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Rita Começanha **Findings from the unexplored field of psychological intimate partner violence**

Universidade do Minho
Escola de Psicologia

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Findings from the unexplored field of psychological intimate partner violence

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Findings from the unexplored field of psychological intimate partner violence

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DECLARATION

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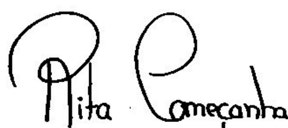

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The spark from others

"At times our own light goes out and is rekindled by a spark from another person.
Each of us has to think with deep gratitude of those who have lighted the flame within us."
Albert Schweitzer

A note of gratitude goes to those who have lighted up my work.

FINDINGS FROM THE UNEXPLORED FIELD OF
PSYCHOLOGICAL INTIMATE PARTNER VIOLENCE

Abstract

Literature has consistently documented the relevance of intimate psychological violence (IPV), including its association with mental health problems. However, there is a scarcity of studies with young adults – where the rates of psychological IPV are higher and often symmetrical, revealing a victim-perpetrator overlap – as well as a lack of data concerning the impact of psychological IPV among men, and the development of effective interventions in this domain. Therefore, this work intends to account to the emerging challenges in Applied Victimology related to psychological IPV. Specifically, the goals are to describe the current state of the empirical research on psychological IPV, to explore the experiences of psychological IPV in young adults, and to suggest an intervention protocol tailored to their needs. For the substantiation of these goals, we present a set of five interconnected studies developed over the last three years. First, a systematic review of literature was conducted in order to explore the current state of the art in the field of psychological IPV, including interventions in this context (Chapter I). The results revealed discrepancies between studies in the estimates of prevalence, a lack of specific measures for psychological IPV, and an alarming lack of interventions in psychologically abused victims, as well as a complete absence of interventions for male victims. Despite a strong support for the effectiveness of interventions in psychological IPV was missing, individual therapy showed considerably larger effect sizes, than group therapy or advocacy interventions. Chapter II comprises the validation of a screening tool to identify psychological IPV in Portugal. The study meant to respond to the lack of agreement on standard measures of psychological IPV and the threshold at which acts can be considered harmful. The goal was to maximize the identification of cases of psychological IPV, during the last six months, and over the lifespan. Five hundred and six participants filled out the e-survey, including the assessment of IPV and psychopathology. Sociodemographic characteristics, construct validity, and internal consistency were analyzed. In addition to the original version, a cut-off point was proposed to discriminate severe IPV levels and a confirmatory factor analysis was added, which provided a more robust statistical picture to the data. Findings confirmed the factor structure of the instrument in a Portuguese sample and its psychometric properties, preparing the ground for the empirical work reflected in Chapter III. In order to promote a deeper understanding of psychological IPV victimization and to make clear the dynamics that can led to differential mental health outcomes, a mixed methodology design was

adopted, involving a quantitative study, in the first phase (Chapter III), followed by a qualitative study (Chapter IV). Thus, Chapter III explores the prevalence and independent impact of psychological IPV on mental health on a sample of young adults of both genders, through a cross-sectional study design, using the screening tool proposed in the previous chapter. The initial sample comprises 661 college students from a Portuguese public university, who completed an e-survey. Statistical analysis focused on a subsample (n = 364), 23% of which were men, after removing cases of physical and/or sexual violence. Findings showed an overwhelming prevalence in rates of psychological IPV victimization (74.65% for men, and 71.89% for women) and its detrimental effects on mental health, specifically post-traumatic stress symptoms, depression, and anxiety, regardless of gender. Symmetry and bidirectionality in psychological IPV victimization was confirmed, in which both genders engaged in psychologically abusive acts. Women report more instigation of psychological IPV and men corroborate these data, which reveals that women are more likely to initiate IPV, according to self-reports. Complementarily, Chapter IV explores the process of leaving a psychologically abusive relationship in 20 college women, as well as the effects in the aftermath of psychological IPV on those who developed post-traumatic stress disorder and those who did not. An inductive content analysis, using Nvivo10, revealed non-sequential stages of leaving a psychologically abusive relationship in a 'slow motion' process, encompassing the categories of Enchantment, Awareness, Ambivalence, Detachment, Restarting, and Healing vs. Psychopathology. Chapter V suggests a gender-neutral intervention protocol, informed by the findings of the preceding chapters. The "Intervention Model for Psychological Abuse & Cope with Trauma" (IMPACT) was specifically tailored for psychological IPV and derives from the third wave of Cognitive Behavioral Therapy, based on using mindfulness techniques to recover from traumatic experiences, by fully living in the present. We expect that this model add the foundations to test the effectiveness of interventions in psychological IPV, given the lack of specific protocols for coping with this issue. The integrative discussion addresses the holistic contributions offered by the chapters, specifically the key findings, practical implications, strengths and limitations, future directions, and final remarks. Additionally, idiosyncrasies and points of contact between studies are discussed, reflecting on the extent to which they complement and inform each other.

RESULTADOS DO CAMPO INEXPLORADO DA
VIOLÊNCIA PSICOLÓGICA NA INTIMIDADE

Resumo

A literatura tem documentado, de forma cada vez mais consistente, a relevância da violência psicológica na intimidade (VPI), incluindo a sua associação a problemas de saúde mental. No entanto, verifica-se uma escassez de estudos com jovens adultos – onde as taxas de VPI são mais elevadas e muitas vezes simétricas, revelando uma sobreposição dos papéis vítima-perpetrador – assim como uma parca informação acerca do impacto da VPI nos homens e a testagem de intervenções eficazes neste domínio. Este trabalho visa responder aos desafios emergentes no âmbito da Vitimologia Aplicada relacionados com a VPI. Especificamente, os objetivos consistem em descrever o estado atual da investigação empírica sobre VPI, explorar as experiências de VPI em jovens adultos e sugerir um protocolo de intervenção adaptado às suas necessidades. Para a consubstanciação destes objetivos, apresentamos um conjunto de cinco estudos interligados desenvolvidos ao longo dos últimos três anos. Em primeiro lugar, foi realizada uma revisão sistemática da literatura para explorar o estado da arte no campo da VPI, incluindo as intervenções nesse contexto (Capítulo I). Os resultados revelaram discrepâncias entre estudos nas estimativas de prevalência, uma escassez de medidas específicas para a VPI e uma alarmante ausência de intervenções em vítimas psicologicamente abusadas, bem como uma completa ausência de intervenções para as vítimas masculinas. Apesar de um suporte robusto quanto à eficácia das intervenções na VPI estar em falta, a terapia individual revelou tamanhos de efeito consideravelmente superiores, relativamente à terapia de grupo, ou às intervenções de aconselhamento. O Capítulo II compreende a validação de um instrumento de triagem para identificar a VPI em Portugal. O estudo visou responder à falta de acordo sobre medidas padrão para avaliar a VPI e o limiar a partir do qual os atos podem ser considerados prejudiciais. Com esta ferramenta, pretendeu-se maximizar a identificação de casos de VPI, nos últimos seis meses, e ao longo da vida. Quinhentos e seis participantes preencheram o questionário eletrónico, incluindo a avaliação da VPI e psicopatologia. Foram analisadas características sociodemográficas, a validade de construto e a consistência interna. Para além da versão original, propôs-se um ponto de corte para discriminar níveis severos de VPI e adicionou-se a análise fatorial confirmatória, que forneceu um quadro estatístico mais robusto aos dados. Os resultados confirmaram a estrutura fatorial do instrumento numa amostra Portuguesa e as suas propriedades psicométricas, preparando o terreno para o trabalho empírico refletido no

