potential to have a detrimental psychological effect on adjustment (Ramos, Carlson, & McNutt, 2004). Indeed, there is evidence that exposure to some abusive behaviours can be traumatizing for victims (Walker, 1984). However, it remains to be determined whether all forms of personal violation are traumatizing.

1.2 A definition of the problem

It has been estimated that as many as 70% of the general population will be exposed to some type of traumatic stressor at some time during their lives. These stressors may include war, accidents, crime, natural disasters or the sudden bereavement of a loved one (Breslau, Davis, Andreski, & Peterson, 1991; Norris, 1992). Of course, not all people exposed to a traumatic stressor will experience clinically significant posttraumatic stress reactions (Basile et al., 2004).

Traumatic events are best seen as extreme versions of stressful events in the continuum of life experiences with severity being defined by the subjective emotional responses to the experience in addition to the objective characteristics of the stressful event (Everly, 1990; Yehuda, 2000). Indeed, Hartman and Burgess (1993) stressed the importance of information processing in the model of trauma; theories of PTSD must account for the meaning the individual assigns to the traumatic event. The importance of the influence of subjective reaction would explain why not all individuals exposed to overwhelming stressors develop PTSD and would also explain why posttraumatic stress symptoms can develop in the absence of an objective threat to physical integrity.

Lovre (1994) reported that posttraumatic stress responses are more likely to develop from exposure to events that deviate from the realm of what is perceived to be a 'normal day' or an accepted way of life. Feelings and thoughts that render an individual as helpless or powerless in a situation are a key feature of traumatic events, as they signify a general loss of control or threat to safety. As a measure of the potential seriousness of exposure to a traumatic event in terms of its impact on the victim, it is evident that the traumatic experience does not have to be direct but can be the result of witnessing another person who is threatened or powerless (Ehrenreich, 2003).

Exposure to traumatic events often leaves victims with a range of reactions. Traumatic experiences provoke the activation of cortical processes that, in turn, facilitate a chain of responses. These involve the release of neurotransmitters, which then activate cognitive, emotional and physical

reactions. This sequence is considered to be a normal reaction to an abnormal event. The traumatic experience is usually illustrated by feelings of fear or anger, the sense of threat and agitation, and physical symptoms such as increased heart rate, sweating and hypervigilance. The duration and intensity of these symptoms will depend upon the individual's subjective experience, coping skills and psychological well being (Lovre, 1994).

As stated, acts of personal violation may be traumatic in nature and can occur in many contexts. At a fundamental level, violation involves an act of harm towards or desecration of the person that is inappropriate, usually forceful, abusive and disrespectful (Frazier, 2000). Acts of personal violation leave the victim with feelings of shame, fear and a sense of being stripped of dignity (Frazier 2000; Walker, 1984).

As with all traumatic experiences, the trauma severity is influenced by personal and environmental factors. These may include the type of event (natural disaster, violent attack), the status of the perpetrator (relationship to the victim, those in a position of power), the proximity to the traumatic stressor, the victim's past experiences and subjective perception of the situation by the victim (Lauterbach & Vrana, 2001; Schnurr et al., 2002). The same is true for personal violation. Factors that define the nature of the experience and determine the subsequent response and outcome may be the same as for other traumatic events.

It is apparent that sexual and physical abuse meet the criteria for a traumatic stressor and exposure to these events can lead to the development of

symptoms of PTSD (Acierno et al., 1999; Barnard-Thompson & Leichner, 1999; Weinstein, Staffelbach, & Biaggio, 2000; Whiffen, Benazon, & Bradshaw, 1997). The traumatic nature of these events and their potential for triggering a posttraumatic stress reaction is well established. However, less attention has been given to examining the traumatic effect of exposure to emotional abuse and sexual harassment. Nevertheless, there is some literature that has supported the proposition that these events are traumatic in nature (Dutton & Painter, 1993; McDermut Fine et al. 2000). Unfortunately, much of this literature suffers from the same problems as other abuse literature in that there is often a lack of distinction of emotional abuse and harassment from other forms of abuse. This will be discussed later in the thesis.

1.3 An overview of the study

This thesis takes a particular structure. The relevant literature from the two areas important to this investigation will be reviewed, that is, the abuse literature and the trauma literature. Consideration will be given to each form of personal violation and a coverage of the literature related to these types will be considered separately and in comparison with one another where possible. An overview of the way in which each chapter is structured will be provided at the beginning of each chapter. Here is a general overview of the thesis as a whole.

The following investigation looks at the psychological and psychophysiological reactions to forms of personal violation that occur within relationships. It endeavors to distinguish between four different types of abusive experiences endured by women in relationships including emotional, physical, sexual abuse and sexual harassment. It is the aim of this research to examine the

traumatic nature of the different types of personal violation that occur during adulthood, with particular reference to the pre-trauma, peri-trauma and post-trauma factors. Personal violation will be the term used to denote the four different types of relationship abuse. The term has been adopted as a generic one that, nonetheless, identifies the common link between these four experiences. The term domestic violence is used to denote personal violation that takes place within intimate relationships. Personal violation that takes place within other types of relationships, such as workplace relationships, would not be considered to be domestic violence.

In chapter 2, personal violation will be defined within the context of abusive behaviours. Fundamental elements of violation, such as shame and humiliation will be discussed. The different types of personal violation that may be experienced will be outlined including sexual abuse, physical abuse, emotional abuse and sexual harassment. Theoretical models that have been used to explain the various types of abuse will be outlined. Recent literature relating to the social and emotional consequences of personal violation will be highlighted and compared. Finally, abusive behaviours that occur within relationships will be discussed including the factors that influence the occurrence of relationship violence and the common pattern of behaviours that are evident in domestic violence.

Chapter 3 outlines the nature and experience of traumatic events. Atypical responses to traumatic experience will be examined along with the factors that affect the experience of traumatic events. Posttraumatic stress reactions and

diagnostic criteria for PTSD will be defined along with the role of traumatic memory and peri-traumatic dissociation. The importance and relevance of trauma focused research will also be outlined.

Pre-trauma factors will be addressed in chapter 4 and the role that they play in adult experiences of abuse. Sex, prior history of traumatic abuse, personality and psychological factors will be outlined. The rationale for study 1 will be introduced and the method, aim and results presented. The findings for study one will then be discussed in relation to the literature.

Chapter 5 examines peri-traumatic factors associated with the experience of personal violation. Personal violation and posttraumatic stress symptoms will be investigated and the individual stress responses of each type of abusive behaviour will be outlined through previous research. Factors that are associated with trauma severity will also be outlined with regard to abusive experiences. Factors such as fear, control, threat perception, anger, anxiety and shame will be addressed. The rationale for study 2 will be presented along with the method and results of the empirical study. The results of the study will be discussed in accordance with previous literature.

Posttraumatic reactions to personal violation will be examined in chapter 6. The traditional view of PTSD will be addressed along with the role of subjective victim perspective. The rationale for study 3 will be resented along with the method, aims and results of the study. The results will be discussed and their relevance to posttraumatic stress literature will be evaluated.

A summary of results will be presented in chapter 7. Demographic findings, the role of personal and environmental contributors will be summarized along with individual reactions to abuse and the traumatic nature of personal violation. The findings of the current study will be evaluated in regard to previous trauma literature and the contributions of the current research will be highlighted. In particular, experiences previously not consistently identified as traumatic, such as emotional abuse and sexual harassment, clearly demonstrate traumatic features similar in nature, although not necessarily magnitude, to the identified traumatic stressors of sexual abuse and physical abuse. The limitations of the current study will be discussed and potential directions for future research will also be outlined.

CHAPTER TWO
FORMS OF PERSONAL VIOLATION

2. Overview

This chapter provides an overview of the relevant literature of the different types of abusive experience encompassed by the term personal violation. To start, the nature of personal relationship is considered including sex differences in the experience of relationships and the various factors that influence the development of relationships. The nature of abusive experiences is considered and each of the four types of personal violation are discussed in relation to the following factors: victim characteristics, contributing factors, typical experiences and general consequences of abuse. The chapter concludes by examining the manifestation and characteristics of abuse in personal relationships.

2.1 Introduction

Relationships are an important part of social and emotional development and are key contributors to perceived life satisfaction (Bowlby, 1979). As a nation, Australians tend to be optimistic in their personal relationships, despite climbing divorce rates (Relationships Australia, 2006). The Relationship Indicators Survey (Relationships Australia, 2006) indicated that friendship and companionship are the key positive elements in adult relationships and 90% of those surveyed stated that they were not worried or worried very little about the future of their relationship. In this survey, 77% of all respondents identified negative issues that impact on relationships with these commonly being constraints on time spent together (36%), working commitments (21%) and lack of communication (21%). These may be considered as some of the key issues for Australian couples with regard to interpersonal difficulties and intimate relationship breakdown.

Vangelisti and Daly (1997) reported that women's experiences of relationships tend to be different from men's experiences. This can be explained by two models, the 'different experiences' model and the 'different cultures' model. In terms of different experiences, it is suggested that perceptions of relationships are often determined by the role typically occupied by the female (caretaker role), style of communication and interactional skills. It has been established that women desire different outcomes from their relationships to men. Family, children and intimate partners are often core elements of the female identity (Bagshaw, Chung, Couch, Lilburn, & Wadham, 1999). The 'different cultures' model relates to the various standards that are upheld by each of the sexes and set cultural rules about what is expected and valued. The factors discussed in these two models are very different for the two sexes, with females being less likely to have their needs met and less satisfied with relationship quality which is relevant to relationship success.

Adult relationships are strongly influenced by childhood experiences and early attachments. Reder and Duncan (2001) entertained the notion that relationship difficulties are strongly governed by the existence of care and control conflicts. Care and control conflicts are created by experiences during childhood, commonly shaped by experiences such as abandonment, rejection and neglect in the family of origin. As adults, care conflicts are illustrated by excessive dependency or intolerance of dependency and fear of abandonment. Control conflicts are demonstrated in adult behaviour by vulnerability to violence, dominance and poor self control. The conflicts demonstrate the

important role played by the family of origin, previous history of abusive behaviour and the risk for subsequent abusive experiences in adulthood that have been recognized elsewhere (Kessler & Biescke, 1999).

It is evident that some relationships are dysfunctional (Feeney, 2004). Further, it is apparent that some relationships are characterized by abusive behaviours that have a significant effect on the victims (Gallaty & Zimmer-Gembeck, 2008; Karmen, 2007). A large percentage of perpetrators of the forms of personal violation are known to their victim at the time of the abuse (Coker, Wallis, & Johnson, 1998; Davis & Lee, 1996; McConkey, Sole, & Holecomb, 2001; Mouzos & Makkai, 2004; Woodward & Ferguson, 2000). Despite several proposed models and identified patterns of abuse, abusive behaviours can occur at any time during a relationship and vary with regard to duration and intensity. Not every relationship that starts out as abusive will continue to be so and other relationships may experience an isolated period of abuse that is not characteristic of the relationship. Abusive behaviours appear to be largely dependent on a range of perpetrator, victim and contextual factors, many of which are unpredictable and unexpected. Hence, victim responses can also vary and no experience of abuse is the same as another (Whalen, 2005).

Different types of abuse are often accompanied by different intentions and motives by the perpetrator, which can have varying effects on the victim. Physical and sexual abuse have typically been characterized as more traumatic in nature, however, many victims report that emotional abuse is harder to cope with and has more long lasting effects than other forms of abuse (Whalen, 2005).

Relationship abuse appears to be more prevalent in younger age groups (Acernio et al., 2001). In fact, in general, victimization is more common among young adults and tends to decrease with age for both men and women, although it remains more prevalent in female populations (Thompson, Sims, Kingree, & Windle, 2008).

The following chapter addresses the nature and scope of abusive behaviours and personal violation and the potential impact these behaviours can have on victims. Physical abuse, sexual abuse, emotional abuse and sexual harassment are examined in relation to definitions, risk factors and prevalence. Abuse that occurs within personal relationships is investigated in order to highlight the growing concern that abusive behaviours have become in society.

2.2 Abusive behaviours and personal violation

These forms of personal violation that are the focus of the current research can occur with varying degrees of intensity, be unexpected or anticipated, and a single or ongoing experience (Whalen, 2005). Exposure to the forms of abuse can result in a variety of symptoms among survivors (Izutsu, Tsutsumi, Asukai, Kurita, & Kawamura, 2004) and, regardless of severity or duration, the abuse can be perceived differently by individual victims (Garcia-Linares et al., 2005).

When confronted with danger or threat, most individuals will attend to self-protection and survival. As a result, any person who experiences some form of abuse that threatens their self worth and safety may experience feelings such

as distress, shock, disbelief, fear or confusion (Kohn, Levav, Garcia, Machuca, & Tamashiro, 2005). Indeed, traumatic events that are of an interpersonal nature have been associated with higher incidences of distress and posttraumatic stress symptoms than those that are not interpersonal in nature (Winje, 1998).

Personal violation is often a humiliating and demeaning experience that strikes at the core of dignity and integrity (Lindner, 2001). It interferes with an individual's sense of self and creates destructive flaws in self-confidence. When the violation is of a sexual nature it is particularly damaging and, for a woman it may intensify the consequences of an aggressive act. Personal violation commonly creates feelings of social isolation, detachment, anger and a sense of being devalued. It breaks down connections with significant others and makes future attachment very difficult (Charney & Russell, 1994).

Physical violation involves injury or desecration of an object or person (Merram-Webster, 1998, pp.1319). In the case of personal violation, physical acts may involve any attempts at violence or physical control such as hitting, kicking, forceful touching and application of physical restraint (Mouzos & Makkai, 2004). Sexual violation commonly refers to the act of rape, inappropriate touching and sexual coercion (Mouzos & Makkai, 2004; Walker, 1984). Humiliation and degradation are frequently associated with actions of sexual violation and can cause significant disturbance in social and emotional functioning (Lindner, 2001). Emotional or psychological violation refers to the act of shaming, humiliating, degrading, disrespecting and invasion of personal dignity (Frazier, 2000). Violation can occur as a consequence of verbal taunts,

degrading comments or acts of social, emotional or financial control (Walker, 1984).

The psychological effects of abuse and personal violation may or may not be readily identifiable. This depends on the experience of the victim, their perceptions of the abuse and consequent emotional reactions. Observers of the behaviour of others have differential success in identifying the indicators of various types of abuse. For example, when asked to identify symptoms of abusive experiences in school children, teachers reported varying success rates in symptom identification when it came to the different types of abuse. The results indicated that symptoms were identifiable in 52% of children who were emotionally abused, 64% of children who were physically abused and only 24% of children who experienced sexual abuse. Teachers reported that children who were victims of abusive behaviours were more commonly academic underachievers, exhibited more problem behaviours and were less socially competent than their non-abused peers (Trowell, Hodges, & Leighton-Lang, 1997). Despite the fact that abused children do not uniformly present with these problems (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003), identification is hindered by the fact that outsiders find it difficult to grasp the true nature of a relationship or the dynamics of a family unit (Goldner, 1998), leading to subtle indicators of abuse being ignored.

Acts of violation can cause psychological damage that is enduring in its effects. Ongoing violation can result in outcomes such as learned helplessness (Whalen, 2005), depression and disruptions to social and emotional functioning

(Bacchus et al., 2002; McCauley et al., 1998). In addition, the psychological injury caused by exposure to abusive behaviour cannot easily be avoided. Indeed, a greater awareness of victim status may result in the experience of greater distress (Lindner, 2001). This may be due to the types of emotional responses that exposure to abusive behaviours evokes.

Guilt and shame appear to be two emotions that are frequently experienced by victims of violation. They are emotions that can cause significant personal distress (Silfver, 2007) and are commonly identified in those exhibiting distress and poor psychological health (O'Connor, Berry, Weiss, Bush, & Sampson, 1997). Silfver (2007) considered guilt and shame to differ on several dimensions. Guilt was understood in the context of it being an emotional response to one's own behaviour. In contrast, shame was understood as a reflection of how a person feels in relation to his or her sense of self. Combinations of worthlessness and powerlessness commonly characterize shame whereas guilt is associated with feelings of tension, regret and remorse. O'Connor et al. (1997) proposed that these two emotions cause the individual to maintain attachments to a person or a situation. These emotions are commonly experienced by victims of abuse and are also exaggerated by the fact abuse victims commonly experience self-blame and responsibility for an event for which they are not at fault. Of course, it may be the case that different types of personal violation evoke different responses. In relation to the current research, it is necessary to consider the nature of each type of abuse prior to determining its potential effects.

2.3 Types of personal violation

2.3.1 Physical Abuse

“It happened one time when I was picking the kids up from him. He got in the car too and said that he wanted to talk. I didn’t want him there, I felt uncomfortable. He was just sitting there in the back of the car with the kids. We started talking and the conversation got heated. I was trying to drive but I felt so stressed, I could see that the kids were getting stressed by the conversation also. A moment later he reached out in anger and wrapped his arm around my neck in a head lock. He was pulling me backwards and choking me. The he released and pushed the side of my head against the driver’s side window. I remember the thud as my head hit the window. I regained composure and I kept trying to drive. I was so frightened and worried. All I could think about was that the kids had seen this happen. I was worried because I was stressed and trying to drive – and my kids were in the car.”

- Victim of physical abuse

Physical abuse can occur in a variety of contexts and to victims of all ages, although typically it has been associated with younger age groups (Aceirno et al., 2001; Kruger, Hutchison, Monroe, Reishel, & Morrel-Samuels, 2007; Whalen, 2005). For example, Acierno, Resnick and Kilpatrick (1997) reported that the highest risk for physical assault exists in the 15 – 34 year age group. Indeed, it is generally the case that rates of victimization tend to decrease with age (Thompson et al., 2008). This considered, feelings of vulnerability in relation to becoming a victim of assault can increase with age with elderly

individuals feeling most at risk of physical harm. Interestingly, it is not only actual physical harm from assault that is detrimental to the individual. It has been suggested that the fear or threat of physical harm has health consequences, with women tending to fear risk of physical harm more than males (Kruger et al., 2007). With regard to women, physical abuse occurs more commonly in relationships and known perpetrators compared with stranger assaults (Mouzos & Makkai, 2004).

Strauss and Ramirez (2007) investigated physical abuse in relationships by considering participants in four different geographical areas. They found that, overall, about one-third of respondents stated that they had physically assaulted a partner in the last 12 months. It was also found that for most of these individuals, the perpetration of physical abuse was not an isolated incident but had occurred on average of 14.7 times over a 12 month period.

An Australian study showed that approximately 57% of women have experienced a physically abusive event (Mouzas & Makkai, 2004). Although these figures included physical assault of a sexual nature, physical abuse of a non-sexual nature was more common. Threats of physical harm was the most common form of physical abuse reported by the sample and predominantly affected younger, single and indigenous groups of women. In domestic settings, 33% of women who experience physical abuse reported experiencing more than one abusive event. Very few women are physically assaulted by someone other than a partner, yet the majority of women attributed more fear to abuse by a stranger than by an intimate (Mouzas & Makkai, 2004).

Like other forms of abuse, physical abuse is commonly perpetrated by someone known to the victim and is prevalent in domestic settings (Mouzos & Makkai, 2004). The most common types of physical abuse perpetrated in relationships include pushing, grabbing, twisting of limbs, throwing or hitting with something and threats of violent force. Mouzas and Makkai (2004), in their investigation of violence against women, found that of all women interviewed who sustained physical injuries from a partner, the majority reported minor injuries with 80% experiencing bruising and swelling. Twenty-two percent of the same sample experienced cuts, scratches and burns and only 4% received breaks or fractures. Hegarty and Bush (2002) reported episodes of pushing, grabbing, shoving, hitting, shaking, slapping and throwing in a sample of women attending a general medical practice with 23% of these women reporting having experienced one of these behaviours in a relationship.

Resnick, Acierno, Holmes, Dammeyer and Kilpatrick (2000) reported female victims of relationship abuse were 13 times more likely than males to acquire injury, mainly to breasts, chest and abdomen. As a consequence, females experiencing physical abuse were more likely to utilize medical assistance for serious injury, yet were not as likely to access mental health assistance (Hudson-Scholle, Rost, & Golding, 1998). It was suggested that physical abuse was a significant contributor to the decision by depressed women to access psychological assistance. It was suggested that physical abuse affects women's ability to actively seek help due to fear of disclosure and controlling behaviours on the part of the perpetrator that commonly accompany physical abuse.

Age, length of relationship and prior victimization has been recognised as contributors to risk of violence in a relationship, and these risk factors are common among other types of abusive behaviours such as emotional and sexual abuse (Elliot, Mok, & Briere, 2004). Controlling male behaviour also has been identified as a risk factor for physical abuse in relationships (Mouzas & Makkai, 2004). The assertion of power has been recognised as a common motive for physical violence and may be linked to perpetrator issues of intimacy, dependency, self esteem or behaviours that were modeled in the family of origin and emulated later in life (Garner & Fagan, 1997).

General reactions to victimization can result in mixed emotions and reactions including anxiety, fear, poor concentration, intrusive memories, denial and disturbances of eating and sleep cycles. Depending on characteristics and context of the abuse, these symptoms may disappear, worsen or reappear at a later stage. Traumatic experiences may also result in intense psychological experiences such as anger, depression, lack of trust, maladaptive coping and consequently interpersonal difficulties (Jackson & Davis, 2000).

The impact of physical assault can have a long lasting effect on an individual both physically and psychologically. Aside from the physical injuries sustained, women who have suffered physical abuse are at a greater risk for depression and negative consequences such as low mood, poor self esteem, self harm ideation, helplessness, PTSD symptoms and anxiety (Clements & Sawhney, 2000; Whalen, 2005). Resnick et al. (2000) found that physical abuse

was more likely to result in PTSD symptomology and that more severe posttraumatic stress symptoms were related to the victim having a prior experience of assault and the level of distress they experienced during the assault. Significant injury and ongoing threat of violence were also associated with higher rates of PTSD. Perception of life threat was also identified as a significant contributor to symptom development. Mouzas and Makkai (2004) stated that although the majority of assaults do not result in severe physical injury, up to 30% of victims reported that they felt that their life was in danger at the time of the assault. This highlights the importance of subjective perception in the determination of risk to self (Reger, Marzaili, & Jansen, 1999).

The cyclic nature of physical abuse has been extensively documented (Garner & Fagan, 1997; Lisak & Beszterczey, 2007; Whalen, 2005). Most commonly, physical abuse has been suggested to be largely episodic in nature with violent episodes interspersed with abuse free periods when the perpetrator is amicable and caring. As the cycle shifts, tension again begins to build in the relationship accompanied by attempts from the victim to diffuse the stress. This escalation continues until the physical assault occurs. This is commonly followed by a reconciliation phase whereby the perpetrator expresses remorse and a promise that the violence will cease. This commonly instills hope in the victim and the cycle continues. Usually the periods between the abusive episodes grow shorter and, over time, the abuse becomes more severe. Episodic violence commonly commences during dating relationships and tends to increase during times of stress or vulnerability, such as with the experience of social stressors or when the victim is pregnant (Whalen, 2005). It should be mentioned that

patterned, predictable violence is only evident in a certain percentage of relationships and that other physical abuse in relationships can be unprovoked, unpredictable and isolated (Whalen, 2005).

Lisak and Beszterczey (2007) stated that cyclic relationship violence is commonly the product of interplay of several risk factors that stem from learned behaviour. These factors include family contexts, substance abuse, developmental factors, abuse severity and male gender roles. If these factors are present in childhood, they can make an individual vulnerable to the experience of physical violence in their adult relationships.

Regardless of the type, context or duration of physical abuse, it has been established it can have a devastating effect on both perpetrators and victims (Jackson & Davis, 2000). In addition, it affects a large number of children, young people and adults (Resnick et al., 2000). Therefore, the seriousness and significance of physical abuse is evident. Other forms of personal violation may be similarly understood.

2.3.2 Sexual abuse

“I was standing in the house with my partner. I had threatened to leave so many times, this time he just stood there, smirked and then laughed at me. I told him that I was serious and that I had already packed my bags. I felt uneasy – he was standing across from me with a threatening look. He kept coming towards me and I kept trying to distance myself from him. I ran to the bedroom to get my bags...I was determined to leave this time.

He ran after me into the bedroom and shut the door. I felt so frightened as I knew what was going to happen next. He slapped me and then pushed me back on to the bed. After he had forced himself on me, he just got up, walked out, and turned on the television. The worst thing was that I know that he felt he had the 'right' to do it. I just felt so frightened. He called out to me and said, 'Next time you think about leaving, I will kill you'."

- Victim of sexual abuse

Data pertaining to a national survey on the experience of violence by women indicated that approximately 34% of women had experienced sexual violence in their lifetime, 11% in the past five years and 4% in the last 12 months. Figures indicated that women reported experiences of sexual violence both as a single event and co-existing with other forms of abuse, most commonly physical abuse (Mouzos & Makkai, 2004). Disturbing results from the survey indicated that age is a large determinant in relation to risk of sexual violence, with over one in ten women aged 18 – 24 years having experienced sexual violence in the 12 months prior to being surveyed.

Sexual abuse can occur across the lifespan and be an isolated event or an ongoing experience (Kaltman, Krupnick, Stockton, Hooper, & Green, 2005). Regardless of the context or frequency, the effects of sexual abuse have been determined to be potentially severe and long lasting (Davis & Lee, 1996), with some researchers suggesting that childhood sexual abuse can alter personality (Bradley, Heim, & Westen, 2005a).

There is a wide spectrum of types of sexual victimisation. Sexual abuse may include any and all non nonconsensual sexual penetration, sexual manipulation and coercion, threats of sexual harm, unwanted sexual acts or touching, non consensual voyeurism, inability to give consent to sexual acts and marital rape. Sexual abuse can have single or multiple perpetrators and sexual contact with the perpetrator may have been consensual at other times (Collins, 2005).

Like other forms of abuse, perpetrators of sexual abuse are commonly known to the victim (Dickson, 1996; McConkey et al., 2001; Mouzos & Makkai, 2004). Date and marital rape have received considerable attention in recent years. These types of sexual abuse are not limited to heterosexual relationships, but can occur in homosexual partnerships (McConkey et al., 2001). Marital rape is often suggested as the most common form of sexual abuse and can occur as part of an abusive relationship (in the presence of physical or emotional abuse), as a force only rape (gaining of sexual access against will without psychological coercion) and obsessive rape (fantasy element on the part of the perpetrator) (Collins, 2005).

Motivations for the perpetration of sexual abuse seem to combine aspects of sexual activity and violence. Jenkins (1996) saw sexual abuse as a sexualized need for control on the part of the perpetrator. More recently, researchers have endorsed previous understandings of sexual abuse as a crime of control, power and rage (Collins, 2005; Nicolaidis, 2002). However, they also highlighted that

sexual pleasure for the perpetrator is commonly derived from these acts of control and through the process of inflicting pain on another human being (Dickson, 1996). Regardless of the motive, sexual abuse is a devastating crime.

Dickson (1996) reported that most women live in fear of sexual victimisation to some degree. This statement was supported by Davis and Lee (1996) in their survey of 14 – 16 year old school students. The survey indicated that fear of sexual assault, considering oneself as a possible victim and restricting one's activities out of fear of victimisation were common in school age girls. The researchers also found that sex crimes were often subject to myth and stereotypes that contributed to self blame in victims. Social structures commonly serve to maintain myths in relation to sexual assault by identifying coercive sex and male aggression as more accepted traits in men.

From the victim's perspective there is little doubt that sexual abuse can be a negative and distressing experience. Rape trauma syndrome was a term first used by Burgess and Holmstrom (1974) to illustrate the spectrum of symptoms that commonly result from sexual abuse. Rape trauma syndrome includes behavioral, somatic and psychological reactions that appear in a stage-like progression after the experience of sexual abuse. The syndrome is characterized by fear, self blame and disturbances to lifestyle and identity and has commonly been associated with the criteria for PTSD (Frazier & Borgida, 1985). Collins (2005) suggested that posttraumatic outcomes occur as a result of a combination of the characteristics of the victim, the specific rape event and the social

environment in which it occurs. No single variable can determine outcomes alone and victim perspective is crucial.

Age is not the only risk factor in relation to sexual abuse. Prior victimisation, particularly during childhood, commonly has been labeled as a risk factor as has the experience of physical assault in adulthood. Risk has also been associated with a history of divorce. These factors have been suggested to not only add to the likelihood of sexual victimisation in adulthood but they also appear to add to the distress experienced in response to future events (Elliot et al.,2004).

Emotional abuse has also been associated with risk of sexual victimization, particularly among intimates (Aosved & Long, 2005). It was reported that women who experienced sexual victimisation also reported a more episodes of emotional abuse by the same perpetrator. Emotional abuse was found to exist either in the lead up to or after sexual violence.

Atkeson, Calhoun, Resick and Ellis (1982) found that depressive symptoms were more prevalent in victims of sexual abuse when compared to controls. These symptoms were found to dissipate as time passed, but premorbid psychological functioning was found to play a greater role than demographic factors in continued psychological problems for victims of sexual abuse. Flanagan and Hayman-White (2000) found that victims of sexual abuse commonly reported symptoms of intrusive thoughts, sexual anxiety, self blame and vulnerability to negative life events. Internalising (anxiety, depression,

withdrawal) and externalizing (aggression, risk taking) behaviours were also common patterns detected in victims of sexual abuse.

Bradley et al., (2005a) identified four personality constellations in those who had been victims of sexual abuse. These included internalised dysregulated, high functioning internalizing, externalizing dysregulated and those with dependent traits. This demonstrates that abusive experiences may potentially have an impact on personality constructs which may not be uniform across different individual. This finding is supported by other literature in relation to the long term impact of sexual abuse, determining that it commonly results in negative affect, depressed mood and emotional dysregulation for survivors. Collins (2005) stated that due to the traumatic nature of sexual abuse, its survivors are more at risk for mental and physical problems, unemployment, disruptions to education, reduced income and divorce. They estimated that 50% of those who experience sexual abuse will develop symptoms of Acute Stress Disorder (ASD)/PTSD. This is a higher rate than reported following exposure to other identified traumatic stressors (e.g., Norris, 1992).

A study of sexual abuse victims investigated the impact of abuse occurring at different stages of the lifespan. Four groups of victims were assessed; those who had experienced childhood sexual abuse, adolescent sexual abuse, revictimisation at a later age, and those with no abuse history. The results indicated that those who had experienced sexual abuse as an adult or had been re-victimised evidenced greater rates of psychopathology than those who experienced no abuse or childhood sexual abuse. Adolescent sexual abuse and

revictimisation participants showed higher rating of intrusions and avoidance symptoms on the Trauma Symptom Inventory (Briere et al., 1995) and showed greater evidence of Borderline Personality Disorder (BPD) symptoms even though no participants met the criteria for BPD. Overall, those who had been sexually re-victimised were shown to have experienced the greatest impact across all functional domains, evidenced by greater likelihood of axis 1 symptomatology, PTSD symptoms and depressive symptoms (Kaltman et al., 2005).

A common research finding associated with sexual abuse is the large degree of self blame and responsibility felt by victims. Self blame has been identified by many researchers as being evident for victims of abuse (Burgess & Holmstrom, 1974; Collins, 2005; Flanagan & Hayman-White, 2000; Frazier, 1990) and has been linked to the long term consequences of abuse. Frazier (1990) stated attributions of self blame are commonly associated with depressive symptoms and are more related to the experience of depression than any other pre-trauma, peri-trauma or post-trauma factors. Attributions of blame are also important in the recovery process for victims of sexual abuse. Attributional style has commonly been linked to the experience of depression outside of traumatic abuse research and has been implicated in depression proneness, depressive personality styles (Abramson, Seligman & Teasdale, 1978), and feelings of hopelessness (Beck, Weissman, Lester, & Texler, 1974; Ralph & Mineka, 1998).

There has been much debate in relation to the labeling of sexual abuse and how sexual victimisation should be defined and measured. This is due to the fact that many women, who do not fit the legal definition of a rape victim, still perceive themselves as rape victims. Harned (2004) found that the process of labeling did not have any effect on the subjective experience of distress in relation to sexual victimisation. The author suggested that traumatic stress arising from an abusive event is related to the event itself and not the label that is afforded to it. Indeed, there are many reasons why a victim may or may not want to label an experience and these reasons are unrelated to the experience of distress. The experience of victimisation that is sexual in nature has been established as a significant stressor. This may also be said of sexualized threats that do not contain a physical element.

2.3.3 Sexual harassment

“I was working in a nightclub... things had been going ok... you deal with stuff with some of the patrons from time to time, but nothing that made me feel uneasy. I needed the work and it suited me at the time. It was a normal night except that the general manager had been drinking a fair bit. It was closing time and there were only a few patrons left and some other staff left. The manager was pretty drunk by this stage. I went to walk past him and he touched my breast. I spun around and told me never to touch me again. He laughed at me and turned to look at the other male staff members. He then unzipped his trousers and took out his genitals. I started to back away into a corner ...I was shocked and disgusted in him. The few remaining patron and staff said and did

nothing. I pushed him aside and walked away...I was frightened. I felt shaken and edgy for a while afterwards."

- Victim of sexual harassment

The consequences of sexual harassment are far reaching as it commonly occurs within a workplace setting, placing pressure and demands on the individual's ability to cope, and threatening not only emotional stability but also employment and economic security (Glutok & Koss, 1993; Popovich, 1988). Stress accounts for a large percentage of compensation claims in the workplace and increases in work stress have commonly been associated with changes in economy, work-family tensions, technology and work pace workplace (Macklin, Smith, & Dollard, 2006). However, work stress can also arise through sexual harassment and violence/aggression in the workplace (Haines, Williams, & Hawkes, submitted). Sexual harassment now accounts for a proportion of work stress claims and the incidence is increasing (Dall'Ara & Maas, 1999). Claims of this type typically involve experiences that are of a gradual onset and that have placed the victim under conditions of sustained stress (Haines et al., submitted).

Women are commonly more vulnerable to sexual harassment and sexual discrimination in the workplace. This may be attributed to the fact that they are typically in a more vulnerable economic position than their male colleagues. This vulnerability can exacerbate the traumatic nature of harassment and pose a greater threat to psychological and financial security (Kurth, Spiller, & Travis, 2000). Certainly, sex issues and male dominated workplaces have been implicated in the occurrence of sexual harassment (Dall'Ara & Maas, 1999;

Thacker, 1996). Contributors such as personal styles, sex role expectations, organisational structures and overall context assist in creating environments where sexual harassment is likely to occur (Kurth et al., 2000).

Throughout the research literature, sexual harassment presents as complex and sometimes controversial (Browne, 2006). The investigation and evaluation of sexual harassment in the past has been difficult due to the absence of a clear definition (Browne, 2006; Dall'Ara & Maas, 1999; Ford & Donis, 1996; O'Donohue, Downs, & Yeater, 1998). An existing problem with sexual harassment is that it constitutes different things to different people, for instance, what one person may find amusing, another may find highly offensive. A good definition of sexual harassment outlines a heterogeneous group of behaviours (Charney & Russell, 1994), typically characterized by a perceived imbalance of power between the victim and the perpetrator of the harassment. Basically, sexual harassment incorporates unwanted sexual attention, including verbal or physical harassment, gender harassment, seductive behaviour, and pressure for sexual activity, unnecessary touching and the demanding of sexual favors (Magley & Shupe, 2005). Sexual harassment most commonly occurs within the workplace and it is often accompanied by the promise of promotion or the threat to employment status (Kelley & Parsons, 2000).

Sexual harassment is becoming increasingly widespread in recent years or, at least, is more commonly reported. It has been reported that approximately 42% of women and 15% of men experienced sexual harassment in the workplace, with only 1 – 7% of these victims making formal complaints. This

figure highlights the high proportion of cases that go unreported even though approximately 90% of victims demonstrate evidence of impaired psychological functioning post harassment (Charney & Russell, 1994). The failure to report harassment is characteristic of the unique nature of gender based abuse. A large majority of individuals do not report their experiences due to ongoing feelings of self-doubt and guilt that are associated with these types of abusive behaviours (Emm & McKenry, 1988).

Browne (2006) described two basic types of sexual harassment in the workplace. Quid pro quo sexual harassment describes any situation where an employee/victim is forced to submit to another worker's (usually those in a higher position) sexual demands/advances either with the condition of receiving a benefit or suffering a set back. This type of sexual harassment constitutes an act of sex discrimination, as the same behaviour would not be applied to a worker of the same sex as the perpetrator. Hostile working environments constitute a second form of sexual harassment and include a wide range of behaviours such as sexual advances not tied to positive and negative consequences, specific behaviours/comments directed at a single person, sexualized atmospheres including the circulation of sexually inappropriate materials such as jokes and comments, which may or may not be directed at one person. Regardless of the intention of the perpetrator, hostile working environments are determined by the victim's perspective and personal attitudes towards the behaviour.

Avina and O'Donohue (2002) suggested a third type sexual harassment,

that of gender harassment. Gender harassment is not sexually coercive, but is more in line with the view of hostile working environments in that it involves the airing of hostile and offensive attitudes towards a gender, typically females.

As perceptions are socially constructed, much attention has been given to what actually constitutes a sexually harassing behaviour (Charney & Russell, 1994). Consensus indicates that if an individual deems a behaviour as unwanted, coercive or intimidating and one that interferes with the individual ability to function appropriately, both personally and in the workplace, it constitutes as sexual harassment (Magley & Shupe, 2005). Situational factors have been considered to have the greatest influence on whether or not behaviour is deemed as offensive.

Previous research has illustrated that sexual harassment can be a traumatic experience for victims (Adams, 1999). Sexual harassment is a unique form of abuse as it is often not the act of harassment itself that induces traumatic stress, it is the direct threat the harassment poses to other spheres of an individual's life, such as their social and financial security and control (Koss, 1990; Quina & Carlson, 1989). Compared with isolated attacks of sexual and physical violence, victims of sexual harassment rarely see themselves as 'survivors' of personal violation but instead often endure the anxiety associated with subsequent attacks and the reality of facing the perpetrator every day in the workplace (Koss, 1990). Charney and Russell (1994) also illustrated that sexual harassment differs from sexual abuse in that it relies on a type of sexual coercion that affects the victim's financial and employment security.

Previous research in the area of sexual harassment has investigated a wide range of personal and workplace characteristics that may influence a worker's experience of harassment. Factors such as predominantly male populated workplaces, blue-collar workplaces, single women, a personal history of abuse, and the perpetrator of the harassment being in a higher position of employment have been associated with an increased likelihood of sexual harassment occurring (McKinney, 1990).

Generally, sexual harassment was found to impact negatively upon job satisfaction, productivity, work attendance and work stress (Avina & O'Donohue, 2002; Charney & Russell, 1994; O'Donohue, 1998). For the individual, it was found to cause negative outcomes (Avina & O'Donohue, 2002; O'Donohue, 1998; Rederstorff, Buchanan, & Settles, 2007), poor psychological consequences, problems with interpersonal relationships and financial difficulties (Grant, 2000; Marin & Guadagno, 1999; O'Connell & Korabik, 2000; Thaker & Gohman, 1996). With regard to psychological consequences, Charney and Russell (1994) reported that typical emotional reactions included fear, depression, anxiety, loss of self-esteem, humiliation, alienation, anger and helplessness. Similarly, those who have experienced sexual harassment also report experiencing physical ailments such as headaches, weight loss and disturbed sleep, as well as posttraumatic stress symptomatology and reduced satisfaction in life (Rederstorff et al., 2007).

There have been several proposed models to explain the nature and

consequences of sexual harassment in the workplace. The four-factor model of sexual harassment (Avina & O'Donohue, 2002) proposed four distinct conditions that predict the occurrence of sexual harassment. The model incorporates factors outlined in previous research models (Biological, Organisational and Socio-cultural Models) and also strives to emphasize the multidimensional nature of sexual harassment. The model is loosely based on Finkelhor and Hotaling's (1984) model of sexual abuse.

The four-factor model suggests that four conditions must be met in order to create a situation for sexual harassment to occur. The first of these conditions is the perpetrator's motivation to harass. Various factors may fuel this motivation such as power, control, deviant sexual arousal, anger towards women or attraction. The second condition is the perpetrator overcoming internal inhibitors that would normally prevent them from engaging in harassment. The third condition focuses on the situational factors that either encourage or inhibit sexual harassment (socio-cultural contexts, organisational context and immediate work environment). Finally, the fourth condition is the need to overcome victim resistance, which relates to the attitudes, behaviours and organisational positions that determine whether or not a person will become a target (e.g., gender roles). The four-factor model encompasses all issues relevant to the occurrence of sexual harassment in the workplace and it highlights the interaction of the perpetrator, victim and context.

There is limited information in relation to the moderating factors of sexual harassment (Rederstroff et al., 2007). Thacker (1996) investigated the

role of working relationships, type of harassment, duration of harassment and the gender of the victim in sexual harassment experiences. The author found that sexual harassment is typically a dominance behaviour utilized to assert power over another person.

Victim responses to sexual harassment were outlined by Salibury, Ginorio, Remick and Stringer (1986) as a stage related pattern of response. The authors proposed that victims of sexual harassment initially respond with feelings of self doubt and confusion as they attempt to understand the nature of the behaviour. These feelings are commonly closely followed by feelings of guilt and questioning themselves as to the possible role that they may have played in the situation. This stage is also linked with feelings of denial. As the behaviour progresses, victims typically become anxious and fearful in relation to the behaviour and become overwhelmed by thoughts about the consequences on their employment and career. This anxiety rapidly shifts to depression and difficulties with self-esteem. Victims commonly experience intense anger at the realisation they are not to blame for the situation. This stage-response process is often typical of abusive behaviour and can be observed in relation to other violating behaviours such as workplace bullying (Lewis, 2006).

Responses to sexual harassment include a range of behaviours adopted by the victim in order to deal with the matter within the workplace. The responses range from passive to assertive approaches such as submission, confrontation and avoidance (Charney & Russell, 1994). The coping strategies employed are largely determined by situational factors such as fear of jeopardizing

employment, fear of negative evaluations by others and the level of acceptance of sexually inappropriate behaviours in a work setting. Gruber (1989), in an assessment of coping strategies of victims of sexual harassment, highlighted the existence of four major categories of coping: avoidance (non recognition, obstruction, self removal), diffusion (masking, social support), negotiation (direct requests, professional mediation) and confrontation (personal responses, power structure). With regard to approach and avoidance coping strategies, Thacker (1996) found that victims tend to give up on approach strategies if the harassment continues and they become more passive and avoidant in their approach.

A limitation that has hindered the majority of research into the area of sexual harassment is the method of assessments that have been used. The majority of studies have relied only on self-report measures such as surveys and questionnaires in order to measure psychological distress. If there is one important factor that survey methods have failed to accommodate, it is that there are many different factors that can influence a person's perception and experience of sexual harassment. Therefore, it would seem more logical to employ the use of a research method that provides a more personalised means of assessment, in order to obtain responses that were consistent with real life experience.

A study by McDermutt Fine, Haaga, and Kirk, (2000) incorporated some interesting measures to investigate the psychological impact of sexual harassment. Participants were required to watch videotaped scenarios of three different events; one depicting sexual harassment, one showing an emotionally

arousing situation and the third being a neutral situation. While watching, participants were monitored for psychophysiological signs of distress using heart rate and skin temperature measures. In conjunction with psychophysiological recordings, self-report measures were taken in relation to experiences of sexual harassment, basic beliefs, psychological distress, posttraumatic stress symptoms and coping strategies. The experiment aimed to gather further information through the use of psychophysiological measures and screening for posttraumatic stress symptoms. The results of the study showed that those who had been sexually harassed in the past harboured more negative beliefs and evidenced more psychopathology than those who had not been harassed.

The symptoms that develop as a consequence of sexual harassment were also found to relate to posttraumatic stress symptomology. This was explained by the fact that those who had been harassed reported more re-experiencing symptoms indicating that they were more likely to meet the diagnostic criteria for PTSD. Interestingly, those who had adopted emotion-focused coping strategies had more PTSD symptomatology than those whose coping was problem focused. With regard to the psychophysiological measures, response activity to the scenarios did not differ regardless of the type of harassment experienced (McDermutt Fine et al., 2000).

There is strong evidence that the experience of sexual harassment is a negative one. There is also an established link between the experience of sexual harassment and the development of psychological symptoms including posttraumatic stress symptoms. This is despite the fact that, in general, sexual

harassment does not represent a direct threat to physical integrity. If harm is done by a threat to psychological integrity it can then be questioned whether other forms of violation that are not associated with a direct threat also have the potential to threaten psychological adjustment.