Capítulo III. Para promover uma compreensão mais profunda da vitimação por VPI e esclarecer as dinâmicas conducentes a resultados diferenciais na saúde mental foi adotado um *design* metodológico misto, envolvendo um estudo quantitativo, numa primeira fase (Capítulo III), seguido de uma abordagem qualitativa (Capítulo IV). Assim, o Capítulo III explora a prevalência e o impacto independente da VPI sobre a saúde mental numa amostra de jovens de ambos os géneros, através de um estudo transversal, utilizando a ferramenta de triagem proposta no capítulo anterior. A amostra inicial compreendeu 661 estudantes universitários de uma universidade pública Portuguesa, que preencheram um questionário eletrónico. A análise estatística concentrou-se numa subamostra (n = 364), com 23% de homens, após remover os casos de violência física e/ou sexual. Os resultados mostraram uma prevalência esmagadora nas taxas de vitimação por VPI (74.65% para homens e 71.89% para mulheres) e os seus efeitos adversos na saúde mental, especificamente sintomas de stresse pós-traumático, depressão e ansiedade, independentemente do género. A simetria e a bidireccionalidade na vitimação por VPI foi confirmada, mostrando que ambos os géneros se envolveram em atos psicologicamente abusivos. As mulheres relataram mais instigação de VPI e os homens corroboraram estes dados, o que revela que as mulheres são mais propensas a iniciar VPI, de acordo com os autorrelatos. De forma complementar, o Capítulo IV explora o processo de deixar uma relação psicologicamente abusiva em 20 mulheres universitárias, bem como as consequências pós-relação nas participantes que desenvolveram e não desenvolveram perturbação de stresse pós-traumático. Uma análise de conteúdo indutiva, utilizando o Nvivo10, revelou estádios não-sequenciais para deixar um relacionamento psicologicamente abusivo num processo de 'câmara lenta', abrangendo as categorias de Encantamento, Consciência, Ambivalência, Desapego, Recomeço e Cura vs. Psicopatologia. O Capítulo V sugere um protocolo de intervenção neutro em termos de género, informado pelas conclusões dos capítulos anteriores. O "Modelo de Intervenção para Abuso Psicológico e Trauma" foi especificamente formulado para a VPI e deriva da terceira geração da Terapia Cognitivo-Comportamental, baseada em técnicas de atenção plena para a recuperação de experiências traumáticas, vivendo plenamente no presente. Esperamos que este modelo adicione os fundamentos para testar a eficácia das intervenções na VPI, dada a carência de protocolos específicos para lidar com esta problemática. A discussão integrativa aborda os contributos holísticos dos capítulos, especificamente os resultados-chave, implicações práticas, pontos fortes e limitações, orientações futuras e considerações finais. Adicionalmente, discutem-se as idiossincrasias e pontos de contato entre os estudos, refletindo em que medida se complementam e informam mutuamente.

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PUBLICATIONS LIST OF THE DISSERTATION

CHAPTER I

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CHAPTER III

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CHAPTER IV

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CHAPTER V

Começanha, R., & Maia, Â. (in press). *Specific approaches for psychological IPV: protocol for a randomized non-inferiority trial*. Oxford, England: Inter-Disciplinary Press.

INTRODUCTION

John Lennon, lyrics for *Jealous Guy*

"I was dreaming of the past,
And my heart was beating fast,
I began to lose control,
I began to lose control,
Refrain:
I didn't mean to hurt you,
I'm sorry that I made you cry,
I didn't want to hurt you,
I'm just a jealous guy.

I was feeling insecure,
You might not love me anymore,
I was shivering inside,
I was shivering inside,
(Refrain twice)

I was tryin' to catch your eye,
Thought that you was tryin' to hide,
I was swallowing my pain,
I was swallowing my pain,
(Refrain)

I'm just a jealous guy,
I'm just a jealous guy,
I'm just a jealous guy."

"Most young people do not recognize jealousy and control as aggressive behaviors. They think they are expressions of love and affection (...). Acts such as checking the partner's calls, text messages, and Facebook are often reported as common behaviors (...) From these acts, until the prohibition of going out with friends and offend intentionally, in order to hurt and humiliate, is a small step."[1]

[1] In Diário de Notícias newspaper, 22/11/2013

Historical Overview of Victimology

The study of Intimate Partner Violence (IPV) has its roots in the field of Victimology, a new branch of Criminology, which shifted the position from ignoring violence against men and women by their intimate partners to publicly condemning it (Dragiewicz, 2016). This sub-discipline, with a short history, explores the needs of victims, the impact of victimization, and the provision of victim services (Wolhuter, Olley, & Denham, 2009).

Theories of victimology were initially focused on the lifestyle factors related to the victim. Von Hentig and Mendelsohn were the first authors of positivist victimology, in the 1940s and 1950s, respectively, reflecting on the propensities of some people to put themselves at greater risk of victimization, as well as their influence in the precipitation of crime (Spalek, 2006).

After the Second World War (1939–1945), an emphasis on the victim's needs was observed, and Governments enacted legislation to compensate the victims of criminal offenses. New Zealand was the first to approve legislation for victims' compensation, in 1963. In Europe, this achievement was attributable to the pioneering work of Margery Fry, a social reformer of the 1950s, who contributed to the implementation of the Criminal Injuries Compensation Scheme, in 1964, in the United Kingdom (Dignan, 2005). This legal framework enabled the creation of the Victims Support Scheme, in the 1970s, and laid the foundations for national organizations with public funds, which provided assistance and advocacy to victims of crime.

Feminist victimology also emerged in the 1970s, bringing the problem of violence against women into the public sphere. This approach reinforced the inadequacy of positivist victimology, especially in cases of rape and domestic violence (Spalek, 2006; Wolhuter et al., 2009), disproving the perspective of "victim blaming" or the argument that victims may contribute to their own victimization. Feminist scholars highlight the active role of women in the defense of their rights, instead of being mere passive receivers of offenses (Wolhuter et al., 2009).

At that time, Europe and America established crime victimization surveys as a major source of information about patterns of crime and a way of collecting crime statistics. These surveys uncovered the burden of crime, the experiences of victims, and the impact of offenses on their life, contributing to the growing level of concern about victims' needs. In this context, important policies and practices were established to empower victims, and the Council of Europe legislated the Compensation Convention for Victims of Crime for their Member States, in 1983 (Wolhuter et al., 2009). In the same decade, radical victimologists shifted their attention from the individual traits of

victims to the broader foundations of victimization and its political, economic, and social correlates (e.g., how people confront the structural conflicts of power and control).

However, it was only in the last two decades that research shifted to a more inclusive approach to victimization, through the voice of critical victimology (Mawby & Walklate, 1994), emphasizing the sense of human agency and the recognition of victims' rights to treatment and assistance. From this point on, there was a decentralization from Theoretical Victimology, which focused on the causes of victimization, to Applied Victimology, which focused on the responses and rights of the victims. Examples of this approach embrace how victims should be treated and the assistance they could expect to receive, the provision of support for victims at court to reduce secondary victimization and encourage testimony, and the possibility of the victim's statement describing the impact of crime upon them (Walklate, 2007). More recently, the Directive 2012/29/EU strengthened victims' rights in the European Union by establishing the minimum standards of protection, including the access to support services.

An emergent field of victimology postulates the study of the "sociology of harm", instead of focusing on crime (Hillyard, Pantazis, Tombs, & Gordon, 2004). This perspective has been considered a contemporary variant of critical criminology and goes beyond the traditional boundaries of crime to consider offenses that may be ignored by the juridical system, including psychological IPV, since it provokes consequences which are harmful to its victims. From this perspective, crime is a social construction and depends on what is considered harmful to a society at a given moment, instead of there being a static definition of crime (Wolhuter et al., 2009).

The current state of art poses great challenges to Applied Victimology, particularly in terms of fostering its body of knowledge, both conceptually and methodologically. To succeed in its mission, this dissertation is grounded in a constructivist paradigm (Ponterotto, 2005), which aims to present a solid theoretical basis to inform stakeholders, to bring research, practice and policies to work closely together, to promote useful material for professionals, to raise public awareness, and to stimulate changes at the political level. The main contributions include: 1) the validation of a comprehensive screening tool, theoretically supported by a clear definition, for detecting the subtle form of psychological IPV; 2) the study of victimization in the period that precedes formal commitment, since young people typically experience higher rates of victimization than adults, but are under-researched; 3) the consideration of psychological IPV perpetrated against men; 4) the inclusion of qualitative research that shed light on the processes of leaving psychological IPV; and 5) the development of a gender-neutral intervention protocol for further testing of effectiveness.

Theoretical Frameworks

"Research developed in six European countries, led by the Institute of Public Health of the University of Porto concluded: both genders are aggressors and victims in equal parts."[2]

Intimate partner violence "encompasses physical, psychological, and sexual abuse by men and by women toward romantic partners of the same or opposite sex" (Capaldi, Knoble, Shortt, & Kim, 2012, p. 232). According to Hines, Douglas, and Straus (2016), the study of IPV is essentially divided into two opposite standpoints: the patriarchal perspective and the family conflict perspective. The first dominates current policies and is anchored in the unilateral, gender-biased framework of power and control of men over women. The patriarchal conceptualization of IPV is grounded in theory related to structural inequalities across genders. IPV perpetration is seen as an exclusively male phenomenon and defends gender as the focus of analysis for understanding IPV. In this view, men use violence to maintain their dominance over women, in the family and society (Barner & Carney, 2011). Contrarily, the second conceptualize IPV as an interactional pattern, considering multiple risk factors to explain violence within the couple, including the individual characteristics and behaviors of each partner, the dynamics within the dyad, and contextual processes (Capaldi et al., 2012). This view considers the bidirectional nature of abuse in intimate relationships (Vall, Seikkula, Laitila, & Holma, 2016), in which both elements of the dyad act in ways that intensify dysfunctional patterns and promote IPV as a way of coping with conflicts, instead of assertive communication. Based on a "circular feedback loop" (Barros-Gomes et al., 2016, p. 3), the negative interpretation of a partner's behavior leads individuals to respond with psychological IPV, which, in turn, alters their decoding and interpretation of their partner's behavior, maintaining the dysfunctional response (Barros-Gomes et al., 2016). Through the lens of the family conflict perspective, and based on empirical research, men are also victims of women IPV perpetration, and the study of bidirectional violence has increased considerably in the last decades (Capaldi et al., 2012; Daigle, Scherer, Fisher, & Azimi, 2016). The vision adopted in this dissertation will be informed by family conflict perspective, since national and international studies suggest that IPV is characterized by mutuality and reciprocity, with women and men either as aggressors or as victims.

[2] In Visão magazine, 17/11/2016

Legislation

Article 152 of the Portuguese Penal Code (Office of the Attorney General for the Lisbon District, 2017) considers domestic violence as a typified crime, punishable with 1 to 5 years of imprisonment. The legal right protected by this law is personal dignity. Since 2000, it has been considered a public crime and consists in the infliction, in a reiterated manner or not, of physical, sexual, or psychological IPV, in the context of a marital or analogous relationship, or even after ending this relationship, with a partner of the same sex or different sex. The last revision includes dating without cohabitation in the definition of domestic violence. The description of the crime is written in a gender-neutral language and defined as degrading or humiliating treatment by a person capable of eliminating or clearly limiting the victim's human condition and dignity. Specifically, psychological IPV covers an extensive range of behaviors, such as humiliation, provocation, verbal threats, insults (including text messages), deprivations, or arbitrary limitations of freedom of movement associated with fear and the position of control or domination that the aggressor intends to exert, which results in a greater vulnerability over the victim. The recognition of the type of crime of domestic violence predicted in article 152 of the Criminal Code does not require the perpetration of physical IPV. The repetition of abusive expressions and the adoption of a psychologically aggressive and reiterated behavior in relation to a partner who is weakening and diminishing is sufficient to qualify as psychological IPV.