2.3.4 Emotional abuse

“I was standing in the kitchen when an argument started.....arguments were pretty common in our relationship. My mother and father were visiting, so I was trying to keep things under control. We started arguing about household matters. I tried to make him understand that I did a lot of work to keep our home life comfortable. Then he started to pull out all the hurtful remarks. He turned around and said that he should never have married me. He said that I did not love my children, that I was a useless wife and mother and that he only married me out of pity. It was all so nasty. I started to get frightened that things would escalate. That night he refused to eat the dinner that I cooked him. The next morning he refused to take the lunch that I had prepared for him.... He wouldn't even speak to my parents for the rest of their stay. I felt so unbelievably hurt and very alone. ”

- Victim of emotional abuse

Emotional abuse occurs in all cultures, communities and settings and is often far more prevalent than other forms of abusive behaviors and can result in more negative consequences for the victim of the abuse and their families (Semple, 2001; Trowell et al., 1997). Sexual and physical abuse often involve

elements of fear, power and control that are used to subdue and intimidate the victim. For this reason, aspects of emotional abuse are inherent in other forms of abusive behaviours. Having said this, emotional abuse can and does occur independently of other abusive behaviours (Pipes & Le Bov-Keeler, 1997). Interestingly, it has been noted that emotional abuse is rarely reported when it occurs in the presence of physical or sexual abuse (Semple, 2001). This is despite the reported negative impact of emotional abuse on victims. Whether it occurs in childhood or during adult relationships, emotional abuse may have traumatic consequences for those who experience it (Semple, 2001; Trowell et al., 1997).

A defining element of an emotionally abusive behaviour is the creation of inequality between the victim and perpetrator. Emotional abuse instills fear, increases dependency in relationships and damages the self-esteem of the victim (Orava, Mcleod, & Sharpe, 1996). Emotionally abusive behaviours can involve a broad range of acts such as humiliation, degradation, undermining self-esteem, perfectionist demands, isolation, possessiveness, withholding of affect and denial or validation of an individual's reality. Emotional abuse is commonly reported in the form of verbal threats and taunts or acts of economic control by one partner to the other (Murphy & Cascardi, 1993; Semple, 2001).

The diversity of behaviours that are considered to be emotionally abusive has made it difficult to define this type of abuse. The absence of a clear definition has impeded research investigation of emotional abuse. When considering emotionally abusive behaviours, like other forms of traumatic experience, it is important to consider the perspective of the victim and whether or not they

perceive an actual behaviour to be abusive (Pipes & Le-Bov-Keeler, 1997). Hoffman (1984) suggested emotional abuse included behaviours that are threatening in nature and have the potential to affect the working, social and family domains of a victim's life. Emotional abuse interferes with the individual's ability to enjoy good physical and mental health as a result of extended exposure to behaviours that are traumatic in nature. Murphy and Cascardi (1993) and Jory and Anderson (1999) emphasized that good definitions of emotional abuse highlight the presence of behaviours that create fear, humiliation, degradation, emotional destabilization and withholding and are damaging of self worth and increase the dependency between two people. Although not central to the research question, it is evident that perceptions of emotional abuse can differ drastically according to different societies and cultures (Tang, 1998).

Jory and Anderson (1999) further explained the importance of mutuality in personal relationships. Mutuality assists in promoting commitment, safety and security in a relationship. In emotionally abusive relationships, this mutuality is negatively influenced by exploitive, controlling and degrading behaviours which lead to the destruction of trust, confidence, self worth and the equality of power between two people. Those who perpetrate emotional abuse tend to have strong beliefs in traditional sex roles and are prone to have particular traits such as possessiveness, jealousy and manipulation (Murphy & Cascardi, 1993). The contribution of personality characteristics to the expression of emotional abuse in relationships is not surprising given that personality styles and traits have commonly been associated with relationship difficulties and marital

dissatisfaction (Fraley, Fazzari, Bonnano, & Dekel, 2006). Further, emotional abuse is a stable predictor of physical or sexual violence within relationships (Murphy & Cascardi, 1993; Marshall, 1996) and occurs commonly in couples who are socially isolated (Pipes & Le-Bov-Keeler, 1997).

Pipes and Le-Bov-Keeler (1997) investigated perceptions of emotional abuse in female college students in order to identify the determinates for viewing a behaviour as abusive. The authors aimed to investigate emotional abuse separately from other forms of abusive behaviors. Participants were included on the basis of being female and having been in an exclusive heterosexual relationship for at least a 2 month duration. Using a predetermined definition of emotionally abusive behaviour, participants were asked whether or not they believed themselves to be in an emotionally abusive relationship. The results indicated that 10.9% of respondents in a sample of 175 believed that they were victims of emotional abuse. Interestingly, 57.9% of this group also reported the existence of emotional abuse in their family of origin. Frequency of abuse was also determined as a contributing factor in identification of the experience as emotional abuse. Of the group who identified as being emotionally abused in their intimate relationship, 33% reported experiencing emotional abuse from other sources such as peers, roommates and relatives. The researchers established that emotional abuse creates negative messages about the self. Emotional abuse that is encountered earlier in life is reactivated and confirmed later in life by adult relationships. For those who remain in abusive relationships, the consequence is commonly poor self worth and dependency issues.

Marshall (1996) identified six different clusters of emotional abuse occurring within personal relationships. In a review of 578 women, a cluster analysis determined six distinct groups, each differing in relation to onset of abuse, age of victim, length of relationship, co-existence of other kinds of abuse and severity of abuse. Cluster 1 included relationships that were relatively short lived and characterized by physical, sexual and emotional abuse. Cluster 2 was characterized by longer relationships with low level emotional abuse and moderate physical abuse. Emotional abuse in this group mainly included acts aimed at undermining an individual's self confidence. Cluster 3 involved low level physical violence and covert emotional abuse, typically dominating and controlling behaviours. Cluster 4 was similar to cluster 3 in terms of physical violence but the emotional abuse was more overt acts of control and criticism. Cluster 5 described relationships that were longer in duration and characterized by high levels of emotional abuse (overt dominance and control) and moderate physical violence. The final cluster described moderate length relationships that were defined by high levels of emotional abuse (creation of powerlessness) and moderate to high physical violence. It was found that the variations between the clusters of abuse were determined by couple characteristics such as reliance on strong sex stereotypes, general acceptance of violence, possessiveness and jealousy. Regardless of the cluster to which it belonged, emotional abuse was found to be associated with several negative health outcomes for victims such as chronic illness, reliance on therapy, increased use of medications and more frequent visits to the doctor.

Emotional abuse has been found to be the most commonly occurring form of relationship abuse. Garcia-Linares et al. (2005) reported that, in a sample of women experiencing abuse in their current relationship, 75% reported that they had experienced emotional abuse. Those who were emotionally abused also reported the highest rates of prior victimization in relationships and childhood victimization. They also found that all three abuse groups (physical, sexual and emotional) reported higher levels of prior victimization in a relationship than those in the non abuse group. Links to previous abusive experiences were also found in groups of individuals with diagnosed eating disorders. Within this group, previous abuse histories were related to higher rates of emotional abuse and emotional neglect compared with physical and sexual abuse (Allison, Grilo, Masheb, & Stunkard, 2007). Interestingly, psychological aggression was also found to be the best predictor of poor coping in a sample of battered women. For this sample, psychological aggression was also found to be a strong predictor of PTSD symptomatology (Taft et al., 2007a).

The mechanisms that lead to emotional abuse have received research attention. General aggression in relationships was investigated by O'Leary, Smith-Slep and O'Leary (2007) in an attempt to conceptualize a model of relationship behaviour and the perpetration of emotional, physical and sexual abuse. They found that for male perpetrators, factors such as dominance/jealousy, power imbalances, marital adjustment, depressive symptoms and anger expression were contributors to the development of abusive behaviours. Although issues such as low income, unemployment and substance abuse can contribute to the development of emotionally abusive relationships,

relational difficulties between partners have been attributed to more fundamental interpersonal elements such as quality of communication, understanding of each other's emotions and beliefs and equality between partners (Relationships Australia, 2006). This considered, it has been determined that various risk factors such as being a younger age victim, having a history of separation or divorce, and having previous history of abusive behaviour and domestic violence in the family of origin are associated with the experience of abusive behaviours (Hegarty & Bush, 2002).

Status incompatibility has been suggested as a major predictor of emotional abuse in personal relationships. Kaukinen (2004) suggested that factors such as culture, employment, education and financial status are important symbolic factors in personal relationships and that when instability occurs non-violent emotional abuse is often used to reaffirm control in a relationship. For example, when status is reversed in a personal relationship (the female attains a higher qualification or earns a higher wage), the male may attempt to regain control through the use of emotionally abusive behaviours. Emotional abuse was postulated to be more common in situations of status incompatibility whereas physical violence was perceived to be more common in association with other relationship stresses. In support of this claim, it was emphasized that, statistically, physical violence is more prevalent in relationships dominated by issues such as unemployment, the care of young children, poor education and low wages. In contrast, in marriages where spouses are equally dependent and engage in joint decision making and power division, greater levels of relationship satisfaction are reported along with a lower risk of separation and the occurrence

of abusive behaviours.

The proportion of individuals who experienced aggressive acts in relationships is far greater than those who sustain actual physical injury. The degree of physical damage sustained does not determine the severity or impact of the act nor does it reflect the intentions behind the act (Goodyear-Smith & Laidlaw, 1999). Lindner (2001) investigated the role of humiliation in traumatic experiences. Humiliation presents as a key aspect of a traumatic experience and may be worthy of consideration when determining the differential effects of traumatic experience on different people. Traumatic events can occur with or without the presence of humiliation. Lindner (2001) described a continuum of traumatic experience with 'pure' traumatic experience at one end (absence of humiliation, e.g., natural disasters) through to situations whereby humiliation exists but may not have been the original intention (sexual assault) and then finally acts where the intention was to humiliate the victim (emotional abuse). Humiliation is described as the process whereby an individual is put down, degraded, embarrassed, bullied or abused. The experience of humiliation may be short or long term and it can result in longstanding effects for victims, such as depression, shame or dissociative experiences. Humiliation was identified as being particularly violating of the individual who experiences it. Humiliation violates self worth and dignity and is often a core element of emotional abuse.

Bagshaw et al. (1999) reported that humiliation is identified as a key emotion in victims of relationship abuse and violation with extreme patterns of cruelty and humiliation being found in long term abusive relationships.

Although physical assault has been suggested to be a more traumatic abusive experience (Vogel & Marshall, 2001), victims of emotionally violative and humiliating acts report that such acts are more devastating, due to their frequent occurrence in daily life (Follingstad, 1990). Victims of co-existing physical and emotional abuse who were interviewed as part of a survey, stated that physical abuse occurred only a few times during the course of the relationship whereas emotional cruelty (both direct and indirect) was more likely to occur nearly every day.

Therefore, it has been demonstrated that emotional abuse has the potential to have a significantly negative effect on the adjustment of victims. Indeed, it would appear that all reviewed forms of personal violation are detrimental to the psychological wellbeing of victims. The linking characteristic of these various forms of abuse is the extent to which they occur in interpersonal relationships. For this reason, it is important to consider the impact of abusive behaviours when they occur within the context of a relationship.

2.4 Abuse in relationships

Abusive behaviours that occur within personal relationship have adverse and severe social and emotional consequences (Goldner, 1998; Matud, 2005; O'Leary et al., 2007). Perpetrators and victims come from all different cultures and classes, and the boundaries between victim and perpetrator are commonly blurred (Bagshaw et al., 1999). There is little doubt that abuse in relationships is a significant social problem. In Australia in 2003, it was estimated that the total number of people who had experienced domestic abuse was 408,100 with

approximately 181,200 children witnessing domestic abuse (ABS, 2004).

The majority of research in this field has focused women's experience of abusive behaviours in personal relationships (Bagshaw et al., 1999; Pakieser et al., 1999; Romito & Grassi, 2007). There has been ongoing debate as to the factors influencing abuse against women including issues such as gender and sex stereotypes. However, samples used in abuse research are usually from legal, social and clinical services and, therefore, tend to represent only the extreme end of the intimate partner violence spectrum. For this reason, demographics on partner violence and abuse in general may not be a true reflection of the problem (Goodyear-Smith & Laidlaw, 1999).

Victimization of women in society has traditionally dominated research (Bagshaw et al., 1999) with men seen more commonly as the perpetrators of abuse and acts of violation in personal relationship. Feminist theories postulate this is due to the existence of gendered messages that are evident in all areas of life, some more predominantly than others. Sexually stereotyped messages commonly make women more vulnerable to defenselessness and powerlessness in personal relationships, and more likely to accept abusive conditions (Ali, 2007).

Certainly, there seems to be little doubt that victims of abuse are predominantly female. In 2002-3, it was estimated that 87% of Australian victims of family based violence were female, with 98% of the offenders being male. Although women are represented as more socially and biologically

vulnerable to emotional, physical and sexual victimization, it should be noted that women may also be perpetrators of abusive behaviours in both heterosexual and homosexual relationships (ABS, 2004). However, female perpetrated relationship violence is not a dominant area of research. Data reflecting the extent of relationship violence perpetrated by women have been affected by the fact that men are less likely to disclose the occurrence of abuse by a female partner due to the potential for social stigma (Bagshaw et al., 1999). In a telephone survey of domestic abuse, 14% of respondents were male, with 3% of these identifying as perpetrators. Men reported experiences of physical, sexual and emotional abuse by their female partners. Male victims of abuse experience difficulties beyond those reported by females. These include public misconceptions that males are always perpetrators and the fact that victimized males have less access to appropriate support and services. Overall, men's experience of relationship aggression appeared different to the experiences reported by women (Bagshaw et al., 1999).

Irrespective of the factors that lead to relationship abuse for women, it is evident that such experiences have a significant impact. The 1996 Women's Safety Survey (ABS, 1996) reported that 38% of women had experienced at least one episode of physical or sexual violence by the age of 15 years, 21% of this occurring in a domestic setting. The 2003 figures for domestic violence showed that 179,600 women had experienced physical assault, 27,700 sexual assault, 39,300 had experienced sexual threat, 5,200 had experienced stalking and, interestingly, 196,200 had experienced emotional abuse within a personal relationship. The health burdens associated with domestic abuse are

approximately 29% for depression, 22% for anxiety, 25% for drugs, alcohol and tobacco use and 12% for suicide. These figures illustrate an alarming picture and demonstrate that domestic abuse is an escalating concern that represents a significant economic cost.

Violence in personal relationships characterizes the extreme end of difficult relationship behaviours (Goodyear-Smith & Laidlaw, 1999). Violence in personal relationship has been attributed to various factors that make couples vulnerable to the occurrence of aggression. Cohabitation at a young age, mental illness, unemployment, drug and alcohol use, early parenthood, juvenile aggression and violence in the family of origin are just some of the issues associated with domestic disputes (Hegarty & Bush, 2002; Moffitt, Caspi, & Silva, 1996). Violence in personal relationships may occur between partners, former partners, family members, household members or those involved in other close relationships (Goodyear-Smith & Laidlaw, 1999). Relationship based violence may range from aggressive acts such as verbal hostility to physical use of force or assaults which include physical acts of violence that are intended to harm.

Goldner (1998) reported that violation and victimization within a relationship can be complicated by intense attachment styles. Those within abusive relationships commonly recognize the relationship dynamics as psychologically damaging, yet find it hard break free due to these attachments and their investment in the relationship. This style of relationship has also been associated with an increased likelihood of victimization occurring in future

relationships.

An Australian study by Mouzos and Makkai (2004) highlighted that the strongest contributors to relationship abuse were associated with male behaviours. They found that the risk of abuse was related to male drinking habits, levels of aggression and controlling behaviours.

Finkel (2007) drew attention to violence impelling factors and violence inhibiting factors in the development of relationship abuse. Finkel's model postulates that the development of relationship violence is commonly the interaction of these two factors. Both factors are made up of distal, dispositional, relational and situational attributes that increase the likelihood of relationship disputes. Impelling violence factors include the impulses that an individual may experience to enact intimate partner violence whereas inhibiting factors relate to the attributes the individual possesses to override these impulses. It was suggested that in terms of violation and relationship violence, many individuals possess impelling violence factors or the occasional impulse to enact aggression. It is the absence of inhibiting factors that places the individual at strong risk of violence perpetration.

Abuse within personal relationships is commonly associated with a variety of personal and environmental stressors (Goodyear-Smith & Laidlaw, 1999). The effects of relationship violence are multifaceted and impact not just on the couple involved but also children, family and surrounding peer networks (Goldner, 1998). Depression is common in victims of abuse (Calvete, Esteves,

& Corral, 2007) and onset of depressive symptoms also may occur after the cessation of the abusive relationship (Russell & Uhlemann, 1994).

Matud (2005) investigated the characteristics of a group of women who had been victims of partner (male) abuse. Participants were aged 17 – 68 years and were compared with matched controls without an abusive relationship history. At the time of the research 62.8% of the clinical sample had left the abusive relationship, 13.7% were in the process of separation and 23.5% were still living with the abusive partner. The breakdown of the type of abuse experienced gives evidence for the existence of concomitant and isolated abusive behaviours (Garcia-Linares et al., 2005). Forty-seven percent of the clinical sample had been victims of physical and psychological abuse, 32.1% victims of physical, psychological and sexual abuse, 5% were victims of sexual abuse alone and 15.8% suffered psychological abuse only. When compared with controls, the clinical sample showed more evidence of psychological symptoms including depressive, anxiety and somatic complaints. Self esteem was also found to be lower in those who had suffered abusive behaviours. This may be largely attributed to the fact that the majority of abuse was long-term and ongoing. Victims of abuse commonly reported that the abusive behaviours occurred in their younger years and in the early stages of the relationship (Matud, 2005). Other studies have identified the link between long term relationships and greater exposure to abuse (e.g., Neufield, McNamara, & Ertl, 1999).

Similar results were reported by Wijima, Samelius, Wingren, and Wijima (2007). In a sample of 4,150 from the general population, 27.5% reported

experiencing abuse in personal relationships, with 19.4% reporting physical abuse, 9.2% sexual abuse and 18.2% psychological abuse. Again, those who had suffered abuse reported poorer psychological health and fewer advantages in social situations. Severity and frequency of abuse had a positive relationship with greater psychological symptoms. This said, even low magnitude abuse experiences were related to poorer health outcomes. Briere and Richards (2007) found that victims of violation in relationships were at greater risk for identity problems, poor affect regulation and interpersonal disturbances. Individuals were also at risk of anxious, depressive and dissociative symptoms as well as dysfunctional behaviour and substance abuse.

Fear is an interesting aspect of abuse research. Statistics have indicated that more fear is reported when the perpetrator is a stranger compared to someone who is known to the victim (Mouzos & Makkai, 2004). This supports claims by Harris and Miller (2000) that a perception of being 'safe' is associated with intimate partners and people who are known, despite having been exposed to violent or abusive behaviour by partners or associates.

Outside of co-inhabiting partners, students in a dating relationship reported that they had experienced verbally aggressive behaviours (82%) and physically aggressive behaviours (21%) in the past year. Violence in the family of origin, personal attitudes, socio-demographic characteristics and substance use were found to predispose dating partners to abusive behaviours (Shook, Gerrity, Jurich, & Segrist, 2000).

Just as sex differences for the prevalence of abuse exist in the literature (e.g., Ali, 2007; Bagshaw et al., 1999) sex has also been investigated in relation to the impact of relationship violation and aggression (Romito & Grassi, 2007). It has been suggested that differences in impact may be dependent on the type of abuse and the situational context of the abuse (domestic/direct experience/witnessing). Regardless of the context, it was found that women report more psychological abuse suggesting that they are more likely to perceive an act as degrading or violative. Similar rates were noted between the sexes for experience of abusive behaviours, however, women reported more negative reactions to these experiences including humiliation, emotional pain and fear. Women's health was also found to be more affected by abusive experiences, with women experiencing greater perceived levels of stress than men. It was suggested that differences should be attributed to the severity and frequency of abuse and the situation in which it occurred, not just gender. Garcia-Linares and colleagues (2005) maintained that there is little evidence for a specific response style of women to types of abuse.

There have been several models used to explain why women remain in abusive relationships and the high incidence of revictimisation in future relationships. A model of the cycle of violence has been applied extensively in educational and community settings. This model is presented in Figure 1. Grief reactions and learned helplessness frequently have been used to explain responses elicited by abused individuals (Russell & Uhleman, 1994). Learned helplessness is described as a response style adopted by victims whereby they fail to escape a abusive/dangerous situation, even though they have the ability to

do so. It is characterized as a lack of control over personal circumstances and has been extensively linked with depression and disturbances of emotion and cognition (Pakieser et al., 1999).

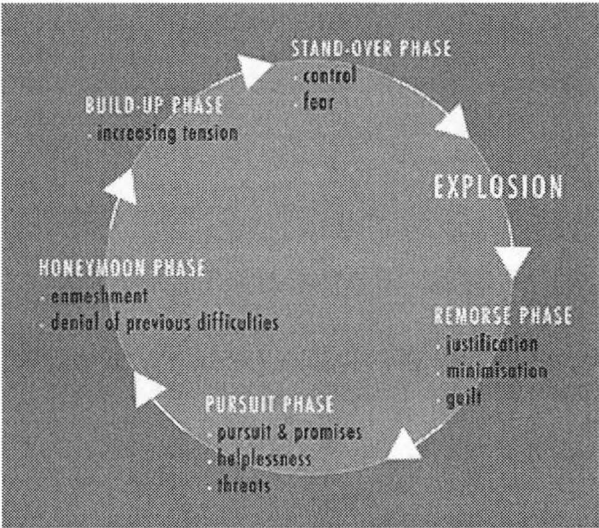


Figure 1. *The cycle of violence.* (South Australian Police Department, 2000).

As the frequency and severity of abuse in a relationship increases, so can learned helplessness, which leads to only the management of associated feelings and not the decision to escape. Stockholm Syndrome is associated with hostage events and describes the development of a situation whereby hostage victims identify with the hostage taker (Namnyak et al., 2008). The Stockholm syndrome has also been used to explain the decision to stay in abusive relationships. This syndrome describes the perceived inability to escape, isolation from perspectives other than the abusers, anticipation of kindness from the abuser and the ongoing presence of perceived threat that diminishes the instinct to flee violent relationships (McMurray, 2005). McMurray went on to explain that emotional investment in a relationship is also a trap, especially for younger victims. It was postulated that women feel bound emotionally, socially, financially to a

relationship. This is often driven by fears of lifestyle change and loss of needed intimacy if they leave their relationship.

In summary, abusive behaviours are traumatic in nature and commonly involve the violation of physical and psychological integrity. Sexual abuse, physical abuse, emotional abuse and sexual harassment all incorporate aspects of violation for the individual. The experience of abuse and violation in personal relationships commonly poses a further threat to psychological functioning, in particular trust networks and personal safety. Abusive behaviours can produce various traumatic consequences for victims.

CHAPTER THREE
THE NATURE AND EXPERIENCE OF TRAUMATIC EVENTS

3. Overview

The purpose of this chapter is to examine the trauma literature, specifically the literature that impacts on the current research question of whether all types of personal violation are traumatic in nature. Initially, the experience of trauma is considered including definitions, typical trauma responses and types, duration and onset of traumatic experiences. This is followed by an examination of the factors that may affect the experience of trauma such as sex differences. Responses to traumatic experience are identified in terms of their psychophysiological and psychological facets. Further, factors that modify the severity of traumatic experience are identified such as coping style. From this, consideration is then given to the potential for the development of psychological maladjustment following trauma exposure and the influence of traumatic memory.

Consideration is then given to posttraumatic stress reactions as categorized in the DSM-IV-TR (APA, 2000), including symptom clusters. Particular attention is given to the stressor criterion as it is this that presents difficulty for the identification of some forms of personal violation as a traumatic experience. As part of the consideration of the way in which people react to traumatic experience, peritraumatic dissociation is covered.

Finally the trauma focused research that considers specific aspects of the traumatic experience as it relates to abuse in relationships is covered. This includes the effect of repeated exposure and the subjective experience of an event as traumatic even in the absence of threat to physical integrity.

3.1 Introduction

Traumatic experiences can interrupt normal functioning by posing an immediate threat to personal safety (Vandervoort & Rokach, 2004). Depending on the age of the victim, traumatic experiences can have an impact on social, emotional and moral development and can lead to the development of psychopathology in both adults and children (Parson, 1995; Pennebaker & Beall, 1986).

Longitudinal researchers, Offer and Sabshin (1984), established basic principals that are required for maintaining 'normal' human development and functioning:

- 1) Absence of gross psychopathology, severe defects and severe physical illness;
- 2) Mastery of previous developmental tasks without serious setbacks;
- 3) Ability to experience emotional states flexibly and to resolve conflicts actively with reasonable success;
- 4) Relatively good relationships with parents, siblings and peers;
- 5) Feeling part of a larger cultural environment and being aware of its norms and values.

It is these factors that influence the way that people perceive and act in their environments. Various stressors, such as illness, childhood abuse, aggressive environments, poor attachments, can alter cognitive processes and the ability to produce 'normal' human reactions. Particularly when faced with an

‘abnormal’ stressor, survival and anxiety reactions may become extreme and prolonged.

Negative events involving extreme stress can lead to disturbances in internal functioning and the development of psychopathology. Psychopathology can arise from poor mastery of many areas of human development including trust, autonomy, initiative, identity, intimacy and integrity (Kaplan & Saddock, 1990).

3.2 The experience of trauma

In psychological terms, traumatic stress is defined as “A disordered psychic or behavioural state resulting from mental or emotional stress or physical injury” (Merram-Webster, 1998, pp. 1257). Similarly, a traumatic stressor is an agent, force or mechanism that causes trauma stress to those who experience it. According to the American Psychiatric Association (2000), a traumatic stressor is typically a stressor that is outside the range of usual human experience and could be considered highly distressing to the average person. In accordance with this, it should be noted that traumatic stress is a subjective experience (Brewin, Andrews, & Rose, 2000; Jeavons, Greenwood, & de L. Horne, 2000). What one individual may find highly distressing, another may not.

During times of extreme anxiety and traumatic stress, humans will typically do whatever it takes to survive. This may include acting in ways that are incongruent to their nature and actions that will later elicit feelings of shame, guilt and remorse. A common finding is that traumatic experience is an

extremely complex event that can have widespread and long-lasting effects (Dobson & Marshall, 1996; Parson, 1995). The experience of trauma can result in a spectrum of symptoms ranging from psychological distress to clusters of symptoms that meet the criteria for PTSD. PTSD can occur for both children and adults. Children who experience traumatic events can present with symptoms of aggression, impulse control, attention, communication, and re-enactment of traumatic experience through play (Rojas & Lee, 2004). Adults, too, can present with deficits in these areas in conjunction with complications associated with substance use, personality changes, eating and sleep disorders, sexual problems and physical illness (Roth, Pelcovitz, Sunday, & Spinazolla, 2005). The effects of exposure to traumatic experience are strongly influenced by factors such as sex (Jeavons et al., 2000), past experience (Lauterbach & Vrana, 2001), psychological status (Jeavons et al., 2000), physical health, proximity to the stressor and, most importantly, victim perspective (Brewin et al., 2000).

Briere and Spinazzola (2005) identified that there are commonly two types of traumatic experiences. The first type encompasses those experiences that are of adult onset, single incident and can occur at any time as the result of an accident or attack. The second type of traumatic experience involves events which are commonly associated with earlier onset, and involve multiple and extended episodes of abuse which are often accompanied by stigma or feelings of shame for the victim. The impact of these types of traumatic experiences will depend upon the vulnerability of the victim, their past history and experience. Some research suggested that single episode traumatic events that are of adult

onset and do not involve violation are associated with better posttraumatic outcomes (Green et al., 2000). van der Kolk et al. (2005) reported that traumatic events that occur within the first decade of life sometimes have greater, longer lasting impact than those that occur later in life and that complex traumatic stress symptoms are also related to prolonged exposure to events. Regardless of age of onset, Pimlott-Kubiak and Cortina (2003) suggested that it is the extent of exposure to a traumatic stressor that will predict the long term consequences for the victim. This considered, it could be suggested that adults who have been victims of ongoing abusive relationships may present with long term negative psychological consequences.

The type, duration and onset of a traumatic experience is an integral part of the current investigation as these factors may be associated with pre-trauma, peri-trauma and posttraumatic reactions in abusive experiences. For example, although emotional abuse has been seen as a lower level traumatic stressor, or in some cases not traumatic at all, when compared with sexual and physical abuse (Vogel & Marshall, 2001), the frequency and enduring nature of emotionally abusive behaviours can reinforce negative self schemas and result in posttraumatic outcomes (Gibb & Abela, 2008).

3.3 Factors affecting the experience of trauma

Traumatic experiences can have a severe psychological effect, as the sufferer is in danger of being overwhelmed by intense feelings, often resulting in dissociation and detachment (Kriedler, Zupancic, Bell, & Longo, 2000). The traumatic experience is induced by marked fear of personal harm, loss of control

and personal vulnerability. The activation of a posttraumatic stress response also can be influenced by factors unique to the individual such as belief systems, current psychological well-being, past experience and coping strategies (Bowman, 1999).

Traumatic events are not a rare occurrence (Cassidy & Mohr, 2001). On both a local and international scale, traumatic stressors can arise from natural disasters, wars, accidents, violence (including assaults, rape and other abusive experiences) and rapid environmental or emotional change. Research has shown that nearly 60% of males and 50% of females have experienced a significant traumatic event in their lifetimes, and the reoccurrence of traumatic events is also common with the large majority of those who have experienced a traumatic event reporting two or more events in their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

The incidence of traumatic experience in clinical populations is also high. Part of the reason that traumatic experience is so prevalent is that it not only affects the direct victim of the event, but also those who witness it. Witnessing an event or learning that traumatic event has occurred for a loved one, can be just as traumatic as direct experience. Vicarious trauma experienced by therapists and health practitioners can also result in the experience of posttraumatic stress symptoms (Clemans, 2004; Ehrenreich, 2003; Schnurr et al., 2002).

Ehrenreich (2003) suggested that the effects of traumatic experience are widespread. The effect of traumatic experience can either be direct (victims and families), summative (wide scale disasters/death, loss of resources), emergent (the carry over effect from the victims to their relationships), reciprocal (stigma of victims) and transgenerational (cultural identities based on past victimization). The author goes on to suggest that traumatic experience is reliant on individual and group resilience, depending on factors such as genetic make-up, personality and coping mechanisms.

Sex differences exist, both in the prevalence of PTSD and the experience of the type of traumatic event. Males have been demonstrated to be more prone to the experience of physical attacks, combat and the witnessing of traumatic events whereas women are more likely to experience traumatic events such as rape, molestation, parental neglect and parental physical abuse (Romito & Grassi, 2007).

It has been suggested that the higher prevalence of PTSD in women is due to the type of traumatic events that they experience (Gavranidou & Rosner, 2003). However, others maintained that even when the type of traumatic experience is taken into account women still present with higher PTSD rates (Schnurr et al., 2002). In addition to this, it has been suggested that traumatic experience and subsequent symptoms are also influenced by factors such as age, education, existing psychiatric disorders, childhood experiences, personality pathology, family history, initial traumatic reactions and available social supports

both during and after an event. These factors will be discussed at greater length in subsequent chapters.

3.4 Responses to traumatic experience

When investigating the experience of trauma, it is important to understand the cognitive, emotional and physiological reactions that may result. Most people respond to a traumatic event with a typical physiological stress response. Stress responses are learned from previous experience and the body ‘remembers’ how to react should it be faced with a similar experience in the future (Kaplan & Saddock, 1990). It is expected that the absence of threat will be recognized after the cessation of a traumatic event and that stress response will not be maintained. Dysfunction in this process can lead to the development of pathological anxiety (Brantley, 2003), including the development of PTSD. In a sense, the development of posttraumatic stress symptoms would be the expected response to this dysfunction.

Frequent or intense activation of the body’s stress response system can lead to the development of anxiety and atypical responses to traumatic experience (Brantley, 2003). Atypical responses to traumatic experience include severe and prolonged stress reactions, characterized by intense fear and apprehension and can often develop into anxiety disorders such as Panic Disorder, PTSD and ASD (APA, 2000).

The likelihood of developing PTSD varies with the type of traumatic experience (e.g., man made or natural disaster) and the personal characteristics of

the victim (e.g., history of traumatic experience, poor coping skills) (Jeavons et al., 2000; Lauterbach & Vrana, 2001; van der Kolk et al., 2005). Many of those who develop PTSD experience symptoms for durations longer than three months and some experience symptoms for longer than a year. PTSD sufferers can also experience a recurrence of symptoms even after many years of remission. It has been suggested that risk factors affecting onset and duration may differ (Maercker et al., 2000).

ASD is a diagnosis given to victims of traumatic events who experience intense symptoms in the first four weeks after a traumatic event. The symptoms of ASD include dissociation, intrusions, avoidance and hypervigilance (APA, 2000), and the condition is similar to PTSD. If symptoms of ASD persist for longer than one month, a diagnosis of PTSD is applied. ASD has sometimes been suggested as a predictor of PTSD (Schnurr et al., 2002).

Research has shown that those who experience pronounced or atypical posttraumatic stress reactions may exhibit sudden and dramatic elevations of sympathetic nervous system (SNS) activity to laboratory simulated traumatic event related stimuli. Atypical stress responses usually include those that are much shorter in latency than normal reactions, have increased amplitude and show an absence of inhibitory mechanisms. Disturbances are also seen in sleep cycles, thyroid function, immune function, information processing and memory (Schnurr et al., 2002). These atypical response patterns have been well documented (Birmes, Hatton, Bruenet, & Schmitt, 2003).

Previous research has examined the stress responses of individuals with a history of traumatic experience. It was found that when exposed to subsequent traumatic stressors, those with a history of traumatic experience reported increased stress responses, such as anxiety and depression, compared to those with no history of traumatic experience. Stress cognitions and recovery from traumatic experience were also investigated and it was suggested that cognitive processes and 'stress tolerance' accounts for individual differences in traumatic stress reactions (Izutsu et al., 2004).

An individual's ability to cope both during and after a traumatic event will impact upon the development of posttraumatic stress symptoms. When input from the environment is beyond what the individual can comfortably manage, the individual will rely on various internal and external processes in order to cope. Coping strategies and resources include cognitive processes, communication skills, emotional expression, relationships and spiritual beliefs. During times of extreme stress, an individual will use one or more of these strategies/resources in an attempt to normalize their behaviours and emotional reactions (Burr, Day, & Bahr, 1993).

Posttraumatic stress symptoms can produce different emotional reactions depending on the individual and experience. Naatanen, Kanninen, Qouta and Punamaki (2002) found that male war prisoners evidenced three different patterns of psychopathology post-trauma. The first group, *Ruminating Alexithymics*, showed an inability to accurately express their emotions. Due to a failure to work through feelings associated with their traumatic experience, they

commonly presented with anger, ruminating thoughts and hyperactive behaviour. The *Depressively Reactant* group showed greater ability to work through their emotions and memories but presented as extremely hypervigilant. This group struggled to control reactions to their traumatic experiences due to depressive symptoms and unresolved unpleasant memories. The final emotional pattern, the *Low Intensity* group used excessive affect regulation to manage their traumatic experience. Not surprisingly, these individuals presented as guarded, unaccepting and emotionally numb. This research is important as it highlights the role of traumatic stress cognitions and demonstrates that the way an individual thinks and acts upon traumatic experience will affect their recovery and psychological outcome.

Brewin et al. (2000) examined the role of subjective estimates of the intensity of the traumatic experience. They found that those who reported intense emotions at the time of a traumatic event were more likely to develop symptoms of PTSD. The authors found that participants who endorsed feelings such as fear, helplessness and horror went on to experience more negative psychological outcomes. Women were found to report more feelings of horror and fear than men and feelings of fear and helplessness were more common than feelings of horror. The research also established that fear is not a predictor of PTSD on its own, particularly when it is accompanied by the hope of escape during the traumatic event. Fear, when coupled with helplessness in a situation, lead to poorer post-trauma functioning. Feelings such as shame and anger that were experienced after the event were found to contribute to the likelihood of PTSD.

Past literature provides evidence for the potential for psychological maladjustment following the experience of a traumatic stressor (e.g., Parson, 1995). Posttraumatic stress reactions differ between individuals and are complex in nature. Characteristics of the event and the victims have the ability to influence the development of psychopathology post-trauma. Recovery from psychopathology that has resulted from traumatic experience involves restoring levels of psychosocial functioning. The role of social support and help seeking behaviour in the recovery from trauma has been well established (Bolton et al., 2004). Russell and Uhlemann (1994) identified that learned helplessness is often an obstacle in recovery. Treatment objectives need to address issues such as motivational apathy, difficulties in problem solving, depression and self-esteem, which commonly are the result of the learned helplessness effect. The following section will address other factors relating to the individual that may alter a traumatic experience.

3.5 Traumatic memory

Consideration must be given to the memory for traumatic experiences, particularly in light of the choice of methodology to be used in study two which relies on the recollection of peritraumatic experiences. Memory for traumatic events has been found to differ between individuals. Just as age and developmental factors affect the ability to remember information and events, cognitive factors, sex, prior experience and emotions may alter memory for an event (Bohanek, Fivush, & Walker, 2005). Porter and Birt (2001) found that variables such as sex and personality characteristics had the greatest impact on

the processing and storage of traumatic memory. Women have been found to report more details in relation to a traumatic event due to the fact that they are more likely to think and talk about traumatic experiences.

Porter and Birt (2001) suggested that traumatic memories are processed and recalled very differently from other types of memory. They also drew attention to differing opinions in relation to traumatic memory and whether or not a traumatic experience will enhance or inhibit a person's ability to store accurate information. Many studies have suggested that traumatic experience commonly leads to memory impairment due to the fact that during traumatic experience, memories are fragmented and unable to be reorganized into coherent accounts of the event (Brewin, Dalgeish, & Joseph, 1996; Ehlers & Clark, 2000).

In contrast, others have argued that traumatic experience, in fact, enhances the quality of memory (Meglias, Ryan, Vaquero, & Frese, 2007; Porter & Birt, 2001). Porter and Birt (2001) reported that memory recall for survivors of traumatic experiences such as sexual assault was better than those who were asked to recall a positive, non-traumatic memory. They noted that traumatic memories possessed greater detail and were more easily recalled. Similarly, Meglias et al. (2007) found that memory quality for both traumatic and positive experiences was better in those who had experienced PTSD compared to those who has not experienced PTSD. It has been suggested that poor memory recall might be associated with more extreme forms of traumatic experience due to the possible influence of dissociative factors (Porter & Birt, 2001) and difficulties in memory control and verbalization of memories (Meglias et al., 2007).

Bohanek et al. (2005) suggested that the emotional component of an experience forms an important role in the ability to create meaning in a situation. Furthermore, an individual's ability to clearly think through an event and integrate emotions related to it may affect their ability to cope with stressful events and negative experiences. Bohanek et al. (2005) examined narratives of traumatic, negative and positive events, highlighting the relationship between memory and emotion. They found that an individual's subjective experience of a traumatic event and the subsequent thought processes that follow a negative event, will determine how it is represented and how it impacts on life functioning.

In summary, it is evident that memory for traumatic events can be influenced by several factors. In some instances, traumatic experiences may enhance an individual's ability to recall an event, however, in situations where peri-traumatic dissociation has occurred, memory may be impaired. It could be suggested that the different symptoms that present after a traumatic experiences impact on the individual's ability to remember the event.

3.6 Posttraumatic stress reactions

3.6.1 Posttraumatic stress disorder symptom clusters

PTSD is a disorder characterized by a range of anxiety symptoms that overlap with affective domains (Schnurr et al., 2002). PTSD is characterized by a set of symptoms that can develop after a person sees, is involved in, or hears of an extreme traumatic stressor (Kaplan & Sadock, 1998). Its development

involves an interaction of factors with traumatic experience being only one. Characteristics of the victim, their previous experience and the context in which the traumatic event occurs can also influence the traumatic experience (Bowman, 1999). When assessing for PTSD, clinicians commonly detect alterations and disturbances in self capacity, cognition and mood. This may be evidenced by the presence of deregulation of attachments, low self esteem, self blame, expectations of maltreatment and marked mood instability. Symptoms of traumatic stress are also commonly evidenced by dissociation, substance use and avoidance responses (Briere & Spinazzola, 2005).

In order to diagnose PTSD, three clusters of symptoms must be present for more than a month and must cause significant distress or impairment in functioning. These symptom clusters include re-experiencing memories, avoidance and numbing, and arousal. Personal factors that can contribute to its development include traumatic childhood abuse, history of personal victimization, the presence of anxiety or depressive features, personality traits, nervous system hypersensitivity and poor social supports (e.g., Bowman, 1999). PTSD can be diagnosed at any age but is found to be more prevalent in young adults (Kaplan & Sadock, 1998), this is due to lifestyle and age related behaviours. It is also found to be reported more in those who are single, divorced, widowed, socially withdrawn and have low socioeconomic status (Brand, 2003).

3.6.2 Posttraumatic stress disorder stressor criterion

The stressor criterion for the diagnosis of PTSD (APA, 2000) states that the victim must either have experienced, witnessed or be confronted by actual or threatened death, serious injury, or a threat to physical integrity. The victim's response, according to the criterion, must involve fear, helplessness or horror.

However, there is increasing recognition that PTSD-like symptoms can develop without the threat to life or physical integrity (Pico-Alphonso et al., 2006). It may be the perceived threat to psychological integrity that is traumatizing for some (Green, 1993). Green suggested that this is particularly true for interpersonal trauma, due to the fact that the victim not only deals with the helplessness and distress of the event, but also feelings of betrayal by the known perpetrator. Brewin et al. (2000) considered the subjective views of traumatic experiences and stated that the development of trauma symptoms would depend upon the nature of the traumatic experience and the subjective emotions that are experienced as a result. Fear, hopelessness and helplessness were associated with the development of significant posttraumatic stress symptoms.

Research shows that not all individuals who experience a traumatic event will develop PTSD, indicating that there is interplay between environmental and individual factors in the development of traumatic stress symptoms (Schnurr et al., 2002; Shalev, Tuval-Mashiach, & Hadar, 2004). Similarly, victims of traumatic experience frequently display emotional processing that is biased and discrepant (Naatanen et al., 2002), and responses to traumatic events are often

exacerbated by personal features such as unresolved earlier traumatic experience. Therefore, there can be an increased likelihood for the development of PTSD in the absence of a life threatening event (Carlson & Dutton, 2003). The traditional view of the development of posttraumatic stress symptoms requiring exposure to a DSM-IV defined traumatic event may need to be modified to include events that do not threaten physical integrity and are less catastrophic than previously defined (Weaver, 2000).

The presence of pre-trauma and post-trauma factors (i.e., prior experience of traumatic event, psychological functioning) have been found to influence posttraumatic stress development and severity (Bowman, 1999). Events that occur during the traumatic experience are also relevant to development of stress symptoms and possible psychopathology.

3.7 Peri-traumatic dissociation

The experience of dissociation is common to traumatic experience and posttraumatic stress research (van der Hart, Nijenhuis, Steel, & Brown, 2004). Dissociation relates to an unconscious defense mechanism which separates a certain type of mental or behavioral process from the rest of the person's conscious functioning (Gershuny, Cloitre, & Otto, 2003). During a dissociative experience, emotions are separated from specific ideas or acts and the individual's recall of the event may be diminished (Kaplan & Sadock, 1996). Peri-traumatic dissociation may occur during exposure to a traumatic event, whereby the individual experiences alterations in the perception of time, place or person, giving them a sense of false reality.

Peri-traumatic dissociation can affect the encoding of information during the traumatic experience resulting in distorted and inaccurate memories (Allen, Console, & Lewis, 1999). Individuals who experience peri-traumatic dissociation will often report altered perceptions of time, having felt that an experience lasted extended periods of time, when, in reality it only lasted minutes. Research has indicated that peri-traumatic dissociation is strongly associated with the development of psychopathology and is a better predictor of PTSD than feelings of anxiety or loss of control during the traumatic experience. It was suggested that recovery from traumatic experience is reliant on the organisation and clarification of traumatic memories. Peri-traumatic dissociation during traumatic experiences affects the encoding of information and results in processing that is less compatible with recovery (Zoeliner, Alvarez-Conrad, & Foa, 2002).

Peri-traumatic dissociation has frequently been associated with sexual abuse and violent crime (Birmes et al., 2001; Griffin, Resick, & Mechanic, 1997). Some have suggested that it is adopted as a coping strategy by victims in order to alleviate psychological distress during the experience of traumatic events (Gershuny et al., 2003; van der Hart et al., 2004). This is an important consideration in the investigation of psychophysiological stress responses to traumatic events as psychological disengagement has been found to produce lower psychophysiological arousal in victims (Griffin et al., 1997), which will be discussed further in subsequent chapters.