Emerging Challenges in Psychological IPV

Despite its invisible scars, psychological IPV is a significant public health issue, with severe implications for both individuals and societies (Barros-Gomes et al., 2016). However, researchers and policy makers neglect this kind of violence, focusing their attention on physical and sexual IPV, because it is presumed that these cause greater damage (Felix, Policastro, Agnich, & Gould, 2016).

In this dissertation, data will be presented to fill this gap, by increasing the visibility of psychological IPV, recognizing its specificities as a construct with its own value, and understanding its significance to legal and clinical purposes (Debono, Xuereb, Scerri, & Camilleri, 2016). The main topics of this work are to describe the current state of the field, to explore the experiences of psychological IPV in young adults, and to suggest an intervention protocol tailored to their needs. This section is dedicated to exploring the emerging challenges in the field of psychological IPV, namely: definition, identification, prevalence, measurement, developmental paths, impact, inclusion of non-traditional victims, a call for comprehensive research, and intervention.

Definition

"Despite all the attempts made, psychological partner violence is still a vague, unclear, and controversial concept." (Winstok & Sowan-Basheer, 2015, p. 5)

Unlike the accepted definition for physical violence, there is a lack of agreement regarding which behaviors fall under the category of psychological IPV (Felix et al., 2016; Vall et al., 2016). Researchers highlight the difficulty in reaching a consensual definition of psychological IPV, which consequently poses methodological challenges, given the multiple definitions and measures for addressing the same construct between studies (Daigle et al., 2016; Debono et al., 2016). A decade ago, Follingstad (2007) argued that psychological IPV had not been adequately defined, validated, or conceptually anchored in a way that provides a solid basis for its measurement, or allows conclusions to be drawn. Despite the relevance in the field of victimology, psychological IPV was not conceptualized into a clear and consensual framework, and the boundaries are undefined regarding which behaviors it includes or excludes (Winstok & Sowan-Basheer, 2015). Examples of different terms used to describe this category of IPV include "psychological" or "emotional violence", "aggression", and/or "abuse". Throughout this dissertation the term "psychological IPV" will be used in most of the cases.

O'Leary (1999) was a key researcher in the field of psychological IPV. Since the publication of his article "Psychological Abuse: A Variable Deserving Critical Attention in Domestic Violence", the construct of psychological IPV has gained strength (Winstok & Sowan-Basheer, 2015). Based on the argument that psychological IPV can be defined in a manner that allows for reliable assessment and use of this construct in both mental health and legal settings, O'Leary (1999, p. 19) proposed a definition for psychological IPV that will be adopted throughout this dissertation: "Acts of recurring criticism and/or verbal aggression toward a partner, and/or acts of isolation and domination of a partner."

Psychological abusive acts may include the categories of dominance/isolation and verbal/emotional abuse (Tolman, 1989). Dominance/isolation behaviors that an abusive partner may exhibit comprise isolating the victim for their friends and family, jealousy or suspicion, limiting their access to cell phones, monitoring a partner's time and check for their whereabouts, accusing them of having affairs, and trying to prevent them from doing things to help themselves. Verbal/emotional abuse includes acts of calling names, swearing, yelling and screaming, telling

them that their feelings are irrational or crazy, insulting or shaming in front of others, treating the partner like an inferior, and blaming their partner for their own problems (Tolman, 1989).

However, it is important to question whether IPV victimization always involves a combination of physical and psychological aspects. Does psychological IPV only exist as a complementary manifestation of physical aggression? Do they always share a common denominator? What is the threshold or the level at which an intimate relationship is labeled as psychological abusive? With respect to these questions, Follingstad (2007, p. 439) clarifies: "psychological aggression is not an oblique rotation on physical aggression; and its investigation is going to require more sophisticated methods." In this quote, Follingstad reflects about the differential nature of psychological and physical IPV. Thus, their conceptual and methodological specificities should be addressed as distinct categories and they may not necessarily be linked or co-occur (Winstok & Sowan-Basheer, 2015). These arguments are supported by the higher prevalence rates of psychological IPV, in comparison to physical IPV (Daigle et al., 2016).

Identification

"The project Artways concluded that 27% of the young respondents believe that psychological intimate partner violence is normal. Psychological violence is perhaps the least obvious form of abuse, but it can happen in many ways. Acts such as picking up the partner's cell phone without permission or forbid certain clothes are considered natural in a relationship. They may seem harmless, but the idea of control, that the partner is their possession, is already a sign of violence."[3]

Research suggests that psychological IPV occurs before physical and/or sexual aggression (Felix et al., 2016; Vall et al., 2016). The other alternative, that is, "physical IPV in the absence of psychological IPV, is essentially non-existent" (O'Leary, 1999, p. 18). Therefore, identifying the early signs and risk factors for psychological IPV might help to prevent the escalation to physical aggression (Capaldi et al., 2012; Vall et al., 2016). Unfortunately, there are few studies that provide data about the relative predictive power and unique variance explained by psychological IPV (O'Leary, 1999). Simultaneously, the recognition of early IPV is not followed by extensive training of professionals and programs to address this issue (Barter & Stanley, 2016).

[3] In Público newspaper, 02/06/2015

Public campaigns are mainly focused on women's physical victimization, neglecting psychological manifestations of abuse, female perpetration, and bidirectional IPV (Capaldi et al., 2012; Hines et al., 2016). Efforts typically explore chronic physical violence perpetrated by men against women, but not the opposite roles. In this context, minor violence is unrecognized and little work is devoted to the acknowledgement of the warning signs of emotional/verbal abuse and dominance/control behaviors in young couples as precursors for future violence (Barros-Gomes et al., 2016; O'Leary, 1999) or protective factors against IPV (Capaldi et al., 2012). According to Hines and collaborators (2016), research needs to emerge in the context of bidirectional IPV, to consider both genders as potential perpetrators of IPV, and change the traditional norms by adopting gender-neutral language. These guidelines were followed throughout the planning of the research project, as well as in the analysis, and interpretation of data.