3.8 Trauma focused research

Trauma focused research has shown that traumatic experience can disrupt psychological functioning in specific ways including an individual's frame of reference, their central belief systems, sense of identity and trust. Research has also allowed the mapping of this disruption and a better understanding of the secondary effects of trauma on families, communities and those who work with the traumatized (Atkinson-Tover, 2003; Ehrenreich, 2003).

Longitudinal research has allowed the investigation and mapping of traumatic stress symptoms over time. Longitudinal studies have started by examining individuals from the point of exposure, taking into account prior experiences and exposure and then mapping and profiling the symptoms as they arise. This has allowed for information to be obtained about symptom severity and longevity and the factors that influence these variables (King et al., 2006). Evidence has shown that extreme forms of traumatic experience can have permanent effects, resulting in adjustments in belief systems and alteration of personality characteristics (Emm & McKenry, 1988).

Other areas of research have considered repeated exposure (Casey & Nurius, 2005; Green et al., 2000; Regehr et al., 1999) and the subjective experience of the individual (Regehr et al., 1999). These studies have expanded the understanding of traumatic experience in relation to resilience and vulnerability to the development of posttraumatic stress. Trauma focused research has also considered the nature of traumatic experience and what it is that constitutes a traumatic event. Examination of the role of subjective experience

and victim perspective has contributed to discussion of the validity of current diagnostic criteria for posttraumatic stress-related disorders (McFarlane, 1994).

All of this research has relied on the voluntary participation of people who have been exposed to a traumatic event in trauma related research. The wellbeing of trauma research participants must be considered. Informed judgment in relation to research participants is an important area of investigation. Ethical considerations in trauma research are particularly pertinent as participants present with significant symptomology (Newman & Kaloupek, 2004). When deciding to participate, individuals must consider that the research may cause them additional distress due to the need to recall traumatizing experiences effects and they must be aware that there is a potential re-traumatisation. Investigators need to ensure that participants are well informed of the possible implications of the research and have support readily available for those who require it.

Despite these precautions, research has indicated that there are also benefits that can arise for the participant. Positive outcomes such as insight, satisfaction related to perceived contribution and a distraction from current challenges have been highlighted by participants who have completed research (Newman & Kaloupek, 2004). Participants who experienced side effects during research participation tended to possess the following factors: pre existing distress, younger and older age, history of multiple traumatic experience, social vulnerability and greater injury severity. However, although certain participants do experience distressing side effects, overall, they do not tend to rate their experience as negative and do not regret participation. Johnson and Benight

(2003) found similar results in that although many participants reported more unexpected distress they also experienced unexpected gain. Their research found that, overall, victims of traumatic events tolerate participation in research very well.

3.9 Summary

The experience of traumatic events can result in posttraumatic stress reactions. The type, duration and onset of a traumatic stressor may influence traumatic stress reactions. Factors associated with the traumatic event and the victim can influence traumatic stress severity. Posttraumatic stress reactions typically follow a pattern of response and diagnosis depends on the individual meeting specific diagnostic criteria. Schnurr and colleagues (2002) suggested that traumatic experience and risk for posttraumatic stress symptoms is best investigated in relation to the individual and what they bring to the event, characteristics of the event itself and the post trauma experiences. For this reason, pre-trauma, peri-trauma and posttraumatic factors will be investigated. The current research will consider how these factors influence the experiences of individuals exposed to personally violative events.

CHAPTER FOUR

STUDY 1: PERSONAL VIOLATION AND PRE-TRAUMATIC FACTORS

4. Overview

The following chapter identifies pretrauma influences and how they relate to the various forms of personal violation. This chapter reports on the first of a series of three integrated studies.

4.1 Introduction

Factors existing before the occurrence of a traumatic event have been found to influence the perceptions (Breslau et al., 1999; Goodman Coccoran, Turner, Yuan, & Green, 1998), adjustment (Parson, 1995) and long term well being of victims (Abramson, 2000; Tubman et al., 2004). Demographic factors including age and sex, prior experience of traumatic events, personality traits and coping resources are part of both the stable and dynamic factors that influence an individual's functioning. For the purpose of this investigation, these elements will be referred to as pre-traumatic factors. The following section addresses the issues relating to the impact of pre-traumatic factors and the role that pre-traumatic functioning plays in the experience of personal violation.

Personality traits and coping mechanisms have been determined to have an important influence on post-traumatic functioning and how individuals respond during exposure to a traumatic stressor (Ng & Leung, 2006). Sex has also been established as a determinant in traumatic stress outcomes. When compared with men, women differ in the types of traumatic events they experience, and the responses they have to the event. Women have also been found to have a higher incidence of PTSD development after the experience of a traumatic event (Brand, 2003). Indeed, research has indicated that the two major

risk factors for the development of PTSD after a traumatic event are sex and a history of traumatic experience. Similarly, the presence of comorbid or preexisting psychological distress and mental illness can influence the traumatic stress response of an individual (Carlson & Dutton, 2003). The investigation of personal and environmental contributors in traumatic experiences may help to explain the differences in the experience of traumatic events and subsequent development of posttraumatic stress symptoms. The presence of pre-traumatic factors may also identify differences between the different forms of personal violation that can be used to assist in the clarification of these forms of violation as traumatic stressors.

Sex roles are also important in the understanding of individual responses to traumatic events. Sex roles make up a large part of social identity and status and there is a well-established connection between social status and psychological distress. Men and women hold distinct social identities within society, which are fostered from a young age (Gustafson, 1998). Social identities are fundamental in guiding meaning, purpose and behaviour. The relevance of major life events and traumatic experiences will be different according to individual's social or sex role identity. For example, a female may be more distressed than a male following an event that threatens her care-giving role or relationships as these areas are highly regarded by the female sex role (Thoits, 1991).

In stressful situations, males and females tend to rely on strategies that are related to their sex role, hence the emphasis on sex related issues when

determining reactions to traumatic events. Cheng (2005) investigated the processes underlying sex role flexibility and found that androgynous individuals showed more flexible coping strategies, showed lower levels of psychological distress and engaged in more situation appropriate coping strategies compared with those who identified with either a male or female sex role. This would suggest that sex roles lead to more rigid in cognitive and coping styles and may influence the way in which an individual deals with life events.

4.2 Traumatic stress and sex

The current study investigated the role of personal violation in a sample of women. Women were chosen for the target population due to the fact that, in the literature, women are reported to sustain more injuries from and are more commonly the victims of domestic abuse and violation than their male partners (Goodyear-Smith & Laidlaw, 1999; Greenfield et al., 1998). Certainly, further investigation of personal violation of women is warranted due to the increasing social problem posed by violence against women (Roberts, 2006; Zand, 2007), the fact that women generally report more stress related health problems than men (Krantz & Ostergren, 2001), and the fact that abused women report severe levels of distress and posttraumatic stress symptomology following the experience of interpersonal violence (Phillips et al., 2006).

Sex is often accountable for significant differences between and within research populations (Crompton & Lyonette, 2005). Sex differences are an important area of research (Gustafson, 1998), particularly when it comes to understanding both physical and psychological health issues (Moynihan, 2002).

A review of the stress related health literature suggested that fundamental differences between men and women exist in the areas of physiological vulnerability to stress, social predispositions to noxious events, social behaviours, sex stereotypes and, lastly, the differing psychological factors that influence coping strategies (Gavranidou & Rosner, 2003).

Sex differences in traumatic experience and stress reactions have been well established (Nazroo, Edwards, & Brown, 1997; Thoits, 1991). Stress and health are closely associated and stressful experiences make individuals biologically and physically more sensitive to stress, increasing the likelihood of future stress reactions to similar events. Reactivity to stress has been associated with poor coping and problem solving abilities and increased risk for anxiety and depression related disorders (Nolen-Hoeksema, 2001).

The influence of sex on stress reactions has been investigated in previous research. Jang and Johnson (2005) incorporated the use of General Strain Theory (Agnew, 1997) to investigate the relationship between emotional distress and behaviour. They maintained that although women are more likely to show higher levels of distress in general, they respond with less anger and deviant behaviour during times of stress than do males. This difference was attributed to the role that social support, resources and coping skills play and the differing buffering effect they have on men and women.

Sex differences are evident in the anxiety/crisis response styles of men and women. The differences have been attributed to females' greater investment

in attachment and care giving systems. In crisis situations, men are more likely to either flee or fight and confront, whereas women are more inclined to tend and care for others in time of stress and crisis (Taylor, 2006). Sex differences in traumatic experience have also been attributed to the important role that relationships play in women's lives (Norris, Perilla, Ibanez, & Murphy, 2001).

Greater emphasis on interpersonal orientation has been implicated in posttraumatic stress reactions for women. Research has suggested that women's emphasis on relationships in their lives often sees them subordinating their needs for those around them, a characteristic that increases with age. Women are also proposed to be more likely to develop depression when conflicts arise within their relationships. Higher rates of depression in women may be attributed to the presence of rumination. Rumination is a characteristic that has been attributed to women who engage in maladaptive coping. Rumination refers to the tendency to internalized distress and emotional concerns rather than taking action to alleviate distress. By early adolescence, girls respond to stress with more rumination than do boys (Nolen-Hoeksema, 2001). Nevertheless, Cardarelli (1997) suggested that, regardless of sex, issues arising in interpersonal relationships create greater vulnerability due to the amount of trust and safety that is attributed to them.

Women present as more vulnerable to traumatic effects and symptoms of PTSD (Breslau, Davis, Peterson, & Shultz, 1997; Gavranidou & Rosner, 2003; Norris et al., 2001; Shalev, Orr, & Pitman, 1993), showing higher levels of distress than males who have experienced a traumatic event. Breslau and colleagues (1997) also noted that these differences are not only evident in adult

samples but that sex differences are also apparent for those who have been victims of childhood abuse.

The sex differences in posttraumatic stress reactions have been attributed to the nature of the traumatic stressors experienced by men and women. Men are more typically confronted by combat trauma, physical assault and trauma related to accidents. Women, in contrast, are more likely to experience rape and childhood sexual abuse (Breslau, 1998; Freeman et al., 2002; Gavranidou & Rosner, 2003; Kessler et al., 1995).

It has been suggested that women may experience more traumatic stress symptoms due to the level of violation associated with the type of traumatic event they are more likely to experience. Rape and sexual victimisation are more likely to interfere with developmental progression, attachments, sexual development and relationships (Gavranidou & Rosner, 2003). Nolen-Hoeksema (2001) also suggested that women are more vulnerable to more chronic strain in their lives due to the multiple roles they often fulfill. It was suggested that women are more prone to poverty, harassment in the workplace, lack of respect from others and constrained choices. Freedman et al. (2002) investigated survivors of serious motor vehicle accidents and found that although there were no overall differences between men and women in relation to PTSD symptomatology or recovery rates, women generally had a higher prevalence of Generalized Anxiety Disorders than did men.

Mendelsohn and Sewell (2004) investigated the role of stereotypes in relation to traumatic experiences for men and women. The authors hypothesized that society reacts differently to traumatic event victims on the basis of their sex and what is sex role appropriate when it comes to emotional expression. It was suggested that women are permitted and encouraged to express distress in relation to an event and are expected to react with fear, sadness and vulnerability in the face of traumatic experience. Men, in contrast, are discouraged from exhibiting weakness and encouraged to hide their feels in relation to distress. Victimization and distress are not commonly associated with the male stereotype in social settings. The authors suggested that the way people internalize sex role beliefs could have significant effects on their reactions to traumatized individuals. The research found that, generally, males received less sympathy which, in turn, affected the frequency of emotional expression and symptom reporting in males. It was suggested that males are less inclined to acknowledge distress and posttraumatic stress as it is seen as violating sex roles and poses a risk to popularity, attractiveness and self-image. This research gives weight to the role that sex plays, not only in traumatic experience and expression but also in the way that society views victims of traumatic events. As stated, the current research used a female sample. This was due to the notion that women are reported to sustain more injuries from and are more commonly the victims of domestic abuse and violation than males (Goodyear-Smith & Laidlaw, 1999). The focus of the current study was on pre-trauma factors that might differentiate the types of personal violation.

4.3 Prior experience of traumatic events

It is evident that mental health problems can develop after exposure to abuse and traumatic events (Gatz et al., 2005). What must be considered is the effect of prior traumatic experience and the impact that it has on subsequent experiences of traumatic events. Just as individual stress responses are learned through prior experience, traumatic stress symptoms can be reactivated when the individual is confronted by a similar or associated event (Kaplan & Sadock, 1998).

There are established links between childhood sexual abuse and adult psychopathology (Allen & Lauterbach, 2007; Bradley et al., 2005a; Brand, 2003; van der Kolk et al., 2005). Brand (2003), in a review of the literature, outlined that experiences of childhood abuse create disturbances in several domains of functioning that can impact on personality style and adult functioning. Abusive experiences in childhood have been determined to cause difficulties in the regulation of affect, impulse control, the development of self and later development of interpersonal relationships.

Bradley et al. (2005a) investigated the common personality patterns of adult survivors of childhood sexual abuse in 74 abused and 74 non abused participants. They found that those with a history of childhood sexual abuse experienced more severe depressed mood, more negative affect and poorer emotion regulation in adulthood. They also identified four typical personality styles in the group of abused individuals, namely, internalizing, externalizing, high functioning and those with dependent/histrionic traits. Internalizing

behaviours were considered to be symptoms of mood and anxiety disorders whereas externalizing individuals were considered to show evidence of antisocial behaviour and substance use.

The research findings were consistent with earlier research on childhood sexual abuse and personality (Allen, Huntoon, & Evan, 2000; Follette, Naugle, & Follette, 1997). These established links between prior abusive experience and personality are important to traumatic stress research as it helps to identify differences in traumatic responses and recovery following treatment by identifying common personality patterns that are seen in those who have experienced abusive behaviours. Allen and Lauterbach (2007) illustrated similar relationships between personality and childhood abuse. They found that victims of childhood abuse rated higher on traits such as tension, neurotism, irritability, insecurity and emotionality. They also established links between childhood abusive experiences and subsequent traumatic events. The researchers found that victims of childhood abuse tended to show higher rates of curiosity, creativity and open-mindedness. These traits may make individuals more vulnerable to future victimization due to their engagement in impulsive and risk taking behaviours.

The experience of abuse in both childhood and adulthood has been linked with both short and prolonged difficulties in psychological, physical, economic and social functioning. Traumatized women commonly show symptoms of PTSD, depressive episodes, complicated grief, anxiety disorders, higher rates of health problems, interpersonal difficulties, revictimisation, divorce, work

difficulties and poor social supports (Carlson & Dutton, 2003). However, not everyone who experiences a traumatic event will suffer negative psychological consequences. Better outcomes have been associated with factors such as good attachment, adaptive coping and good quality social support. Certainly, attached women have better long term outcomes after a traumatic event than those with insecure attachments (Brand, 2003), suggesting that better pre-trauma adjustment may act to protect the traumatized individual in the long term.

The cumulative effects of traumatic experience have been well established with multiple event exposure being detrimental to victims of traumatic events (Green et al., 2000; Tubman et al., 2004). In addition, previous traumatic experience has been shown to increase the likelihood that subsequent events will be viewed as traumatic (Breslau et al., 1999; Goodman et al., 1998; Vrana & Lauterbach, 1994), and has been associated with increased anxiety, depression and general strain later in life (Izutsu et al., 2004). Gatz et al. (2005) found that women who had recollections of repeated traumatic experience were more vulnerable to poor mental health outcomes than those who had experienced a single event traumatic experience (Vrana & Lauterbach, 1994; Winje, 1998). Earlier onset abusive experiences were also associated with the experience of more traumatic events throughout the lifespan.

It is evident that prior experience of traumatic events can result in increased distress during subsequent traumatic experiences. Prior experience of traumatic stress is just one factors that can influence posttraumatic outcomes.

Other pre-trauma factors such as personality have also been associated with different peri-traumatic and posttraumatic experiences.

4.4 Personality factors

Individual styles of thinking and acting are determined by biology and experience and, to a large degree, are learned (Durkin, 1995). By nature, humans are psychologically diverse and most life decisions and outcomes are affected by personality traits. Personality influences personal and social domains of life and will impact on health, interpersonal networks, experiences and career success (Kaplan & Sadock, 1998).

Personality is a term used to encompass the diverse spectrum of psychological differences and characteristics that are relatively stable over time, and with increasing age. Personality style will influence how an individual will view a situation, process and respond to it. It is often a determining factor in relationships and external expressions with others (Flett, 2007).

There is no doubt that the development of self comes from a complex interaction of temperament, emotional response and the social world, with influences on this interaction ranging from parenting styles to the different interpersonal interactions that are encountered throughout the lifespan (Flett, 2007). The interplay between the role of personality and situation in life outcomes has been a subject of much discussion. It has been suggested that situational variables better predict how individuals will react under certain situations and conditions whereas personality traits better establish how people

will react in general. To further this, biological traits tend to provide the individual with a psychological starting point but do not solely determine the life outcome for the individual (Allport, 1968). Heritability studies have served to illustrate the relationship between genetic factors and personality and the role that biology plays in psychological dysfunction, distinctive pathologies and extremes in personality traits (Funder, 2007).

The understanding and measurement of personality must come through the observation of its multiple forms of expression. Flett (2007), in a review of the literature, illustrated that personality has affective, behavioural, cognitive, motivational and social features. The author gave the example of trait hostility and how it can be observed through each of these features; affective – typical feelings of anger in given situations, behavioural – antagonistic behaviours, cognitive – cynical perceptions and mistrust and motivations – elevated arousal and retaliation. This view of personality is particularly important when dealing with traumatic stress and traumatic experiences as it can assist with understanding as to why individuals react differently in traumatic circumstances.

Cramer (1999) outlined that personality disorders can be discriminated from normal personality traits when certain personality features manifest with evidence of maladaptive behaviour and signs of psychological distress. Despite the categorical nature of personality disorder classifications, personality disorders tend to overlap with one another, sharing common features (Nakao et al., 1999).

Personality disorders are defined by characteristics that are pervasive, longstanding and dysfunctional. Traits are typically extreme and make an individual vulnerable to rigid beliefs and styles of interaction. There is no consensus with regard to the aetiology of personality disorders but research has maintained that it is a combination of genetic, organic and behavioural features and the experience of traumatic or significant events. The timing of these experiences is particularly crucial, especially if they occur during critical developmental stages (Goodman, New, & Seiver, 2004; Tredget, 2001).

The development of personality disorders has often been associated with interplay between inherited susceptibility and environmental factors, particularly abuse and neglect during childhood. Borderline Personality Disorder has been associated with experiences of childhood abuse (Goodman et al., 2004; Joyce et al., 2003). Golier et al. (2003) investigated this association in a study of 180 male and female patients with a personality disorder diagnosis. The authors reported that 41.7% of those with personality disorders had experienced physical abuse as a child and 26.3% had experienced sexual abuse. For the group, the majority had experienced a traumatic event by age 18 years and, overall, the group had been exposed to higher rates of traumatic experience in adulthood than would be expected. PTSD was diagnosed more commonly in Borderline and Paranoid personality disordered individuals and those who had experienced childhood abuse and assault in adulthood. It was discussed that the personality characteristics of this group (i.e., mistrust, paranoia), may have been the product of their early maltreatment and, consequently, made them more vulnerable to revictimisation as adults.

A study was conducted to investigate the role of traumatic experiences and parental attitudes as possible predictors of adult personality disorders (Modestin, Oberson, & Erni, 1998). The research suggested that biological vulnerability and social environment both play critical roles in personality development. The authors investigated 90 inpatients of both sexes who had been diagnosed with personality disorders. Personality disordered individuals were found to have experienced higher rates of traumatic events across the lifespan and experienced more parental control and less parental care during childhood. Cluster A and B personality disorders were also more commonly linked with abusive experiences, particularly physical and sexual abuse.

Personality and depression have also been linked in the posttraumatic stress literature. Torgersen (1997) investigated the role of personality in the development and relapse rates of those with major depression. They found that Borderline and Avoidant personality disorders were associated with higher rates of development of depressive symptoms, lower rates of recovery of depressive symptoms and higher rates of chronicity in depressive illness. The study gave weight to the link between personality styles exhibiting emotional lability and depression rates and also the proposition that personality disorders can make individuals more vulnerable to negative life events and poorer coping.

Self-regulatory mechanisms, such as mind reading and self-monitoring, tend to be used at a dysfunctional level in personality disordered individuals and commonly lead to poorer self-regulation and social failure. Self-regulatory

dysfunctions commonly lead to an absence of insight into the process and cause of emotions, impaired goal setting and attainment and poor perspective taking. This is associated with traits such as egocentrism and absence of empathy that are commonly seen in Cluster B personality disorders. Therefore, personality disordered individuals' experiences of situations and the motives of others may be distorted as they are based only on their personal schemas (Dimaggio, Nicolo, Popolo, Semerari, & Carcione, 2006). This may give evidence to the notion that knowledge systems and thinking style will affect an individual's appraisal of an event and may determine the chronicity of their traumatic experience.

Along with personality, psychological factors have also been found to contribute towards differences in the experience of traumatic stress. For example, it is reasonable to assume that psychological factors, such as mood and coping, can lead to different experiences during exposure to a traumatic event and different posttraumatic outcomes.

4.5 Psychological factors

Trauma processing can be affected by the presence of anxiety or depressive symptoms (Dalgard, Bjork, & Tambs, 1995). Research has documented links between a history of psychiatric disturbance and the experience of traumatic stress (Blanchard & Hickling, 1998). Individual experiences and psychological factors must be taken into account when evaluating posttraumatic stress responses as they may affect the subjective experience of the individual.

Preexisting psychological issues and disorders may influence an individual's reactions to a traumatic event, in particular their ability to understand their experience, reprocess and recover (Carlson & Dutton, 2003; Stein et al., 2002). Recovery from traumatic experience is largely dependent upon the individual working through information related to the event. In their study, Winje (1998) reported that those individuals who felt they had a good understanding of their traumatic experience and viewed it as a random lifetime event showed better recovery rates compared to those who felt confusion and the need to continually question the experience.

Guay, Billette and Marchand (2006) reported a high incidence of comorbidity with PTSD symptomatology. They reported that 88% of individuals with symptoms of PTSD had a comorbid disorder and 59% showed evidence of two comorbid disorders. Depression was found to be common in those who experienced traumatic events and is not only significant in the recovery from traumatic experience but also in the development of posttraumatic stress symptoms. Depression impacts upon perceptions of self, others and events and is associated with higher rates of negative affect in general.

Stein et al. (2002) investigated the role of mood disorders in posttraumatic stress severity. They found that Major Depressive Disorder and Bipolar Disorder pose as risk factors for the experience of posttraumatic stress later in life. The results were consistent with previous findings in relation to the connection between major depressive disorders and subsequent PTSD. In addition, pre existing anxiety and substance use increased the risk for traumatic

events to be experienced, particularly assault and sexual victimisation. This finding was attributed to the likelihood that those with a history of anxiety will be more prone to anxious responses to and interpretations of an event as traumatic and subsequent heightened distress. Abler, Erk, Herwig, and Walter (2006) also reported that the experience of depression creates negative attitudes towards future events.

Vulnerability to posttraumatic stress reactions was also assessed in relation to neuroticism and introversion (Brodaty, Joffe, Luscombe, & Thompson, 2004; Tsay, Halstead, & McCrone, 2001). Individuals high in neuroticism and introversion were identified as at a greater risk for traumatisation. Brodaty et al. (2004) also found that these traits were also associated with the severity of the traumatic experience, immature defense styles and dissatisfaction in relation to social life, poor physical health and prior treatment for psychological issues. Similarly, Kohn et al. (2005) investigated risk factors for poor reactions to natural disasters, postulating that the impact of a disaster was determined by a mixture of personal, social and environmental factors. The study identified that pre-event psychological problems were found to be related to poor psychological outcomes and that personal threats to life and physical integrity have a greater impact on posttraumatic outcomes than do ecological factors. Winje (1998) stated that traumatic events that are of an interpersonal nature pose a greater threat of distress than do those of a non-interpersonal nature.

The link between psychological factors and the experience of traumatic stress has been demonstrated in previous research. Coping resources, such as personal support, also play a role in the experience of traumatic exposure and posttraumatic stress.

4.6 Coping resources

The literature on coping resources has been confounded by difficulties in relation to definitions of coping resources, strategies and skills, as these terms have been used interchangeably in the past (Fagin et al., 1996). It is important that the different dimensions of coping be accurately defined and measured, and this point has been highlighted in previous research (e.g. Heaney, House, Israel, & Mero, 1995). For this reason, in the present investigation, coping resources and coping strategies have been defined and measured as separate factors.

Coping resources play important roles in the experience of stress, stress responses and management. A coping resource refers to external and internal elements that the individual sees as available to them during times of stress. A coping resource is applied to a stressful situation in order to manage it more effectively. Effective levels of coping resources can make an individual more resilient whereas low levels and poor utilization of resources can cause vulnerabilities during times of stress. A coping resource differs from a coping strategy. A coping resource is a precursor to a stressful event and is already in effect before the event occurs. A coping strategy refers to how an individual will actually perform in a situation and appears only after a stressor has presented

(Hammer & Marting, 1988). Coping strategies will be discussed in a later chapter as part of post-trauma reactions.

Investigation of the role of coping resources has been broad and not isolated to trauma studies (Penninx et al., 1997; Shacham & Lahad, 2004). Coping resources, both internal and external, have been shown to have a direct effect on stress and strain levels (Shaw, Fields, Thacker, & Fisher, 1992). Penninx et al. (1997) investigated the role of coping resources on mortality rates in older individuals. The longitudinal study followed in excess of 2,500 participants aged between 55 and 85 years, paying particular attention to both external and internal coping resources and the role that social supports play in health and wellbeing. It was determined that reduced mortality rates were associated with lower levels of self-reported loneliness and greater feelings of mastery. Those with high to moderate emotional supports had far less risk of early mortality than those with low to moderate emotional support.

Children's coping resources were investigated in relation to beliefs, emotions, social, imaginative, cognitive and physical domains. The results indicated that girls under 12 years of age have greater resources in social and emotional coping domains than do boys of the same age. Boys tended to rely more on physical, imagination and cognitive domains in stressful situations (Shacham & Lahad, 2004). In adults, women have been found to have available to them a greater variety of coping resources than men, and relying more actions such as seeking emotional support. This said, women have also been found to engage in more problem rumination than men and also have a tendency to

perceive stressors as more serious than men. Sex differences in coping resources and strategies have also been associated with the type of stressor experienced (Tamres, Janicki, & Helgeson, 2006).

Social support is important to psychological well-being and reduction of psychological distress (Kitamura et al., 2002; Taylor, 2006) and recovery from posttraumatic stress (Bolton et al., 2004). Social supports have been described as information from various sources that one is respected, loved and valued. Social support can come from parents, family, peer networks and even pets. It has been proven to be a moderator in the experience of stress, coping and stress related illness. Social support can take various forms such as tangible assistance, information, emotional support or invisible support. Invisible support occurs when social support is provided but the receiver of the support does not notice it. This has been suggested to be the most beneficial form of social support for the individual (Taylor, 2006). Links between social supports and traumatic stress outcomes have been found to be particularly strong for those who have experienced sexually abusive traumatic events as it can have a significant effect on disclosures and perceived ability to cope (Guay et al., 2006).

Kitamura et al. (2002) discussed the role of perceived and received social support. Perceived social support relates to the individual's perception that support is readily available if they need it and received support relates to the actual act of social support experienced by the individual. It was suggested that the key elements of perceived social support are the availability and satisfaction of that support. Those with lower levels of depressive and anxious traits were

found to perceive more satisfaction in relation to social supports and satisfaction was also found to be more closely linked to better mental health outcomes. Personality and childhood experience were also identified as key moderators in individuals' perceptions of social support networks. This, again, forms a link between prior experience and an individual's ability to cope with a traumatic event.

Previous research has investigated the role of coping resources in samples of women who have experienced violence within their personal relationships. Zand (2007) highlighted the intense social problem that is created through domestic violence and stated that the lives of domestic violence victims are made more complex by the fact that they commonly have poor social networks. Similarly, Levendoskey and colleagues (2004) reported that female victims of relationship violence showed evidence of less emotional and practical support in their social networks. It was also suggested that victims of relationship violence commonly experience greater levels of criticism from their social networks, which may result in a tendency to withdraw from others during times of need.

The role of personality, psychological factors and coping resources in the experience of traumatic events and posttraumatic stress has been established in the literature. The current investigation will further add to previous findings by determining the role that these same factors play in the experience of different types of personal violation.

4.7 The present study

This study examines the pre-trauma factors associated with four different experiences of personal violation. Although previous research has considered some forms of personal violation, no study has compared all four forms. For this study, information relating to psychological, physical, social and interpersonal functioning was gathered from participants, along with any prior history of abusive victimisation. Previous research has indicated that individuals who have a history of traumatic abuse are far more likely to find traumatic events later in life significantly distressing (Breslau et al., 1999; Duncan, Saunders, Kilpatrick, Hanson, & Resick., 1996; Goodman et al., 1998; Vrana & Lauterbach, 1994), and that a large proportion of those who have experienced abusive behaviours in adulthood have also experienced abuse as a child (Carlson & Dutton, 2003). Based on this finding, the first hypothesis predicts that there will be evidence of prior victimisation in the sample, particularly victimisation that involves significant perceptions of physical threat such as physical and sexual abuse. Further, the second hypothesis predicts that the majority of participants experiencing abuse within relationships will be within the 20 – 29 year age group. This is based on previous findings that the experience of abuse and assault occurs more commonly in females under the age of 30 years of age (Bagshaw et al., 1999).

The third hypothesis is that those who have experienced personal violation in their adult relationships will show evidence of having experienced mood disorders before the experience of personal violation. This is based on research by Stein et al. (2002) who found that the experience of mood disorders

made individuals more vulnerable to traumatic events later in life. The fourth hypothesis is that there will be an increased likelihood of borderline personality traits in the sexual abuse group. This is based on the research of Kaltman et al. (2005) who reported greater rates of Borderline Personality Disorder in those who have experienced abusive behaviours, in particular, sexual abuse.

Research has indicated that victims of interpersonal traumatic events are more likely to isolate themselves from support networks after an abusive experience, which causes further pain and distress (Sonis & Langer, 2008). Withdrawal and feelings of isolation are further exacerbated by the fact that the perpetrator is known to the victim and commonly exists in their social/family networks (Rokack, 2006). This considered, the fifth hypothesis is that victims of interpersonal abuse will have reduced coping resources relative to normative data and small social support networks, especially, those who have experienced sexual abuse.

4.8 Method

4.8.1 Participants

This study included 48 female participants (an additional 6 did not complete the second phase of testing therefore their data were not included in this intensive design). The groups were comprised of 12 physically abused, 12 sexually abused, 12 emotionally abused and 12 sexually harassed women between the ages of 18 and 55 years. All participants were recruited by advertisement on the University of Tasmania Website and through local newspapers. Recruitment took place over a period of 24 months. Participants

were allocated to groups according to their personal experiences of traumatic abuse. Participants were asked to recall an abusive interpersonal event that they considered to be distressing at the time of the experience. In order to take part, the traumatic experiences needed to be sexual, physical, emotional or sexually harassing in nature. All participants took part in all three of the studies included in this investigation. In the circumstances that a participant experienced more than one type of abuse, they are allocated according to the type of abuse that they perceived to be the most serious. It is recognised that emotional abuse can occur concomitantly with other types of abuse, such as sexual and physical abuse, but can also occur independently of these other types of abuse. Information in relation to personality, coping resources, social support and pre-trauma history was collected. Ethical approval for this study was obtained by the University of Tasmania Human Ethics Committee.

4.8.2 Materials

All materials used in study one are presented in Appendix A and B. The Demographic Questionnaire was developed by the investigator in order to gather personal information that was relevant to pre-trauma functioning. Participants were asked to identify the type of abuse that they have experienced (sexual, physical, emotional or sexual harassment), whether or not they had experienced any psychological difficulties prior to the abusive experience (presence or absence of psychological disturbance rather than retrospective evaluation of severity), any history of other abusive behaviours in adulthood or childhood and whether or not the abuse that they experienced was an isolated or ongoing event.

Participants were not required to put their name to the demographics sheet. Information was coded to ensure confidentiality.

The Abusive Behaviour Inventory (ABI) (Shepard & Campbell, 1992) was administered to all participants to measure the possible presence of physically and emotionally abusive behaviours. The ABI is a 29 item inventory that assesses a range of psychologically and physically abusive behaviours. Participants indicate on a 5-point scale the frequency of which they have experienced each of the abusive behaviours. There are three scales, these being the Psychological Subscale, the Physical subscale and the Total Scale. The Psychological and Physical scales indicate the prevalence of these behaviours in the chosen relationship, the total scale indicates the prevalence of all abusive behaviours (psychological and physical). For the Total scale, Cronbach's Alpha co-efficient is .92, the Physical subscale is .86 and the Psychological subscale is .91 (Sheppard & Campbell, 1992).

The Millon Clinical Multiaxial Inventory – third edition (MCMI-III) (Millon, 1994) was used to measure psychopathology and symptomology. Information obtained from the Axis II, Clinical Syndromes scale was used for study one. The MCMI-III is a self-report measure derived from an integrated model of psychopathology and personality. It aims to provide information on the larger context of the individual's style of perceiving, thinking, feeling and behaving through the provision of profiles in terms of clinical personality patterns (i.e., dependent, compulsive), severe personality pathology (i.e., Borderline, Paranoid), clinical syndromes (i.e., anxiety, alcohol/drug

dependence) and severe clinical syndromes (i.e., thought disorder). The MCMI-III can assist in the diagnosis of personality disorders and clinical syndromes/disorders.

Scoring of the MCMI-III involves examining scale elevations that exceed scores of 75 and 85. For Axis II disorders (personality), if an individual obtains a scale score of 75 or above on a particular scale, it is likely that this person possesses personality traits that relate to this scale. If a person obtains a score of 85 or more on a particular scale it indicates psychopathology pervasive enough to be called a 'personality disorder'. For Axis I disorders (Anxiety, Depression, etc.), a score of 75 or more indicates the *presence* of a syndrome and a score of 85 or above indicates *prominence* (Millon, 1994). The profiles in this assessment provide an overview of how the individual tends to generally think and interact.

The MCMI-III has strong internal consistency. For 20 of the 26 scales, the alpha coefficients exceed .80, the highest being for the Depression scale (.90) and the lowest for the Compulsive scale (.66). Retest reliability is also high with an alpha coefficient of .91. With regard to validity, the MCMI-III correlates well with other related measures. Correlations with the MMPI-2 are high, Major Depression .71 and Dysthymia .68 (Millon, 1994).

The Coping Resources Inventory (CRI) (Hammer & Marting, 1988) was used to identify the coping resources that each participant has available to them in order to cope with daily challenges. The scale provides five subscale scores and a total score. The Cognitive subscale measured positive feelings and

optimistic attitudes towards self and others. The Social subscale assesses the social support network of the individual. The Emotional subscale measures the individual's expression and acceptance of affect. The Spiritual/Philosophical subscale measures religious, familial, cultural and personal beliefs, and assesses the extent to which an individual's thoughts and actions were influenced by a solid value base. The Physical subscale assesses the extent to which the individual engages in behaviours associated with health promotion and those that have been demonstrated to reduce responses to stress. Cronbach's alpha coefficients for internal consistency for each subscale are as follows: Cognitive .77; Social .79; Emotional .84 Spiritual/Philosophical .84, and Physical .71. The coefficient for the total scale is .91 (Hammer & Marting, 1988).

4.8.3 Procedure

Participants were recruited by advertisement and selected on the basis that they had experienced ongoing abuse or an episode or isolated incident of traumatic abuse within a personal relationship. Once written informed consent was obtained, participants were asked to complete the above mentioned questionnaires. Instructions were given in relation to the completion of questionnaires. Participants were instructed not to put any identifying information on the questionnaires, instead they were numerically coded. Completed questionnaires were scored and data entered by the investigator.

4.8.4 Design

A four group questionnaire study was used. The groups were sexual abuse, physical abuse, emotional abuse and sexual harassment. The dependent

variables were history of abuse, premorbid personality traits and psychological syndromes and coping resources.

4.8.5 Data Analysis

Analyses of variance were used to examine the differences between groups in relation to the dependent variables. Chi-square analyses were used to determine differences between the groups in relation to the descriptive variables (demographic variables), previous abuse variables and the type of abuse experienced. A significant criterion of .05 was adopted. It should be noted that results at this level were interpreted with caution.

4.9 Results

4.9.1 Description of sample

Consideration was given to age differences in the four groups. There was no significant age category differences, $\chi^2(N=48, df=9) = 8.3, p>.05$. The percentage from each group in each age category is presented in Table 1.

Table 1. The percentage of each group in each age category.

Age Category	Group			
	SA	PA	EA	SH
15-19 years	0.0	8.3	8.3	8.3
20-29 years	50.0	25.0	50.0	50.0
30-39 years	25.0	25.0	25.0	41.7
40-49 years	25.0	41.7	16.7	0.0

When consideration was given to history of previous abuse in relationships there was a significant deviation from expected, $\chi^2(N=48, df=9)=17.4, p<.05$. There were significantly more people who had been sexually assaulted who reported having previously been sexually abused. The percentages from each group in each previous abuse category is presented in Table 2.

Table 2. The percentage of each group in each previous abuse category.

Previous abuse category	Group			
	SA	PA	EA	SH
Sexual	33.3	0.0	0.0	0.0
Physical	8.3	0.0	0.0	0.0
Emotional	16.7	41.7	41.7	50.0
No previous abuse	41.7	58.3	58.3	50.0

When consideration was given to the mean scores for the emotional abuse and physical abuse scales of the ABI, there were significant group differences for the physical abuse scale, $F(3,35) = 3.9, MSE = 3.2, p<.02$. The physical abuse group scored significantly higher than did the sexual harassment group (Fisher LSD = 0.9, $p<.05$). There was a trend for a difference between groups for the emotional abuse scale, $F(3,35) = 2.8, MSE = 2.9, p=.052$. In this case, both the physical abuse and the emotional abuse groups scores higher than the sexual harassment group. The means and standard deviations for these scales for the two groups are presented in Table 3.

Table 3. The mean scores and standard deviations for each group for the emotional and physical scales of the Abusive Behaviour Inventory.

Abuse type	Groups							
	SA		PA		EA		SH	
	M	SD	M	SD	M	SD	M	SD
Emotional	2.3	1.0	3.0	1.3	2.8	0.6	1.8	0.9
Physical	1.8	0.8	2.5	1.1	1.8	1.0	1.1	0.4

Consideration was given to whether or not the abusive experience was an isolated or an ongoing event. No significant group deviations were evident. Table 4 presents the percentages of each group indicating the nature of the experience.

Table 4. Percentages for nature of the abusive event.

Nature of Event	Group			
	SA	PA	EA	SH
Isolated event	66.7	58.3	25.0	66.7
Ongoing event	33.3	41.7	75.0	33.3

4.9.2 Premorbid psychological adjustment

Initially, consideration was given to the BR scores for the MCMI-III personality subscales. There were no significant differences between groups. The mean scores and standard deviations along with the results of the statistical analysis are presented in Table 5.

Table 5. Results for the MCMI-III BR scores for personality subscales.

Subscale		Group				Result
		SA	PA	EA	SH	
Schizoid	M	59.9	45.3	47.5	46.9	F(3,37)=0.7
	SD	21.2	27.1	25.9	27.0	
Avoidance	M	46.8	34.0	48.6	36.6	F(3,37)=0.7
	SD	28.4	28.8	26.8	27.7	
Depressive	M	37.7	34.5	45.5	29.6	F(3,37)=0.5
	SD	29.9	26.5	31.2	32.5	
Dependent	M	41.5	43.6	58.0	42.0	F(3,37)=0.8
	SD	30.7	26.8	29.4	31.7	
Histrionic	M	48.1	68.8	61.4	66.8	F(3,37)=2.2
	SD	19.8	16.2	21.7	23.9	
Narcissitic	M	55.3	63.5	56.6	59.8	F(3,37)=0.4
	SD	22.3	8.0	23.3	17.8	
Antisocial	M	47.2	42.4	48.9	44.0	F(3,37)=0.2
	SD	20.9	25.6	26.0	19.9	
Sadistic	M	45.9	42.5	50.2	51.5	F(3,37)=0.3
	SD	23.6	24.9	22.4	24.0	
Compulsive	M	55.9	68.5	48.5	53.0	F(3,37)=2.0
	SD	14.4	18.1	21.1	25.8	
Negativistic	M	38.6	29.5	47.3	54.9	F(3,37)=1.5
	SD	25.0	27.9	30.3	35.4	
Masochistic	M	34.7	21.9	46.5	32.1	F(3,37)=1.2
	SD	26.6	30.8	31.0	33.4	
Schizotypal	M	30.1	39.5	49.0	45.1	F(3,37)=1.1
	SD	22.7	31.4	22.6	22.5	
Borderline	M	36.2	24.6	48.5	36.4	F(3,37)=1.1
	SD	28.9	30.6	34.3	32.4	
Paranoid	M	54.7	37.9	53.0	53.4	F(3,37)=0.8
	SD	20.6	35.8	30.5	24.7	

Consideration then was given to the percentage of each group who obtained a clinically significant score on the MCMI-III personality scales. No significant deviations from expected were evident. These percentages are presented in Table 6.

Table 6. Percentages for clinical significance on MCMI-III personality scales.

Personality Scale	Clinical Status	Group			
		SA	PA	EA	SH
Schizoid	Non-clinical	81.1	90.9	90.9	87.5
	Presence	9.1	9.1	9.1	12.5
	Prominence	9.1	0.0	0.0	0.0
Avoidance	Non-clinical	90.9	81.8	81.8	100.0
	Presence	0.0	18.2	18.2	0.0
	Prominence	9.1	0.0	0.0	0.0
Depressive	Non-clinical	81.8	90.9	81.8	87.5
	Presence	0.0	9.1	9.1	12.5
	Prominence	18.2	0.0	9.1	0.0
Dependent	Non-clinical	72.7	72.7	54.5	75.0
	Presence	27.3	27.3	18.2	0.0
	Prominence	0.0	0.0	27.3	25.0
Histrionic	Non-clinical	90.9	54.5	72.7	62.5
	Presence	9.1	36.4	9.1	0.0
	Prominence	0.0	9.1	18.2	37.5
Narcissistic	Non-clinical	90.9	90.9	72.7	62.5
	Presence	0.0	9.1	9.1	37.5
	Prominence	9.1	0.0	18.2	0.0
Antisocial	Non-clinical	90.9	90.9	90.9	87.5
	Presence	0.0	0.0	9.1	12.5
	Prominence	9.1	9.1	0.0	0.0
Sadistic	Non-clinical	100.0	90.9	90.9	100.0
	Presence	0.0	0.0	9.1	0.0
	Prominence	0.0	9.1	0.0	0.0

Compulsive	Non-clinical	90.9	72.7	81.8	75.0
	Presence	0.0	9.1	18.2	0.0
	Prominence	9.1	18.2	0.0	25.0
Negativistic	Non-clinical	90.9	81.8	72.7	87.5
	Presence	9.1	18.2	18.2	0.0
	Prominence	0.0	0.0	9.1	12.5
Masochistic	Non-clinical	81.8	90.9	72.7	75.0
	Presence	18.2	0.0	9.1	12.5
	Prominence	0.0	9.1	18.2	12.5
Schizotypal	Non-clinical	100.0	100.0	100.0	100.0
	Presence	0.0	0.0	0.0	0.0
	Prominence	0.0	0.0	0.0	0.0
Borderline	Non-clinical	90.9	90.9	72.7	87.5
	Presence	0.0	9.1	18.2	0.0
	Prominence	9.1	0.0	9.1	12.5
Paranoid	Non-clinical	90.9	81.8	63.6	75.0
	Presence	9.1	9.1	27.3	25.0
	Prominence	0.0	9.1	9.1	0.0

Pre-abuse psychological symptoms was considered. There were no significant deviation from expected for the groups. Table 7 presents the percentage of each group reporting psychological symptoms or combinations of symptoms.

Table 7. Percentages of each group reporting psychological symptoms prior to abuse.

Psych Symptom	Group			
	SA	PA	EA	SH
Anxiety	0.0	8.3	0.0	0.0
Depression	33.3	8.3	25.0	16.7
Both	8.3	8.3	8.3	0.0
None	58.3	75.0	66.7	83.3

4.9.3 Coping resources

Examination was made of group differences in coping resources. No significant differences were evident. The means and standard deviations for the CRI standard scores are presented in Table 8.

Table 8. Mean scores and standard deviations for CRI subscales for each group.

Subscale		Group				Result
		SA	PA	EA	SH	
Cognitive	M	38.1	43.9	40.8	49.0	F(3,36)=1.6
	SD	11.2	8.1	13.3	10.6	
Social	M	40.3	45.8	43.9	46.9	F(3,36)=0.8
	SD	11.1	12.2	8.2	6.7	
Emotional	M	39.3	40.8	42.1	47.0	F(3,36)=1.1
	SD	7.3	7.8	10.1	11.8	
Spiritual	M	38.0	39.5	42.4	43.4	F(3,36)=0.6
	SD	10.3	6.2	11.0	11.9	
Physical	M	45.9	43.9	42.5	45.4	F(3,36)=0.3
	SD	8.9	5.4	9.5	8.9	

4.10 Discussion

The purpose of this study was to examine the pre-traumatic factors associated with each type of personal violation (sexual abuse, physical abuse, emotional abuse, and sexual harassment). Demographic variables, pre-trauma functioning, coping resources and any history of previous abuse were analysed in relation to the four groups. This information provides an indication of the level of functioning before the traumatic experience. Previous trauma research has

frequently highlighted the role of pre-trauma factors in the experience and perception of a traumatic event (Breslau et al., 1999; Goodman et al., 1998) and the development and maintenance of posttraumatic stress symptoms (Parson, 1995).

In relation to demographic variables, the study one analysis produced no significant age differences for pre-trauma factors. Nevertheless, for the sexual abuse, emotional abuse and sexual harassment groups, the most common age for participants was 20-29 years. For the physical abuse group, the most common age group was 40-49 years of age. It is unclear as to whether this outcome reflects the sample or recruitment methods, or whether is it indicative of vulnerability for physical abuse within this age group. It should be highlighted that participants in this study were not interviewed at the time of the traumatic experience, but were volunteering information in relation to an experience they had encountered at some time in their adult lives. The majority of participants had experienced an abusive event in the last 2 – 10 years. In reality, only three participants had experiences that occurred between 5- 10 years. It is reasonable to include events that occurred less recently because Creamer, Burgess and McFarlane (2001) indicated that victims of sexual abuse were still evidencing significant psychopathology at 14 years post-trauma.

The higher incidence of physical abuse in the 40 – 49 years age category contradicts research by Bagshaw et al. (1999) who found that higher rates of physical violence and sustaining of injury were experienced by women in the 18 – 24 age group. Even if the participants in the 40 – 49 age group had

experienced the abuse up to 10 years ago, this still places them above the reported average. The finding in the present study may be attributed to the fact that the majority of the participants in the 40 – 49 year age group had experienced abuse at the hands of an intimate partner, with whom they were either co-inhabiting or in a long term relationship. This may indicate that the experience of physical abuse was part of pattern of escalating severity that resulted in physical injury in the later years. It may also indicate those who are not willing to report abusive behaviours until the cessation of the relationship. Bagshaw et al. (1999) reported that more ‘extreme patterns of cruelty’ were noted in longer-term relationships. The younger age groups, in the current investigation, tended to experience abuse from either short term dating relationships or non-partner relationships. It may be that the longer an individual has been in a relationship, the greater the risk there is for violence at the hands of their partner (Neufield et al., 1999).

However, not all research has suggested that abuse within relationships escalates over time. Campbell, Miller, Cardwell, and Belknap (1994) reported that relationship violence could follow many patterns of intensity over time. They reported that it is possible for relationships to be abusive for only brief periods or for abuse to reduce in frequency and severity.

For the present study, it would appear that the majority of participants of a particular age category in the physical abuse group, when compared with all other groups, may be due to the fact that the participants were in longer term relationships and did not report the experience of abuse until after the

relationship had ended. The experience of physical abuse may have also affected the victim's decision making ability in relation to leaving the abusive relationship. Previous research has indicated that poor self worth can influence decisions to remain in abusive relationships. Poor self esteem and negative cognitive schemas can significantly reduce an individual's sense of self respect. This can create belief systems in victims that justify the presence of abusive experiences (Regehr et al., 1999). Ramos et al. (2004) also reported that the experience of intimate partner violence impacts upon the victim's mental health. The experience of depression in victims of abuse can also increase the likelihood that they will remain in their abusive relationship or enter another one in the future (Cleveland, Herrera, & Stuewig, 2003).

Higher proportions of sexual abuse and sexual harassment in the 20 – 29 age groups are supported by previous research. A survey of violence against women indicated that for sexual abuse victims, age is a large determinant in relation to risk of sexual violence, with over one in ten women aged 18 – 24 years having experienced sexual violence in the 12 months prior to survey (Mouzos & Makkai, 2004). For sexual harassment victims, younger age groups tend to be more vulnerable, due to the fact that sexual harassment commonly occurs when the victim is in a less powerful position than the perpetrator (O'Donohue et al., 1998). Socio-cultural and dating behaviours also tend to place younger age groups at greater risk of victimization (Karmen, 2007), which would explain the prominence of abusive experiences in the 20 – 29 age group.

With regard to prior history of victimisation, childhood sexual abuse was common in those who experienced sexual victimization in adulthood. Research has suggested that prior sexual assault and childhood sexual victimization makes an individual more vulnerable to sexual assault in adulthood (e.g., Carlson & Dutton, 2003). Kaltman et al. (2005), in their investigation of sexual abuse victims, found that those who had experienced revictimisation showed greater overall psychopathology including depression and PTSD symptoms, compared to those who had only experienced one episode of sexual abuse.

Although there is extensive research that links experiences of abuse with prior victimisation (Schewe, Riger, Howard, Staggs, & Menon, 2006), there is also evidence to support the contrary. Harris and Miller (2000) suggested that prior victimisation can sometimes lead to protective behaviours later in life due to the fact that the victim is more likely to identify with being vulnerable and, hence, take precautions in the future. These authors suggested that those with no history of victimisation do not always seriously entertain the idea that they may fall victim to abuse and, therefore, take fewer precautions when interacting with familiars and strangers.

Results from the Abusive Behaviour Inventory indicated participants who had experienced physical and emotional abuse scored significantly higher on the emotional abuse scale than did the sexual harassment group. This result shows that physical abuse and emotional abuse may co-exist in abusive relationships. These results are supported by Pipes and Le Bov-Keeler (1997) who stated that emotional abuse is a common co-existing factor in the experience of traumatic

abuse. As physical abuse often involves elements of fear, intimidation, power and control, aspects of emotional abuse are inherent in other forms of abusive behaviours. Significantly lower rates of emotional abuse for the sexual harassment group may indicate that these participants may view their experiences as offensive and violative, but not emotionally abusive in nature. This may be due to the fact that the perpetrator is not someone with whom they have an emotional attachment. Most groups reported elements of different kinds of abuse. For example, for those who had experienced physical abuse, the presence of emotional abuse in their relationships was also evident.

The co-existence of emotional abuse in the sexual assault and physical assault groups raises the question as to why participants in these groups did not also nominate emotional abuse as an experience that they had encountered. This may be because physical and sexual abuse are socially considered to be more severe traumatic experiences due to the fact that they are more objective indicators of victimisation and potentially result in observable injury (Bagshaw et al., 1999). However, socio-cultural factors may play a role with regard to what individuals feel are acceptable behaviours within a relationship (Mouzos & Makkai, 2004). It may be the case that emotional abuse is not considered a legitimate traumatic stressor until it is at a severe level.

With regard to premorbid psychological adjustment, there were no significant differences between groups for the personality scales of the MCMI-III. Despite the fact that the literature identifies Borderline Personality Disorder as being a prominent personality style associated with the experience of abuse,

particularly sexual abuse (Kaltman et al., 2005), the current data did not support this finding. Dependent Personality Disorder was more prominent in the data and Histrionic traits were also detected. This supports results from Cogan and Porcerelli (1996) who found that 28% of women who were experiencing abuse in their intimate relationships produced clinical elevations for the Dependent Scale of the MCMI-III.

Coolidge and Anderson (2002) also examined personality profiles of abused women, focusing on those with multiple and single abuse histories. Groups were assessed using the Coolidge Axis II Inventory (Coolidge & Merwin, 1992), an assessment tool based on DSM-IV criteria (APA, 1994). The results indicated that women who had experienced multiple abusive relationships showed greater levels of dependent, paranoid and self-defeating personality traits compared to both those who had experienced a single abusive relationship and controls. Bradley, Schwartz, and Kaslow (2005b) also found evidence of Dependent and Histrionic traits in those who had experienced sexual abuse.

The links between relationship abuse and dependent and histrionic traits suggest that these types of personality styles may leave a person vulnerable to victimisation in relationships. Dependent Personality Disorder (DPD) is associated with implicit needs to obtain and keep relationships. Submissive dependence, exploitative dependence and love dependence are three factors that have been found to characterize dependent personalities (Pincus & Wilson, 2001). DPD has also been associated with poor self confidence, seeking of dominance from others, and poor attachments (Bornstein, 1997). It has also been

closely associated with the experience of depression (Neitzel & Harris, 1990).

Whereas, DPD is characterized by typically anxious symptoms, Histrionic Personality Disorder (HPD) has been associated with dramatic traits (Bornstein, 1998). People with histrionic personality styles commonly are emotionally dramatic, drawing attention to themselves in order to secure relationships.

Histrionic and Dependent personality traits do not appear to share common attributes and people with each personality style show very different patterns of interaction in interpersonal relationships. However, one common element is that they are both linked with high levels of dependency needs within significant relationships (Bornstein, 1998). Bornstein (1998) suggested that a person with HPD is typically manipulative in relationships and although there are strong dependency needs, individuals commonly give the outward impression of being independent. Reactions to negative events in relationships of people with HPD is commonly responded to with repressive behaviours. In contrast, people with DPD are more likely to deny the existence of relationship difficulties in order to facilitate favorable images of relationships. These individuals tend to rationalize abusive behaviour due to fears of abandonment. It is clear to see that dependent and histrionic personality traits may make an individual vulnerable to the experience of abusive relationships and more likely to remain in abusive environments.

In terms of past psychological symptoms of the groups, there were no significant group differences. Depression was the most commonly reported premorbid symptom across the groups. This finding is supported by Stein et al.

(2002) who found that mood disorders pose as risk factors for traumatic experience later in life. Of relevance is the research of Regehr et al., (1999) who discussed the role of cognitive schemas in self-esteem and subjective appraisals and how these can relate to traumatic experiences. It may be the cognitive distortions that come with depression that make people vulnerable to the influences of an abusive and controlling relationship. Poor self worth may also determine whether or not an individual remains in an abusive relationship. Those with low self esteem and negative schemas may be more likely to remain in the abusive relationship due to the fact that they do not believe that they deserve to be free from abuse.

In reference to the coping resources of the groups there were no significant group differences. The data showed that although many participants appeared to have the coping resources available to them, this does not necessarily equip them to deal with the abusive experiences that they encountered. This could be related to the traumatic nature of personal violation. Coping with a traumatic event is not the same as coping with everyday stressors. During times of stress, coping ability is reduced because of the extraordinary nature of the event and the heightened stress responses (Collins & Collins, 1995). Therefore, having good coping resources is not necessarily a predictor of how a person will cope during a traumatic event due to the fact that it is outside of normal experience. Gutner, Rizvi, Monson, and Resick (2006) also reinforced this view by demonstrating that individuals who experience interpersonal abuse tend to withdraw from social networks, even when they are available for support.

In summary, the influence of pre-trauma factors in the experience of personal violation indicated that experiences of sexual abuse in childhood were often associated with later sexual victimization in adulthood. Dependent personality traits and premorbid psychological factors such as depression were also found to be present in those who had been victims of personal violation. With regard to coping resources, the current sample was found to have good support networks available; however, the experience of abuse may have impacted on their ability to use them. This will be determined later in the thesis.

It is evident that pre-traumatic factors can impact on vulnerability for and experience of traumatic events (Breslau et al., 1999; Goodman et al., 1998). Although it is important to understand the precursors to traumatic experience, it is also necessary to examine the factors that influence perception and experience of a traumatic event at the time of actual exposure to the stressor.

CHAPTER FIVE

**STUDY 2: PERI-TRAUMATIC EXPERIENCE OF PERSONAL
VIOLATION**

5. Overview

The following chapter considers the peritraumatic response to personal violation. This study is the second of the integrated series of three studies.

5.1 Introduction

The development of PTSD after the occurrence of a traumatic event has been linked to several factors. Posttraumatic stress reactions associated with motor vehicle accidents have been found to be influenced by sex, degree of physical injury sustained at the time of the accident, duration of sick leave and perceived social support (Coronas, Garcia-Pares, Vildarich, Santas, & Menchon, 2007). Other studies have supported these findings (Beck, Palyo, Canna, Blanchard, & Gudmundsdottir, 2006; Donohue, 2007; Freedman et al., 2002). Sex has been investigated previously with regard to the experience of traumatic events, with differing results. For motor vehicle accidents, Freeman et al. (2002) suggested that males and females had similar psychological recovery rates after a traumatic experience, however, in relation to other traumatic events, women have been found to suffer more negative psychological consequences (Simmons, 2007). Typically, women experience more violative traumatic events (sexual assault, rape, stalking, domestic assault) whereas men are confronted with more physical injury and combat related traumatic experience (Berlinger, 2004).

Izutsu et al. (2004) suggested that trauma type is important to consider when examining symptoms and posttraumatic stress reactions. Creamer et al.

(2001) found that in a sample of male and female PTSD sufferers, once the type of trauma was controlled for, there were no differences in the prevalence of PTSD between the sexes. It may be that the higher prevalence of PTSD in women is attributed to the situation and degree of violation that they experience in traumatic events (Romito & Grassi, 2007).

5.2 Peri-traumatic experiences of traumatic events

There is a plethora of research suggesting that several factors contribute to whether PTSD symptoms develop following exposure to a traumatic event (e.g., Lauderbach & Vrana, 2001). Pre-trauma and post-trauma factors have been identified as risk factors for PTSD symptoms, for example, a having a history of abuse (Naar-King, Silvern, Ryan, & Sebring, 2002), psychological factors and personality characteristics (Lauderbach & Vrana, 2001), self esteem and coping (Briere & Spinazzola, 2005; Bradley et al., 2005b).

Other factors can be considered to be peri-traumatic, that is, factors that impact at the time of the traumatic event, such as the severity of the traumatic event (Lauderbach & Vrana, 2001). In particular, interpersonal traumatic experience places greater emphasis on peri-traumatic risk factors due to the fact that the perception of threat is usually higher in these situations and influenced by intense emotional reactions (e.g., fear and violation), and these experiences are more influenced by subjective perception (Schnurr et al., 2002).

In accordance with the severity of the traumatic event, emotions experienced by the victim at the time of the event contribute to the traumatic

nature of the experience. Sexual abuse, whether perpetrated by an intimate or a stranger, involves a strong sense of violation, vulnerability and powerlessness at the time of the threat. Research has determined that women who had experienced sexual abuse by their intimate partner experienced very high levels of fear and anxiety at the time of the event and subsequent fear related to possible future attacks (DeMaris & Swinford, 1996). Similarly, in a survey of Australian mental health and wellbeing, sexual molestation and rape were rated as the most distressing types of traumatic experience by women due to the emotional reactions associated with them (Frazier & Borgida, 1985).

Previous research has documented the experience of peri-traumatic reactions in relation to work stress (e.g. Cardoz, 2007; Haines, Williams & Carson, 2002) and other interpersonal stressors such as date rape (Soler-Baillo, Marx, & Sloan, 2005). Cardoz (2007) found that different arousal responses were evident during the experience of work stress and that these responses differed according to the nature of the stressor. Anticipation responses to work stress were also evident, indicating that in the case of repeated exposure, context and memory can facilitate stronger responses during exposure to a stressor. The evident changes in arousal during the experience of a traumatic event support the role that peri-traumatic factors play and how they can alter perception and emotional responding.

5.3 Factors influencing trauma severity

In order to understand the impact of peri-traumatic factors, it is important to examine the role they play during the experience of a traumatic event.

Factors such as cognitive schemas, the experience of actual or perceived threat, emotional responses (e.g., fear, anxiety, violation) and peri-traumatic dissociation may be present during exposure to a traumatic event and contribute towards physiological arousal and psychological distress. Of course, peri-traumatic experiences do not occur without the influence of pre-existing tendencies to view one's self and the world in particular ways. This has to be recognised in any discussion of peri-traumatic factors.

5.3.1 Cognitive attributions

High symptom variability is commonly found in victims of abuse (Gallaty & Zimmer-Gembeck, 2008). Many have attributed these variations to differences in self perception prior to the abusive experience. For example, Regehr et al. (1999) investigated the strengths and vulnerabilities of women who had experienced sexual abuse in adulthood in order to investigate the role of pre-abuse factors in the different type and severity of traumatic responses. They found that symptom severity was highly variable among sexual abuse victims and associated these differences with pre-established self schemas held by the victim. The authors found that those who possessed positive self schemas, either from positive past experience or positive attachments with caregivers in childhood, were more likely to still view themselves in a positive way during and after an assault. Those with positive pre-trauma experiences were able to utilise adaptive coping skills which, in turn, would affect their peri-traumatic experience. These individuals still experienced typical traumatic reactions during and immediately after the assault, but were able to better regulate their

emotional responding during the traumatic experience and were able to better restore a sense of safety once the event had resolved.

In comparison, those with negative self schemas, including those with negative experiences, disrupted attachments and experiences of childhood abuse, only had their pre-existing negative concepts of self reinforced by their abusive experience in adulthood. These individuals were unable to adopt adaptive coping, made poor use of supports and resources when they were available and reported general mistrust in others and concerns for ongoing safety. This demonstrates the close association between pre-trauma, peri-trauma and posttraumatic factors in traumatic experience. Although the pre-traumatic and posttraumatic factors determined functioning before and after the event, it is clear that factors that take place during the experience of the event can further alter traumatic outcomes.

Meston, Rellini and Heiman (2006) also investigated the self perceptions of women with and without histories of sexual abuse. They found that apart from the effect that sexual abuse has on social and emotional functioning, it also impacts upon an individual's sexual schemas and, consequently, how they view themselves as sexual beings in adulthood. In the sample that had experienced sexual abuse, these women were more likely to view themselves and less romantic and passionate in relationships and showed greater negative sexual affect than those who had not been abused. The authors attributed this finding to the fact that sexual abuse links sexuality with negative affect. For those with a history of traumatic abuse, consequent experience of traumatic stressors is more

likely to be associated with negative affect at the time of the traumatic experience. This may contribute to greater psychological distress and greater negative peri-traumatic reactions.

Cognitive attributions may be particularly important for events that involve elements of violation or the feeling that one has been taken advantage of. Vohs, Baumeister and Chin (2007) discussed the impact of events when an individual feels cheated or taken advantage of in an interpersonal exchange. They reported that such exchanges leave the victim with aversive emotional experiences and feelings of self blame in relation to their own involvement in the exchange. This is based on the fact that cognitive appraisals of interpersonal exchanges usually assume fairness between parties and a mutual trust of one another's intentions. A situation where someone is taken advantage of involves one party deliberately violating the other's trust. The victim cannot help but question their decisions that contributed to the situation. Although discussing general interactions, it is evident that the genesis of this process is at the time of the aversive experience. As such, it would be necessary to identify the peri-traumatic features that trigger this process.

Although pre-trauma factors have been established as an important part of the experience of posttraumatic stress reactions, factors that arise during the experience of the traumatic event can also influence traumatic outcomes. Cognitive and emotional processing during exposure to an event can vary depending on context, and may be influenced by, but still operate independently of pre-traumatic factors.

5.3.2 *The perception of risk*

Risk appraisal is an instinctual behaviour designed for self protection. Judgments of risk are based on intuitive processes and are a reaction to the emotion derived from a given situation, person or object. Risk appraisal is a dynamic process and evaluations are commonly influenced by prior experience (Marshall et al., 2007). The prediction of threat is an adaptive process. It involves prediction based on memory and learning and the incorporation of new information (McNally & Westbrook, 2006).

Individuals may assume that they are safe in the presence of intimates or known associates. A key aspect of relationship development is trust and the feeling of safety (Bowlby, 1979). So, when this is broken, it can be a devastating experience for the individual. Harris and Miller (2000) suggested that judgments of whether or not a situation is potentially harmful may influence reactions during and after the event. With regard to intimate relationships, the perception of safety may determine whether a victim of abuse remains in an abusive relationship. Sex roles affect attributions of danger and women are generally socialized to be more fearful of victimization and are more likely to see men as more dangerous perpetrators.

It has been suggested that women who have prior experiences of abusive behaviour may have deficits in their ability to perceive risk in future situations, affecting their ability to adopt defensive and protective behaviours. A study of 339 college women indicated that those with histories of sexual victimization

demonstrated impaired risk perception, particularly in relation to interactions with acquaintances, compared with women who had no history of abuse. The study found that this deficit resulted in delayed responses to situations of threat with an acquaintance. It was reasoned that women may have become sensitized to the cues with acquaintances and, therefore, do not make attempts to escape victimization. It was also suggested that, in general, strangers may be feared more than acquaintances during situations of threat, leading to victims taking fewer precautions when they are in the company of someone who they know (Messman-Moore & Brown, 2006). This supports the notion that the familiarity status of the perpetrator to the victim can influence traumatic stress outcomes (Coker, Wallis, & Johnson, 1998). In addition, this impaired risk perception may make a person fail to respond to a threatening event until such time as the personal attack is occurring. This would be demonstrated by a sudden onset of response to threat at the time of the attack but no evidence of an increase in a stress response immediately prior to the attack. An examination of peri-traumatic processes would be necessary to determine if this is the case.

Certainly, others have suggested an impact on the ability to perceive risk in people who have been exposed to threat in the past. An investigation by Soler-Baillo et al. (2005) demonstrated differences in risk recognition for sexual victimization in those who had previously experienced sexual abuse. The psychophysiological measure of heart rate was used to detect differences in risk perception and the results showed that those who experienced sexual assault in the past showed an impaired ability to recognize threat in standardized scenarios. Victims of sexual abuse showed a different pattern of responding across the

scenario compared with non abused controls, indicating lower levels of arousal at the earlier stages of the scenario when risk cues were evident. This indicated that, psychophysiological, those who had been sexually abused showed less reaction to cues of threat, even though they still rated the entire experience as unpleasant and distressing. In contrast, non abused controls showed greater elevation in psychophysiological responses at the earlier stages, indicating that they were able to identify cues and felt uncomfortable as a result.

Interestingly, those with a history of sexual abuse showed a decrease in arousal to the scenario during the stage that illustrated the perpetration of the abuse. This was interpreted as evidence of disengagement from the task when the actual abuse was described. However it may be suggested that a decrease in psychophysiological arousal is indicative of dissociative processes triggered by the intense fear associated with sexual abuse rather than a reluctance to engage in the experimental task. Certainly, decreased heart rate has been associated with dissociation experiences at the time of traumatic events, including sexual assault (Williams, Haines, & Sale, 2003).

Other research has indicated that prior victimization and, in particular, symptoms of hypervigilance, can lead to heightened distress in specific situations. For some individuals, abusive experiences make individuals more sensitive to interpersonal exchanges and the threat of danger. This said, perceptions of danger may be biased due to attention to fear and preoccupation with potential danger cues (McNally & Westbrook, 2006). Predicting danger depends on the retrieval of fear memories and the encoding of new information

that is unique to the situation. If fear becomes the dominant emotion, predictions of danger may be incorrect.

These findings provide important information in relation to how perceptions of threat may impact upon revictimisation and increased experiences of traumatic stress. Attributions of danger may lead to anticipated fear, particularly if the abusive event is one that has been endured before. Detection of potential danger may lead to the victim seeking assistance or fleeing the situation, if possible, whereas an absence of perceived danger may lead to escalation of the abusive event and subsequent experience of traumatic stress (Harris & Miller, 2000). The perception of being safe with a known or intimate partner may prevent an instinctual fear response and safety precautions.

5.3.3 Fear, control, shame and anger

Fear, shame, anger and loss of control are some of the psychological reactions reported by victims of abuse (Baumeister, Stillwell, & Wotman, 1990; Frazier, 1990). These emotions can vary depending on the type and severity of abuse. Experiences of these emotions commonly overlap and the presence of one emotion may sometimes increase the likelihood of another. For example, the initial experience of fear has been linked to later feelings of helplessness or perceived lack of control (Brewin et al., 2000). Feelings of helplessness have then been identified as a contributor to the development of shame (Wicker, Payne, & Morgan, 1983).

Fear can have a multidirectional effect on a victim's experience of traumatic events. It can either prompt the individual to get help or leave a threatening situation or it can immobilize them, making escape seem impossible despite the presence of options (Demaris & Swinford, 1996). Fear can also influence the processing of emotional content in information exchange. When confronted by threat or crisis, emotional information becomes more relevant. The individual will sort through negative and positive cues in order to either affirm or discredit the threat of potential danger (Schnall & Laird, 2007).

Abusive experiences, especially those of a repetitive nature, commonly create a 'climate of fear' for victims. Fear is typically used as a mechanism of control in abusive relationships and can lead to consequences of heightened anxiety and helplessness. Fear in abusive relationships is not only associated with the enactment of abusive behaviours but also the possible repercussions of seeking help, disclosures to professionals and fear related to the potential consequences of the victim's own retaliation in abusive exchanges (Demaris & Swinford, 1996).

Fear of death or losing control during a traumatic event have been associated with more severe PTSD symptoms in victims of traumatic experience and the greater likelihood for the emergence of peri-traumatic dissociation (Gershuny et al., 2003). Fear and helplessness are typically prominent in the experience of traumatic events. It is the combination of these two emotions that poses a greater risk for PTSD, rather than just the experience of fear alone (Brewin et al., 2000).

Control is a key aspect of traumatic experience and often contributes to posttraumatic stress symptoms. The perceived degree of control at the time of the event can often alter the meaning of an event. The feeling of having some control over what happens allows for the application of effective coping strategies. A sense of losing control may lead to perceived helplessness and hopelessness. Problem focused coping post-trauma is associated with higher levels of perceived control whereas perceived loss of control is associated with more avoidant coping and wishful thinking (Tsay et al., 2001).

Hopelessness and helplessness stem from pessimistic attributions and beliefs (Ralph & Mineka, 1998). Learned helplessness is the term attributed to a particular style of responding whereby the individual feels that they have no control over a situation and no chance of escape. Learned helplessness arises when an individual feels that their own personal desires are unattainable and that feared outcomes are probable. The individual begins to feel that they have no defenses or behaviours that are likely to change their situation and they surrender to the experience as a consequence. Learned helplessness is often present in situations of prolonged and repetitive abuse (Abramson et al., 1978), and is often used to explain the reasons why individual remain in abusive relationships.

Wulsin and Goldman (1993) suggested that control is particularly important in relation to the development of PTSD symptomology. Investigations of individuals who had experienced failed suicide attempts showed that they had only a very low prevalence of PTSD after the experience.

Given that suicide attempts may be considered traumatic for some individuals, the researchers concluded that low incidence of PTSD was due to the fact that individuals felt that the experience was relatively in their control, that is, an action they chose rather than an external event that happened to them.

Feelings of control at the time of the event have been implicated in the development of severe anxiety in the aftermath of traumatic experience. Negativity and anxiety, such as rumination, panic, avoidance, numbing and hypervigilance may be seen as attempts to control emotional reactions to the event and restore equilibrium (Orsillo, Batten, Plumb, Luterek, & Roessner, 2004).

Negative emotions such as shame and anger have been determined as possible risk factors for PTSD (Andrews et al., 2000; Brewin et al., 2000; Leskela, Dieperink, & Thuras, 2002). Shame and anger are emotions typically experienced either during or after the event that then act as contributors to the traumatic experience. In comparison with feelings of guilt, shame was found to have a more debilitating effect on the individual, placing them more at risk for feelings of submission, inferiority, powerlessness and poor self confidence. The experience of shame during traumatic exposure has also been associated with avoidant coping and greater feelings of loss of control in victims (Wicker et al., 1983). Violation is commonly associated with feelings of shame, particularly when exposure and vulnerability have been viewed as unavoidable (Naso, 2007).

Andrews et al. (2000) found that both peri-traumatic and posttraumatic experiences of shame and anger in crime victims play a role in the development of PTSD, although shame was determined to have greater influence on the maintenance of symptoms posttraumatic stress. Shame was found to arise from peri-traumatic perceptions of helplessness, acts of humiliation and fear of negative appraisal by significant others. Anger was found to continue to be significant in post crime appraisals and anger directed at others was more closely associated with PTSD than anger directed at self. Riggs, Dancu, Gershuny, Greenburg, and Foa (1992) also found that the experience of anger related positively with PTSD symptomology and high ratings of anger have also been detected in combat related PTSD (Chemtob, Hamada, Roitblat, & Muraoka, 1994). This demonstrates how the presence of strong, negative emotions at the time of the traumatic event can then contribute towards emotional processing and maintenance of symptoms after the traumatic event has resolved. Peri-traumatic emotions such as shame, violation and anger appear to be persistent symptoms that do not resolve at the cessation of the traumatic event.

5.3.4 Peri-traumatic dissociation

The range of conscious awareness is defined by the level and field of consciousness. The level of consciousness refers to the degree of conscious awareness that is experience, whereas the field of awareness refers to the amount and class of internal and external stimuli that are available to an individual at a particular time. Both the level and field of consciousness vary when an individual is under threat or in crisis. The level of consciousness commonly becomes high, yet the field of consciousness is restricted in order to detect cues

of threat or danger. The occurrence of dissociative or 'trance like' states is sometimes reported in traumatic experience, and, at the time of the event, can serve as a defensive mechanism against emotionally painful stimuli (Van der Hart et al., 2004). These ordinarily adaptive responses to traumatic experience and crisis can become maladaptive post-trauma. The persistence of hypervigilant states can lead to excessive panic and anxiety and reoccurring dissociation can interfere with emotional processing.

Dissociation can be described as a psychological defense mechanism, sometimes applied as a coping strategy that allows for psychological escape when physical escape is deemed impossible. It commonly occurs when the individual becomes overwhelmed by internal and external stimuli and is unable to process both what is occurring in the environment and their own personal response to it. Dissociative states are commonly associated with fear, threat of death and perceived loss of control. Dissociative experiences have been linked to increased rates of PTSD in people exposed to traumatic experiences (Gershuny et al., 2003).

Birmes et al. (2001) investigated the role of peri-traumatic dissociation in the development of PTSD symptoms for victims of violent assault. From a sample of 35 participants, 22 reported experiencing peri-traumatic dissociation at the time of the assault. Of the 12 participants who met the diagnostic criteria for PTSD, 11 had experienced peri-traumatic dissociation. The outcomes of this study provided evidence that peri-traumatic dissociation is common in the

experience of traumatic events and that it is possibly a major contributor to the development of PTSD in the aftermath of the event.

Dissociative experiences were investigated in a sample of rape victims who were assessed two weeks after the abusive event. Two groups were distinguished; those who scored highly on dissociation and those who scored lower. PTSD symptomology, levels of distress and psychophysiological arousal were measured and differences were detected between the two groups. For the high dissociation group, significant differences were found in relation to psychophysiological responding indicating that this group showed greater levels of psychophysiological suppression compared to the low dissociation group. The suppression of arousal came in response to specific aspects of the traumatic event and the immediate aftermath. The high dissociation group also showed more severe PTSD symptomology, greater perceptions of life threat, and greater discrepancies between self reports of distress and psychophysiological arousal. The results suggested that dissociation may be used as a coping strategy for situations of high anxiety. The high dissociation group also scored higher on measures of avoidance and the results suggested that there may be a subtype of PTSD sufferers who are more prone to dissociation (Griffin et al., 1997).

Although peri-traumatic dissociation may alleviate intense distress at the time of the event, it has been shown to increase the risk of PTSD and is associated with poorer long term outcomes. The factors that influence the onset of peri-traumatic dissociation are varied, and may be related to the severity of the traumatic stressor (Maercker et al., 2000) or pre-trauma factors (Marx & Sloan,

2005). This considered, dissociative experiences at the of exposure to a traumatic stressor have been found to alter peri-traumatic stress reactions.

5.4 The present study

Study Two examined the peri-traumatic psychophysiological and psychological responses to each type of personal violation (sexual, physical, emotional abuse and sexual harassment). Study Two investigated the reactions of the participants to the traumatic experience, at the time of the event, from the victim's point of view. To date, there has been limited investigation of how a person reacts to acts of personal violation at the time of the actual abusive event. Therefore, it would be beneficial to investigate personal violation with regard to psychophysiological and psychological victim experiences during exposure to the abusive event.

The current investigation incorporated the use of personalized, staged guided imagery scripts, which depicted the participant's abusive experience, allowing for the recording of the individual's psychophysiological response at the time of the traumatic experience. The ability to access psychophysiological states using imagery that mirror the response at the time of the actual experience is well established (see Lang, 1979). It is a commonly used methodology in trauma research (e.g., Blanchard & Hickling, 1998; Shalev, Orr, & Pitman, 1993). The staged approach allows for the identification of possible changes in arousal and emotions across the traumatic experience, from the lead up to the event, the actual experience of the abusive incident, through to the immediate

consequences of the event. Visual analogue scales provided an indication of the emotional reactions experienced, stage by stage.

The first hypothesis proposed was that all groups would produce the highest levels of arousal during the abusive script, compared with the non abusive and neutral script due to the traumatic nature of the abusive event. With regard to changes in arousal and emotion, stage by stage, it was hypothesized that the sexual abuse group would show the highest levels of psychophysiological arousal and violation at the incident stage and consequence stage of the traumatic abuse script compared with the other groups. Thirdly it was hypothesized that the non-abuse scripts will produce higher ratings of psychophysiological arousal and psychological responses than the neutral script due to the presence of the perpetrator in the non abuse script. This is based on the assumption that the mere presence of the perpetrator in a given situation will produce distress for the victim, regardless of the nature of the interaction.

5.5 Method

5.5.1 Participants

As per study one.

5.5.2 Materials

All materials used in study two are presented in Appendix C and D.

5.5.3 Imagery Scripts

Participants were interviewed in order to establish details for personalized imagery scripts for three different events. The first script depicted an event in which they experienced an abusive interaction with a known perpetrator (abusive), the second script depicted an interaction with the same perpetrator that was not abusive or threatening (non abusive), and, the third depicted an emotionally neutral event not associated with the abuse or perpetrator, such as making a cup of coffee at home (neutral).

Participants were asked to recall details of the physical environment, the nature of the situation and their psychological and psychophysiological reactions to the event. Care was taken to use as many of the participants own words as possible in the description of the event.

Each script included four stages. These included:

1. Scene: the context, circumstances and physical environment in which the event occurred;
2. Approach: the events leading up to the incident;
3. Incident: details relating to the actual incident that occurred;
and
4. Consequence: the events that immediately proceeded the incident.

Script content was representative of a continuous series of event of a time-limited period. The construction of the scripts followed the guidelines suggested by Haines, Williams, Brain & Wilson, 1995).

5.5.4 Visual analogue scales

Visual analogue scales (VASs) were administered to provide a measure of subjective emotional reactions to imagery (McCormack, de Horne, & Sheather, 1988). Scores on these scales were from 0 – 100 and were assessed on opposite dimensions of not anxious/anxious; not afraid/afraid; control/out of control; not angry/angry; normal/unreal; not violated/violated. Scales were also used to determine the clarity of the imagery (clear/not clear), and the accuracy of the content (close/not close). The higher the score on the VAS, the greater the negative experience.

5.5.5 Apparatus

Psychophysiological responses were recorded using a PC linked to a Powerlab data acquisition system using Chart 4.0. Recordings were made at 1mm/s, with a sampling frequency of 200 samples/s. Measurements of electrocardiograph (ECG) were integrated to obtain a mean heart (HR). Electrodes were placed each side of the body at the base of the rib cage and on the mastoid bone. Respiration was measured using a Pneumotrace respiration transducer.

5.5.6 Procedure

Interviews were conducted with each participant with regard to their own personal experiences. Participants were asked to describe their experience of personal violation by a known perpetrator (sexual abuse, physical abuse, emotional abuse or sexual harassment), a non-abusive interaction with the same

known perpetrator, and a neutral event not related to the abusive experience. The imagery scripts were then constructed with the information obtained at interview, only including elements described by participants.

The second phase of testing involved the measurement of the psychophysiological and psychological responses to the imagery scripts. Electrodes and other arousal measuring devices were explained and applied to the participant. Participants were required to close and relax so that a 60 second baseline recording could be made. At the end of the baseline recording, participants were requested to keep their eyes closed for the verbal administration of each script and were required to open them briefly in between each of the four stages of the scripts. Scripts were verbally administered by the experimenter while in the same room as the participant. Scripts were delivered in a counterbalanced order and read to the participant in a continuous sequence while physiological measures were recorded. Visual analogue scales were completed at the end of each script and participants were given reminders of each of the script stages in order to facilitate ratings for each stage. Participants were debriefed.

5.5.7 Design

Study two used a 4 x 3 x 4, mixed factorial design with repeated measures. Factor 1 (Group) was between subject with four levels (sexual abuse, physical abuse, emotional abuse, sexual harassment). Factor 2 (Script type) was within subject with three levels (abusive event, non-abusive event, neutral event). Factor 3 (Script stage) was within subject with four levels (scene, approach,

incident, and consequence). Dependent variables were the subjective reactions on VAS dimensions and the psychophysiological measures of heart and respiration rate.

5.5.8 Data Analysis

Data transformation was by the investigator and questionnaires were scored manually or through the use of a computer assisted scoring program where available. A 30 second scoring period was used. Heart rate was measured by beats per minute and respiration was measured by breaths per minute. Repeated measures analyses of variance were used to examine differences between groups, between scripts and across script stages. A criterion of .05 was used to determine significance. A Hunyh-Feldt correction was applied to repeated measures ANOVAS.

5.6 Results

The means and standard deviations for each group for each stage of each script for the psychophysiological and psychological data are presented in Appendix E. The mean ratings for the control VAS's measuring clarity of imagery and closeness of imagery script content to actual events were within acceptable limits.

5.6.1 Psychophysiological response to imagery

There was no significant script by stage by group interactions for heart rate or respiration. There was a significant script by stage interaction for heart

rate, $F(6,18) = 3.66$, $MSE = 30.00$, $p < .002$. Figure 2 presents this interaction and the means and standard deviations are presented in Appendix F.

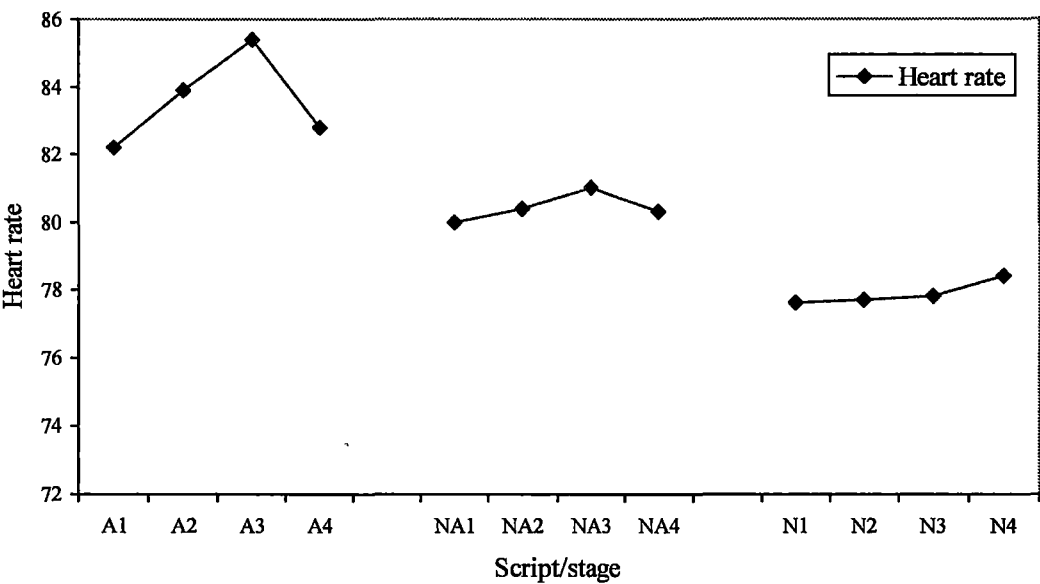


Figure 2. The mean heart rate for each stage of each script.

Comparisons were made between scripts at each stage. The analysis results are presented in Table 9. At each stage, the abuse script elicited a higher heart rate than both the non abuse and neutral scripts. In addition, the non abuse scripts elicited a higher heart rate than did the neutral script.

Table 9. The analysis results comparing heart rate between scripts at each stage.

Stage	F	MSE	p	Fisher	Difference
Scene	14.5	258.6	.0001	1.7	A>NA,N;NA>N
Approach	28.6	468.2	.0001	1.6	A>NA,N;NA>N
Incident	26.4	714.8	.0001	2.1	A>NA,N;NA>N
Consequence	14.5	231.6	.0001	1.6	A>NA,N;NA>N

Comparisons were then made across the stages of each script. Table 10 contains the analysis results. Across stage differences were evident for the abuse event only. Heart rate at the scene stage was significantly lower than at the approach and incident stages. There was a significant reduction in heart rate from the incident stage to the consequence stage.

Table 10. The across stage analysis results for heart rate for each of the three scripts.

Script	F	MSE	p	Fisher	Difference
Abuse	6.5	97.0	.0004	1.5	1<2,3;3>4
Nonabuse	1.8	8.7	ns		
Neutral	1.4	7.1	ns		

There was a significant script main effect for respiration rate, $F(2,6) = 19.98$, $MSE = 216.80$, $p < .0001$. The mean respiration rate for each script is presented in Figure 3 and the means and standard deviations are presented in Appendix G. The respiration rates elicited by the abuse and non abuse scripts were higher than for the neutral script (Fisher LSD = 0.6, $p < .05$).

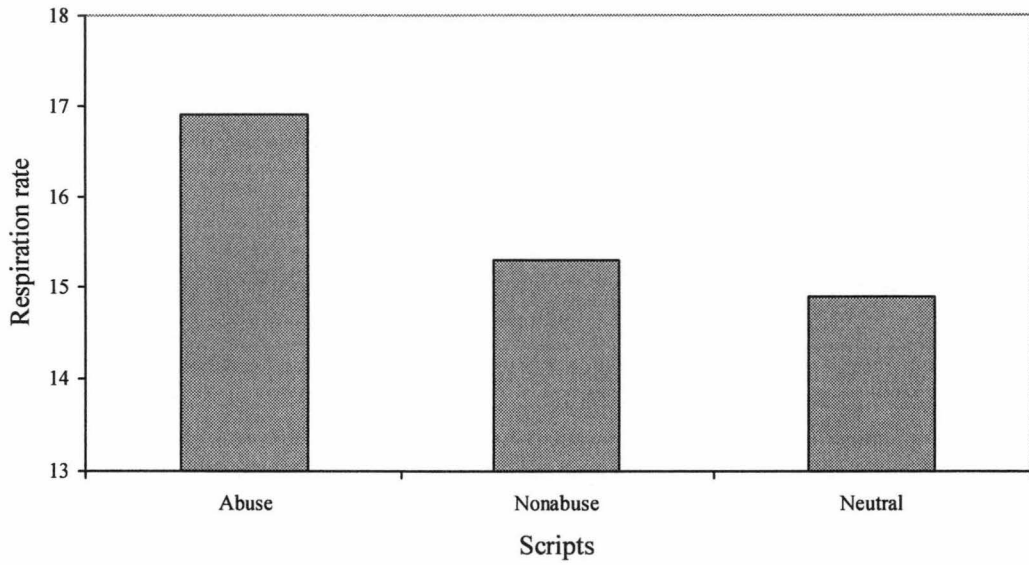


Figure 3. The mean respiration rate for each script.

5.6.2 Psychological response to imagery

There were significant script by stage by group interactions for violation, $F(18,264) = 2.15$, $MSE = 431.25$, $p > .005$, unreality, $F(18,264) = 2.95$, $MSE = 721.84$, $p < .0001$, and fear, $F(18,264) = 2.01$, $MSE = 536.38$, $p < .01$. These interactions are presented in Figure 4, 5 and 6 respectively.