Prevalence

"A study carried out in 32 schools in the district of Porto, involving 456 young people between 11 and 18 years old revealed that most of the intimate partner violence is psychological in nature (...). It is estimated that in Portugal one in four young people has already been exposed to dating violence at least once during their lifetime."[4]

The National Family Violence Survey was the first national attempt to collect crime victimization data in the United States, in 1975. However, these estimates do not include controlling behaviors and psychological IPV. Indeed, studies tend to report the prevalence of psychological IPV in combination with other forms of IPV (Capaldi et al., 2012), neglecting its own specificity as a separate entity (Debono et al., 2016). In terms of data analysis, it was Coker, Smith, Bethea, King, and McKeown (2000) who provided one of the first estimates of psychological IPV as a separated category of violence. Since then, this work has been extensively cited among IPV researchers, opening the possibility of psychological victimization in a non-physically-violent dyad. Of 1,152 women surveyed in a primary health care establishment, 13.6% experienced lifetime psychological IPV, without physical or sexual IPV, and the mean age for the first victimization was 22.1 years. This finding would have been missed if scholars focused solely on physical violence, or global measures of IPV.

[4] In Jornal de Notícias newspaper, 02/06/2015

Prevalence rates for IPV diverge significantly depending on the characteristics of the sample, definitions used, forms of IPV included, and the context of data collection (Barter & Stanley, 2016). Recently, researchers found that about half of the all young people in their study (Stonard, Bowen, Lawrence, & Price, 2014) reported some form of psychological IPV, concluding that this category of abuse represents a significant problem. Moreover, another recent study (Barter et al., 2015) suggests that males were more likely to evoke a negative response in the face of psychological IPV, probably because they are unwilling to report feelings of vulnerability due to stereotypical conceptions of masculinity (Barter & Stanley, 2016).

Although it is difficult to quantify numerically, the "hidden numbers" of psychological IPV are much greater than that of physical violence. Psychological IPV can be so slow that the affected persons might not even be aware of their own victimization. Abusers may begin with subtle behaviors (e.g., initial control over clothes, expenses, or social relationships), which later evolve into humiliations and attempts to isolate the partner (Echeburúa & Muñoz, 2017). Surveys that assess both victimization and perpetration are recommendable for evaluating the dynamics within the relationship and the hypothesis of symmetry of abuse. Frequently, results revealed similar rates of IPV victimization and perpetration regardless of gender (Capaldi et al., 2012; Felix et al., 2016), and a pattern of bidirectional IPV, as the most common form of violence, in part because minor or occasional levels of psychological IPV are common and acceptable (Daigle et al., 2016; Echeburúa & Muñoz, 2017; Hines et al., 2016). In most couples, psychological IPV is reciprocal, based on an exchange of unhealthy behaviors, where the figures of victim and abuser fluctuate according to the circumstances (Fernández-González, O´Leary, & Muñoz-Rivas, 2012).

Along with psychological IPV, men's victimization is a relevant topic to explore. In Portugal, the first study about IPV including male victims was developed in 2007, under the request of the Commission for Citizenship and Gender Equality, which has prepared the ground for future research within this group (Machado, 2016). A national study on the prevalence of dating violence (Machado, Caridade, & Martins, 2010), involving 4,667 young people between the ages of 13 and 29 reveals that psychological IPV (19.5%) was the most frequent form of IPV, with 25% of IPV self-reported victimization in the last year, and 31% self-reported IPV perpetration. Statistical data from the 2015 annual report of the Portuguese Association for Victim Support (APAV) reveals that psychological IPV (n = 7.507, 32.2%) and physical IPV (n = 5.167, 22.2%) make up more than 50% of criminal records of crimes against persons. According to the same source, the number of complaints from male victims has increased by 15% between 2013 and 2015.

International data available from the National Intimate Partner and Sexual Violence Survey (Black et al., 2011), which includes psychological victimization, shows that almost half of U.S. adults have experienced psychological IPV during their lives, regardless of gender. In fact, recent outcomes reveal that psychological IPV occurs three times as often as physical IPV, in both adolescent and adult samples (Sargent, Krauss, Jouriles, & McDonald, 2016). Men and women report psychological IPV victimization at similar rates (Daigle et al., 2016; Felix et al., 2016; Sargent et al., 2016), with men representing 48.8% of psychological victimization, and women 48.4% (Black et al., 2011). When significant differences on perpetration emerge, they tend to reveal superiority of female perpetration. This data is sustained in the meta-analysis of Archer (2000) based on 37 studies with college students, in which the rate of female perpetration exceeds that of male perpetration.

Thus, results support the argument that IPV is not a gender-based issue, indicating similar rates of male and female victimization and perpetration of IPV, and a tendency for reciprocity in partner violence. However, most of the studies and policies have focused on violence against women. According to the patriarchal perspective, all women's aggression is used in self-defense. Nevertheless, this argument has relatively sparse evidence and has been dismantled in several ways by Hines and collaborators (2016). First, many studies reveal that, in at least 25% of abusive relationships, women are the sole perpetrators (Langhinrichsen-Rohling, Selwyn, & Rohling, 2012). Second, women are more likely to initiate IPV according to their own reports (Daigle et al., 2016; Fernández-González et al., 2012). Third, women do not identify self-defense or retaliation as their own motives for perpetrating IPV (Medeiros & Strauss, 2006). Fourth, women were, on average, more dominant within romantic relationships than men, and dominance was associated with increased probability of IPV perpetration (Hines et al., 2016). This dissertation will include a study of the prevalence of psychological IPV in premarital relationships among young adults (Chapter III). For accomplishing this goal, the first assessment tool specific for screening psychological IPV will be validated for the Portuguese context (Chapter II).

Measurement

In the brief review by Barter and Stanley (2016), concerning mental health outcomes of IPV victimization, only 10 of the 33 studies included considered the evaluation of psychological IPV. As stated by the authors, this data reveals that a wider definition of IPV is needed to include comprehensive manifestations of psychological IPV in the screening protocol, with well-validated

measures. In fact, systematic evaluation of psychological abusive acts is needed in research, with potential impact for clinical practice, public policies, and allocation of funds for prevention and intervention programs. However, the development and validation of screening tools for psychological IPV faces the absence of a clear definition of the construct and its components, as a result of adopting a non-gender-neutral perspective (Winstok & Sowan-Basheer, 2015).