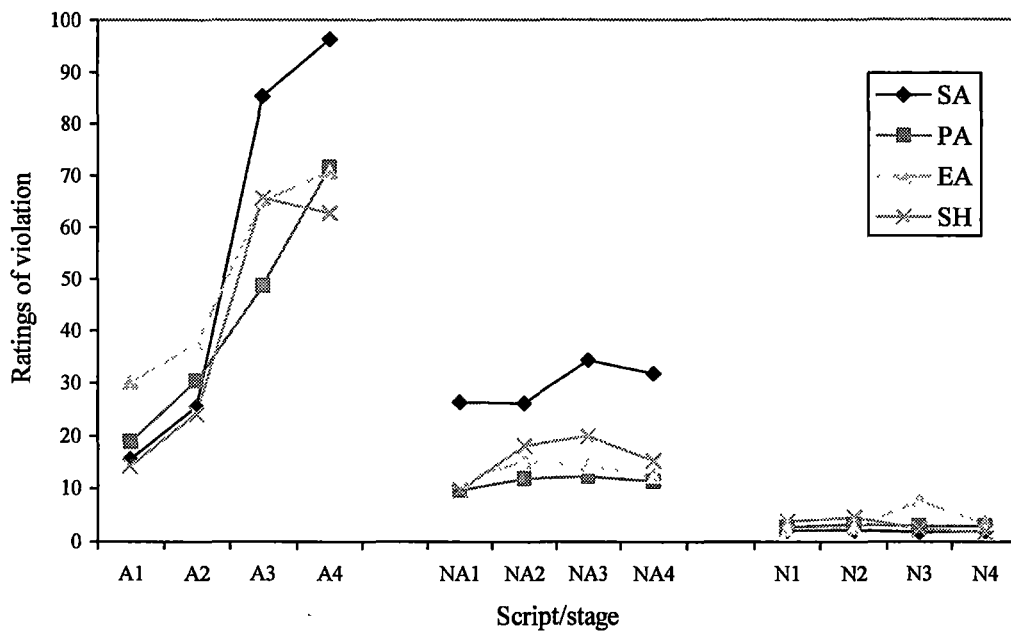


Figure 4. The mean ratings of violation for each stage of each script for each group.

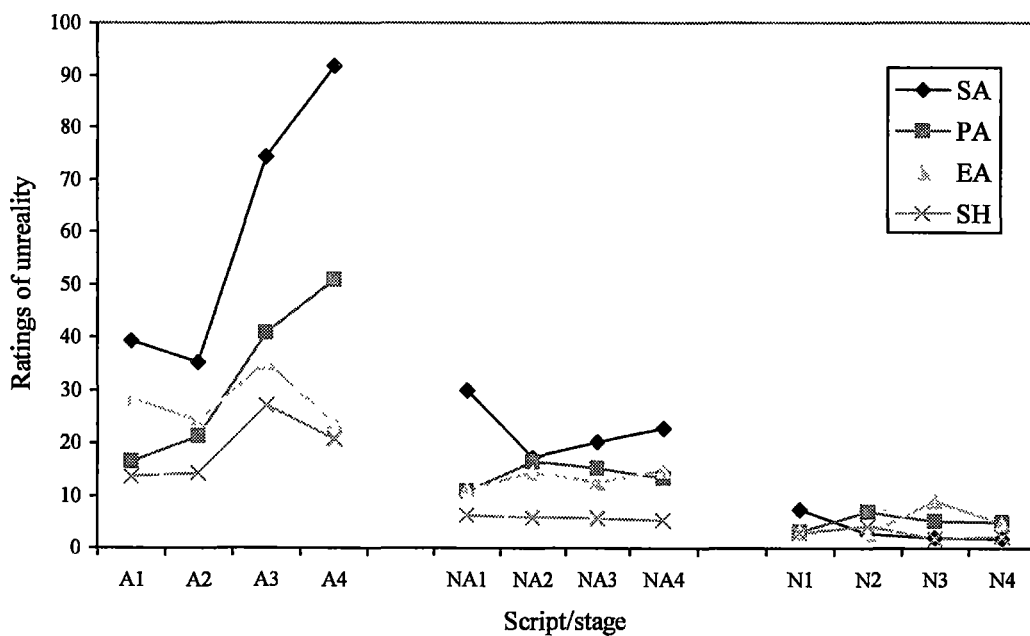


Figure 5. The mean ratings of unreality for each stage of each script for each group.

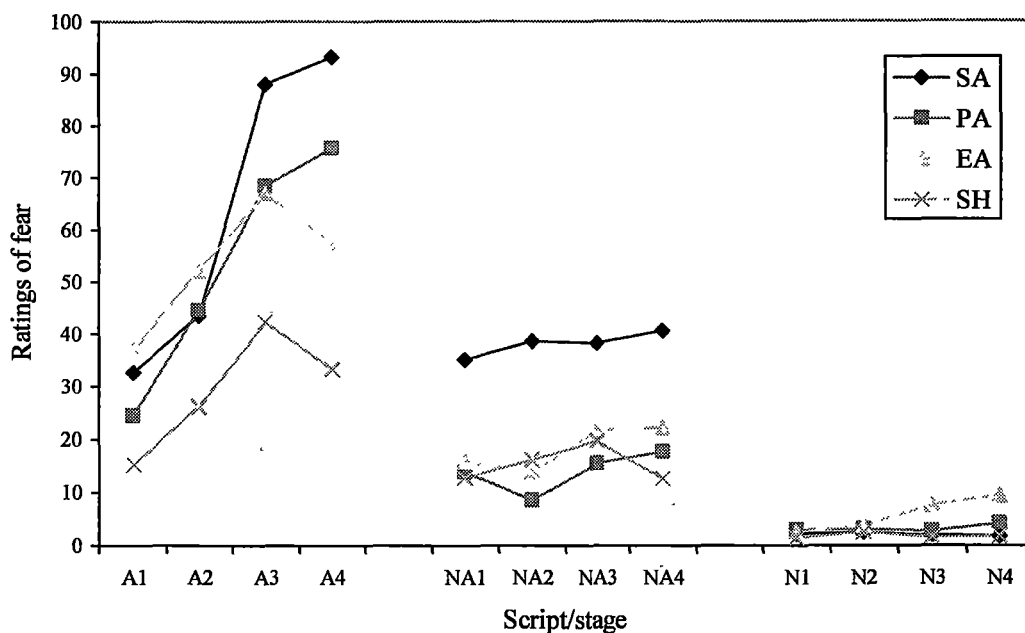


Figure 6. The mean ratings of fear for each stage of each script for each group.

Initially, comparisons were made between groups at each stage of each script. These results are presented in Table 11. There was a significant difference between groups at the consequence stage of the abuse script with regard to ratings of violation. The sexual abuse group made higher ratings of violation in comparison with all other groups (Fisher LSD = 23.8, $p < .05$).

For unreality, there were significant group differences at the incident and consequence stages of the abuse script. The sexual abuse group made higher ratings of unreality than all other groups at both the incident (Fisher LSD = 29.2, $p < .05$) and consequence stages (Fisher LSD = 24.8, $p < .05$). In addition, at the consequence stage, the physical abuse group made higher ratings of unreality than did the emotional abuse and sexual harassment groups.

When ratings of fear were considered, group differences were noted at the incident and consequence stages of the abuse script. At the incident stage, both the sexual abuse and physical abuse groups made higher ratings of fear than did the sexual harassment group. At the consequence stage, both the sexual abuse and physical abuse group made higher ratings of fear than did the emotional abuse and sexual harassment groups. In response to the non-abuse script, the sexual abuse group made higher ratings of fear at the approach stage when compared with the physical abuse, emotional abuse and sexual harassment groups.

Table 11. The analysis results for group differences at each stage of each script for ratings of violation, unreality and fear.

Scale	Script	Stage	F	MSE	p	Fisher	Difference
Violation	Abuse	Scene	1.0	633.4	ns	23.8	SA>PA,EA,SH
		Approach	0.4	433.5	ns		
		Incident	2.3	2701.2	ns		
		Conseq.	3.1	2555.1	.04		
	N-abuse	Scene	1.5	786.7	ns		
		Approach	0.6	453.9	ns		
		Incident	1.4	1197.6	ns		
		Conseq.	1.5	1096.1	ns		
	Neutral	Scene	0.5	7.1	ns		
		Approach	0.5	10.9	ns		
		Incident	1.1	81.6	ns		
		Conseq.	0.6	6.0	ns		
Unreality	Abuse	Scene	1.9	1634.7	ns	29.2	SA>PA,EA,SH
		Approach	1.2	936.5	ns		
		Incident	4.1	5171.1	.02		
		Conseq.	14.3	12987.5	.0001	24.8	SA>PA,EA,SH;

						PA>EA,SH	
Fear	N-abuse	Scene	2.2	1310.9	ns	25.0	SA,PA>SH SA,PA>EA,SH
		Approach	0.7	333.4	ns		
		Incident	0.9	439.3	ns		
		Conseq.	1.2	502.9	ns		
	Neutral	Scene	0.5	55.7	ns		
		Approach	0.8	46.4	ns		
		Incident	1.0	134.5	ns		
		Conseq.	1.0	31.4	ns		
	Abuse	Scene	1.3	1087.4	ns		
		Approach	1.5	1466.8	ns		
		Incident	4.6	4247.8	.007		
		Conseq.	10.8	7928.4	.0001		
	N-abuse	Scene	2.1	1327.5	ns	20.2	SA>PA,EA,SH
		Approach	3.5	2098.4	.03		
		Incident	1.3	1190.4	ns		
		Conseq.	2.2	1786.3	ns		
	Neutral	Scene	0.7	4.5	ns		
		Approach	0.3	4.8	ns		
		Incident	1.1	96.9	ns		
		Conseq.	1.2	152.0	ns		

Next, comparisons were made between scripts at each stage for each group separately. These results are presented in Table 12. It was evident that the abuse script elicited higher ratings of violation, unreality and fear than did the other scripts at the incident and consequence stages for the sexual abuse, physical abuse and sexual harassment groups, and violation and fear for the emotional abuse group. Ratings of unreality in response to the abuse script were elevated relative to the other scripts only at the incident stage for the emotional abuse group. In addition, the abuse scripts elicited higher ratings of violation and fear in comparison to the ratings for the other scripts at the scene and approach stages for the emotional abuse group. For the physical abuse group, ratings of violation

and fear at the approach stage of the abuse script were higher than in response to the other scripts. For the sexual harassment group, the ratings of unreality at the approach stage of the abuse script were higher than in response to all other scripts.

Interestingly, the ratings of violation at the approach stage and fear at the scene and approach stages of the abuse script and non-abuse scripts were elevated relative to the ratings made in response to the neutral script, with no difference between the abuse and non-abuse script ratings being evident. Although the ratings of violation and fear made in response to the abuse script at the incident and consequence stage and ratings of unreality at the consequence stage were highest for the abuse script, it was evident that, for the sexual abuse group, the ratings to the non-abuse script were higher than to the neutral script.

Table 12. The analysis results of comparison between scripts at each stage for each group separately.

Scale	Group	Stage	F	MSE	P	Fisher	Difference
Violation	SA	Scene	3.0	1745.9	ns		
		Approach	3.6	2226.8	.05	21.0	A,NA>N
		Incident	28.7	21220.4	.0001	23.0	A>NA,N;NA>N
		Conseq.	54.2	27909.7	.0001	19.2	A>NA,N;NA>N
	PA	Scene	2.7	798.0	ns		
		Approach	5.1	2295.6	.02	18.0	A>NA,N
		Incident	10.9	6994.4	.0005	21.5	A>NA,N
		Conseq.	44.0	16900.8	.0001	16.6	A>NA,N
	EA	Scene	6.8	2426.7	.006	16.0	A>NA,N
		Approach	7.9	3689.7	.003	18.3	A>NA,N
		Incident	18.3	11848.1	.0001	21.5	A>NA,N
		Conseq.	33.9	16051.6	.0001	18.4	A>NA,N

Unreality	SH	Scene	2.6	326.4	ns		
		Approach	3.3	1216.6	ns		
		Incident	25.0	12754.1	.0001	19.1	A>NA,N
		Conseq.	24.4	12233.4	.0001	19.0	A>NA,N
	SA	Scene	3.1	3199.8	ns		
		Approach	6.7	3213.6	.006	18.5	A>N
		Incident	23.3	17022.5	.0001	22.9	A>NA,N
		Conseq.	59.2	26514.1	.0001	17.9	A>NA,N;NA>N
	PA	Scene	1.8	537.3	ns		
		Approach	1.6	641.3	ns		
		Incident	5.8	4015.9	.01	22.3	A>NA,N
		Conseq.	9.4	7189.0	.002	23.5	A>NA,N
	EA	Scene	4.6	2006.3	.03	17.7	A>N
		Approach	3.2	1379.7	ns		
		Incident	3.5	2444.2	.05	22.4	A>NA,N
		Conseq.	2.8	1075.1	ns		
Fear	SH	Scene	4.6	363.4	.03	7.5	A>N
		Approach	5.3	338.4	.02	6.8	A>NA,N
		Incident	11.5	2237.4	.0004	11.8	A>NA,N
		Conseq.	7.2	1193.4	.004	10.9	A>NA,N
	SA	Scene	6.7	4039.2	.006	20.7	A,NA>N
		Approach	8.9	5978.4	.002	22.0	A,NA>N
		Incident	33.9	22374.8	.0001	21.7	A>NA,N;NA>N
		Conseq.	59.7	25269.4	.0001	17.4	A>NA,N;NA>N
	PA	Scene	2.8	1408.4	ns		
		Approach	17.0	6107.2	.0001	16.0	A>NA,N
		Incident	45.2	14510.2	.0001	15.2	A>NA,N
		Conseq.	64.0	17345.4	.0001	13.9	A>NA,N
	EA	Scene	7.5	3597.7	.004	18.5	A>NA,N
		Approach	15.3	7811.1	.0001	19.1	A>NA,N
		Incident	16.6	11518.7	.0001	22.3	A>NA,N
		Conseq.	8.3	7418.2	.003	25.4	A>NA,N
	SH	Scene	3.5	652.1	.05	11.5	A>N
		Approach	4.6	1669.0	.03	16.2	A>N
		Incident	9.5	4921.5	.002	19.3	A>NA,N
		Conseq.	6.7	3059.4	.006	18.0	A>NA,N

Examination was then made of across stage changes for each script for each group separately in relation to ratings of violation, unreality and fear. These

results are presented in Table 13. Significant across stage changes were evident only for the abuse script. There were elevated ratings at the incident and consequence stages in comparison with the scene and approach stages for the sexual abuse, emotional abuse and sexual harassment groups for violation, the sexual abuse and physical abuse groups for unreality and the sexual abuse, physical abuse and sexual harassment groups for fear. In addition, when ratings of violation were considered, rating made at the consequence stage of the abuse group was significantly higher than at all other stages and there was an increase in ratings of violation from the scene to the incident stage for the physical abuse group. Further, there was an increase in fear from the scene to the approach stage of the abuse script for the physical abuse group.

Table 13. Analysis results examining across stage changes for each group separately for violation, unreality and fear.

Scale	Group	Stage	F	MSE	p	Fisher	Difference
Violation	SA	Abuse	39.5	20279.4	.0001	18.8	1,2<3,4
		Nonabuse	0.5	197.0	ns		
		Neutral	0.1	0.3	ns		
	PA	Abuse	12.5	6391.1	.0001	18.7	1,2,3<4;1<3
		Nonabuse	0.3	17.0	ns		
		Neutral	0.4	0.7	ns		
	EA	Abuse	9.8	4804.2	.0001	18.3	1,2<3,4
		Nonabuse	0.3	31.2	ns		
		Neutral	1.1	69.2	ns		
	SH	Abuse	26.9	8265.5	.0001	14.6	1,2<3,4
		Nonabuse	2.9	247.1	ns		
		Neutral	1.6	17.9	ns		
Unreality	SA	Abuse	10.8	9033.1	.0001	24.1	1,2<3,4
		Nonabuse	1.3	350.9	ns		
		Neutral	1.1	83.2	ns		

Fear	PA	Abuse	7.1	3142.7	.0008	17.4	1,2<3,4
		Nonabuse	1.0	72.3	ns		
		Neutral	1.1	27.0	ns		
	EA	Abuse	0.6	342.1	ns		
		Nonabuse	0.4	35.1	ns		
		Neutral	0.9	97.6	ns		
	SH	Abuse	2.2	492.6	ns		
		Nonabuse	0.3	1.7	ns		
		Neutral	1.2	12.4	ns		
	SA	Abuse	23.1	11351.6	.0001	18.4	1,2<3,4
		Nonabuse	0.3	61.7	ns		
		Neutral	0.3	1.1	ns		
	PA	Abuse	18.8	6507.6	.0001	15.5	1<2,3,4;2<3,4
		Nonabuse	1.3	183.6	ns		
		Neutral	0.7	4.3	ns		
	EA	Abuse	2.4	1896.5	ns		
		Nonabuse	0.5	206.2	ns		
		Neutral	0.9	122.9	ns		
	SH	Abuse	4.6	1537.5	.009	15.2	1,2<3;1<4
		Nonabuse	0.8	129.7	ns		
		Neutral	1.2	2.7	ns		

There were significant script by stage interactions for anxiety, $F(6,18) = 30.11$, $MSE = 7796.89$, $p < .0001$, control, $F(6,18) = 36.83$, $MSE = 8390.56$, $p < .0001$, and anger, $F(6,18) = 30.72$, $MSE = 7284.67$, $p < .0001$. These interactions are presented in Figure 7 and the means and standard deviations are presented in Appendix H.

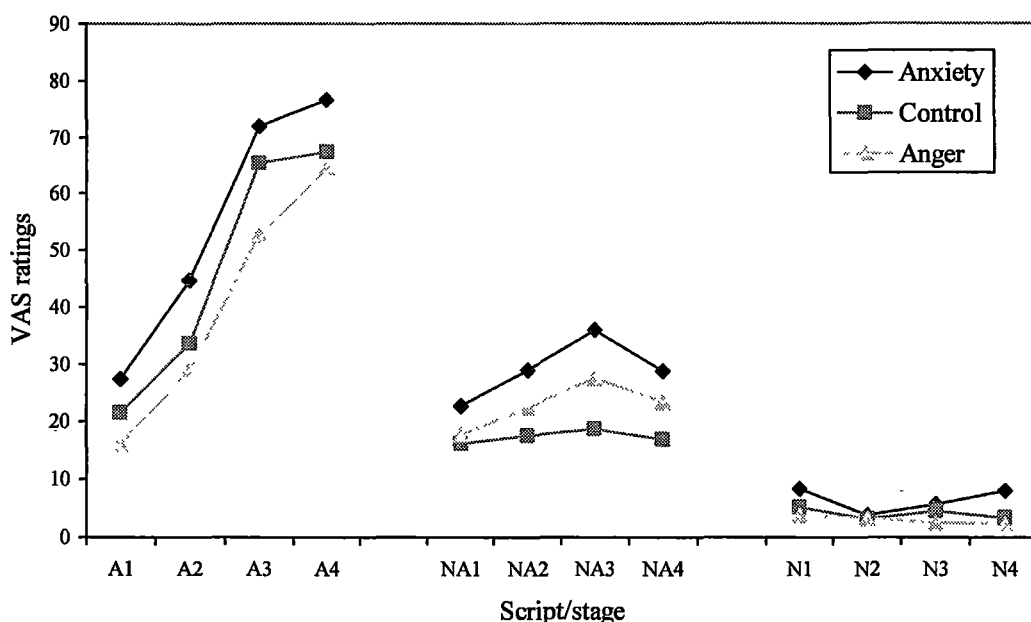


Figure 7. The mean rating for anxiety, control and anger for each stage of each script.

Between script differences at each stage were considered. The results of these analyses are presented in Table 14. The abuse script elicited higher ratings than did the non-abuse and neutral scripts at the approach, incident and consequence stages for anxiety and control, and the incident and consequence stages for anger. Both the abuse and non-abuse scripts elicited higher ratings than did the neutral script at the scene stage for anxiety, control and anger, and at the approach stage for anger. Finally, the non-abuse script was associated with higher ratings than the neutral script at the approach, incident and consequence stages for anxiety and control, and at the incident and consequence stages for anger.

Table 14. The analysis results for between script differences at each stage for anxiety, control and anger.

Scale	Stage	F	MSE	P	Fisher	Difference
Anxiety	Scene	10.6	4716.8	.0001	8.5	A,NA>N
	Approach	42.5	20262.9	.0001	8.9	A>NA,N;NA>N
	Incident	110.0	52977.5	.0001	8.9	A>NA,N;NA>N
	Conseq.	117.9	59432.5	.0001	9.1	A>NA,N;NA>N
Control	Scene	10.0	3297.7	.0001	7.4	A,NA>N
	Approach	28.4	11129.3	.0001	8.0	A>NA,N;NA>N
	Incident	95.9	48647.5	.0001	9.1	A>NA,N;NA>N
	Conseq.	119.9	54615.7	.0001	8.6	A>NA,N;NA>N
Anger	Scene	8.0	2713.3	.0006	7.5	A,NA>N
	Approach	18.3	8492.2	.0001	8.7	A,NA>N
	Incident	43.0	30325.9	.0001	10.8	A>NA,N;NA>N
	Conseq.	82.5	48141.0	.0001	9.8	A>NA,N;NA>N

Examination was made of the across stage changes for anxiety, control and anger. The results of these analyses are presented in Table 15. When the abuse event was considered, there was an increase in anxiety, lack of control and anger from the scene to the approach stage with a further increase from the approach to the incident stage. Rating elevations were maintained thereafter with the exception of ratings of anger, which again increase from the incident to the consequence stage.

Across stage changes also were evident in relation the non-abuse script. There were increases in ratings from the scene to the incident stages for anxiety and anger with a subsequent decrease in anxiety only from the incident to the consequence stage.

Table 15. Analysis results for across stage changes for each script for anxiety, control and anger.

Scale	Script	F	MSE	p	Fisher	Difference
Anxiety	Abuse	63.9	25988.9	.0001	8.1	1<2,3,4;2<3,4
	Nonabuse	4.5	1399.3	.005	7.1	1<3;3>4
	Neutral	2.0	215.5	ns		
Control	Abuse	51.2	25366.4	.0001	9.0	1<2,3,4;2<3,4
	Nonabuse	0.3	53.5	ns		
	Neutral	1.0	43.1	ns		
Anger	Abuse	39.7	23384.1	.0001	9.8	1<2,3,4;2<3,4;3<4
	Nonabuse	4.7	798.9	.004	5.2	1<3,4
	Neutral	2.8	26.2	ns		

5.7 Discussion

The purpose of the second study was to investigate peri-traumatic reactions to acts of personal violation. For the psychophysiological measure of heart rate, there was a script-by-stage interaction. Overall, the abuse script elicited the strongest arousal response. This finding was expected due to the fact that this script illustrated the abusive interaction with the perpetrator. This considered, the results indicated that the non-abusive script also was associated with higher levels of arousal than the neutral script. Even without the occurrence of an abusive behaviour, the participants were still experiencing a stress response to an interaction with the perpetrator. Clearly, there is an association between the abuse experienced and general interactions with the perpetrator. This indicates that the perpetrator is perceived as threatening even

when acting in a non abusive way, suggesting that the victim becomes sensitized to the presence of the perpetrator.

The high arousal responses for the abuse script occurred across all groups. This was expected given the traumatic nature of the abusive interaction and the associated stress responses that are induced by the perception of threat. Interestingly, the lack of group differences in arousal responses to the abusive event indicates that, for the current sample, forms of personal violation such as sexual harassment are just as psychologically arousing as experiences of sexual assault, at least in response to the recollections of these events.

Lang (1979) reported that emotional imagery can elicit a psychophysiological response that is similar to that experienced at the actual time of the event depicted in the imagery. The results in the present study indicate that the abusive event caused significant psychophysiological arousal (stress) at the time of its occurrence and that this response was again triggered by the presentation of personalized imagery of the event. Similarly, Ellessor, Sartory and Tackenburg (2004) reported that trauma victims will display specific fear reactions to trauma related stimuli. Psychological reactions to specific traumatic stimuli have been observed in veterans (e.g., Blanchard, Kolb, Taylor, & Wittrock, 1989), motor vehicle accident survivors (e.g., Blanchard et al., 1996), survivors of childhood abuse (e.g., Orr et al., 1998) and in response to occupational stress (e.g., Haines et al., 2002; Ritvanen, Louhevaara, Helin, Väisänen, & Hänninen, 2006).

The abusive script also elicited changes in arousal across the stages of the script. Overall, stage-based changes indicated that increases in arousal were evident at the approach stage of the event, even before the abusive behaviour occurred. This is consistent with the description of the experiences provided by the participants. This demonstrates that there were elements of the interaction that participants recognized as threatening before the abuse occurred.

Participants were able to identify when the interaction with the perpetrator was becoming abusive and were able to detect personal threat by the approach stage. This supports research in relation to the recognition of trauma cues and the perception of danger in an abusive event (Harris & Miller, 2000). Castillo and Calvo (2000) also reported that anxiety responses escalate with the perception of increased threat. In the current study, participants are able to recognize cues in the imagery scripts that activated stress responses. The visual analogue ratings of fear that are discussed later in this section also indicated that participants could recognise changes in interpersonal relations and perceive that the exchange was becoming more threatening.

There was a noticeable decrease in arousal from the incident to the consequence stage of the abuse script. By the consequence stage, participants were able to recognise when the threat of the situation was decreasing and their stress response resolved. This change was evident for all groups. This supports findings by Butler and Mathews (1987) who stated that during potentially threatening events, risk estimates tend to decrease as the event progresses and resolves. This shows that psychophysiological arousal in relation to interpersonal threat does not continue after the perception of threat has subsided.

Calvo and Eysenck (2000) suggested that inhibitory processes, such as coping strategies, serve to reduce experienced anxiety after encountering personal threat. The onset of these inhibitory processes, regardless of whether the coping is adaptive or maladaptive, can serve to reduce subjective distress at the time of the event, hence, reduce levels of arousal.

For respiration there was a script main effect with two of the scripts eliciting a stronger response. The abuse and non-abuse scripts elicited a stronger response for respiration than did the neutral script. This demonstrates the stressful nature of abusive interactions and conditioned stress responses to the perpetrator even in non-abusive situations. The fact that the neutral script did not elicit a strong response was because it was selected as an emotionally neutral event.

With regard to emotional reactions to guided imagery, violation, unreality and fear produced significant script by stage by group interactions. Even though participants were responding with similar patterns psychophysically, psychologically they were responding differently. Group responses to violation showed that all were responding similarly until after the incident stage of the script. At the consequence stage, significant differences were noted, with the sexual abuse group reporting higher levels of violation, in comparison with all other groups. At the consequence stage, the sexual abuse group reported significantly higher levels of violation overall. However, the increase in violation from the incident stage to the consequence stage for the sexual abuse group was

not significant. The physical assault group also produced an increase in violation from the incident to consequence stage, and this increase was significant.

These results demonstrate possible differences in psychological experience in the aftermath of different abusive behaviours. The increase in violation for the sexual assault group is supported by previous research. de Visser, Rissel, Richters, and Smith (2007) indicated that women who have experienced forced and unwanted sexual contact commonly exhibit poorer levels of psychological wellbeing after the event. Regardless of the type of abuse experienced, when an event is forceful or violative in nature, it is associated with poorer psychological outcomes (de Visser et al., 2007). The experience of violation in the physical assault group can be attributed to the threat to physical integrity that is experienced during exposure to physical abuse. One interpretation of the significant increase in violation that was noted from the incident to the consequence stage may be the need to focus on and attend to physical injury.

With regard to feelings of unreality, all groups responded similarly until the incident and consequence stage when the sexual abuse group experienced a greater sense of unreality than the other groups, showing possible evidence of peri-traumatic dissociation. Certainly, as previous literature has indicated that sexual victimization tends to trigger a stronger peri-traumatic dissociative response than other types of abuse (Griffin et al., 1997). There is evidence to suggest that in response to particularly distressing incidents, peri-traumatic dissociation operates as a coping strategy to alleviate the amount of trauma experienced (Van der Hart et al., 2004).

This finding of greater unreality for the sexual abuse group may account for an absence of group differences in relation to psychophysiological arousal. If it is accepted that sexual victimisation is a more traumatic experience and associated with a strong sense of violation, then higher ratings of unreality can be associated with a suppression of heart rate and, it may be the case that the heart rate response of the sexual abuse group has been capped. Decreased psychophysiological arousal has been associated with experiences of dissociation in research literature. Griffin et al. (1997) investigated changes in psychophysiological arousal in the presence of peri-traumatic dissociation for victims of sexual abuse. Although the method of assessment was different to the current study, that is interview and guided imagery, the results indicated that those who reported high levels of dissociation also produced lower psychophysiological arousal during interviews. Using a similar methodology, Williams and colleagues (2003) investigated the role of dissociation in psychophysiological arousal in a person with diagnosed with Dissociative Identity Disorder (DID). The results of the investigation indicated that dissociation was associated with the reduction of arousal in response to stressful imagery. Unlike the present study, the participant of the investigation showed congruency between psychophysiological and psychological arousal. This was attributed to the controlled use of dissociation to alleviate distressing experiences.

At the consequence stage, the physical abuse group had greater feelings of unreality than the emotional abuse and sexual harassment groups. This may be

explained by the aftermath of physical abuse and how it differs from emotional abuse and sexual harassment. With the experience of physical abuse, individuals are commonly dealing with the physical effects of the assault first, that is physical injury. The increase in unreality may be triggered by the physical effects of the attack and not the attack itself. Even if expected, the need to cope with the physical effects of the assault would be sufficient to strengthen a dissociative reaction. Certainly, if dissociative experiences are considered to be caused by a release of endogenous opioids (Maier & Keith, 1987) triggered by a significant stress response then physical injury, in itself, would be considered to be a stressor of significant strength to act as a catalyst for increase in the strength of the dissociative response.

Depending on the frequency of the abuse, physical assault may still be unexpected and out of the realm of the individual's normal experience. This considered, even repetitive physical assault within an abusive relationship may not be associated with a reduction over time in a sense of threat to self. Certainly, there is literature to support the notion of an escalation of physical abuse over time within a physically abusive relationship (Zink et al., 2004). The threatening nature of physical assault may cause individuals to experience feelings of shock and unreality.

Of course, the severity of the dissociative response for the sexual abuse group was greater suggesting that the act of sexual assault is associated with a factor beyond threat to physical integrity. It has been demonstrated that the experience of physical assault, or indeed, traumatic events, results in poorer

outcomes when the victim perceives malicious intent on behalf of the perpetrator (Parson, 1995). Turner and Gorst-Unsworth (1990) suggested that when traumatic experience is seen to be caused by another human being, victims seek and attribute personal meaning to the traumatic event, often increasing the experience of psychological distress. It is likely that the very personal nature of sexual activity makes the experience of sexual assault more threatening. If sexual abuse is understood as a means of sexually harming or controlling an individual then it is not surprising that the event is interpreted in such a negative way relative to other abusive events.

In relation to fear, the sexual abuse and physical abuse groups had the greatest fear response at the incident and consequence stages of the scripts. This can be attributed to the greater sense of threat to physical integrity associated with these types of abuse. It is interesting to note that there were reports of greater fear at the approach stage of the non abuse script for the sexual abuse group. This may be explained by the level of apprehension the victim may feel towards the perpetrator given the traumatic nature of the sexual assault or the more disturbing even non abusive interactions are with people capable of sexual assault. In the absence of dissociation, Porter and Birt (2001) reported that traumatic memory is commonly detailed and easy to recall. It may be that the participant was easily able to access memories in relation to the event and subsequently the potential threat that is posed by the presence of the perpetrator. It may be that even for non abusive events that occurred before the targeted abusive event, the experience of that abusive event has caused a post event reinterpretation of the risk the perpetrator represented. It is expected that this

process would result in a fear response. During the approach stage, it is likely that the individuals are trying to determine whether or not the situation is going to be dangerous or threatening for them (primary and secondary appraisal) (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). If they decide that it is not a threat, the feelings of fear will not escalate. This is the process of reappraisal. Maercker et al. (2000) suggested that later symptomology is affected by initial information processing. Their study of prisoners of war found that those who went on to develop PTSD reported stronger initial emotional reactions to events at the time of the traumatic experience.

Examination was made for group differences in violation, fear and unreality in relation to each of the script types. For the physical and sexual assault groups, an escalation in violation was detected at the incident stage that did not resolve at the consequence stage of the abuse script. This is expected given the traumatic nature of sexual and physical abuse. It is interesting to note that the sense of violation does not diminish despite the cessation of the abusive event. In the aftermath of an abusive event the victim must begin to process the meaning of the attack and its effects. Typically, victims of traumatic abuse do not begin to process the experience until after the fact. This is a natural part of emotional processing. Active processing of an event has been linked to better long-term outcomes for victims, whereas failure to adequately process traumatic experience has been linked with greater risk of the development of PTSD (Horowitz, 1986). Again, resolution of these posttraumatic stress symptoms depends on characteristics of the event and the individual (Mendelsohn &

Sewell, 2004), and their current context (Gavranidou & Rosner, 2003; Norris et al., 2001).

Greater violation was reported in response to the non-abuse script compared to the response to the emotionally neutral control event. This is an outcome that only occurs in the sexual abuse group and is occurring only at the approach stage. Again, this indicates that the precipitating events in the non-abuse script are making the individual wary of the situation, due to the presence of the perpetrator. For situations where abuse occurred, the apprehension at the approach stage escalated. For non-abusive experiences it decreased at the incident and consequence stages due to the failure of an abusive episode to develop. This demonstrates that violation for this group occurs simply through interacting with the perpetrator and that feelings of violation can occur without further experiences of abuse. The long lasting effects of sexual violation have been reported (i.e., Davis & Lee, 1996), particularly, on self identity and self esteem (Bacchus et al., 2002; Frazier & Borgida, 1985), but may also be felt on the way in which a person reinterprets past experience as being associated with greater risk than was evident at the time. Of course, it may be the case that the nature of the non abusive event for those who were ultimately sexually assaulted was more problematic and risky for the individuals.

For the physical abuse and emotional abuse groups, levels of violation were strongest in response to the abuse script. In contrast to the sexual abuse group these two groups did not react with a greater perception of violation to the non abuse script relative to the neutral script. For the abuse script, the physical

abuse group made stronger ratings of violation at the approach and consequence stages relative to the control scripts. The results showed that this group not only feel violated after the event, irrespective of whether the physical abuse was ongoing or isolated, but also experience violation in the lead up to the event. This may have been caused by an anticipation of the assault, especially for those involved in a relationship with ongoing abuse. The role of anticipation in emotional processing has been studied extensively (Abler, Erk, Herwig, & Walter, 2006; Butler & Mathews, 1987; Derakshan, Eysenck, & Myers, 2007; Perzullo, Hoffman, & Falcone, 2007). Anticipation of an event allows for processing of the objective event and information in relation to the intentions and actions of others. Abler et al. (2006) found that depressive symptoms lead to negative anticipation and biased interpretations of events.

For the emotional abuse group, violation was elevated at all stages relative to the control scripts, indicating that they know that the situation is abusive from the very beginning. Relatively, there was a significant escalation in ratings for violation for this group which occurred at the incident stage when the abusive behaviours were experienced. The presence of feelings of violation across all stages of the script indicates that emotional abuse is a potentially humiliating and emotionally destructive experience.

For the sexual harassment group, the sense of violation only occurred in relation to the abusive script and only at the incident and consequence stages. This group did not feel violated in the lead up to the event, which is different from all other groups. The result may be influenced by the difference in the

nature of the relationship within which the abuse occurred. Unlike other groups, the abuse occurred outside of an intimate relationship for the sexual harassment group. Abuse from an intimate has been linked with greater feelings of violation and humiliation due to the emotional ties the individual has with the perpetrator (Lazare, 1987). When abuse occurs in a work environment, although it may pose a threat to physical integrity and financial security, the effects to emotional wellbeing may not be as severe. However, it could be argued that sexual harassment does fall outside of a normal experience and is not typical of the nature of workplace relationships. Therefore, sexual harassment in the workplace is unexpected and not anticipated as an example of workplace behaviour. In addition, it could also be argued that the emotional commitment to intimate relationships would be greater than found in workplace relationships and, therefore, a victim of intimate relationship abuse may be more willing to tolerate behaviours that could be identified as precursors to abusive behaviour.

Overall, the sense of violation in the aftermath of the abusive event did not resolve for any of the groups. This is evidenced by the elevated levels of violation at the consequence stage of the script without a reduction from the elevated level at the incident stage. Certainly, previous research has highlighted the damaging and potentially long lasting nature of personal violation (Silver, 2007; Lindner, 2001). It has been identified that personal violation causes emotional damage, interferes with sense of self and is destructive with regard to self esteem. Feelings of violation leave the victim feeling devalued, disrespected and disconnected from others (Charney & Russell, 1994).

With regard to feelings of unreality, greater levels were detected in response to the abuse script relative to the control scripts for all groups. For the sexual assault group, ratings of unreality were greater at the approach, incident and consequence stages. For the physical assault group, elevations in unreality were evident only at the incident and consequence stages. For the emotional abuse group, the most noteworthy result was an elevated rating of unreality at the incident stage and for the sexual harassment group, unreality was greater at all four stages relative to the control scripts. These findings are interesting as they demonstrate that unreality is experienced differently for each of the four types of abuse. These results need to be considered in the context of what is known about the triggers of peri-traumatic dissociation. Certainly, greater experiences of dissociation have already been determined for sexual assault (Griffin et al., 1997) and, to a degree, physical assault (Birmes et al., 2001).

Dissociative experiences during a traumatic event are triggered by the victim's desire to avoid unwanted emotions, thoughts and memories (Foa & Hearst-Ikeda, 1996). In a review of literature by Fikretoglu et al. (2007), it was discussed that peri-traumatic dissociation is experienced by vulnerable individuals when confronted with feelings of fear, helplessness or horror. For some individuals, the experience of these intense emotions triggers panic reactions that facilitate the onset of dissociation. This considered, for traumatic experiences where the victim experiences intense fear and helplessness, the risk of dissociation is greater, due to a need by the victim to avoid distressing thoughts and feelings associated with the traumatic stressor. It is logical to conclude that the severity of the traumatic stressor will impact upon the

perceptions and emotional distress of the victims, as will proximity and duration of a traumatic stressor.

Therefore, if severity of event and severity of the response to the event are considered to be precipitants of peri-traumatic dissociation, then it would appear that these factors have a differential influence for the various groups. For example, for the sexual assault group, it must be the case that prior to the sexual assault the person becomes aware of the dangerousness of the situation and the likelihood that sexual assault will ensue. This increased sense of threat coincided with the increased ratings of unreality at the approach stage of the abuse imagery. In contrast, the onset of physical assault may be more rapid and unexpected as physical assault can occur without warning signs that would be evident with sexual assault, such as inappropriate touching or signs of sexual arousal. As stated, increased ratings of unreality were evident at the incident stage of the abuse imagery. For the emotional abuse group, it would appear that the negative aspects of the experience have their strongest influence on a peri-traumatic dissociative process only at the incident stage. Although the negative effects of emotional abuse can be long lasting, the threatening nature of the experience of emotional abuse seems to be relatively shorter lived. For the sexual harassment group, the elevations across all four stages relative to control events may be a function of the incongruous nature of such behaviour in a work place or exposure to a more generally hostile environment in the workplace that fosters the actual sexually harassing event.

With regard to ratings of fear, greater fear was elicited by the abuse script than by other script types. For the sexual assault and sexual harassment groups, greatest fear was detected at the incident and consequence stages of the script. For physical assault group, greater fear was evident at the approach, incident and consequence stages. For the emotional abuse group there were elevated fear ratings at all four stages of the script relative to the control scripts. Changes in fear levels across the stages of the abuse script were different for all the groups. For the sexual assault group, increases in fear were detected from the approach to the incident stage. For the physical assault group, increases were evident from the scene to approach stage and then from the approach to incident stage. For the emotional abuse group, a mid range level of fear remained constant across the stages and, for the sexual harassment group, there was an increase in fear from the approach stage to the incident stage but levels of fear were generally low.

The presence of fear prior to the incident stage was only evidenced for the physical and emotional abuse groups. This may be a consequence of the potentially ongoing nature of these abuse experiences in these types of adult relationships (Follingstad, 1990; Mouzas & Makkai, 2004). The detection of fear before the abusive incident suggests that the victims recognize the pattern of abusive behaviour and begin to anticipate an abusive event. This explanation would make sense in relation to the current sample as the majority of emotional and physical abuse experiences occurred in the context of ongoing relationship problems. Those in the physical assault group, in particular, were from older age groups and had endured abusive relationships for a longer period of time.

When considering the ratings of fear in response to the non abusive script, it was evident that some fear was experienced by the sexual abuse group, at least relative to the emotionally neutral event. Even though participants were instructed to use a non threatening event for the non abusive script, their reactions showed that the response to the perpetrator was a negative one even when abusive behaviours were not demonstrated. This may have reflected an objective risk represented by the perpetrator or may be a function of a posttraumatic reinterpretation of the risk the perpetrator represented.

For the experience of anxiety, control and anger there were script by stage interactions but no group differences. For all groups, the abuse script elicited higher ratings of these measures than all other scripts. At the scene stages of the abuse and non abuse scripts there was a significant elevation in ratings of these responses relative to the neutral event although the overall intensity of the negative emotional responses was not severe. These elevations at the scene stage can be explained by the challenging nature of the presence of the perpetrator even when objective signs that an abusive event is about to ensue are absent. For the scene stage, there were only moderate ratings for the two scripts that elicited an interaction (abuse and non abuse script).

When it becomes apparent that an abusive experience is imminent, ratings on these measures indicate a considerably more negative experience. Interestingly, anxiety and feeling of lack of control developed earlier at the approach stage than did feelings of anger, which were not rated as strongly negative until the incident stage. It is clear that the recognition of the nature of

the interpersonal interaction caused distress and the individual recognises the helplessness of the situation. Anger, as a response to abusive behaviour, was not experienced until the abusive behaviour is enacted by the perpetrator. At this point, the victim would have come to realize that the abusive behaviour will be demonstrated and not merely threatened. Again, the ratings for the non abuse script were greater than for the neutral script. This again illustrates the discomfort felt in the presence of the perpetrator.

Overall, with regard to anxiety, anger and control, significant increases were detected between the scene to approach and the approach to incident stages representing a build up of intensity of negative reaction over the course of these events. Interestingly, anger continued to grow from the incident stage to the consequence stage reflecting the cognitive processes that occur with the experience of anger. Feelings of helplessness and an inability to stop the abusive behaviour would cause angry feelings to escalate as the abusive experience would continue to be emotionally and cognitively processed after the event. Therefore, it is not surprising that feelings of anger continued to grow.

It is clear that reactions to traumatic events at the time of exposure differ with regard to psychophysiological and psychological reactions. The current investigation has shown that psychophysiological, the experience of events such as sexual assault does not differ from the experience of emotionally abusive experiences. Psychologically, the various types of abusive experiences differ in relation to the feelings of violation, unreality and fear. The groups responded similarly with regard to anxiety, control and anger, however, differences were

noted in the abuse scripts when compared with other scripts. These peritraumatic reactions are important in the understanding of traumatic stress reactions to personal violation. The following chapter investigates the factors that impact on psychological well being post traumatic experience.

CHAPTER SIX

**STUDY 3: POSTTRAUMATIC REACTIONS TO PERSONAL
VIOLATION**

6. Overview

The following chapter focuses on the posttraumatic reactions to personal violation. It is the final study in the integrated series of three studies.

6.1 Introduction

PTSD and posttraumatic stress symptoms can arise as a result of events occurring within a hostile relationship. Relationship abuse can occur on a continuum of severity but, more commonly, severe violence and rape are associated with PTSD (Vogel & Marshall, 2001). The occurrence of multiple types of abuse in a relationship is common and, again, is associated with higher rates of posttraumatic stress symptoms. Women present as more likely to be victims of relationship abuse and suffer posttraumatic stress symptoms as a consequence (Brand, 2003).

Previous research has identified difficulties associated with the application of PTSD diagnostic criteria for victim of traumatic experience (McFarlane, 1994). Diagnostic criterion A outlines the nature and characteristics required of the stressful event in order for it to be considered traumatic. The DSM-IV-TR (APA, 2000) indicates that the traumatic event must encompass direct personal experience or witnessing of an event that involves actual or threatened death, serious injury or threat to physical integrity. The stressor criterion further describes that the individual's experience of this event must involve intense fear, helplessness or horror.

The application of criterion A has proved to be difficult in situations involving some forms of interpersonal abuse and personal violation, namely, emotional abuse and sexual harassment. With these events not always encompassing a life threatening event, they are not, by definition, traumatic. To clarify, those experiences that do not represent a threat to physical integrity, namely, emotional abuse and sexual harassment, do meet the demands of the stressor criterion. In contrast, sexual and physical abuse do fit comfortably with the stressor criterion. Despite this, many individuals who have experienced emotional abuse or sexual harassment present with varying degrees of symptomology that suggests the presence of PTSD (McDermut Fine et al., 2000; Pico-Alfonso et al., 2006). Recent research has indicated that all forms of relationship abuse have been associated with an increased likelihood of developing PTSD. Although some individuals may not meet full PTSD diagnostic criteria, the experience of selected PTSD symptomology can be as debilitating (Basile et al., 2004).

6.2 A traditional view of posttraumatic stress symptoms

A traumatic event is an occurrence that has the ability to overwhelm the victim (Kriedler et al., 2000), and is extreme and threatening in nature (Vandervoort & Rokach, 2004). During the experience of a traumatic event, our normal defenses and coping mechanisms may be not readily available, making threat of the traumatic experience more pronounced, due to the fact that the victim is vulnerable and suggestible (Collins & Collins, 1995). It has been estimated that at least 50% of the population have experienced a traumatic event at some time in their lives (Flett, Kazantizis, Long, MacDonald, & Millar, 2002).

The traumatic events that are commonly associated with PTSD include many different experiences such as violence, sexual attacks, accidents, natural disasters, personal illness, and accumulative traumatic experience (Elkitt, 2002).

Traumatic stress reactions differ between individuals and may present in varying degrees of intensity. Traumatic stress can affect an individual’s emotion, behaviour, cognition, development and environment. Changes in these areas may occur at any time after the experience of a traumatic event and, depending on the individual, may be short lived or enduring. At the time of the crisis, typical reactions include increased heart rate, restricted affect, emotionality, racing thoughts and relational problems (Collins & Collins, 2005). The further development or resolution of these symptoms depends upon characteristics of the event and the individual (Mendelsohn & Sewell, 2004), and context (Gavranidou & Rosner, 2003; Norris et al., 2001). Figure 8 presents a postulated progression pathway of anxiety responses after the experience of a traumatic event.

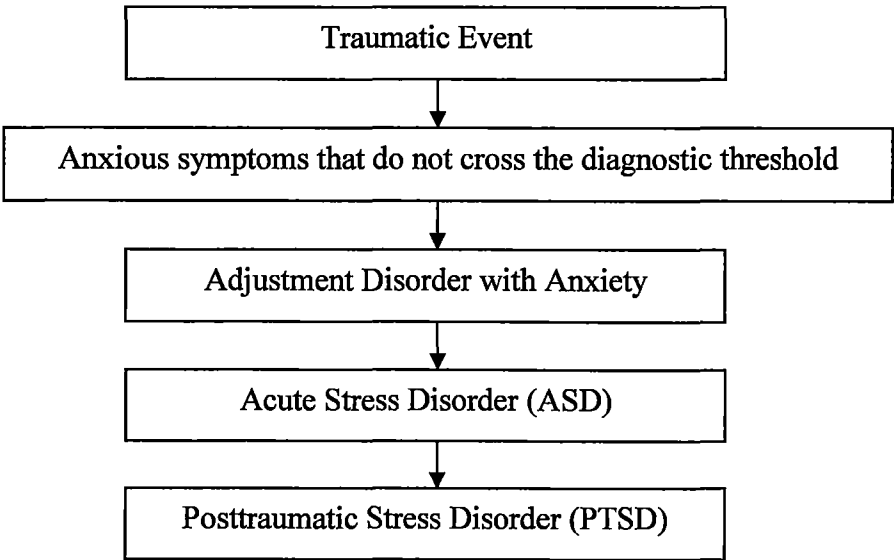


Figure 8. Passage of progression of anxiety response to a traumatic event (Collins & Collins, 2005).

Typical affect, behavioural and cognitive reactions include the development of fear, low mood, poor regulation of emotion, excesses or deficiencies in behaviour, incoherence, fragmentation of thought and feelings of unreality. It is important that diagnosis of posttraumatic stress reactions clearly links the individual's current experiences with the elements of the traumatic event. After the experience of a traumatic event, the individual will experience 'normal' posttraumatic stress reactions that may or may not progress into psychopathology (Collins & Collins, 2005). Overall, an individual's thoughts and emotions may take on a negative view and may be structured to bring about a sense of control to their experience (Orsillo et al., 2004).

6.3 Posttraumatic stress reactions and abusive behaviours

Posttraumatic stress research has studied various populations, types of traumatic experience and posttraumatic stress reactions. The experience of traumatic events is unique to the individual. Psychopathology and recovery outcomes vary highlighting the complex and multifaceted nature of PTSD (Dobson & Marshall, 1996). Kliem, Ehlers, and Glucksman (2007) investigated ASD and PTSD in assault victims at 2 weeks and 6 months after the traumatic experience. Of the 222 injured victims, 17% met the diagnostic criteria for Acute Stress Disorder (ASD) at 2 weeks, and 24% had developed PTSD by 6 months. Peri-traumatic reactions were found to contribute to PTSD vulnerability. Maintenance of symptoms after the event were found to be related to cognitive processes after the event such as mental defeat and rumination. Peri-traumatic variables (dissociation and perceived life threat) were also found to be

contributors to PTSD maintenance. Ullman, Townsend, Filipas, and Starzynski (2007) found that avoidance, coping and perceived social reactions were important in the development of PTSD.

The three-factor structure of PTSD (re-experiencing, avoidance, hyperarousal) has been criticised (Palmieri & Fitzgerald, 2005). Empirical evidence has provided preferential support for the use of a four-factor model of traumatic stress that differentiates avoidance symptoms into two groups. Avoidance symptoms are comprised of two different cognitive/emotional processes which some suggest should be treated as separate diagnostic categories. Effortful avoidance and emotional numbing have been shown to have different relationships with external variables through the use of correlational analysis. A four-factor structure would comprise re-experiencing, effortful avoidance, emotional numbing and hyperarousal which would allow for greater diagnostic flexibility and a distinction between the cognitive and emotional components of avoidance symptoms. Along with the experience of subjective appraisal of threat, Krause, Kaltman, and Goodman (2006) also highlighted the significant role of emotional numbing in interpersonal violence and the psychological impact it has post trauma.

The risk of developing PTSD after the experience of a traumatic event within a relationship has been found to vary according to age. Those in their 20s have been found to be at greatest risk for PTSD, with this risk dropping for those in their 30s and then rising again as age progresses past 40 years of age (Yoshihama & Horrocks, 2003). Just as risk factors have been highlighted in

PTSD, protective factors such as preparedness and belief systems have been linked with resilience (Johnson & Thompson, 2008).

The prevalence of PTSD in Australia is estimated to be 1.3% (Creamer et al., 2001) even though estimated exposure to traumatic events is quite high in all populations (Lauderbach & Vrana, 2001). All types of abusive experiences have been associated with the development of PTSD symptomology (Basile et al., 2004), with sexual and physical victimization more frequently so (Norris, 1992; Vogel & Marshall, 2001). Each of these types of abusive behaviour contains a traumatic element for the victim. This traumatic experience may be reinforced by aspects of the environment, individual or the perpetrator. Not all individuals who experience a traumatic event will develop all the symptoms required for a PTSD diagnosis. Having said this, the development of PTSD symptomology can be just as harmful as full PTSD (Basile et al., 2004).

6.3.1 Sexual and physical abuse

Physical and sexual abuse are associated with increased experiences of physical symptoms, depression, anxiety, somatisation, drug and alcohol abuse and suicide attempts, lower self esteem, PTSD and self harm (Bacchus et al., 2002; McCauley et al., 1998). Although these types of abuse increase a person's need for both physical and mental health services, often victims of abuse do not seek professional help due to coercive and controlling behaviours that often accompany the abuse (Scholle et al., 1998). Regardless of help seeking behaviours, abuse in these forms is more frequently associated with physical damage and, hence, a potential threat to life. However, Mouzas and Makkai

(2004) reported that, in a sample of women sustaining injury through physical abuse, only a very small proportion received significant injuries. Despite this, at time of the assault 30% felt that their lives were in danger. This demonstrates the subjective nature of the experience of traumatic events.

An Australian study found that rape and molestation commonly result in PTSD with 18.6% of molestation victims and 17.8% of rape victims having a PTSD diagnosis (Creamer et al., 2001). The long lasting effect of traumatic experience was demonstrated in a study by Elliot and colleagues (2004). These investigators found that 14 years after the occurrence of sexual assault in adulthood, victims of the assault still presented as symptomatic.

Naar-King et al. (2002) found that physical abuse, when experienced on its own, was associated with more severe PTSD symptoms in a sample of abused women. Sexual abuse did not produce elevated levels of PTSD on its own, but differences emerged when it was experienced in the presence of physical force. Experience of more than one type of abuse (physical and sexual abuse) was also associated with higher rates of PTSD symptomology, depression and anxiety.

Similar results were reported by Resnick et al. (2000) who found that physical abuse was more likely to result in PTSD symptomology and that more severe traumatic stress symptoms were related to both the victim having a prior experience of assault and the level of distress they experienced during the assault. Significant injury and ongoing threat of violence were also associated

with higher rates of PTSD. Perception of life threat is also a significant contributor to traumatic experience (Maercker et al., 2000).

Gutner et al. (2006) found that PTSD in those who had experienced sexual and physical abuse in personal relationships was associated with poor emotional expression after the event and social withdrawal. Greater emotional expression over time was found to lead to better recovery in PTSD sufferers. Elkind (2002) also found that symptoms of PTSD commonly lead to difficulties with boundary setting, emotional stability, and relationship stability.

In intimate relationships, sexual and physical abuse typically follows a cycle of violence, illustrated by a series of violent episodes that increase in both severity and frequency (Berlinger, 2004). Fear associated with abuse in intimate relationships may be linked to the anticipation of future abuse, due to victim's remaining in contact with the perpetrator. It has often been reported that a woman assaulted by an intimate partner may experience greater levels of posttraumatic stress than if assaulted by a stranger (Frieze & Browne, 1989), suggesting that the status of the perpetrator may have a strong effect on posttraumatic stress.

Sexual and physical assaults, by definition, are traumatic experiences. It has already been established that personal contributors and peri-traumatic experience can influence the experience of distress at the time of exposure. The literature also indicates that traumatic experience can affect coping after the event, resulting in the development of posttraumatic stress symptoms.

6.3.2 Emotional Abuse

Emotional abuse creates isolation and is common in individuals who have poor social networks (Pipes & Le-Bov-Keeler, 1997). It can be perceived by the victim as a traumatic experience, and, as it escalates, the risk for the occurrence of physical or sexual violence increases (Marshall, 1996; Murphy & Cascardi, 1993). For women in abusive relationships, emotional abuse has been reported as one of the strongest predictors of poor coping and increases the risk of developing PTSD symptoms (Taft et al., 2007b).

The investigations of Pico-Alfonso et al. (2006) indicated that emotional abuse can be considered to be as detrimental as other forms of abuse, such as sexual and physical assault. Their analysis of physical, sexual and emotional abuse in relationships indicated that when it does not occur in conjunction with other forms of abuse, emotional abuse is a better predictor of poor psychological health. Co-morbidity of depressive disorders and PTSD was also found to be particularly prevalent for victims of abuse in relationships, and, again, psychological abuse was determined to be a key contributor to the development of these symptoms. The outcomes of that study are important as they help to illustrate the traumatic nature of emotional abuse, particularly when it occurs in isolated form.

The role of aggression, both physical and emotional, has been examined within personal relationships. Although both commonly contribute to poor health outcomes, verbal aggression alone can have an independent influence on

the decline of marital adjustment and relationships (Schumacher & Leonard, 2005). Spector, Coulter, Stockwell and Matz (2007) also recognized the role of verbal aggression in physical and emotional strain and suggested that it is the process of being faced with aggression that is detrimental to psychological outcomes and that the sustaining of physical injury does not necessarily make outcomes worse. Reed and Enright (2006) also acknowledged the psychological impact of emotional abuse reaches far beyond the cessation of the abusive relationship.

Psychological aggression and emotional abuse were further established as independent contributors to PTSD symptomology in a study of 145 heterosexual couples in a community sample (Taft et al., 2007b). Emotional abuse was suggested as a strong unique predictor of negative physical and mental outcomes and this was attributed to it being more frequent and pervasive than other types of abuse that occur in relationships. It was also suggested that emotional abuse can have long term psychological damage because victims do not commonly recognize it and, therefore, endure the experience of emotional abuse longer than other types of abuse.

Dutton and Painter (1993) established clear links between emotional abuse and PTSD symptoms. Their investigation of emotionally and physically abused women yielded interesting results with regard to the prevalence and consequences of relationship abuse. The sample of physically abused participants also reported experiencing emotional abuse that accompanied physical incidents. For the emotional abuse group, their experiences consisted of psychologically

damaging behaviours and acts of isolation and dominance. The women in the sample experienced high levels of posttraumatic stress symptomology not limited to anxiety, depression, dissociation and sleep disturbance. Other problems detected in victims were low self esteem and paradoxical attachments to perpetrators.

Although emotional abuse is not traumatic by definition, it is clear that the experience of an emotionally abusive event can result in poor psychological functioning and in some cases the development of posttraumatic stress symptoms. Emotional abuse presents a threat to psychological integrity, rather than physical safety, which can impact on self esteem, identity and belief systems.

6.3.3 Sexual harassment

Traumatic experiences in the workplace can lead to wide range of physical and psychological reactions. Dembe (2001), in a review of the literature, identified that occupational stress has been linked with psychological outcomes such as anxiety and depression, and the experience of extreme emotions such as sadness, anger and humiliation. Sleep and lifestyle disturbances are also evident as is family conflict, substance use, sexual problems, poor self concept, and self harm ideation. These issues can be further complicated by the financial burden of physical and psychological workplace injury and the traumatic stress associated with complicated and drawn out compensation claims.

Sexually harassing behaviours have been reported to lead to the development of PTSD symptomology in victims. McDermut Fine et al. (2000) found that those who had been sexually harassed in academia evidenced signs of negative belief systems, general distress and negative mood states compared to those who had not been harassed. They found that the severity of sexual harassment was related to the development of PTSD symptoms but that general distress levels were lower than for those who had experienced more severe forms of sexual encounters such as rape. The results of the study were used to support the notion that sexual harassment should be included at the lower end of a continuum of sexual assault, with rape being at the more severe end.

Charney and Russell (1994) reported approximately 90% of victims show some evidence of functional disturbance after an experience of sexual harassment. These disturbances may arise in the form of, but not limited to, fear, depression, anxiety, loss of self esteem, humiliation, alienation, anger and helplessness. Consequences of harassment were also found to be physical in nature with reports of head aches, weight loss and disturbed sleep, physiological symptoms of PTSD and poor life satisfaction (Rederstorff et al., 2007).

A review of the literature was conducted to examine the impact of sexually harassing experiences (Willness, Steel, & Lee, 2007). A meta-analysis was conducted of all relevant literature and included 41 separate studies and comprising approximately 70,000 participants. The results emphasized the negative impact that sexual harassment can have on the functioning of the victim. The consequences of exposure to sexual harassment were found to be job related,

physical and psychological. The findings also indicated the consistent finding of PTSD symptomology in those who had experienced sexual harassment, even though the more minor forms of sexual harassment may not fit diagnostic criteria for a traumatic event. The presence of PTSD symptomology in those exposed to events that do not fit diagnostic criteria for a traumatic event is further support for the notion that current PTSD criteria fail to acknowledge the complexity of interpersonal trauma and the traumatic, yet diverse spectrum on which it exists (Hegadoren, Lasiuk, & Coupland, 2006).

Although sexual and physical abuse are the only types of personal violation that fit diagnostic criteria for a traumatic event, it is evident that events that threaten an individual's psychological functioning can be perceived as traumatic and distressing to the victim and result in the development of symptoms of posttraumatic stress. For this reason, the role of subjective perception must be considered, in order to understand the role that it plays in the experience of personal violation and traumatic stress outcomes.

6.4 Subjective emotional responses and victim perspective

It could be argued that the traumatic nature of an event is derived from the meaning that the individual attributes to it. The victim's perspective of an event stems from what they see as the major cause behind the event's occurrence and the effect the event has on their functioning and sense of safety. Traumatic experience that is of an interpersonal nature commonly causes greater subjective distress (Charvuastra & Cloitre, 2008). This may be because the perpetrator has greater involvement in the victim's life because of the relationship that exists

with the victim. Subjective distress may also arise because of the emotional attachment to the perpetrator that creates greater rumination in relation to the intent behind the abusive act. Certainly, abuse in this context violates norms with regard to relationship and intimate behaviour. Hurtful, hostile, controlling and aggressive behaviours are incongruent to the behaviours that one would expect from an intimate partner or trusted associate.

Although many different elements may influence the experience of PTSD (Briere & Spinazzola, 2005), the perspective of the victim will determine how the information in relation to the traumatic experience is processed. This will be influenced by what the individual has brought to the traumatic experience with regard to past experience and functioning, and their understanding of the traumatic event and its potential threat (Schnurr et al., 2002). As a result, perceptions and memories are constructed from the experience. The impression that an individual takes from an event is often constructed from the event itself and self schemas. Therefore, the memory or representation of the event is made up of what was witnessed (or implied) and personal mental theories of the individual. Information encountered after the event can also add to traumatic memory and representations of the event (Memon & Wright, 2000).

Psychological consequences of traumatic experience are more commonly linked to the perception of threat rather than to the event itself (Ehlers, Maercker, & Boos, 2000). As it has been demonstrated throughout the literature, some events are more likely to be considered traumatic than others (van der Kolk et al., 2005). This does not mean that just because an event does not meet criterion A

for a traumatic event that an individual will not find it personally distressing due to prior experience or personal beliefs. Similarly, individual resilience factors may cause an individual to not perceive a traumatic event to be threatening or traumatic even though others would consider the event to be both of these things. Indeed, investigation of this matter has demonstrated that the majority of individuals in the sample had experienced one or more events that could be identified as traumatic in their lives, yet only one fifth of these individuals perceived the event as threatening or injurious (Rasmussen, Rosenfeld, Reeves, & Keeler, 2007). Vulnerability for increased subjective distress can be associated with pre-existing factors. For example, pre-existing anxiety may result in anxious perceptions and thoughts in relation to an event (Stein et al., 2002). Protective factors that increase resilience and decrease subjective distress include things such as mental hardiness, healthy self esteem, greater positive experience, involvement and engagement with others and good social supports (Bagshaw et al., 1999).

A study of subjective distress in relation to a DSM defined traumatic event found that the majority of participants did not strongly respond to the event and experienced only moderate distress levels. Outcomes were linked to ways of coping and resilience factors, and highlighted the ambiguity associated with the perception of traumatic experience (O'Hare et al., 2006). Greater levels of subjective distress in relation to events such as physical and sexual assault were found to be related to the development of PTSD and high risk taking behaviour.

Stallard and Smith (2007) reported that traumatic memory is developed overtime and not finalised at the time of the event. They maintained that personal appraisals and coping have ongoing effects with regard to PTSD development and negative subjective appraisals and maladaptive coping are responsible for the maintenance of PTSD symptoms.

In accordance with the perception of risk and trauma literature, Lui and Kaplan (1999) found that subjective distress differs according to gender. Females were found to make stronger ratings of subjective distress than males. This was attributed to the notion that females have more sensitivity to peer rejection, more ongoing changes in self image and rely more on avoidant coping strategies. The role of socialisation appears to be an influential factor in traumatic stress differences.

Rasmussen et al. (2007) found that higher rates of PTSD and subjective distress were associated with events that involved violence from authorities or a domestic partner. This outcome may be due to the perception of control during the experience of these events and the creation of inequality between two parties who should have equal rights and respect. The authors suggested that events of this type are more distressing due to the experience of violation, feeling unsafe in the home, the ongoing presence of the perpetrator in the victim's life and fear of stigma and social effects. Increased distress may also be associated with the fact that the victim may be trying to flee a dangerous situation but is finding this step difficult or impossible.

Seemingly milder forms of abuse such as sexual harassment are not classed as criterion A events. This considered, Avina and O'Donohue (2002) suggested that sexual harassment is traumatic in nature and poses a threat to physical integrity in a number of ways. They maintained that with experiences of sexual harassment the victim encounters threats to financial wellbeing, personal boundaries and personal control. The authors believed that this constitutes a threat to physical integrity. They also discussed the notion that loss of control in sexually harassing experiences is particularly important. During a sexually harassing event, the victim may lose control in three ways: at the time of the sexually harassing event itself; through the perpetrator's dismissal of assertive attempts by the victim to cease the behaviour; and through possible retaliation by the perpetrator for the victim's non compliance (e.g., loss of job, etc.). This loss of control is what commonly creates feelings of distress and learned helplessness and should legitimise the experience as traumatic

In summary, it has been identified that many abusive experiences, by definition, are not traumatic, even though the victim may experience high levels of distress in relation to the event. Green et al. (2000) suggested that the criterion A classification of a traumatic event is subjective and does not encompass all that may be viewed as traumatic when individual factors are considered. They suggested that any event that induces PTSD symptoms should be considered as traumatic in nature, regardless of whether or not real or threatened death or harm to physical integrity occurred. The following section will address the role that coping strategies play after the experience of a traumatic event, and how they

contribute to posttraumatic stress symptoms and the victim's perception of personal distress.

6.5 Post-trauma coping strategies

Study one investigated the role that coping resources play in the experience of personal violation. Coping resources refer to the perceived supportive and coping networks an individual has in their possession, and the adequacy and availability of these resources in times of need. By contrast, coping strategies are an ongoing and dynamic process that involves the application of cognitive and behavioural strategies by the individual, in order to manage both internal and external demands of a situation (Lazarus & Folkman, 1984). Personality, situation and experience will influence how an individual reacts in any situation (Freedy & Kilpatrick, 1994), and it has been established that the experience of a traumatic event can alter or interfere with an individual's ability to cope after exposure (Ingeldew et al., 1997).

Coping strategies are often more generally classified into adaptive and maladaptive styles and are defined by the extent of avoidant/approach behaviours that make up the coping strategy. Coping strategies may be emotion-focused and problem-focused. Emotion focused coping refers to strategies that are used to manage the felt emotions in any given situation. The purpose of problem focused coping is to constructively deal with the issue at hand and is thought to be a more adaptive coping strategy (Lazarus & Folkman, 1984). Emotion focused coping, although appropriate in some situations, has been associated with poorer psychological outcomes and greater reliance on substance use during

times of stress (Lazarus & Folkman, 1984; Schafer, 1998; Veenstra et al., 2007). Tobin, Holroyd, Reynolds and Wigal (1989) proposed a hierarchical model of coping strategies. The model illustrates both the problem/emotion and avoidance/approach elements of coping strategies and how they are related to one another. The three-tiered model contains 8 primary factors, four secondary and two tertiary factors, and is demonstrated in Figure 9.

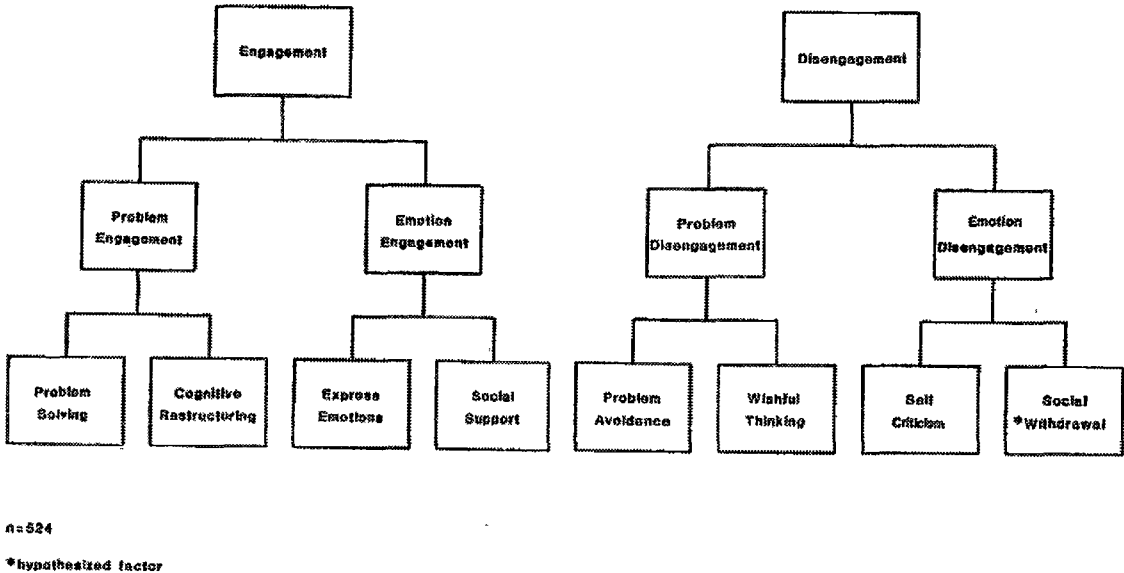


Figure 9. The hierarchical structure of coping (Tobin et al., 1989).

Negative appraisals of events and various coping strategies have been linked with higher rates of PTSD and poorer psychological outcomes (Gibb & Abela, 2008). The experience of a traumatic event changes beliefs about the world, particularly in relation to safety and the well-being. Traumatic experience can lead to heightened awareness of danger, increased arousal and the employment of protective behaviours such as avoidant coping. Stallard and Smith (2007) investigated the role of coping and negative appraisal in children who had survived motor vehicle accidents. They found that child survivors of

traumatic experience typically used cognitive coping strategies such as rumination, suppression and distraction and that these strategies were successful in bringing temporary relief from traumatic stress symptoms. However, individuals who used rumination, but did not reprocess traumatic experiences were more susceptible to cognitive rehearsal of traumatic events and heightened distress.

Different coping strategies can have multidirectional effects, particularly when the nature of the traumatic stressor is considered (Rafnsson, Jonsson, & Windle, 2006). Although problem approach strategies typically have been associated with being a more adaptive approach to coping, they can sometimes be more harmful in high stress situations. There is evidence to suggest that for some individuals, problem avoidance and emotion focused strategies can be beneficial in the recovery from trauma and have been associated with lower levels of distress and depression in high stress situations (Street, Gibson, & Holohan, 2006).

Sex is a factor that often influences the way that coping is expressed (Jones & Elkitt, 2007). Glass, Prigerson, Kasl, and Mendes de Leon (1995) found that men show more stress reactions to work and finance related issues and poor coping commonly resulted in greater reliance on drug and alcohol use. Women, in contrast, showed greater stress reactions to difficulties in their social networks and poor coping resulted in depressive and anxious symptoms.

Gavranidou and Rosner (2003) investigated coping strategies after exposure to traumatic events. Uncontrollability is distinguished as a key factor in the adoption of coping styles during traumatic exposure and is associated with a greater likelihood of PTSD symptoms following a traumatic event. For the majority of individuals, problem-focused coping strategies are associated with better outcomes for victims of traumatic events and tend to be utilized more when an individual perceives a sense of control over a situation.

Disengagement is a common strategy used in victims of relationship abuse and violation, particularly when the abuse is psychological in nature.

Disengagement is a reaction to perceived loss of control. If the victim perceives that they cannot escape the situation, disengagement provides a strategy that is less emotionally distressing than being exposed to the full traumatic nature of the event (Taft et al., 2007a).

A perceived lack of control during a traumatic event is likely to result in an individual adopting coping strategies that alter the meaning of the event or attempt to change the individual's emotional state. Low controllability has been associated with the development of PTSD and commonly changes the meaning of the event for the individual (Tsay et al., 2001). Due to the higher psychophysiological distress levels experienced by women during traumatic experience (Norris et al., 2001), and the violative and controlling nature of the types of traumatic events to which women are more vulnerable, the greater reliance on emotional coping strategies may be considered to be expected.

6.6 The present study

The aim of this study is to examine the post-trauma reactions to the various forms of personal violation (sexual abuse; physical abuse; emotional abuse; sexual harassment). Data related to PTSD, general symptomology, coping strategies and physical health are analysed. The information from this study was used to determine the impact that personal violation has on the individual with regard to their psychological functioning and general wellbeing. Based on the understanding that trauma is a subjective experience (Green, 1990), firstly, it was hypothesised that all four groups would show evidence psychological distress post-trauma. Secondly, it has hypothesised that the sexual abuse group would show greater post-trauma symptoms and evidence of PTSD. This was based on previous research indicating that sexual abuse is commonly associated with the experience of PTSD (Griffin et al., 1997) by victims of sexual assault. Finally, it was hypothesised that all groups would show evidence of maladaptive coping strategies. This is based on the assumption that the experience of traumatic events interferes with an individual's ability to cope and can increase the likelihood of the adoption of maladaptive coping strategies to reduce the experience of stress (Gershuny et al., 2003).

6.7 Method

6.7.1 Participants

As for Study one.

6.7.2 Materials

All materials used in study 3 are presented in Appendix I. Posttraumatic stress symptoms were assessed using the Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997). The IES-R is a self report measure with 22 items in total. It is comprised of three symptom subscales, these being Intrusion, Avoidance and Hyperarousal. The highest score attainable on this test is 88. The IES-R has good internal consistency, Intrusion = .87-.92, Avoidance = .84-.86 and, Hyperarousal = .79-.90. Retest reliability is also good for the three scales, Intrusion = .94, Avoidance = .89 and, Hyperarousal = .92.

The Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1992) was administered to evaluate levels of symptomatology and is a measure of psychological adjustment and distress. The SCL-90-R consists of 90 items and assesses a range of psychological symptoms. Participants indicate on a 5 point scale the extent to which they have been distressed or troubled by each symptom within the past seven days. Subscales of the SCL-90-R measure Somatization (S), Obsessive-compulsive (OC), Interpersonal Sensitivity (IS), Depression (D), Anxiety (Anx), Hostility, Phobic-Anxiety (PA), Paranoid Ideation (PI), and Psychoticism (Psy).

The SCL-90-R also provides a Global Severity Index (GSI), Positive Symptom Total (PST), and a Positive Symptom Distress Index (PSDI). The GSI is a single summary score of the current level of symptomatology that is derived by combining information regarding the number of items endorsed and the degree of distress experienced by the individual. The PSDI provides a measure of perceived distress that is separate from the number of items endorsed. The

PST is a measure of the extent of symptomatology by scoring the number of items endorsed by the individual. Seven additional items that are not included in the primary symptom dimensions are included in the calculation of the global indices. The symptoms measured by these additional items are related to multiple symptom dimensions but are not exclusive to any one dimension.

Internal consistency of the nine symptom dimensions ranges from .77 for Psychoticism to .90 for the Depression subscale. This has indicated that symptom items do reflect the measurement dimension or underlying factor. In addition, test-retest reliability has ranged from .80 for the Anxiety subscale to .90 for Phobic Anxiety, indicating stability over time. Convergent and construct validation research has demonstrated that the SCL-90-R is a good measure of current symptomatology (Derogatis, 1992). The SCL-90-R was designed to provide a measure of 'caseness'. The GSI or two or more dimension scores equal to or greater than a standard score of 63 have been considered to indicate a positive diagnosis or case (Derogatis, 1992).

Posttraumatic stress symptoms were also assessed using the Trauma Symptom Inventory (TSI, Briere, 1995). The TSI is a self report questionnaire and is comprised of 100 items. The participant is required to focus on trauma related symptoms that have occurred in the past 6 months prior to the time of interview. There are 10 clinical scales in all: Anxious arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive experiences (IE), Defensive avoidance (DA), Dissociation (DIS), Sexual concerns (SC), Dysfunctional sexual behaviour

(DSB), Impaired self reference (ISR), and Tension reduction behaviour (TRB).

The test produces T scores for each of the scales. A score of 65 or above on any of the scales indicates a clinically significant result.

The TSI also has three validity scales: Response level (RL), Atypical response (ATR) and Inconsistent response (INC). RL indicates an attempt on behalf of the participant to appear symptom free and scores about 65 should be interpreted with caution. Scores above 73 for this scale should invalidate the test. ATR indicates the desire to appear disturbed and with heightened symptomology. Scores above 70 indicate that the protocol should be interpreted with caution and those above 90 should be deemed invalid. High scores indicate random endorsement of items and lack of concentration and scores above 65 should be interpreted with caution. Scores over 75 would invalidate the test.

The scales of the TSI have been assessed with regard to reliability and validity. For internal consistency the clinical scales had a mean alpha coefficient of .86 and the validity scales had coefficients of .80, .75 and .51 respectively. The measures of the TSI have been found to be significantly associated with other measures of posttraumatic stress.

The MCMI-III (Millon, 1994) clinical scales were used in this study. The nature of the test and its psychometric properties have been reported in study one.

The Coping Strategies Inventory (CSI, Tobin et al., 1984) is an assessment tool used to determine an individual's reliance on various coping strategies during times of perceived stress. The tool is a self-report measure comprised of 72 items that are responded to using a 5 point likert scale. The item pool was adapted from the Ways of Coping Checklist (Folkman & Lazarus, 1980). The CSI measures reliance on 8 different coping strategies as determined by Tobin et al.'s (1984) hierarchical structure of coping. The coping hierarchy outlines two main coping mechanisms, problem engagement and disengagement and from this devises 8 facets: problem solving, cognitive restructuring, express emotions, social support, problem avoidance, wishful thinking, self criticism and social withdrawal. For the inventory, participants are requested to indicate the extent to which they use each of the eight coping domains on a 5 point likert scale. A mean score is provided for each of the scales.

With regard to reliability, alpha coefficients for subscales range from .71-.94. Retest reliability is not commonly reported for coping measures due to the fact that coping has been determined to change over time. For validity, construct and criterion validity have been demonstrated to be appropriate (Tobin et al., 1984).

6.7.3 Procedure

As for Study one.

6.7.4 Design

A four group questionnaire study was used. The groups were sexual abuse, physical abuse, emotional abuse and sexual harassment. The dependent variables were psychological symptoms, posttraumatic stress symptoms and coping strategies.

6.7.5 Data analysis

Analyses of variance were used to examine the differences between groups in relation to the dependent variables. Chi-square analyses were used to determine differences between the groups in relation to the frequency data. A significant criterion of .05 was adopted. All results at this criterion level have been interpreted with caution.

6.8 Results

6.8.1 Psychological Status

Examination was made of the presence of psychological symptoms. Significant group differences were apparent for the Obsessive Compulsive, Depressive and Anxiety subscales and for the Positive Symptom Total. For Obsessive Compulsive symptoms, the sexual harassment group scored significantly lower than the sexual abuse group (Fisher LSD=7.5, $p<.05$), the physical abuse group (Fisher LSD=7.5, $p<.05$), and the emotional abuse group (Fisher LSD=7.5, $p<.05$). For the Depressive symptoms, the sexual harassment group scored significantly lower than the sexual abuse group (Fisher LSD=6.7, $p<.05$), and the emotional abuse group (Fisher LSD=6.7, $p<.05$). For the anxiety symptoms, the sexual abuse group scored lower than the physical abuse

group (Fisher LSD=8.9, $p<.05$), and the sexual harassment group scored lower than the emotional abuse group (Fisher LSD=8.7, $p<.05$). For the PST score the sexual harassment group scored lower than the sexual abuse group, the physical abuse and the emotional abuse group (all Fisher LSD=6.8, $p<.05$). Table 16 presents the means, standard deviations and statistical results of these analyses.

Table 16. Means and standard deviations and statistical results for psychological symptoms using the SCL-90-R for each group.

Subscale		Group				Result
		SA	PA	EA	SH	
Somatisation	M	54.5	56.6	58.2	51.8	F(3,41)=1.0
	SD	8.9	8.9	8.5	11.2	
Obsessive Comp.	M	63.7	62.0	66.0	53.8	F(3,41)=4.2, $p<.02$
	SD	6.9	5.6	8.2	12.8	
Interpers. Sens	M	60.9	56.3	59.7	52.5	F(3,41)=1.3
	SD	7.3	10.4	12.3	13.7	
Depressive	M	62.0	57.7	60.1	52.8	F(3,41)=3.0, $p<.05$
	SD	7.9	6.6	8.3	8.6	
Anxiety	M	53.8	63.5	63.4	52.3	F(3,41)=2.9, $p<.05$
	SD	8.6	9.8	9.5	12.8	
Hostility	M	53.6	54.6	58.9	53.6	F(3,41)=1.0
	SD	6.2	8.9	10.2	8.1	
Phobic Anxiety	M	55.0	54.6	57.6	52.4	F(3,41)=0.4
	SD	10.7	9.7	13.8	11.7	
Paranoid Ideation	M	55.4	52.2	57.8	52.2	F(3,41)=0.6
	SD	10.3	9.0	13.8	12.8	
Psychoticism	M	62.1	53.4	61.3	52.5	F(3,41)=2.7
	SD	2.8	9.7	14.0	11.7	

GSI	M	61.0	59.6	62.6	53.0	F(3,41)=2.1
	SD	6.0	6.6	12.2	12.5	
PSDI	M	58.7	58.6	56.3	54.5	F(3,41)=0.6
	SD	6.9	9.4	9.7	9.4	
PST	M	60.5	59.4	62.4	51.2	F(3,41)=4.3, p<.02
	SD	6.3	6.6	9.1	9.8	

Clinical cut off scores for the SCL-90-R were considered. No significant group differences were evident in relation to the percentage of each group reaching clinical caseness. These results are presented in Table 17.

Table 17. Percentage of each group meeting clinical cut off for the SCL-90-R for each group

Scale	Group			
	SA	PA	EA	SH
Somatisation	18.2	18.2	45.5	16.7
Obsessive Compulsive	70.0	54.5	81.8	33.3
Interpersonal Sensitivity	27.3	36.4	36.4	25.0
Depressive	54.5	27.3	36.4	8.3
Anxiety	9.1	36.4	54.5	25.0
Hostility	0.0	27.3	36.4	16.7
Phobic Anxiety	18.2	27.3	36.4	25.0
Paranoid Ideation	18.2	18.2	36.4	25.0
Psychoticism	45.5	27.3	36.4	25.0
GSI	45.5	36.4	45.5	16.7
PSDI	36.4	45.5	27.3	16.7
PST	45.5	27.3	54.5	16.7

Group differences in clinical syndrome scale scores of the MCMI-III were investigated. No significant differences were found between groups. Table 18 shows the BR scores for the MCMI-III clinical syndrome scales.

Table 18. BR scores for the MCMI-III clinical syndrome scales for each group.

Subscale		Group				Result
		SA	PA	EA	SH	
Anxiety	M	68.1	39.3	67.7	52.8	F(3,37)=2.3
	SD	26.3	30.0	25.5	38.4	
Somatoform	M	33.7	30.3	36.9	36.9	F(3,37)=0.1
	SD	30.2	23.4	28.2	30.2	
Bipolar	M	38.5	32.2	56.3	49.8	F(3,37)=1.6
	SD	27.6	32.2	28.0	19.5	
Dysthymia	M	26.9	17.5	39.9	36.4	F(3,37)=1.1
	SD	29.3	18.4	35.5	41.2	
Alcohol Dep.	M	44.2	49.5	52.9	44.5	F(3,37)=0.3
	SD	25.7	23.1	24.0	31.3	
Drug Dep.	M	43.8	43.4	46.1	41.2	F(3,37)=0.01
	SD	30.2	34.1	27.9	24.0	
PTSD	M	60.5	32.4	51.0	35.1	F(3,37)=2.7, p=.059
	SD	23.1	29.6	24.5	27.4	
Thought Disorder	M	31.5	31.1	55.8	46.2	F(3,37)=2.0
	SD	25.1	28.3	26.0	33.1	
Major Depression	M	35.0	23.8	47.4	38.2	F(3,37)=1.0
	SD	29.7	22.9	36.9	36.6	
Delusional Dis.	M	28.5	29.6	45.5	30.9	F(3,37)=0.8
	SD	31.0	32.1	24.9	28.4	

Consideration then was given to the percentage of each group who obtained a clinically significant score on the MCMI-III clinical syndrome scales. There were no significant deviations from expected were evident. These percentages are presented in Table 19.

Table 19. Percentages for clinical significance on MCMI-III clinical syndrome scales.

Clinical Scale	Clinical Status	Group			
		SA	PA	EA	SH
Anxiety	Non-clinical	45.5	90.9	45.5	37.5
	Presence	27.3	9.1	36.4	50.0
	Prominence	27.3	0.0	18.2	12.5
Somatoform	Non-clinical	100.0	100.0	90.9	87.5
	Presence	0.0	0.0	9.1	12.5
	Prominence	0.0	0.0	0.0	0.0
Bipolar	Non-clinical	90.9	90.9	81.8	100.0
	Presence	9.1	0.0	0.0	0.0
	Prominence	0.0	9.1	18.2	0.0
Dysthymia	Non-clinical	81.8	100.0	72.7	62.5
	Presence	18.2	0.0	18.2	25.0
	Prominence	0.0	0.0	9.1	12.5
Alcohol Depend.	Non-clinical	100.0	100.0	90.9	87.5
	Presence	0.0	0.0	9.1	12.5
	Prominence	0.0	0.0	0.0	0.0
Drug Depend.	Non-clinical	90.9	90.9	90.9	100.0
	Presence	9.1	0.0	9.1	0.0
	Prominence	0.0	9.1	0.0	0.0
PTSD	Non-clinical	81.8	100.0	100.0	100.0
	Presence	18.2	0.0	0.0	0.0
	Prominence				
Thought Disorder	Non-clinical	100.0	100.0	90.9	87.5
	Presence	0.0	0.0	0.0	0.0
	Prominence	0.0	0.0	9.1	12.5
Major Depression	Non-clinical	90.9	100.0	72.2	75.0
	Presence	9.1	0.0	0.0	0.0
	Prominence	0.0	0.0	27.3	25.0
Delusional Disorder	Non-clinical	100.0	100.0	90.9	100.0
	Presence	0.0	0.0	9.1	0.0
	Prominence	0.0	0.0	0.0	0.0

6.8.2 Posttraumatic stress symptoms

Consideration was given to the scores for the IES – R for each group.

There was a significant group difference for the avoidance symptoms. The sexual abuse group obtained a higher avoidance score than the physical abuse group (Fisher LSD=6.4, $p<.05$), the emotional abuse group (Fisher LSD=6.4, $p<.05$), and the sexual harassment group (Fisher LSD=6.9, $p<.05$). Table 20 presents the mean scores, standard deviations and the statistical analysis results.

Table 20. Mean Scores and Standard Deviations for IES-R scales for each group.

Subscale		Group				Result
		SA	PA	EA	SH	
Avoidance	M	22.3	14.5	14.1	14.2	$F(3,36)=3.1, p<.04$
	SD	5.1	7.0	5.6	10.8	
Intrusion	M	21.7	16.9	18.9	11.9	$F(3,36)=1.9$
	SD	7.6	10.2	8.4	9.7	
Hyperarousal	M	16.0	15.1	14.3	9.5	$F(3,36)=1.6$
	SD	4.9	7.3	5.4	9.1	
Total	M	59.9	46.5	47.3	35.6	$F(3,36)=2.1$
	SD	13.8	22.8	16.9	28.6	

Consideration was given to the clinical significance of the IES-R scores.

No group differences were evident and the percentage of each group obtaining clinically significant scores. Table 21 presents these results.

Table 21. Percentage of each group meeting clinical significance for the IES-R.

Clinical Cut Off Score	Group			
	SA	PA	EA	SH

Less than 44	10.0	45.5	45.5	62.5
44 – 65	60.0	18.2	36.4	25.0
66+	30.0	36.4	18.2	12.5

Examination was made of group differences in the TSI scale scores. No significant group differences were evident. The results are presented in Table 22.

Table. 22 Results for TSI scale scores for each group.

Subscale		Group				Result
		SA	PA	EA	SH	
Anxious arousal	M	50.0	53.4	57.5	51.0	F(3,34)=1.2
	SD	7.5	8.5	10.3	12.9	
Depression	M	51.6	49.7	56.9	47.6	F(3,34)=1.3
	SD	8.3	7.6	12.8	13.3	
Anger/Irritability	M	51.8	47.6	54.3	48.7	F(3,34)=1.6
	SD	6.6	5.4	9.1	8.0	
Intrusive experiences	M	56.2	54.6	61.3	53.4	F(3,34)=1.0
	SD	9.9	9.7	12.2	11.9	
Defensive avoidance	M	54.8	52.4	59.5	55.1	F(3,34)=0.9
	SD	10.6	5.2	10.2	13.0	
Dissociation	M	59.0	52.4	56.6	49.3	F(3,34)=1.9
	SD	9.5	8.6	10.2	7.8	
Sexual concerns	M	54.8	48.7	61.9	51.7	F(3,34)=2.6
	SD	11.5	8.7	11.9	12.0	
Dysfunctional arousal behaviour	M	53.9	49.6	61.0	48.6	F(3,34)=1.9
	SD	12.7	9.6	15.3	12.1	
Impaired self reference	M	53.1	47.9	55.5	44.7	F(3,34)=2.6
	SD	6.9	6.4	9.6	13.0	

Tension reduction behaviours	M	54.8	49.7	63.5	49.7	F(3,34)=2.7
	SD	10.4	9.8	16.3	11.7	

An investigation was made of the clinical significance of the TSI scores. The percentage of people in each group obtaining clinically significant scores did not differ. Table 23 presents the results for each group

Table 23. Percentages for clinical significance on TSI for participants in each group.