The *Conflict Tactics Scale (CTS)* has been the most commonly used measurement in the field of IPV research for the last 40 years (Capaldi et al., 2012). In Portugal, the tool was validated in 2006. The instrument asks participants about the strategies they use to manage conflicts with their intimate partners, including "psychological aggression", "physical assault", "injuries", "sexual coercion", and "negotiation", in the last 12 months and/or lifetime (Hines et al., 2016). This behavioral checklist was developed in the 1970s (CTS-1; Straus, 1979), when academics began to explore family violence, and a revised version was launched in the 1990s (CTS-2; Straus, Hamby, Boney-Mcoy, & Sugarman, 1996), with adequate reliability and validity. For this reason, other newly developed tools are largely assessed in comparison to, or in response to, the CTS (Hines et al., 2016). From this perspective, psychological IPV is conceptualized as a tactic of coping with partner conflicts, defined as the use of verbal and nonverbal acts or threats, which symbolically hurt the other (Winstok & Sowan-Basheer, 2015). The category of psychological IPV comprises eight items, and is divided into minor and severe manifestations. The minor subcategory includes the behaviors "Insulted or swore at partner"; "shouted or yelled at partner"; "stomped out"; and "said something to spite the partner". The severe subcategory includes "called partner fat or ugly"; "destroyed something belonging to the partner"; "accused partner of being a lousy lover"; and "threatened to hit or throw something at partner". The cited items have been considered incomplete, vague, and with unclear boundaries (Winstok & Sowan-Basheer, 2015).

A main aspect of the CTS is that it allows the measure of IPV for both partners, and assumes the possibility of gender symmetry in perpetration and victimization, in accordance with the family conflict perspective. Indeed, findings from studies which use the CTS reveal the same rates of IPV perpetration in female and male partners (Chan, 2012; Langhinrichsen-Rohling et al., 2012). Unsurprisingly, the CTS has been criticized by feminists and patriarchal theorists.

Tolman (1989; 1999), succeeding the CTS, presented the Psychological Maltreatment Women Inventory (PMWI), a 58-item measurement of psychological IPV. However, this screening tool has not yet been validated for the Portuguese population and the original version only

considered women as victims. Factor analysis revealed a two-factor structure emerging from the analysis, specifically dominance/isolation (e.g., limited access to telephone; asked explanations for their whereabouts) and emotional/verbal abuse (e.g., yelled; called names; told that their feelings were crazy). The tool was developed to be compatible with the CTS, adding a broader spectrum of psychologically abusive acts, including, in particular, monitoring and isolation behaviors (O'Leary, 1999). A short version of the PMWI was later developed (PMWI-SF, Tolman, 1999) containing 14 items with the same scales of dominance/isolation (7 items) and verbal/emotional abuse (7 items). This brief version seems to answer the challenge of routinely screening for psychological IPV to detect and reduce its consequences, being "short, easy to administer, sensitive, and specific" (Coker, et al., 2000, p. 456).

If, on one hand, there seems to be zero tolerance for physically abusive behaviors, on the other hand, agreement about what level of psychological IPV would meet some legal or mental health criterion seems harder because psychological IPV is very common in relationships (O'Leary, 1999). The establishment of cutoff scores for psychological abusive behaviors considered harmful would move the field forward and give the necessary significance to psychological IPV and its adverse impact on mental health (O'Leary, 1999). Additionally, the background in which the violence occurs must be considered separately to introduce consideration of the causes, contexts, and meanings associated with IPV (Hines et al., 2016). This thesis intends to create a gender-neutral language for the assessment of psychological IPV, considering the quantitative self-reports of both genders (Chapter III), and aims to understand the processes underling living with, leaving behind, and healing from psychological IPV, through a qualitative methodology (Chapter IV).

Developmental paths

"Psychological IPV is damaging to young adults in ways that are unique from others forms of victimization. From a developmental perspective, dating relationships become more serious and important during the early college years and young adults are the most frequent victims of IPV. Given their prevalence, repetitiveness, and persistence (...) experiencing psychological IPV might be especially harmful during this developmental period." (Sargent et al., 2016, p. 2)

Psychological IPV is especially prevalent among adolescents and young adults (Daigle et al., 2016). Despite the high comorbidity between different types of IPV in adulthood,

psychological IPV often occurs in the absence of other types of abuse in young samples, justifying further research to examine the extent of this phenomenon. Its acceptance may extend into future commitment relationships, prolonging IPV from adolescence into adulthood. This finding is supported by a recent systematic review, which found a peak of IPV among late adolescence and young adulthood, which then declines (Capaldi et al., 2012, p. 264). Thus, a negative relation between age and IPV was found, i.e., older age is associated with decreased risk for IPV (Capaldi et al., 2012). Surprisingly, there are more studies focusing on samples with adults than with adolescents or young adults (Capaldi et al., 2012), showing that research is primarily centered on marital violence, instead of dating violence (Daigle et al., 2016). Indeed, many studies used clinical samples or samples derived from legal system settings and shelters, and, therefore, do not typically address young persons (Daigle et al., 2016).

Dating violence is generally the term used to describe cases of IPV in adolescent and early-adult relationships, before a formal commitment, such as cohabiting or marriage (Daigle et al., 2016). In fact, most young people don't share a household or have children, and are not economically dependent on their partner (Barter & Stanley, 2016). As a result, psychological IPV is more prevalent than physical manifestations of violence (Daigle et al., 2016), since, in most cases, the couple don't live together, presenting fewer opportunities for an escalatory conflict.

Possible explanations for why youngsters are more susceptible to psychological IPV may be that they do not interpret their own experiences as abusive (Barter & Stanley, 2016), have low awareness of the boundaries of acceptable behaviors, and romanticize controlling behaviors (Papp, Liss, Erchull, Godfrey, & Waaland-Kreutzer, 2017), and, consequently, they accept more dysfunctional interaction patterns (Debono et al., 2016). Therefore, they may underestimate the risk of staying in the relationship because they value emotional intimacy and interpret controlling or jealous behaviors as signs of love and commitment (Daigle et al., 2016), reflecting a "fairytale narrative" (Papp et al., 2017, p. 2). In fact, they may overlook or normalize their abusive experiences and not conceptualize jealousy as a predictor of future aggression (Capaldi et al., 2012). These factors may contribute to getting trapped in an abusive relationship, without disclose of their experiences or seeking formal help (Barter & Stanley, 2016). When they disclose the abuse, they are most likely to share their experiences with their friends, instead of formal resources (Barter et al., 2015). For the reasons highlighted above, our work intends to reveal the rates of psychological IPV and the impact on mental health in a sample of young adults, using both quantitative (Chapter III) and qualitative (Chapter IV) research methods.