TSI Scale	Clinical Status	Group			
		SA	PA	EA	SH
Anxious arousal	Less than 50	45.5	22.2	27.3	57.1
	50 - 64	54.5	66.7	54.5	28.6
	65+	0.0	11.1	18.2	14.3
Depression	Less than 50	45.5	77.8	45.5	85.7
	50 - 64	45.5	11.1	18.2	0.0
	65+	9.1	11.1	36.4	14.3
Anger/Irritability	Less than 50	27.3	66.7	18.2	42.9
	50 - 64	63.6	33.3	63.9	57.1
	65+	9.1	0.0	18.2	0.0
Intrusive experiences	Less than 50	18.2	33.3	27.3	57.1
	50 - 64	63.6	55.6	36.4	14.3
	65+	18.2	11.1	36.4	28.6
Defensive avoidance	Less than 50	36.4	33.3	18.2	42.9
	50 - 64	45.5	66.7	54.5	14.3
	65+	18.2	0.0	27.3	42.9
Dissociation	Less than 50	27.3	44.4	45.5	57.1
	50 - 64	36.4	44.4	27.3	42.9
	65+	36.4	11.1	27.3	0.0
Sexual concerns	Less than 50	36.4	77.8	27.3	57.1
	50 - 64	45.5	11.1	18.2	28.6

	65+	18.2	11.1	54.5	14.3
Dysfunctional sexual behaviour	Less than 50	54.5	77.8	36.4	85.7
	50 - 64	36.4	11.1	18.2	0.0
	65+	9.1	11.1	45.5	14.3
Impaired self reference	Less than 50	27.3	55.6	36.4	85.7
	50 - 64	72.7	44.4	54.5	0.0
	65+	0.0	0.0	9.1	14.3
Tension reduction behaviours	Less than 50	36.4	66.7	36.4	71.4
	50 - 64	45.5	22.2	18.2	14.3
	65+	18.2	11.1	45.5	14.3

6.8.3 Coping strategies

An analysis was conducted in order to determine group differences in coping strategies. There was a significant difference between groups for Problem solving strategies. The sexual abuse group obtained a lower mean score for this strategy compared with the physical abuse group (Fisher LSD=0.6, $p<.05$), and the sexual harassment group (Fisher LSD=0.7, $p<.05$). In addition, there was a significant group difference for the strategy Emotional Expression. The sexual abuse group obtained a lower mean score than the physical abuse group (Fisher LSD=0.7, $p<.05$), the emotional abuse group (Fisher LSD=0.7, $p<.05$), and the sexual harassment group (Fisher LSD=0.8, $p<.05$). The results are presented in Table 24.

Table. 24 Means and standard deviations for the CSI for each group.

Subscale		Group				Result
		SA	PA	EA	SH	
Problem solving	M	2.2	3.1	2.6	3.2	F(3,37)=4.2, p <.02
	SD	0.6	0.9	0.7	0.7	
Cog. Restructure	M	2.1	2.5	2.4	2.9	F(3,37)=1.1
	SD	0.9	0.8	0.9	1.0	
Social Support	M	1.5	2.1	2.5	2.5	F(3,37)=2.2
	SD	0.8	0.8	1.2	0.9	
Emotion Express.	M	1.4	2.4	2.3	2.8	F(3,37)=5.2, p<.005
	SD	0.7	0.8	1.0	0.7	
Problem Avoid	M	3.0	2.8	2.8	2.5	F(3,37)=0.7
	SD	0.6	0.4	0.6	1.2	
Wishful Thinking	M	3.1	3.3	3.8	2.8	F(3,37)=1.9
	SD	1.0	1.0	0.8	1.3	
Social Withdraw	M	3.0	3.1	2.6	2.6	F(3,37)=0.5
	SD	0.9	1.0	1.1	1.2	
Self Criticism	M	3.2	2.5	3.0	2.1	F(3,37)=1.2
	SD	1.5	1.4	1.4	1.0	

6.9 Discussion

The aim of Study Three was to investigate posttraumatic stress reactions, psychological maladjustment and utilisation of coping strategies to deal with the traumatic experiences of personal violation. The general findings of the SCL-90-R indicated that obsessive-compulsive, anxious and depressive symptoms were the most distressing symptoms post-trauma.

More specifically, the sexual abuse, physical abuse and emotional abuse groups displayed more obsessive-compulsive and depressive symptoms in the

aftermath of the traumatic experience than did the sexual harassment group. Certainly, anxiety and anxious feelings that coincide with obsessive compulsive symptoms can be seen as responses to stressful events. However, components of anxiety such as avoidance, worry and anxious rituals, may be used by the individual to restore control to their environment.

Perceived lack of control is commonly a determining factor in the severity of posttraumatic stress symptomology (Tsay et al., 2001). Depressive symptoms as a consequence of exposure to abusive experiences are not surprising when consideration is given to the ways in which depressive symptoms develop. For example the onset of depressive symptoms has been reported to co-occur with feelings of helplessness (Abramson et al., 1978) and feelings of hopelessness (Beck, Weissman, Lester, & Trexler, 1974). Helplessness with regard to an inability to control the abusive behaviour of another and hopelessness with regard to a capacity to extricate oneself from an abusive relationship could lead to the onset of depressive symptoms. These findings are also consistent with those of Miller (2006) who found obsessive-compulsive attributes and depression in samples of battered women.

The differences found between the sexual harassment group and the other three abuse groups can be understood with consideration to the context in which the abusive behaviour occurs. Those who were victims of sexual harassment showed less distressing obsessive-compulsive and depressive symptoms. A number of factors may contribute to this. Certainly, the participants in the sexual harassment group were not involved in the sexually

harassing relationship at the time of the investigation, in contrast to some participants in the other groups who were still involved in abusive relationships or had ongoing associations with the perpetrator. Disengagement from the hostile work environment and distance from the abuser could have provided relief for the sexual harassment participants.

It may also be the case that the emotional commitment to the perpetrator of the abuse is less for those who have been sexually harassed than it would be for those whose abuse occurred in an intimate relationship. Without the intimacy in the relationship it would be easier to reject as aberrant offensive behaviours by the perpetrator. In comparison with other abusive events involving an intimate partner, it may be easier for those who have been sexually harassed to hold the perpetrator responsible and not engage in self blame thus psychologically protecting the victim.

Certainly, abuse occurring within intimate relationships has been suggested to be particularly traumatic. It was reported that traumatic experiences that occur within relationships are associated with considerable distress and posttraumatic stress symptoms (Winje, 1998). This may be due to the amount of emotional and social investment in an intimate relationship that is typically experienced by women (McMurray, 2005). It is the destruction of a sense of safety that contributes to the negative effects of intimate violence as personal relationships are deemed to provide a sense of safety and security (Harris & Miller, 2000).

In relation to Anxiety and the Positive Symptom Total (PST), the physical abuse group obtained the highest scores overall and the emotional abuse group produced higher scores compared to the sexual harassment group. The PST is indicative of the total number of self reported symptoms identified by participants to be distressing for them. The higher scores for Anxiety and PST may be a reflection of the more enduring patterns of abuse that occur within physically and emotionally abusive relationships. Anxiety symptoms and general maladjustment may be contributed to by an anticipation of repeated exposure to abuse in the future. As mentioned in the previous chapter, the role of anticipation of negative experiences can trigger the recall of feelings of anxiety causing an individual to identify an event as anxiety provoking. Anticipation can trigger prior anxious experiences, causing an individual to view an event as anxiety provoking (Abler et al., 2006). Those who are already high in trait anxiety commonly perceive greater threat in ambiguous situations (Castillo & Calvo, 2000). Trait anxiety may be caused by long term exposure to anxiety provoking situations such as would occur in long term abusive relationships.

Overall, there were no detectable differences in the percentages for each group in relation to clinical caseness for the SCL-90-R subscales. This considered, the clinical scores show that obsessive-compulsive clinical symptoms were high and clinical anxiety scores were high for the emotional and physical abuse groups. Therefore, when considered together, the mean scores for these groups were clinically relevant. The absence of between group differences in clinical symptoms indicates that one event is not more likely to trigger one particular type of symptom over another. Research has indicated

that there is little evidence for the existence of a specific response style to particular types of abuse experienced by women (Garcia-Linares et al., 2005)

Similarly, with regard to the MCMI-III clinical syndrome scales, the results indicated that there was not one clinical syndrome that occurred more in any one type of abuse. The sexual assault group produced the highest score with regard to the PTSD scale although this reflected only a trend towards a difference between groups. Nevertheless, this finding has been supported by previous research (Collins, 2005; Creamer et al., 2001; Elliot et al., 2004; Kaltman et al., 2005) that found that posttraumatic stress symptomatology was commonly reported by survivors of sexual abuse and that approximately 50% of victims of rape go on to experience symptoms of ASD and PTSD (Collins, 2005), a rate considerably higher than generally reported following traumatic experience. For example PTSD is found in approximately 20% of bushfire victims (McFarlane, 1994), 15-25% of disaster victims (Brom & Kebler, 1989) and 25-33% crime victims (Yehuda et al., 1993). The current results also were supported by Frazier and Borgida (1985) who stated that the symptoms associated with Rape Trauma Syndrome commonly overlap with the diagnostic criteria for PTSD.

Interestingly, the group that obtained the second highest score on the PTSD scale of the MCMI-III was the emotional abuse group. This finding is consistent with the claims made by Semple (2001) and Trowell et al. (1997) that emotional abuse has traumatic consequences. There were no noticeable differences between the physical abuse and sexual harassment groups. This could indicate that risk for PTSD may also be related to a threat to psychological

integrity as well as a physical threat. Goodyear-Smith and Laidlaw (1999) reported that physical damage does not necessarily determine the impact or severity of an abusive event as the perception of malicious intent by the perpetrator of a abusive act causes that act to be traumatic in nature, even in the absence of objective signs of threat.

The groups could not be distinguished on the basis of the percentage of each group who obtained clinically significant scores on the MCMI-III clinical scales. More considered examination of the results indicated that, overall, more clinically significant anxiety scores were obtained compared with all the other scales. This finding is expected due to the well established relationship between traumatic experience and symptoms of anxiety (Bacchus et al., 2002; Birnes et al., 2003; Brantley, 2003; Burr et al., 1993; Kaplan & Sadock, 1998; McCauley et al., 1998). As a consequence of a traumatic experience, anxiety results in excessive worry in an attempt to develop effective coping strategies and problem solving (Eysenck, Derakshan, Santos, & Calvo, 2007). Anxiety is often the product of a discrepancy between desired level of control and the perceived level of control by the victim (Moulding & Kyrios, 2006). Perceived lack of control will often result in high anxiety, whereas greater perceptions of control will result in lower anxiety levels (Moser et al., 2006). The more evident anxiety in the current sample indicates the effect of the traumatic experience and the individual's attempts to cope with the situation and restore normal functioning.

The literature has suggested that the establishment of control in victims of sexual assault is particularly difficult and is commonly associated with

rumination in relation to causal attributions and what the victims could have done differently to avoid the assault (Frazier, Mortensen, & Steward, 2005). However, in the current study the groups could not be distinguished on anxiety, except for a significant result on the SCLR-90-R. This suggests that this process was problematic for all participants. It may be factors such as the damage to trust, destruction of safety and the need to be hypervigilant that causes this problem. This is evident in relation to all types of abuse and not only sexual abuse.

In reference to the measures of posttraumatic stress symptomology, the IES-R scores indicated that all groups experienced posttraumatic stress symptoms in relation to the specific abusive events. The sexual assault group obtained the highest avoidance scale scores in comparison with the other groups. Kaltman et al. (2005) reported similar results in their study of sexual abuse victims. They determined that avoidance was evident in those who had experienced sexual victimisation. This finding is indicative of the violating and traumatic nature of sexual abuse and is a testament to the coping efforts used to alleviate distress. Due to the context in which sexual abuse commonly occurs, avoidance mechanisms may be more effectively executed. In contrast, physical and emotional abuse is considerably more likely to occur in long term relationships, making their avoidance more difficult.

For sexual abuse, participants perhaps felt that they had more opportunity to bring control to the situation through the adoption of avoidance techniques. This supports Jenkins (1996) reporting of survivor strategies used by victims of sexual abuse. Just as control is a key element for the perpetrator, it too becomes

a survival strategy for the victim. Victims of repeated sexual abuse commonly try to overcome the threat of the abuse by controlling various aspects of it such as when and where it occurs. Avoidance is a typical strategy used among those who feel that they cannot stop subsequent occurrences of abuse. As a result, they modify their behaviours, routines and environment in an attempt to prevent the occurrence or minimise the impact of the next event.

This may also be applicable to the experience of sexual harassment, although there is less pressing need to avoid the behaviours, resulting in a lower avoidance score. There are mechanisms in place to protect workers from sexual harassment. In contrast, these established processes may make it relatively easier to disclose sexual harassment and be protected. In contrast, there has been a well reported reluctance of sexual assault victims to avail themselves of the mechanisms that would serve to protect them from future assault (Ogletree, 1993) leading to a need to actively avoid situations perceived as threatening.

The results for the TSI did not produce any significant results. The majority of the scores for this scale were within the normal range with only a small proportion of scores falling within the clinically significant range. The results demonstrated that all the events investigated share similarities, particularly with regard to aspects of posttraumatic experience. Therefore, it is not the objective experience of the different types of violation that makes one experience more negative than other. Indeed, it could be argued that it is the shared perception of threat that makes abusive experiences similar.

Coping strategies were measured in relation to Tobin et al.'s (1989) eight coping domains. The eight domains encompass basic problem engagement and problem avoidance strategies and include problem solving, cognitive restructuring, express emotions, social support, problem avoidance, wishful thinking, self criticism and social withdrawal.

Two significant group differences were noted. These indicated that the sexual abuse group was less likely to use problem solving and cognitive restructuring coping strategies compared to other groups. Generally, the use of cognitive restructuring was low for all the groups as was usage of social supports. The sexual abuse group also showed poor use of emotional expression, which may be further evidence of dissociation and attempts by the participants to distance themselves from the event. Poor emotional expression has been linked with the development of PTSD and is a common finding in relationship abuse (Gutner et al., 2006). Social support has been found to be extremely beneficial in the recovery from traumatic experience as it assists to rebuild trust and a sense of safety (Charvastra & Cloitre, 2008). Nevertheless, social support is commonly poorly utilised by abuse victims (Gutner et al., 2006).

Social withdrawal as a coping strategy is common in interpersonal abuse when the perpetrator is known to the victim. The presence of shame, guilt and fear contribute to social withdrawal due to the destruction of basic trust mechanisms. Self blame commonly results in the social withdrawal of victims of sexual abuse (Frazier et al., 2005). Social withdrawal may also be the product of post trauma difficulties in maintaining personal and social relationships, which

is a problem commonly reported by sexually abused women (Harvey, Orbuch, Chivalisz, & Garwood, 1991).

Problem engagement is usually the most effective coping strategy. However, disengagement is commonly associated with all types of abusive experiences (Taft et al., 2007a). In the present study, problem solving as a coping strategy was not strongly utilised for the sexual abuse group. This is attributed to the control ruminations in relation to guilt, shame and self blame associated with sexual abuse rendering victims unable to make adaptive decisions as they feel humiliated and responsible. A similar result was reported by Frazier et al. (2005) who found frequent use of problem avoidance by sexual assault victims.

Generally, adaptive coping strategies were poorly used by participants in this study to cope with abusive events, and all groups showed reliance on maladaptive strategies such as avoidance and wishful thinking. This finding is interesting given that the results of study one indicated that the group had good coping resources. It seems that the abusive experience had an effect on participant's ability to use adaptive coping strategies in the face of a traumatic event. The sexual abuse group appears to be the one that is the most negatively affected, showing that the experience has an effect on adjustment and perceived ability to cope, even when resources are available.

In summary, there is evidence of traumatic stress symptoms across all groups, however, it is the sexual abuse group that appears to show greater levels

of posttraumatic stress symptomology after the experience of a traumatic event. Anxiety and depression were also found to be present in the aftermath of traumatic experience. Strategies chosen to cope with the abuse were found to be maladaptive across groups, which is interesting given that all groups had good coping resources before traumatic exposure. This indicates that the experience of traumatic stress impacts on an individual's ability to cope after an event, even though resources are available. That is, the abusive experience exceeded the individual's capacity to cope. The nature of the experience meant that participants reached a point beyond which normal coping resources were insufficient or could not be applied. This would suggest that these abusive experiences were outside normal experience and this is indicative of their traumatic nature.

CHAPTER SEVEN
CONCLUSIONS

7. Overview

The following chapter is a summary of the findings from the series of three integrated studies. The findings are discussed in relation to the previous literature and their contribution to the understanding of trauma responses.

7.1 Summary and integration of results

The aim of the current investigation was to examine the experiences of four groups of females who had been victims of personal violation within a personal relationship. Personal experiences of sexual abuse, physical abuse, emotional abuse and sexual harassment were examined in relation to pre-trauma, peri-trauma and post-trauma factors in order to determine if the experiences of the groups in relation to abuse were different. Study one examined pre-trauma factors including the experience of prior victimisation, personality styles, psychological traits (i.e., anxiety, depression) and , coping resources (i.e., social support, spiritual beliefs). Hypotheses one and three were the only ones that were supported by the results. The results indicated that prior victimisation was evident for those who had experienced adult sexual abuse, and across the groups there was evidence to suggest a prominence of dependent, histrionic and depressive traits. Evidence of good coping resources was detected for all groups.

Study two examined the psychophysiological reactions to acts of personal violation through the measures of heart rate, respiration and visual analogue scales. Hypotheses one and three were supported and hypothesis two was partially supported. The results indicated that the process of psychophysiological responding to traumatic events was the same, regardless of the type of abuse,

with all groups showing similar levels of arousal, stage by stage to visual imagery scripts. However, visual analogue scale ratings of psychological reaction to abusive episodes indicated that although psychophysiological responding to abusive experiences was similar, some psychological responses showed variation between groups.

Study three examined posttraumatic reactions for each of the groups as well as coping strategies used to deal with the abuse. All three hypotheses for this study were supported. Obsessive-compulsive, anxious and depressive symptoms were evident across all groups post-trauma, and results of the MCMI-III clinical scales show a trend for more severe PTSD symptomology in the sexual assault group. Generally, the results indicated that all groups had evidence of some impaired psychological symptoms post-trauma, the majority did not score in the clinical range. This may be due to the fact that a certain amount of time had elapsed since the abusive event for most participants. It may be the case that any posttraumatic stress reactions suffered by these victims of abuse may have largely resolved by the time of testing. Coping strategies were found to be largely maladaptive with poor use of problem engagement and cognitive restructuring. Sexual assault victims showed evidence of particularly poor problem solving and use of cognitive restructuring when compared with other groups.

7.2 Factors that did not distinguish groups

It was apparent that there were factors that did not distinguish between the groups in the present investigation. Therefore, these factors can be

interpreted as not being exclusive to any one type of abusive experience, but factors that are common to all experiences of personal violation.

7.2.1 Pre-trauma factors

There were no significant group differences for age. In the present study, the results showed victims of sexual abuse, emotional abuse and sexual harassment, the greatest proportion of the sample were in the 20 – 29 year old age group. Factors such as dating practices, risk taking behaviours and lifestyle patterns can place younger age groups at greater risk for victimisation (Mouzos & Makkai, 2004), and this may explain the trend in the current investigation. The association of abusive experiences with younger age groups has been well established in the literature (e.g., Acierno et al., 2001; Fagan, Garner, & Maxwell, 1997; Mezey, Post, & Maxwell, 2002) and, to an extent, is supported by the current investigation, although the result is non-significant. It was found that, in Australia, risk of violence by a male against a female was greater for those who were young, single and unemployed (Mouzos & Makkai, 2004). Similar findings have been reported internationally (e.g., Mirrlees-Black & Byron, 1999).

In the current investigation, the greater proportion of the physical assault group was in the 40-49 year old age group. There have been different findings in the literature in relation to physical violence and age of the victim (Acierno et al., 2001; Mezey et al., 2002). Some studies have suggested that physical violence in relationships tends to escalate over time. Tzamalouka et al. (2007) reported that the prevalence of aggression, both physical and verbal, in a relationship can

increase with years of co-inhabiting as intimates become more comfortable with externalising emotions, whether they be positive or negative. Bagshaw et al. (1999) suggested that extreme forms of humiliation and mental cruelty are often found in long standing abusive relationships and can become more severe over time. To the contrary, Mezey et al. (2002) reported that the prevalence of physical violence can decrease as individuals get older, possibly due to the fact that perpetrators of abuse, as they age, sometimes rely less on physical force, instead relying on non-physical forms of control in order to intimidate the victim and induce fear. The results of the current investigation tended to support the findings of Tzamalouka et al. (2007). This considered, some studies have suggested that reported differences may be due to disclosure rates among victimized women (Acierno et al., 2001; Kilpatrick et al., 1987). It was suggested older women are often less likely to disclose abuse. Similarly, women are more likely to report victimisation that has occurred in the last five years. For this reason, women who have experienced abusive behaviours earlier in their relationships may be less likely to acknowledge that they have been victims of abuse.

The high incidence of physical abuse disclosures in an older age group in the current sample may be representative of women who have experienced physical assault at an earlier stage in their life. It should be noted that the time of the abusive event in the current sample spanned up to 10 years prior to interview. This would make the actual time of their experience of physical abuse more consistent with age trends for the experience of physical victimisation.

The absence of age differences in the present investigation may reflect the wide variability of the occurrence of personal violation within interpersonal relationships. The fact that no one age group experienced significantly greater levels of abuse shows that women, across ages are often equally affected by relationship abuse. This finding replicates that of Garcia-Moreno et al. (2006). They found that intimate partner violence was a common and frequently occurring world wide experience. The sample of 1500 women aged between 15 – 49 years showed only minor differences in relation to age, education, and marital status. It was concluded that overall, these factors did not elicit overall differences with regard to the prevalence and type of abusive behaviours experienced.

There were no significant group differences in relation to whether or not the abusive experience was an isolated or ongoing event. It was expected that those who had experienced emotional and physical abuse would be more likely to indicate that their abusive experience had been one in a number of ongoing abusive incidents. This was based on previous findings that indicated that physical violence among intimates is commonly associated with an escalating cycle of violence (Tzamalouka et al., 2007). Similarly, emotionally abusive experiences are commonly part of an ongoing pattern of behaviour that is designed to control and subordinate the victim. Emotional abuse has been suggested to be particularly traumatic due to its ongoing and cumulative impact (Follingstad, 1990). This considered, in the present sample, no one type of abusive experience was found to be more likely to be ongoing than any another.

An absence of differences with regard to frequency patterns of abusive behaviours may be attributed to several factors. The literature on intimate partner violence has indicated that the course of relationship aggression is not stable (Dutton et al., 2005). Incidents of abusive behaviours may be isolated or part of an ongoing pattern of behaviour. Isolated experiences of partner abuse may be attributed to partners leaving the relationship after a single episode of abuse (Coker, Hall Smith, McKeown, & King, 2000). For the present investigation, the occurrence of isolated abusive events may be due to them being experienced within dating relationships. Therefore, victims felt more able to leave the abusive situation. Ongoing patterns of abuse have been linked to victims' decisions to remain in the relationship (Dutton et al., 2005). It was reported that women often experience obstacles to leaving a violent relationship such as feeling pressured to stay, or becoming ambivalent about the abuse. Certainly, this would result in the experience of revictimisation within the relationship. In the current study the sample included those who had been in both long term and brief dating relationships. This may account for the absence of differences in relation to the frequency patterns of abusive behaviours.

There were no significant differences between groups in relation to pre-trauma personality traits. This is contradictory to previous findings indicating that borderline personality traits are common in those who experienced sexual victimisation, particularly childhood sexual abuse (Landecker, 1992; Modestin et al., 2005; Westen et al., 1990). Borderline traits in victims of abuse have been associated with the experience of repeated traumatic exposure and its associated impact on character structure and cognitive functioning (Westen et al., 1990).

Borderline and antisocial personality traits have also been associated with increased likelihood for victimisation (Lauterbach & Vrana, 2001). This is mainly attributed to cognitive and behavioural patterns of such personality styles and the increased likelihood for risk taking and impulsive behaviour. The absence of borderline personality traits in the current sample may be attributed to the fact that the majority of participants had only experienced abusive behaviours in their adult lives. Personality is considered to be a stable factor by the time an individual reaches adulthood (Flett, 2007). The presence of borderline traits in adult victims of childhood sexual abuse is attributed to the fact that childhood sexual abuse can interfere with the development of character and psychological functioning (Westen et al., 1990), hence, placing the individual more at risk for the development of a personality disorder.

Closer analysis of the current results did indicate prominence of dependent and histrionic personality styles in participants. These findings support those reported by others (Bradley et al. 2005b; Cogan & Porcerelli, 1996; Coolidge & Anderson, 2002). This considered, the presence of these personality traits was not associated with any particular group. As outlined in chapter 4, histrionic and dependent personality styles are commonly associated with the experience of abusive relationships, due to the implicit emotional needs (Pincus & Wilson, 2001) and typical patterns of relationship interactions associated with the personality styles (Bornstein, 1998). The results of the current investigation suggested that these personality styles make an individual vulnerable to the experience of abuse in a relationship, but not any one type. It may be that this vulnerability exists in relation to the conditions that give rise to aggressive and

volatile relationships (i.e., low self esteem, mood instability, submissiveness). It may be that the type of abuse that occurs is influenced more by factors associated with the perpetrator, which is an area of suggested future research. Although these personality styles make an individual more vulnerable to the experience of personal violation in a relationship, this does not mean that all victims of relationship abuse will exhibit these personality traits.

There were no significant differences between groups in relation to pre-trauma self-reported psychological symptoms. This contradicts findings by Stein et al. (2002) who reported that mood disturbances operate as risk factors for victimisation. Cleveland et al. (2003) also found that previous history of depression was associated with entering abusive relationships. Although the present investigation did not produce significant findings for depression, examination of results found that depression was a more prominent psychological symptom pre-trauma.

7.2.3 Post-trauma factors

There were no significant differences between groups for clinical SCL-90-R scores, MCMI-III clinical syndromes or symptom scales of the IES-R and TSI. There was a trend noted for the PTSD scale of the MCMI-III, but this will be discussed at a later point.

The absence of clinical PTSD indicator differences between groups suggests that no one type of abuse is significantly more likely to experience PTSD. This contradicts earlier findings (e.g., Clements & Sawhney, 2000;

Frazier & Borgida, 1985; Kaltman et al., 2005; Mertin & Mohr, 2001; Norris, 1992; Resnick et al., 2000; Rothbaum et al., 1992; Whalen, 2005) that suggested that sexual and physical assault are more likely to result in symptoms of PTSD. Modestin et al., (2005) also suggested that different types of abuse experiences are associated with different traumatic stress pathologies, which was not supported by the present investigation. The findings of Basile et al. (2004) are more consistent with the present study, suggesting that various forms of interpersonal violence (sexual, physical, emotional) are all associated with the experience of PTSD symptoms.

With regard to PTSD symptomology, although previous literature has established that certain types of abuse are more likely to result in the development of PTSD (Bacchus et al., 2002; McCauley et al., 1998), the current investigation did not support this. This may indicate that, for the present sample, the experience of personal violation was equally distressing across groups, which gives greater support to the suggestion that traumatic experience is highly subjective (Brewin et al., 2000), or that symptoms may have resolved over time.

7.3 Factors that distinguished the four groups

In the present investigation there were personal and environmental factors that distinguished the four groups. There was a significant difference between groups for history of prior victimisation. Adult sexual abuse was found to be more likely to be associated with earlier experiences of sexual abuse and childhood sexual victimisation. Several previous studies have established this

finding (e.g., Cloitre, Scarvalone, & Difede, 1997; Cloitre, Tardiff, Marzuk, Leon, & Poteria, 1996; Wyatt, Guthrie, & Notgrass, 1992). The link between childhood sexual abuse and adult revictimisation has been attributed to the fact that childhood sexual abuse is commonly associated with greater sexual risk taking behaviour in adulthood (Senn, Carey, Venable, Courey-Doniger, & Urban, 2006), due to difficulties in establishing safe and stable intimate and sexual relations (Testa, VanZile-Tamsen, & Livingstone, 2005). The findings of the present investigation have provided further evidence of the detrimental and long term affects of sexual abuse and the role that it has in revictimisation. Norris and Kaniasty (1994) suggested that not only is prior victimisation a good predictor of revictimisation, but that it also is a predictor of lasting symptomology.

There were significant group differences detected for psychological reactions of violation, unreality and fear in relation to imagery depicting the abusive interaction. The sexual abuse group showed higher levels of violation than other groups and higher levels of unreality at both the incident and consequence stages of the abusive event. For the physical abuse group, greater levels of unreality were detected at the consequence stage of the abusive event, when compared with the sexual harassment and emotional abuse groups. The results indicated the presence of dissociation for the sexual and physical abuse groups during imagery relating to the traumatic event. Previous research has indicated that dissociation commonly occurs during the experience of significant traumatic distress (Fikretoglu et al., 2007), and that it may serve to operate as a coping strategy for extreme distress (Thomas, 2005). Ratings of unreality at the

incident and consequence stage of the abusive script indicated the presence of dissociation at the more distressing and violating stages of the incident. The presence of dissociation at the consequence stage may be indicative of the experience of shock after an abusive event has occurred.

Group differences were evident for fear ratings at the incident and consequence stages of the abusive event. Sexual abuse and physical abuse participants showed significantly higher ratings of fear than the sexual harassment group at the incident stage and at the consequence stage, and sexual and physical abuse groups showed higher fear ratings overall than both the emotional abuse and sexual harassment groups.

Fear has been found to be a common reaction to interpersonal violence (Capaldi & Owen, 2001). Fear is recognised as a legitimate stress response to traumatic events and its occurrence is identified in the diagnostic criteria for PTSD (APA, 2000). In the current investigation, greater fear responses by the sexual and physical abuse groups at the incident stage of the abusive script may indicate that greater fear is associated with perceived physical threat and possible injury. Participants who anticipated physical or sexual injury at the time of the incident may be more fearful for their safety than those who experience controlling or humiliating acts such as emotional abuse or harassment. Emotional abuse and verbal sexual harassment may be associated more with threats to self worth and attempts to subordinate rather than threats to actual physical safety. Interestingly, fear was also reported by the sexual abuse group at the approach stage of the non-abusive event. This is further evidence of the

perception of threat experienced by victims of sexual abuse and the activation of trauma cues when in the presence of the perpetrator.

Overall, reactions to the abusive event showed that for the sexual abuse, physical abuse and sexual harassment groups, psychological reactions such as violation, unreality and fear had the highest ratings, whereas the emotional abuse group produced the highest ratings for only violation and fear. This finding would indicate that feelings of unreality were not dominant in those who have experienced emotional abuse, suggesting that dissociation did not play a role in the experience of emotional abuse in the current sample. This finding is interesting and may be indicative of the subtle effects of ongoing emotional abuse. Because emotional abuse is typically less severe in terms of the immediate traumatic impact and threat to physical integrity, there is a lesser need to dissociate. These findings may suggest that the traumatic symptoms experienced after a physically or sexually abusive event or a sexually harassing event may be associated with the direct threat made to physical safety and general security, whereas, the posttraumatic stress symptoms experienced after an emotionally abusive event may be linked to implications of the event on self esteem and self worth, and a tendency to ruminate about and internalise the meaning behind the emotional abusive actions of a partner.

There was evidence of significant group differences for psychological symptoms post-trauma with differences noted between groups for Obsessive compulsive, depressive and anxiety symptoms. With regard to Obsessive compulsive symptoms, the sexual harassment group scored lower than all other

groups. A similar pattern was evident for depressive symptoms. It could be argued that the sexual harassment group experience more perceived control post-trauma and this accounted for the relatively less severe symptoms. Anxiety symptoms post-trauma have been linked to attempts by the victim to reinstate some kind of control over their lives (Orsillo et al., 2004). The difference between the sexual harassment group and all the other groups may be related to the fact that the occurrence of abusive behaviour is restricted to one area of their lives, that is, the workplace. This may allow individuals to feel more in control in their everyday life as they are away from the abusive context. Due to the fact that the other types of abuse were associated with domestic or social interactions, victims of these other types of abuse may feel less control and feel that they are less able to escape reminders of the traumatic experience.

There was a significant difference between groups for avoidance symptoms post-trauma. The sexual abuse group scored higher for avoidance symptoms than all other groups. It may be that the presence of greater avoidance symptoms in this group is associated with feelings of self blame associated with sexual assault (Ullman et al., 2007) and the distinct lack of control experienced in this type of abuse. Taft et al. (2007a) reported that sexual assault experiences are often associated with disengagement behaviours, which contributes to longer term negative effects for victims. Avoidance symptoms may be understood as attempts to re-establish control by the victim.

There were significant group differences in relation to coping strategies. The sexual abuse group showed lower scores for utilisation of problem solving

compared to the physical assault and the sexual harassment groups. In relation to the coping strategy of emotional expression, sexual abuse showed less reliance on this strategy than all other groups. Again, the poor usage of coping skills may be associated with greater symptoms of avoidance in sexual abuse victims. Self blame may also have an impact, resulting in reduced ability to problem solve or achieve acceptance both from self and others. The current investigation may also be further proof of the fact that rape constitutes a more extraordinary event in terms of abusive experiences and, therefore, more effortful coping is required (Janoff-Bulman, 1979).

Overall, group differences were detected for pre-traumatic factors such as prior history of victimisation, peri-traumatic psychological reactions and posttraumatic psychological symptoms, and coping strategies. These results indicated that the different types of personal violation experienced by the current sample are influenced by different aspects of pre-traumatic, peri-traumatic and posttraumatic experience.

7.4 Patterns of response to personal violation across all four groups

Patterns of response to personal violation were examined across the four participant groups. The current investigation demonstrated that psychophysiological patterns of arousal to abusive, non-abusive and neutral imagery scripts could be differentiated but were similar for all groups. This provides evidence that psychophysiological stress responses are similar in traumatic experience and are not specific in any one type of abusive experience.

Krantz, Forsman, and Lundberg (2004) documented physiological recordings in relation to stress exposure and found increases in heart rate measures in response to induced stress conditions. They concluded that stress provoking conditions are able to induce significant increases in sympathetic arousal and muscle tension in males and females and that psychophysiological recording such as heart rate are sufficient to demonstrate rapid responses to stress. The personalised nature of the imagery scripts in the present investigation allowed for the recreation of the event, as the victim perceived it, and hence an accurate indication of their arousal response pattern at the time.

High arousal responses were detected across all groups for the abusive event script. This indicates that participants found the interactions in the abusive experience more stressful than those in the non-abusive and neutral event. This result was expected given the traumatic nature of the abusive event. Experiences of traumatic events are commonly associated with symptoms such as psychological and psychophysiological distress

Arousal changes were also evident for the non-abuse script for all groups, which elicited greater stress, heart rate and respiration measures than the neutral script. This increase in arousal is due to the presence of the perpetrator in the non-abusive interaction. This demonstrates that even though participants were not at risk during this event or did not perceive the interaction as threatening, the presence of the perpetrator alone is enough to elicit a stress response. Stress responses associated with future encounters with the perpetrator have been examined in the literature related to legal processes and court appearances for

victims of violent crime (Herman, 2003; Koss, 2000). Orth and Maercker (2004) also acknowledged that victim trial attendance in the presence of the perpetrator is a psychologically distressing experience.

Victims of crime commonly feel the need to limit exposure to reminders of their crime. Future encounters with the perpetrator, even in non threatening and safe environments, are distressing due to triggers that reactivate the traumatic experience (Herman, 2003). Victims of crime also fear future interactions with perpetrators due to fear of retaliation or revictimisation. This is particularly true for victims of interpersonal violence, when abusive experiences have been frequent in the relationship (Koss, 2000). It would be interesting to further investigate this association by controlling for factors associated with the non-abusive incident. For instance, it may be worthwhile to examine non-abusive interactions with the perpetrator that occurred both before and after the abusive incident.

Participants showed differences in psychophysiological responding across the different stages of the abusive interaction. Heart rate and respiration were lower at the setting the scene stage, increased in the approach and incident stages and then decreased at the consequence stage. This is consistent with other studies that have shown psychophysiological arousal in relation to trauma-relevant stimuli (Blanchard et al., 1989,1996; Haines et al., 2002). The stage based changes are indicative of changes in traumatic exposure intensity and the perceived threat experienced by the victim. The personalised nature of the scripts in the current investigation allowed for accurate recording of

psychophysiological arousal, stage by stage, from the victim's perspective. This is important as it allowed for detection of changes across groups and showed that different stages of the interaction were more stressful for some types of abuse than others.

There were some interesting variations in relation to anger, anxiety and perception of control across stages for the abusive script in all groups. Feelings of anxiety, anger and control were found to increase from the beginning of the script through to the incident stage, which is expected due to the escalation of abusive behaviours and increase in traumatic experience. From the incident stage, feelings of anxiety and lack of control were maintained, however, feelings of anger increased through to the consequence stage. Similar results were also evident in relation to the non abusive script but arousal levels were generally lower.

Anxiety responses and the perception of loss of control are common reactions to traumatic events and are triggered by initial perception of threat. The perception of threat in traumatic stress literature has been evidenced by changes in psychophysiological arousal (Soler-Baillo et al., 2005). Responses to threat cues were evident by increases in arousal in both victims of crime and controls. This literature helps to demonstrate that when threat cues are evident, anxiety and feelings of helplessness are either maintained or escalate, until appraisal of the situation indicates that threat is no longer present. When this happens, physiological arousal decreases, as evidenced by resolution of arousal at the consequence stage in the current investigation. Feelings of anxiety and

helplessness also dissipate at this stage and do not increase. The participants in the current investigation demonstrated classic anxiety responses to stressful stimuli.

Feelings of anger at the incident and consequence stages, in particular, an escalation of anger from the incident stage to consequence stage indicated the role of emotional processing in participants. Research has indicated that feelings of anger are often intensified following the experience of a traumatic event (Orth, Cahill, Foa, & Macrcker, 2008) and that anger contributes greatly to the experience of psychophysiological arousal during stress responses (Rochman & Diamond, 2008).

Anger has also been shown to be an important factor in the experience of posttraumatic stress symptoms and has been associated with heightened perception of threat during the traumatic event. Ray, Wilhelm and Gross (2008) identified the role that rumination after an event plays in the development and maintenance of negative emotions such as anger. Where rumination leads to negative emotions, reappraisal is suggested to result in more positive emotions. The increase in anger responses at the consequence stage of the abusive event may indicate the onset of the use of maladaptive coping strategies and that participants in this sample were engaging in rumination after the event, rather than cognitive coping strategies such as reappraisal and cognitive restructuring. The experience of anger post-trauma demonstrates that anger does not resolve immediately after the incident.

Overall, the pattern of responding across stages of the imagery scripts indicated the presence of traumatic stress reactions to abusive events, regardless of the type of abuse experienced. Psychophysiological arousal increased throughout the event, peaking at the incident stage, and then dissipating as the experience ends. Feelings of anxiety control and anger also changed according to the stage of the experience. Most interesting is the escalation of anger detected at the consequence stage of the abusive and non abusive scripts. These results showed that anger does not reduce after the event finishes but instead continues to be present for the individual.

7.5 Posttraumatic stress reactions to personal violation across groups

Although the levels of posttraumatic stress symptoms were not significant, in the present investigation there was evidence of psychological symptoms post-trauma across all groups as evidenced by scores on the Positive Symptom Total Index. This indicates that experiences of personal violation, regardless of frequency or severity, are psychologically distressing for the victim. This gives weight to the argument that subjective perception influences individual experiences of traumatic events (Brewin et al., 2000) and that different experiences of traumatic events can result in the development of psychological symptoms for the individual.

In relation to the symptom clusters associated with posttraumatic stress symptomology, avoidance symptoms appeared to be the most dominant for the current sample. Similar to the results of the current study, Kaltman et al. (2005) also found higher rates of avoidance symptoms in victims of sexual assault. The

presence of avoidance symptoms has been seen to be central in the diagnosis of PTSD, as this symptom cluster requires three avoidance symptoms in diagnosis (McMillen, North, & Smith, 2000). As mentioned in chapter 6, avoidance symptoms are commonly seen in victims of sexual abuse because of a need by the victims to restore control to seemingly uncontrollable thoughts and images related to the traumatic event (Jenkins, 1996).

The presence of avoidance symptoms in this group may also be understood in the context of an argument proposed by Davidson and Foa (1991) that avoidance symptoms such as numbing are more common in experiences where the victim perceives poor public or social support. It would be interesting to further distinguish the reported avoidance symptoms in the current investigation to determine the prominence of either numbing or effortful avoidance. There has been much discussion in relation to these two components of avoidance behaviour and the suggestion that the two should be considered separately in diagnosis (Feuer, Nishith, & Resick, 2005). Another point of consideration is the fact that criterion C avoidance criteria of PTSD is commonly the least likely to be met in victims of traumatic events (McMillen et al., 2000). Avoidance symptoms have been associated less with immediate consequences of traumatic exposure but instead have been suggested to be more prominent in the aftermath of traumatic experience (Blank, 1993). With regard to the present sample, the prominence of avoidance symptoms in the sexual abuse group may be indicative of the fact that participants were not victims of recent traumatic experience.

There was evidence of a trend for more severe PTSD symptoms in the sexual abuse group, which is consistent with previous research indicating that sexual assault is commonly associated with experiences of PTSD symptomology (Creamer et al., 2001). The absence of a significant finding for this result may be due to the small sample size in the current investigation. Nevertheless, the trend is not surprising, given that the sexual abuse group produced more significant findings for pre-trauma, peri-trauma and post-trauma factors than any other group. The significant finding of previous victimisation within this group also increases the risk of PTSD (Breslau et al., 1999; Carlson & Dutton, 2003). This group also showed higher rates of avoidance symptoms, arousal in relation to abusive interactions and greater feelings of violation and lack of control. Sexual assault, whether perpetrated by an intimate or stranger, has been implicated as an experience that involves feelings of violation, vulnerability and powerlessness and high levels of fear and anxiety compared with other types of abusive experience (DeMaris & Swinford, 1996). The results of the present investigation confirm findings made by previous research that sexual abuse generally is a stronger predictor of poor psychological functioning long term (Taft et al., 2007b).

Across groups, the utilisation of adaptive coping strategies, post-trauma, was poor. Groups generally showed stronger endorsement of maladaptive strategies such as wishful thinking, social withdrawal and problem avoidance. The ability to use positive coping strategies was limited in this sample, in particular, strategies such as cognitive restructuring and problem solving. This finding is interesting given that study one results indicated that all groups

generally possessed good coping resources. Typically, coping resources have been seen to promote adaptive coping (Lazarus & Folkman, 1984). Research has demonstrated that individuals who have good coping resources are usually able to utilise problem-solving efforts in order to transform or adapt to stressors (Armstrong-Stassen & Cameron, 2003; Thoits, 2006). This considered, it has also been established that the experience of stress is associated with avoidance coping (Littleton, Horsley, John, & Nelson, 2007), although this is suggested to be less so for those who have perceived social resources (Ingledew et al., 1997). However, it has also been recognised that coping efforts change as a stressful event unfolds (Lazarus & Folkman, 1984). For the present investigation, it may be concluded that the experience of personal violation interferes with an individual's ability to apply and access coping resources and strategies, even when they are available.

Although the current investigation failed to produce a significant finding for the presence of PTSD symptom in the current sample, the presence of psychological symptoms post-trauma indicated that the experience of personal violation impacts upon psychological functioning and wellbeing.

7.6 Limitations of the investigation

The small sample sizes in the present study must be acknowledged as a limitation. Sample size was limited by study 2 because of the time associated with collection of psychophysiological and psychological imagery data. Another factor impacting on sample sizes was obtaining numbers of individuals who had experienced abusive behaviour within a relationship. Due to the sensitive nature

of research within these client groups, only small numbers volunteered for participation. Also, due to the fact that the psychophysiological data were recorded in a second session at a different time from the initial interview, there were a substantial percentage of participants who did not turn up for the second set of testing. As a consequence, the data from their first testing session could not be utilised. The drop out rate in the present investigation was due to the fact that participants found it beneficial to participate in the initial interview and felt satisfied to be able to tell their story and, as a consequence, felt no personal need to return for the second round of testing. Nevertheless, despite the small sample size, the results can be interpreted in a meaningful way as the characteristics of the abuse experiences and the characteristics of the participants do not fundamentally differ from those reported in the literature for abuse victims in general.

Another limitation is the fact that there were some data missing from the investigation. To investigate all of the necessary components of personal violation, it was vital that a range of questionnaires were used. The number of questionnaires used in this investigation was quite large, which would have proven time consuming for participants. The consequence of this is that not all of the questionnaires were returned, or some were returned incomplete. There were obviously other factors that could have been investigated as contributors in this investigation. A compromise was made due to time constraints and to place less demand on participants with regard to questionnaire completion.

Limitations exist with regard to the time that the data were collected. For the majority of participants, the traumatic event had occurred in the past two years whereas, for some, it was longer. It may be that the absence of posttraumatic stress disorder symptomology is due to the fact that for many of these symptoms may have resolved in the time that had elapsed since the assault.

There may also be some limitations with regard to the comparability of the sample. The majority of participants were from a University population, which may not be representative of the general population.

7.7 Directions for future research

Although some factors that are associated with pre-trauma functioning were addressed, it is evident that there are other factors that should be considered. Future studies should investigate the role of attachment in experiences of personal violation, and the possible role it plays in posttraumatic stress experiences. Attachment theory suggests that stressful events activate attachment systems. Depending on whether or not childhood attachments were positive or negative, the way an individual reacts to stressful events and views their adult relationships may be different (Bukato, 2008). It is reasonable to suggest that insecure attachments can result in the greater likelihood that events will be perceived as stressful and hence greater vulnerability to posttraumatic stress reactions. Attachment plays a key role in subjective perception of an event. Fraley et al. (2006) suggested that posttraumatic growth was commonly associated with the ability to derive meaning from existing relationships and that better PTSD outcomes were associated with secure attachment systems. It

would be interesting to further investigate the role of attachment in the current investigation, particularly in relation to those who evidenced prior experience of abuse.

Sex role attitudes may also impact on the experience of acts of personal violation in relationships. Sex roles distinguish value systems and sex characteristics that an individual deems important (Moynihan, 2002). Female sex roles place importance on family, nurturance and care giving roles, hence the greater posttraumatic stress reactions among women who experience difficulties or abusive experiences within these context (Norris et al., 2001). Of particular interest would be the role that gender attitudes play in the identification of abusive behaviours. Research has shown that beliefs associated with sex roles may influence perceptions of traumatic experience (Norris et al., 2001). Therefore, individuals who value more traditional masculine and feminine sex roles may be less likely to view an interaction as abusive. It would be interesting to further establish the role that this plays in the recognition of abusive victimisation.

With regard to post-trauma factors, access to therapeutic intervention, the involvement of police or legal processes and the time elapsed between the time of the abuse and disclosure would be interesting factors to investigate. Previous studies have shown that legal procedures related to victimisation are particularly traumatic for crime victims and often contribute to secondary trauma factors (Quas et al., 2005).

Factors associated with disclosure have been found to impact on anxiety levels (Pachankis, 2007) suggested that concealed stigmas place considerable stress on an individual. Cognitive factors such as preoccupation, rumination, vigilance, guilt and shame have been associated with withholding information about a perceived negative experience or attribute. Withholding disclosures of abusive experience may contribute to the experienced stress levels by the individual and hence, prolong the experience of posttraumatic stress symptoms after the experience of an abusive event.

Treatment for traumatic stress symptoms is focused on specific events and the processing of specific memories (van der Kolk et al., 2005), and has been associated with better outcomes post-trauma. Herman (1992) outlined a three-stage recovery process for victims of trauma, particularly violent and abusive experiences. The work outlines the importance of reconstructing a sense of empowerment and the creation of new relationships. Normal recovery processes are often inhibited by maladaptive coping mechanisms that have been adopted by the victim. This includes things such as self-harm, self-protective beliefs and substance use (Herman, 1992). Post-trauma factors, such as engagement in therapy, could be associated with better posttraumatic outcomes in victims of personal violation. It would be beneficial to compare posttraumatic outcomes of those who had engaged in trauma focused therapy compared to those who had not.

Post-traumatic growth has been associated with traumatic experiences for some (Hall et al., 2008). The type of event experienced has been suggested to

impact on rates of posttraumatic growth (Cobb, Tedeschi, Calhoun, & Cann, 2006), and traumatic experience relating to interpersonal functioning has been found to be associated with lower rates of posttraumatic growth (Ickovics et al., 2006). It would be interesting to determine the role of posttraumatic growth on experiences of personal violation, both within and outside of personal relationships. Just as environmental factors and personal contributors affect the development of posttraumatic stress symptoms, it would be interesting to also assess their affect on opportunities for resilience and growth.

It may be interesting to look at ongoing symptomology for individuals who had experienced early or childhood episodes of abusive behaviour. Previous research has suggested that those who have experienced revictimisation show lasting symptomology post-trauma (Norris & Kaniasty, 1994). Although this study produced evidence of a link between childhood sexual victimisation and adult sexual victimisation, it would be interesting to see if symptoms were prolonged or more severe in participants who had been revictimised.

7.8 Summary

In summary, the present study aimed to investigate the role of pre-traumatic, peri-traumatic and post-traumatic contributors in victims of personal violation, within the context of interpersonal relationships. Adult experiences of sexual abuse, physical abuse, emotional abuse and sexual harassment were investigated in a sample of women between the ages of 18 – 55 years. Peri-traumatic factors were found to contribute more significantly between groups than pre-traumatic or posttraumatic factors. Although there were no clinically

significant levels of posttraumatic stress symptoms in the present investigation, the results indicated that all groups showed evidence of some posttraumatic stress symptoms and psychological symptoms after the experience of personal violation. Sexual abuse was found to be associated with increased traumatic reactions, which was attributed to more revictimisation and higher reports of violation. Dissociation was also found to be common in victims of sexual abuse, which has previously been linked with poor psychological outcomes post-trauma (Halligan, Michael, Clark, & Ehlers, 2003). The results supported the claim that sexual abuse is a greater predictor of poor psychological functioning long term (Taft et al., 2007b). However, results also suggested that no one type of abuse is associated with specific psychopathology post-trauma and that victim perspective is important when considering the traumatic impact of an event.

According to the results of the present study, the impact of a traumatic event is determined by characteristics of the victim, the event and the victim's post-trauma experience. Determining traumatic impact is not as simple as assessing the type of abuse that has occurred as the present study has shown that no one type of abuse results in consistent symptomology or traumatic reactions.

The current results indicated that memory of the experience remains traumatic or stressful for victims. Psychophysiological and psychological reactions to the abusive event show the presence of arousal and distress, and evidence of distress in non threatening situations shows the presence of trauma cues in relation to the perpetrator. The results of the present study are important when considering psychological intervention strategies for victims of abuse.

Treatment and interventions need to encompass all aspects of the person, their environment and their experience.

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APPENDIX A

Information Sheet and Consent From

INFORMATION SHEET

Psychological and psychophysiological reactions to personal violation

The above project is being conducted by Dr. Janet Haines and Ms. Amy Washington of the School of Psychology at the University of Tasmania. The purpose of this study is to examine whether emotional abuse and sexual harassment can be considered to be traumatic events in the same way as physical abuse and sexual abuse are considered to be traumatic events. The results of this study may contribute to the understanding of the way in which people respond to traumatic events and may be used in the development of appropriate management strategies for people who have been emotionally abused or sexually harassed. This project is being undertaken as part of a Doctor of Philosophy (Clinical Psychology) Degree.

We are interested in comparing the reactions of people to abusive events that are considered to be personal violation. In particular, we are interested in comparing the psychological and psychophysiological reactions of people who, in the past, have experienced emotional abuse, physical abuse, sexual abuse and sexual harassment. Consideration will be given to psychological functioning before the event, the reaction to the event and the development of psychological responses after the event.

If you agree to participate, your reactions to the abusive event or interpersonal conflict will be discussed with you. In addition, you will be interviewed about a non abusive interpersonal interaction and an emotionally neutral even such as making a cup of coffee that will be used for comparison purposes. This interview will be recorded on audio cassette. The information from the interview will be used to devise imagery scripts that will be used to guide you through the memory of the events. An imagery script is a structured, written account of the story provided by you during interview. You will be required to attend the laboratory and have electrodes and measurement instruments applied to your torso and finger tips so that measures of heart rate and respiration can be taken. The administration of these electrodes and measurement instruments do not cause discomfort although it should be noted that there is a very small risk of skin rash. Please let us know if you have any allergies.

The measurements will be taken while you are guided through the imagery of the abusive event or conflict event, the non abusive interaction and the emotionally neutral event. You will be asked to rate your psychological response to the content of the imagery scripts. In addition, you will be interviewed about your reactions to the abusive events and you will be asked to complete a range of questionnaires and rating scales that are designed to elicit information about abusive experiences, the psychological symptoms that may develop as a consequence of experiencing an abusive event and the way in which you cope in general and in relation to the abuse, your social network and your physical status. The interview will take approximately one hour of your time and the laboratory session will also take one hour. You may complete the

questionnaires in your own time and they would take approximately one hour to complete.

We wish to emphasize that the information you share with us will be treated in a confidential manner. All written information, computer data files and audio cassettes will be stored with a participation number rather than your name. The data will be secured in a locked cabinet.

Participation in this study is completely voluntary. If you agree to participate in the study but then change your mind and wish to withdraw, you may do so at anytime without prejudice. If you are receiving counseling or psychological support, you may wish to discuss participation in this project with your counselor or psychologist prior to commencement. If you wish to have someone accompany you to the sessions and escort you home, please feel free to bring this support person with you.

Some people may find that talking about their traumatic experiences is difficult and causes anxiety. If this is the case for you, we recommend that you do not participate in this project because we will require people to discuss the nature of their reactions to their experiences. In addition, if you agree to participate but then find that it causes you undue anxiety to talk about the issues, please let us know. We will assist you with your anxiety and provide you with the opportunity to withdraw from the study. We do not wish for participation in the project to be distressing for you.

If you wish to discuss the project, before, during or after participation, please contact Dr Janet Haines on (03) 6226 7124 or J.Haines@utas.edu.au. This project has been approved by the Southern Tasmanian Social Sciences Human Research Ethics Committee. If you have any concerns about the ethical nature of the project, you may contact the Chair or the Executive Officer of the Southern Tasmanian Social Sciences Human Ethics Research Branch. The contact numbers are as follows: A/Prof Gino DalPont, Chair, (03) 62262078; Ms Amanda McAully, Executive Officer, (03) 62262763.

If you would like to discuss your psychological reactions to the abusive event, we would suggest that students contact Student Counselling (telephone 6226 2697) at the University and other contact Victims of Crime Service (telephone 6228 7628). You may also wish to discuss your reaction with your general practitioner. The services provided by Student Counselling and Victims of Crime Service are free of charge. If you require immediate assistance, please let us know and we will be happy to arrange support.

We wish to make you aware that the results of this project are for research use only and are unavailable for use in any legal proceedings.

We would be happy to discuss your individual results with you. Overall results will be available in hard copy or electronic form on the School of Psychology website at the completion of the project if you are interested (www.scieng.utas.edu/psychol/).

If you decide to withdraw from the project, we would welcome the opportunity to discuss with you any concerns that you have about the project or your participation in it. Please keep this information sheet and, if necessary, refer to the information it contains. In addition, if you agree to participate, you will be asked to sign a statement of informed consent. A copy of this statement will be supplied to you.

Thank you

STATEMENT OF INFORMED CONSENT

I have read and understood the 'Information Sheet' for this study. The nature and possible effects of the study have been explained to me.

I understand that the study involves:

- Discussing an abusive event that I have experienced;
- Discussing a non abusive event that I have experienced;
- Discussing and emotionally neutral event of my choosing;
- These discussions will be recorded on audiotape to facilitate the preparation of imagery scripts;
- Attending a recording session and having electrodes and measurement instruments fitted so that recordings of my heart rate and respiration can be taken while I am being asked to imagine scripts of the events;
- Rating my psychological responses to each of these events;
- Completing my interview about the presence of posttraumatic stress symptoms;
- Completing questionnaires about the nature of my psychological responses to the events, general symptoms, personality, coping, social support and health status;
- The duration of the interview and the laboratory session is approximately one hour each. Completion of the questionnaires will take approximately one hour.

I understand the data collected from this study will be kept in the School of Psychology for at least 5 years.

I understand that all research data will be treated as confidential and that my name will be not attached to the data that are collected. Any questions that I have asked have been answered to my satisfaction. I agree to participate in this study and understand that I may withdraw at any time without prejudice. I agree that research data gathered for the study may be published. I am aware that I will not be able to be identified in published material

Name _____ of _____ Participant:
.....

Signature of Participant: Date:
.....

I have explained this project and the implications for participation in it to this volunteer and I believe that the consent is informed and that she understands the implications of participation.

Name _____ of _____ Investigator:
.....

Signature _____ of _____ Investigator:..... Date:
.....

APPENDIX B

Questionnaires for study 1.

ABUSIVE BEHAVIOUR INVENTORY

Here is a list of behaviours that many women report have been used by their partners or former partners. We would like you to estimate how often these behaviours during the worst six months of abuse in the relationship. Your answers are strictly confidential.

CIRCLE a number of each of the items listed below to show your closest estimate of how often it happened in your relationship with your partner or former partner during the worst *six months*.

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

- | | |
|---|-------------------|
| 1. Called you a name and/or criticised you | 1 2 3 4 |
| 5 | |
| 2. Tried to keep you from doing something you wanted to do | 1 2 3 4 |
| 5 | |
| (eg going out with friends, going to meetings) | |
| 3. Gave you angry stares or looks | 1 2 3 4 |
| 5 | |
| 4. Prevented you from having money for your own use | 1 2 3 4 |
| 5 | |
| 5. Ended a discussion with you and made the decision himself | 1 2 3 4 5 |
| 6. Threatened to hit or throw something at you | 1 2 3 4 5 |
| 7. Pushed, grabbed or shoved you | 1 2 3 4 5 |
| 8. Put down your family and friends | 1 2 3 4 5 |
| 9. Accused you of paying too much attention to someone or something else | 1 2 3 4 5 |
| 10. Put you on an allowance | 1 2 3 4 5 |
| 11. Used your children to threaten you (eg. told you that you would lose custody, said he would leave town with the children) | 1 2 3 4 5 |
| 12. Became very upset with you because dinner, housework or laundry was not ready when he wanted it or done the way he thought it should be | 1 2 3 4 5 |
| 13. Said things to scare you (eg. told you something 'bad' would happen, threatened to commit suicide) | 1 2 3 4 5 |
| 14. Slapped, hit or punched you | 1 2 3 4 5 |
| 15. Made you do something humiliating or degrading (eg. begging for forgiveness, having to ask his permission to use the car or do something) | 1 2 3 4 5 |
| 16. Checked up on you (eg. listened to your phone calls, checked the kilometres on your car, called you repeatedly at work) | 1 2 3 4 5 |
| 17. Drove recklessly when you were in the car | 1 2 3 4 5 |
| 18. Pressured you into having sex in a way that you didn't like/want | 1 2 3 4 5 |
| 19. Refused to do housework or childcare | 1 2 3 4 5 |
| 27. Choked or strangled you | 1 2 3 4 5 |
| 28. Used a knife, gun, or other weapon against you | 1 2 3 4 5 |
| 20. Threatened you with a knife, gun, or other weapon | 1 2 3 4 5 |
| 21. Spanked you | 1 2 3 4 5 |
| 22. Told you that you were a bad parent | 1 2 3 4 5 |
| 23. Stopped you or tried to stop you from going to work or school | 1 2 3 4 5 |
| 24. Threw, hit, kicked or smashed something | 1 2 3 4 5 |
| 25. Kicked you | 1 2 3 4 5 |
| 26. Physically attacked the sexual parts of your body | 1 2 3 4 5 |
| 27. Choked or strangled you | 1 2 3 4 5 |
| 28. Used a knife, gun, or other weapon against you | 1 2 3 4 5 |
| 29. Choked or strangled you | 1 2 3 4 5 |
| 30. Used a knife, gun, or other weapon against you | 1 2 3 4 5 |

DEMOGRAPHIC QUESTIONNAIRE

PARTICIPANT CODE:

GROUP: **SA** **PA** **EA**
 SH

DATE OF BIRTH:

In relation to the traumatic event that you have described during interview, was this event an isolated or ongoing occurrence?

Prior to this traumatic experience, had you ever experienced any psychological difficulties? (i.e., anxiety, depression).

Prior to this traumatic experience, had you ever experienced any other forms of traumatic abuse? If yes, please indicate which type (i.e., emotional, sexual, physical, harassment).

APPENDIX C

Visual analogue scales

Participant number.....

VISUAL ANALOGUE SCALES

Script:

Stage:

Please indicate with a mark on each line how you are feeling.

Not anxious | _____ | Anxious

In control | _____ | Out of control

Not angry | _____ | Angry

Not violated | _____ | Violated

Real | _____ | Unreal

Not afraid | _____ | Afraid

How clear was your image of the scene described?

Unclear | _____ | Clear

How close to real life was that scene?

Not close | _____ | Close

APPENDIX D

Examples of Personalised Guided Imagery Scripts of Stressful, Non Stressful and Neutral Events

Example of Stressful – Abusive Script

Setting the Scene

Right. You are standing in your lounge room. You are in the house that you lived in with your ex husband 5 years ago. It is quite a large house with a large back garden. It is white on the outside and has a terracotta tiled path that leads up to the front door. The furniture inside is very modern and it is always neat and tidy. Picture it now. Imagine the different rooms in the house. Picture the kitchen with the white tiles and black bench tops. From the kitchen you can see outside to the landscaped gardens. The kitchen leads through to a dining room with a large table. The lounge room is large but comfortable. There are large cream coloured leather lounge suits. As you look around you remember the feel of your old home. Concentrate on this now. Now open your eyes and switch the scene off.

Approach

Right. You are sitting in the lounge room on the couch. It is about 5 pm in the evening. There is a game show on television and you have been folding washing. Your husband is due home from work at any time now. He has been extremely stressed of late and there have been many arguments. He has been violent towards you in the past and you are hoping that it will not happen again. You feel anxious about this. Concentrate on this now. You hear your husband come home from work. You hear him walk down the hallway and throw his keys on the kitchen bench. You immediately feel anxious as you are expecting him to be in a bad mood. Concentrate on this feeling now. Now open your eye and switch the scene off.

Incident

Right. You are sitting on the lounge still when your husband walks into the room. He makes a comment about the house being in a mess. You immediately feel uneasy. He turns and asks you if you have taken care of the bills today. You stand up to talk to him and report that you have not had a chance to do it yet. He reaches out and slaps you across the face. You are shocked by this. He tells you that you are useless. He states, "You had one lousy thing to take care of and you could not even get it done." You sit back down on the couch in shock. He storms from the room. You start to cry. You feel shocked and hurt. You remember that your cheek is hot and stinging from where he hit you. Concentrate on this now. Now open your eyes and switch the scene off.

Consequence

Right. You are sitting on the lounge crying after what has just happened. Your husband walk back past the lounge and says that he is going back out. He states that he does not know when he will be home. He slams the door. Concentrate on the sound of the door slamming. You feel alone. You start to fold the washing again and try to put it out of your mind. You feel distressed and anxious and wonder what he will be like when he comes home. Concentrate on this now. Now open your eyes and switch the scene off.

Example of Non stressful – Non Abusive Script

Setting the scene

Right. You are standing at home in your bedroom. You are in the house that you shared with your ex husband. It is quite a large house with a large back garden. It is white on the outside and has a terracotta tiled path that leads up to the front door. The furniture inside is very modern and it is always neat and tidy. Picture it now. Imagine the different rooms in the house. Your bedroom is large and has a boxed window. There are cushions on the box seat and heavy curtains. There is a large wooden bed and a sit down dressing table. There is a large painting on the wall and an ensuite to the left. There is soft music coming from the radio in the ensuite. Concentrate on this now. Now open your eyes and switch the scene off.

Approach

Right. You are getting ready for your husbands work dinner. The same dinner occurs every year and it is a fancy affair. You usually enjoy your time with your husband at the dinner. He is a very good dancer and you enjoy dancing too. You are standing in the bedroom trying to decide what to wear. You have several dresses laid out on the bed. Picture them now. You choose a dress and put it on – it is black with sequins on it. You look in the mirror and like the look of the dress. You walk back into the ensuite to finish your make up. As you walk back in you turn up the music. You are feeling happy and carefree. Concentrate on this now.

Incident

Right. You hear your husband come in the front door – he has come to pick you up to go to the dinner. He walks into the bedroom and smiles at you. You turn around once to show him your dress. You giggle as you do it. Concentrate on this now. He walks over to you and kisses you on the cheek. He tells you that you look beautiful in the dress. He asks you if you are ready to go. You both walk out of the bedroom and towards the front door. You pick up your purse from the hall table and you both step outside. It is just starting to get dark outside and a little cold. Concentrate on this now. Now open your eyes and switch the scene off.

Consequence

Right. You are walking towards the car with your husband. He opens the door for you and he is being particularly attentive tonight. This makes you feel good. You get into the car and he shuts the door. Think about the fact that you are looking forward to the dinner and that you are looking forward to spending time with your husband. You are feeling calm and relaxed and content. You and your husband chat on the way to the dinner, talking about his work and your plans for the weekend. Imagine this now. Now open your eyes and switch the scene off.

Example of Emotionally Neutral Script

Setting the Scene

Right. I want you to picture your kitchen. It is white and very large. There are large windows that look out in to the back garden. It has white tiles on the floor and lots of bench space. There is a dining area in the kitchen near the window. There is a dining table and chairs. On the table is a large vase with flowers in it. Concentrate on this now. On one of the walls there is a large print. Look over and see the cook top and a large oven. There is very little on the bench tops, except for a coffee and tea station. Concentrate on this now. Now open your eyes and switch the scene off.

Approach

Right. You are standing in your kitchen and it is mid morning. You have been doing housework this morning and you feel a little tired. You start to think about having a cup of coffee. You look outside and notice that it is a nice sunny day. Concentrate on this now. Think about how nice it would be to make a coffee and then sit in the sunshine and relax. You walk over to the kettle, fill it with water from the sink and then switch on the kettle. You start to hear the sound of the water boiling. Concentrate on this now. Now open your eyes and switch the scene off.

Incident

Right. You are standing in the kitchen and the kettle is boiling. You reach over, open a cupboard and take out your favourite mug. It is pale pink and it has butterflies on it. You place it on the bench and reach for the instant coffee. You

take a spoon from the drawer and spoon some coffee into your mug. Next you walk to the fridge and retrieve the milk. You pour some into the cup and then replace the milk in the fridge. Concentrate on this now. When the kettle is boiled, you pour the water into the mug. As you do you can smell the aroma of the coffee. You stir the coffee and then place the spoon in the sink. You are feeling calm and relaxed and you are looking forward to drinking your coffee. Concentrate on this now. Now open your eyes and switch the scene off.

Consequence

Right. You walk over to the dining table with your cup of coffee. It is nice and sunny and you sit down in the sun. You take a sip of your coffee. It tastes good. You can feel the hot liquid go down your throat as you drink. Think about how much you like the flavour. Concentrate on this now. As you drink, you are looking out into your back garden. Think about how nice it looks at this time of year. You can see the path that goes down to the bbq area and the large walnut tree. You are feeling content and peaceful. Concentrate on this now. Now open your eyes and switch the scene off.

APPENDIX E

**Means and standard deviations for psychophysiological and psychological
peri-trauma data**

Table 25. The mean scores and standard deviations for the psychophysiological data for each stage of each script for the four groups.

Measure	Script	Stage		Group			
				SA	PA	EA	SH
Heart rate	Abuse	Scene	M	87.1	79.1	82.7	80.2
			SD	10.6	7.3	11.8	10.1
		Approach	M	89.2	79.4	85.5	81.6
			SD	10.3	8.0	9.7	10.3
		Incident	M	90.8	80.6	84.8	85.7
			SD	10.6	7.3	11.8	13.3
		Conseq.	M	87.5	78.6	84.4	81.0
			SD	9.7	8.7	9.9	9.7
	Nonabuse	Scene	M	83.0	76.6	82.5	78.2
			SD	11.2	6.5	13.2	10.5
		Approach	M	83.3	76.8	82.5	79.3
			SD	11.0	6.3	13.3	10.8
		Incident	M	84.2	76.7	83.4	80.1
			SD	12.7	8.4	13.0	11.7
		Conseq.	M	83.0	76.0	83.6	79.1
			SD	12.1	7.1	11.7	10.0
	Neutral	Scene	M	80.1	74.9	79.0	76.6
			SD	10.9	9.3	8.8	10.0
		Approach	M	80.4	74.1	80.0	76.5
			SD	11.2	7.2	7.9	10.6
		Incident	M	81.4	74.3	79.2	76.5
			SD	11.0	6.5	9.4	11.7
		Conseq.	M	81.6	74.9	79.6	77.9
			SD	10.9	6.0	8.2	10.9
Respiration	Abuse	Scene	M	15.9	16.8	17.7	14.9
			SD	2.9	2.3	3.3	4.1
		Approach	M	16.3	16.8	18.6	17.2
			SD	3.3	3.0	3.6	5.4
		Incident	M	16.5	17.1	18.4	17.3
			SD	5.7	3.6	3.5	4.5
		Conseq.	M	17.0	17.8	16.1	16.6
			SD	4.8	5.1	4.1	3.0
	Nonabuse	Scene	M	14.0	14.6	15.9	14.2
			SD	3.3	2.1	3.3	3.6
		Approach	M	14.5	15.1	16.2	14.7
			SD	3.0	2.9	3.7	4.4
		Incident	M	14.7	16.0	16.8	16.5
			SD	3.3	3.0	3.6	4.6

Anxiety	Neutral	Conseq.	M	15.0	15.7	16.3	15.2
			SD	3.5	3.3	4.0	4.5
		Scene	M	13.6	15.1	16.0	14.9
			SD	3.8	3.4	3.3	4.5
		Approach	M	14.0	14.7	15.7	15.0
			SD	3.2	3.0	3.3	4.3
		Incident	M	14.7	15.0	16.2	14.6
			SD	3.6	3.6	3.0	4.6
		Conseq.	M	14.5	15.2	15.7	14.2
			SD	3.1	3.0	3.3	4.4
	Abuse	Scene	M	30.7	21.2	42.3	15.7
			SD	30.6	20.2	30.3	16.8
		Approach	M	45.5	48.0	50.6	34.7
			SD	32.4	31.9	28.5	27.9
		Incident	M	80.5	70.4	76.7	60.5
			SD	27.7	23.1	27.1	29.5
		Conseq.	M	93.2	82.0	79.7	51.7
			SD	9.4	19.5	17.8	38.7
	Nonabuse	Scene	M	40.7	13.3	12.8	23.7
			SD	28.9	18.5	13.6	31.9
		Approach	M	40.7	23.2	23.3	28.3
			SD	31.4	23.4	24.5	36.6
		Incident	M	44.0	33.9	33.0	32.6
			SD	32.0	18.5	31.8	34.5
Control	Neutral	Conseq.	M	43.7	22.7	29.7	18.7
			SD	30.9	17.1	35.7	27.1
		Scene	M	14.8	6.1	6.1	6.7
			SD	24.9	11.4	8.5	15.4
		Approach	M	1.8	3.9	3.9	6.1
			SD	2.8	3.8	3.8	8.8
		Incident	M	8.3	3.2	7.6	3.7
			SD	20.6	2.7	10.2	6.0
		Conseq.	M	13.0	5.2	10.2	4.0
			SD	24.6	7.0	20.6	8.6
	Abuse	Scene	M	22.2	18.0	33.0	12.7
			SD	26.6	21.7	26.0	15.3
		Approach	M	25.8	40.7	47.3	20.8
			SD	31.3	34.9	28.8	15.7
		Incident	M	73.9	65.2	77.6	44.9
			SD	33.8	29.8	21.4	28.3
		Conseq.	M	83.5	78.2	67.9	40.0
			SD	24.7	26.2	27.4	31.6
	Nonabuse	Scene	M	21.7	13.7	19.6	10.1
			SD	30.9	19.5	24.2	16.5

			Approach	M	19.5	19.2	21.0	10.6
				SD	21.7	24.0	23.4	17.6
			Incident	M	21.7	20.6	22.7	10.1
				SD	29.4	22.8	23.5	12.1
		Conseq.		M	20.8	19.3	20.9	6.7
				SD	28.0	23.5	24.2	10.1
	Neutral	Scene		M	7.9	3.3	5.2	4.4
				SD	15.2	1.9	6.5	8.4
		Approach		M	1.6	3.7	3.7	4.0
				SD	2.0	3.0	4.1	5.9
		Incident		M	7.8	3.0	4.7	2.7
				SD	19.7	2.1	5.9	2.9
		Conseq.		M	4.4	4.2	2.9	2.1
				SD	10.1	4.7	4.0	3.6
Anger	Abuse	Scene		M	19.0	12.4	23.0	9.8
				SD	30.2	16.4	22.1	14.1
		Approach		M	25.2	33.7	37.6	19.7
				SD	31.6	27.3	27.6	21.0
		Incident		M	52.5	45.3	59.8	53.3
				SD	40.8	30.7	37.9	36.9
		Conseq.		M	84.4	55.2	63.2	55.7
				SD	24.0	29.7	36.0	39.0
	Nonabuse	Scene		M	32.7	13.3	12.2	12.3
				SD	35.1	18.6	18.8	25.8
		Approach		M	35.0	14.8	19.0	20.8
				SD	30.0	22.1	26.6	35.0
		Incident		M	45.7	18.9	21.9	23.8
				SD	34.1	20.2	31.8	37.7
		Conseq.		M	41.8	20.3	15.7	15.7
				SD	35.3	21.8	25.4	29.2
	Neutral	Scene		M	4.6	2.9	3.2	5.0
				SD	6.4	1.9	2.2	7.9
		Approach		M	2.1	2.8	3.1	5.7
				SD	3.2	1.8	3.5	7.6
		Incident		M	2.0	3.0	2.4	2.5
				SD	2.6	2.3	3.3	3.0
		Conseq.		M	2.9	2.8	2.0	1.8
				SD	4.8	2.0	1.3	2.9
Violation	Abuse	Scene		M	15.5	18.9	30.2	14.3
				SD	26.8	24.0	27.9	20.0
		Approach		M	25.4	30.3	37.4	24.2
				SD	34.7	31.1	29.3	28.6
		Incident		M	85.3	48.7	65.0	65.6
				SD	28.3	40.1	36.9	31.1
		Conseq.		M	96.4	71.7	70.7	62.7

			SD	7.9	32.4	34.2	32.4
	Nonabuse	Scene	M	26.3	9.6	11.6	9.6
			SD	32.5	20.7	18.2	16.3
		Approach	M	26.2	11.9	15.1	18.1
			SD	31.8	22.6	23.8	32.6
		Incident	M	34.3	12.2	14.2	20.0
			SD	39.6	18.3	23.3	30.5
		Conseq.	M	31.8	11.4	12.3	15.2
			SD	39.2	15.0	20.7	28.6
	Neutral	Scene	M	2.2	2.7	2.3	3.9
			SD	2.3	1.7	2.5	6.3
		Approach	M	2.2	3.2	2.8	4.5
			SD	3.3	2.2	4.0	7.0
		Incident	M	1.9	3.0	7.6	2.4
			SD	2.4	1.6	16.9	2.7
		Conseq.	M	2.1	2.9	3.4	1.9
			SD	3.3	1.8	4.5	2.5
Unreality	Abuse	Scene	M	39.2	16.6	28.4	13.7
			SD	40.9	23.3	29.5	21.0
		Approach	M	35.3	21.2	24.2	14.1
			SD	37.9	25.8	29.1	13.3
		Incident	M	74.4	40.7	35.2	27.2
			SD	36.7	40.9	37.4	24.9
		Conseq.	M	91.7	50.9	23.7	20.8
			SD	16.5	42.5	30.1	25.5
	Nonabuse	Scene	M	29.9	10.9	11.2	6.3
			SD	36.9	21.6	21.6	10.8
		Approach	M	17.2	16.6	14.5	5.8
			SD	28.4	24.0	23.8	9.6
		Incident	M	20.2	15.2	12.4	5.7
			SD	32.3	22.3	18.5	7.1
		Conseq.	M	22.8	13.4	14.8	5.4
			SD	33.0	20.8	20.1	9.5
	Neutral	Scene	M	7.4	3.2	3.1	3.0
			SD	19.5	1.6	3.8	5.1
		Approach	M	2.7	6.9	2.8	4.2
			SD	4.3	12.2	4.0	6.5
		Incident	M	2.0	5.2	9.0	1.9
			SD	2.6	8.0	21.0	2.4
		Conseq.	M	1.9	4.9	4.7	2.2
			SD	2.3	7.7	7.1	2.9
Fear	Abuse	Scene	M	32.7	24.6	36.9	15.3
			SD	32.5	29.5	30.7	19.4
		Approach	M	43.5	44.6	52.2	26.1

Clarity	Abuse	Incident	SD	32.8	33.4	31.7	27.8
			M	88.0	68.3	67.0	42.1
		Conseq.	SD	25.5	26.3	30.3	37.9
			M	93.3	75.7	57.4	33.2
			SD	10.7	23.8	32.2	35.0
		Scene	M	35.1	13.9	15.8	12.8
			SD	29.2	25.3	23.4	23.2
		Approach	M	38.5	8.5	13.9	16.1
			SD	36.0	8.1	16.8	27.5
		Incident	M	38.2	15.5	21.7	19.6
			SD	39.7	19.8	27.8	31.4
	Nonabuse	Conseq.	M	40.6	17.7	22.2	12.6
			SD	35.6	20.2	31.0	25.5
		Scene	M	2.2	2.9	2.6	1.5
			SD	2.4	1.9	2.7	2.9
		Approach	M	2.6	3.1	3.9	2.6
			SD	4.3	2.0	5.0	3.5
		Incident	M	2.0	2.7	7.7	1.7
			SD	2.4	1.3	18.3	2.5
		Conseq.	M	1.9	4.1	9.4	1.8
			SD	2.3	4.9	21.5	2.9
Clarity	Abuse	Scene	M	84.5	85.5	77.3	94.0
			SD	27.6	14.2	26.5	8.2
		Approach	M	93.1	88.0	80.8	92.2
			SD	6.2	15.0	17.9	8.4
		Incident	M	96.4	85.4	85.8	91.7
			SD	4.3	21.0	15.6	9.1
		Conseq.	M	96.1	85.4	85.6	94.7
			SD	5.8	22.8	24.6	5.4
		Scene	M	86.2	90.6	84.9	93.8
			SD	21.1	11.1	17.9	6.1
		Approach	M	88.2	89.9	85.9	95.0
			SD	18.5	11.4	18.9	5.1
	Nonabuse	Incident	M	94.7	89.5	88.5	93.8
			SD	6.1	12.0	13.1	5.0
		Conseq.	M	94.4	90.2	83.5	94.9
			SD	6.1	10.3	19.0	4.7
		Scene	M	95.9	97.0	95.9	96.2
			SD	5.1	2.3	7.2	3.9
		Approach	M	97.2	94.4	95.3	96.2
			SD	4.0	10.7	8.4	4.1
		Incident	M	97.0	92.5	96.0	96.0
			SD	4.0	17.0	9.0	5.1
		Conseq.	M	97.5	94.2	94.9	96.0
			SD	3.1	13.3	9.7	4.4

Closeness	Abuse	Scene	M	91.8	87.7	71.6	90.8
			SD	10.1	13.3	33.2	10.0
		Approach	M	94.1	89.1	86.4	90.0
			SD	8.3	13.8	12.1	9.9
		Incident	M	94.4	88.3	81.2	87.9
			SD	11.2	14.2	19.6	13.6
		Conseq.	M	94.2	89.3	87.7	89.7
			SD	11.1	11.8	13.6	13.0
	Nonabuse	Scene	M	93.7	90.4	85.8	91.7
			SD	7.8	14.6	16.0	9.2
		Approach	M	95.3	82.7	84.1	92.9
			SD	4.6	24.7	20.0	7.6
		Incident	M	95.3	89.5	89.1	93.3
			SD	5.3	12.0	13.2	6.7
		Conseq.	M	94.7	87.2	89.7	92.3
			SD	5.6	15.1	9.5	7.4
	Neutral	Scene	M	95.6	95.8	96.7	95.7
			SD	5.7	5.5	3.3	5.6
		Approach	M	97.2	94.7	95.7	94.7
			SD	4.3	10.1	5.9	7.1
		Incident	M	95.7	94.2	96.1	94.8
			SD	6.3	10.9	7.0	6.4
		Conseq.	M	96.4	95.1	95.4	94.7
			SD	5.2	10.5	7.6	6.2

APPENDIX F

The mean heart rate and standard deviations for the script by stage interaction

Table 26. The mean heart rate and standard deviations for the script by stage interaction.

Script	Stage							
	Scene		Approach		Incident		Consequence	
	M	SD	M	SD	M	SD	M	SD
Abuse	82.2	10.2	83.9	10.0	85.4	11.2	82.8	9.8
Nonabuse	80.0	10.6	80.4	10.6	81.0	11.6	80.3	10.5
Neutral	77.6	9.7	77.7	9.4	77.8	9.9	78.4	9.2

APPENDIX G

The mean respiration rate and standard deviations for each script.

Table 27. The mean respiration rate and standard deviations for each script.

Abuse		Script Nonabuse		Neutral	
X	SD	X	SD	X	SD
16.9	4.0	15.4	3.5	14.9	3.5

APPENDIX H

The mean ratings and standard deviations for the script by stage interactions for anxiety, control and anger.

Table 28. Mean ratings of anxiety, control and anger and standard deviations for each stage of each script.

Scale	Script	Stage							
		Scene		Approach		Incident		Conseq.	
		M	SD	M	SD	M	SD	M	SD
Anxiety	Abuse	27.5	26.5	44.7	29.9	72.0	27.2	76.7	27.8
	Nonabuse	22.7	26.2	28.9	29.4	35.9	29.3	28.7	29.2
	Neutral	8.4	16.2	3.9	5.4	5.7	11.8	8.1	16.8
Control	Abuse	21.4	23.3	33.7	29.7	65.4	30.5	67.4	31.6
	Nonabuse	16.3	23.1	17.6	21.5	18.7	22.6	16.9	22.6
	Neutral	5.2	9.2	3.2	4.0	4.5	10.3	3.4	6.1
Anger	Abuse	16.1	21.5	29.0	27.2	52.7	35.9	64.6	33.8
	Nonabuse	17.7	26.2	22.4	28.9	27.6	32.4	23.4	29.5
	Neutral	3.9	5.2	3.4	4.6	2.5	2.8	2.4	3.0

APPENDIX I
Questionnaires for Study 3

IMPACT OF EVENT SCALE (REVISED)

Instructions: Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how distressing each difficulty was for you *the first seven (7) days after* the traumatic event and how much you were distressed or bothered by these difficulties.

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real	0	1	2	3	4
8. I stayed away from reminders of it	0	1	2	3	4
9. Pictures about it popped into my mind	0	1	2	3	4
10. I was jumpy and easily startled	0	1	2	3	4
11. I tried not to think about it	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time	0	1	2	3	4
15. I had trouble falling asleep	0	1	2	3	4
16. I had waves of strong feelings about it	0	1	2	3	4
17. I tried to remove it from my memory	0	1	2	3	4
18. I had trouble concentrating	0	1	2	3	4
19. Reminders of it made me have physical reactions such as sweating, trouble breathing, nausea, or a pounding heart	0	1	2	3	4
20. I had dreams about it	0	1	2	3	4
21. I felt watchful and on-guard	0	1	2	3	4
22. I tried not to talk about it	0	1	2	3	4

COPING STRATEGIES INVENTORY

The purpose of this inventory is to look at how people deal with experiencing a stressful work event. Take a few minutes to think about your chosen stressful work event. Consider each item, and **circle** the extent to which you used it handling your chosen event.

Please rate the extent to which you used each strategy using the scale below:

1 = Not at all
2 = A little
3 = Somewhat
4 = Much
5 = Very much

- | | | | | |
|---|---|---|---|---|
| 1. I just concentrated on what I had to do next;
5
the next step. | 1 | 2 | 3 | 4 |
| 2. I tried to get a new angle on the situation.
5 | 1 | 2 | 3 | 4 |
| 3. I found ways to blow off steam
5 | 1 | 2 | 3 | 4 |
| 4. I accepted sympathy and understanding from
5
someone. | 1 | 2 | 3 | 4 |
| 5. I slept more than usual
5 | 1 | 2 | 3 | 4 |
| 6. I hoped the problem would take care of itself.
5 | 1 | 2 | 3 | 4 |
| 7. I told myself that if I wasn't so careless things
5
like this wouldn't happen. | 1 | 2 | 3 | 4 |
| 8. I tried to keep my feelings to myself.
5 | 1 | 2 | 3 | 4 |
| 9. I changed something so it would turn out all
5
right. | 1 | 2 | 3 | 4 |
| 10. I looked for the silver lining, so to speak; tried
5
to look on the bright side of things | 1 | 2 | 3 | 4 |
| 11. I did think of some things to get it out of my
5
system. | 1 | 2 | 3 | 4 |
| 12. I found somebody who was a good listener
5 | 1 | 2 | 3 | 4 |
| 13. I went along as if nothing were happening
5 | 1 | 2 | 3 | 4 |

14. I hoped a miracle would happen 5	1	2	3	4
15. I realised that I brought the problem on myself 5	1	2	3	4
16. I spent more time alone 5	1	2	3	4
17. I stood my ground and fought for what I needed 5	1	2	3	4
18. I told myself things that helped me feel better 5	1	2	3	4
19. I let my emotions go 5	1	2	3	4
20. I talked to someone about how I was feeling 5	1	2	3	4
21. I tried to forget the whole thing 5	1	2	3	4
22. I wished that I had never let myself get involved 5 with the situation.	1	2	3	4
23. I blamed myself 5	1	2	3	4
24. I avoided my family and friends 5	1	2	3	4
25. I made a plan of action and followed it 5	1	2	3	4
26. I looked at things in a different light and 5 tried to make the best of what was available	1	2	3	4
27. I let out my feelings to reduce the stress 5	1	2	3	4
28. I just spent more time with people I liked 5	1	2	3	4
29. I didn't let it get to me; I refused to think 5 about it too much	1	2	3	4
30. I wished that the situation would somehow 5 go away	1	2	3	4
31. I criticised myself for what had happened 5	1	2	3	4
32. I avoided being with people 5	1	2	3	4
33. I tackled the problem head on 5	1	2	3	4
34. I asked myself what was really important, 5 and discovered that things weren't so bad after all	1	2	3	4
35. I let my feelings out somehow 5	1	2	3	4

36. I decided that it was really someone else's 5 problem and not mine.	1	2	3	4
38. I wished that the situation had never started 5	1	2	3	4
39. Since what happened was my fault, I really 5 chewed myself out	1	2	3	4
40. I didn't talk to other people about the problem 5	1	2	3	4
41. I knew what had to be done, so I doubled 5 my efforts and tried harder to make things work	1	2	3	4
42. I convinced myself that things aren't quite as 5 bad as they seem	1	2	3	4
43. I let my emotions out 5	1	2	3	4
44. I let my friends help out 5	1	2	3	4
45. I avoided the person who was causing the 5 trouble	1	2	3	4
46. I had fantasies or wished about how things 5 might have turned out	1	2	3	4
47. I realised that I was personally responsible 5 for my difficulties and really lectured myself	1	2	3	4
48. I spent some time by myself 5	1	2	3	4
49. It was a tricky problem, so I had to work 5 around the edges to make things come out OK	1	2	3	4
50. I stepped back from the situation and put 5 things into perspective	1	2	3	4
51. My feelings were overwhelming and they 5 just exploded	1	2	3	4
52. I asked a friend or relative I respect for advice 5	1	2	3	4
53. I made light of the situation and refused to get 5 too serious about it	1	2	3	4
54. I hoped that if I waited long enough things 5 would turn out OK	1	2	3	4

55. I kicked myself for letting this happen 5	1	2	3	4
56. I kept my thoughts and feelings to myself 5	1	2	3	4
57. I worked on solving the problems in the 5 situation	1	2	3	4
58. I re-organised the way I looked at the 5 situation so things didn't look so bad	1	2	3	4
59. I got in touch with my feelings and just let 5 them go	1	2	3	4
60. I spent some time with my friends 5	1	2	3	4
61. Every time I thought about it I got upset; 5 so I just stopped thinking about it	1	2	3	4
62. I wished I could have changed what happened 5	1	2	3	4
63. It was my mistake and I needed to suffer the 5 consequences	1	2	3	4
64. I didn't let my family and friends know what 5 was going on	1	2	3	4
65. I struggled to resolve the problem 5	1	2	3	4
66. I went over the problem again and again in 5 my mind and finally saw things in a different light	1	2	3	4
67. I was angry and really blew up 5	1	2	3	4
68. I talked to someone who was in a similar 5 situation	1	2	3	4
69. I avoided thinking or doing anything about 5 the situation	1	2	3	4
70. I thought about fantastic or unreal things 5 that made me feel better	1	2	3	4
71. I told myself how stupid I was 5	1	2	3	4
72. I did not let others know how I was feeling 5	1	2	3	4