Impact

Even though most IPV research has focused on physical violence, psychological IPV has also found to be associated with higher risk for mental health problems.

(Adapted from Al-Modallal, 2012)

One of the earliest studies to reveal the effects of psychological IPV as being as detrimental as those of physical IPV was reported by Walker, in her book of 1979, entitled *Battered Woman:* "Most of the women in this project describe incidents involving psychological humiliation and verbal harassment as their worst battering experiences, whether or not they have been physically abused" (Walker, 1979, p. 15). This quote, despite centering the analysis exclusively on female victimization, highlights evidence that physical IPV is not needed in order to provoke negative health outcomes (Daigle et al., 2016).

The emblematic study of Coker and collaborators (2000) reveals that psychological IPV was as strongly associated with adverse health outcomes as was physical IPV (e.g., chronic neck or back pain, migraines, stomach ulcers, beginning to stammer or stutter), in comparison with nonvictims (Coker et al., 2000). Thus, the data derived from research provides evidence that psychological IPV can arouse a negative effect that is as great as that of physical IPV, and often greater than physical IPV (O'Leary, 1999). Additionally, recent studies show that the mental health effects of psychological IPV are similarly damaging for both sexes (Capaldi et al., 2012).

Few studies have examined the correlates of psychological IPV to a comparable extent of those focused on physical and sexual IPV (Felix et al., 2016). While physical injuries are reflected in the form of bruises and fractures, psychological damage does not have an explicit or recognized correspondence, manifesting itself in the form of clinical problems, such as post-traumatic stress disorder (PTSD; Pico-Alfonso, 2005) and anxious and depressive symptoms (Muñoz, 2013). Accordingly, recent cross-sectional studies found that, among community youth couples, psychological IPV is associated with an increased risk of depressive symptoms (Bonomi, Anderson, Nemeth, Rivara, & Buettner, 2013; Harned, 2001; Kar & O'Leary, 2010; Van Dulmen et al., 2012; Volpe, Hardie, & Cerulli, 2012), stress, and anxiety (Al-Modallal, 2012; Harned, 2001). Given these outcomes, authors conclude that non-physical forms of IPV require careful consideration (Barter & Stanley, 2016). Moreover, longitudinal research confirms psychological IPV to be predictive of later depressive symptoms (Haynie et al., 2013). In summary, studies

show that psychological IPV contributes to depressive symptoms (Sargent et al., 2016), anxiety, and PTSD (Harned, 2001).

In addition, it should be noted that repeated psychological IPV is a form of chronic stress, where high levels of cortisol are produced. Stress causes changes in the nervous and endocrine system that can affect the cardiovascular and immune system. If stress is chronic, there is an increased risk of infections and physical problems (e.g., permanent fatigue, headaches, and stomach and gastrointestinal problems) and, consequently, a greater issue for physicians. That is, psychological IPV can produce psychological damage, but also physical harm. The somatic symptoms described and the emotional alterations suffered by the victims may be a response to highly unpredictable and intermittent abuse (Reed, 2004), and a consequence of compensatory over-effort or adaptation to a chronic stressful experience (Echeburúa & Muñoz, 2017). Chapters III and IV of the present work are dedicated to exploring the impact of psychological IPV on the life of young adults, bringing together quantitative and qualitative data about mental health and global functioning in the aftermath of abuse.

Inclusion of non-traditional victims

Historically, the support system was created to provide assistance for women with a violent male partner, assuming a "gender-motivated violence" (Dragiewicz, 2016, p. 441). The feminist movement in the 1970s led to the emergence of the first women's shelter, and federal protection in the United States was established in 1994, with the Violence Against Women Act, which criminalized domestic violence in the United States (Dragiewicz, 2016) and which has been reauthorized in 2000, 2005, and 2013. Despite the gender-neutral language of the legislation, women were the main targets of the law, neglecting the existence of male victims. Since then, specialized services have responded and funds have been proliferated, including domestic violence agencies, shelters, advocacy, support groups, hotlines, police, attorneys, healthcare professionals, and prevention and intervention programs, primarily to combat violence against women (Dragiewicz, 2016). From 2007 to 2010, 93% of the victims who received services from the Campus Program, an initiative from the Violence Against Women Act, were females (Daigle et al., 2016).

Therefore, IPV interventions are not prepared to deal with men's victimization experiences and those of other underrepresented groups. Stark (2010), assumes the following quote, anchored in the patriarchal perspective on IPV: "I do not believe there is compelling evidence that

any substantial proportion of men assaulted by female partners want or require more protections, assistance and support than are currently available (...) or that male victims have needs for protection, treatment or support that require new funding streams or services (pp. 202-204)."

Recent studies revealed that men face several barriers to help-seeking, are more reluctant to disclose abuse, and found services not to be helpful. When they seek formal help, they are less satisfied with the responses they received, in part, due to gender biases among providers, violence agencies, and the criminal justice system (Cook, 2009; Douglas & Hines, 2011; Machado, Hines, & Matos, 2016). This data may explain why it is so difficult to access samples with male victims. Additionally, help providers strongly underestimate the need for early identification and routine screening for psychological manifestations of IPV (Debono et al., 2016), focusing their efforts on physical violence when it is already installed, instead of paying attention to its early forms and the context in which arises (Barter & Stanley, 2016). Our work intends to be gender-inclusive, adopting gender-neutral language and suggesting a protocol for intervening in cases of victims of psychological IPV (Chapter V).

A call for comprehensive research

Little is known about the processes of living with, leaving behind, and healing from a psychologically abusive relationship. Therefore, data from sources other than quantitative studies is needed to understand the in-depth dynamics of the phenomenon. At an international level, only a few qualitative studies have focused on the thematic analysis of the leaving processes in abusive relationships for young people (e.g., Edwards, et al., 2012; Few & Bell-Scott, 2002; Wiklund, Malmgren-Olsson, Bengs, & Öhman, 2010). Despite their contributions, these studies include comorbidity with physical and/or sexual IPV. In addition, research has often focused on the pathway of psychopathology derived from abuse, and there is scant information about the survivors' strengths and resources and the course of recovery after the abuse (Anderson, Renner, & Danis, 2012). A comparison between cases with post-traumatic stress symptoms versus asymptomatic cases would be helpful for understanding the specificities of these pathways.

Individual responses in the face of potentially traumatic events have been investigated by Bonanno and Mancini (2012). They concluded that there is a heterogeneity of trajectories adopted by individuals in response to a traumatic event. Accordingly, the relationship between exposure to adversity and mental health responses does not entails a linear or direct effect. Whereas a subset of individuals develop chronic pathological reactions, such as PTSD, others

may experience only transitory stress reactions, maintaining normative levels of functioning, despite being exposed to potentially traumatic events, showing a resilient trajectory (Bonanno & Mancini, 2012), and others show a recovery trajectory, with pathological reactions followed by adaptation. Qualitative research is recommended to specifically explore the survivors' own perspectives on the process of leaving psychological IPV, in the absence of other forms of IPV. In fact, the nature of the abuse experienced may have a different impact on the survivors' reactions and this issue must be explored, by going beyond the quantitative methods of data collection (Chapter IV).

Intervention

"Whilst there is a growing literature reporting prevalence and impact in this field, there is a very little published evidence, or indeed practical knowledge regarding interventions for either victims or perpetrators (...) Moreover, a failure to offer appropriate interventions in adolescence makes it likely that experiences of both victimization and perpetration will continue into adulthood with the associated impacts on the mental health of the next generation of parents and children."

(Barter & Stanley, 2016, p. 14)

A decade ago, Reed and Enright (2006) stated that evidence-based intervention models specific to psychological IPV were rare, and this still holds true today. Moreover, a lack of responses and services is observed for people experiencing psychological IPV (Barter & Stanley, 2016), with little evidence about the effectiveness in this field. Interventions are mainly focused on handling cases of crisis and offering short-term support groups to provide victim safety, community information, and resources. According to Reed (2004), these programs present significant methodological limitations, including mixed problems (e.g., victims of psychological and physical IPV in the same group), with different situations (including participants who still live with the abusive partner and participants who have already left the partner), and different treatment methods (the content of psychotherapy and the therapeutic style differ non-systematically between groups). To overcome these barriers, intervention protocols must clarify the living arrangement, specific problem, and therapeutic style (Reed, 2004).

Concerning effectiveness, there is a paucity of well-documented empirical outcome studies to support the efficacy of therapy for psychologically abused survivors (Reed, 2004). Additionally, psychotherapy in the aftermath of psychological IPV, which aims to work through the

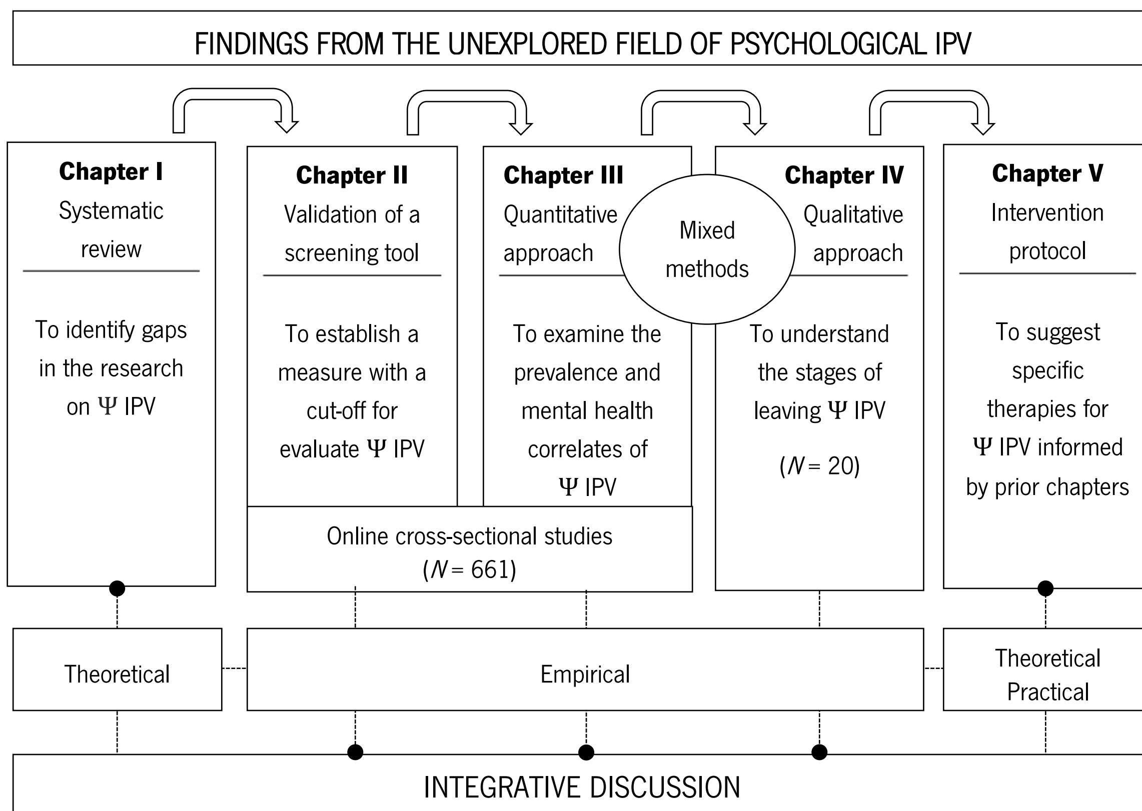
consequences of abuse, is practically non-existent. Psychotherapeutic interventions are restricted to the training of assertiveness, interpersonal skills, and anger management, and the only published evidence-based treatment is forgiveness therapy (Reed, 2004), which is insufficiently disseminated among therapists. In this framework, emerging approaches need to be tested, in order that effective and acceptable interventions may be identified and disseminated (Debono et al., 2016). Experts from the applied field draw attention to the need for "evidence based practice" (Dragiewicz, 2016) to enable understanding of IPV manifestations in a contextualized framework, rather than simplistic responses. This approach intends to take psychological IPV seriously, by listening to survivor's perspectives and needs, personalizing solutions according to the multiple contexts that shape their experience, and complementing data sources and methodologies (Dragiewicz, 2016). After revealing the gaps in the field of psychological IPV (Chapter I) and being informed by the quantitative and qualitative findings (Chapters II-IV), this dissertation ends with a suggestion of a protocol for intervening in psychological IPV (Chapter V), taking the theoretical and empirical contributions developed throughout the thesis into consideration.

Layout of chapters

The purpose of this dissertation is to address key gaps identified in the literature by addressing emergent challenges in the field of Applied Victimology related to psychological IPV. Specifically, the main topics of this work are to describe the current state of the field, to explore the experiences of psychological IPV in young adults, and to suggest an intervention protocol tailored to their needs. For the substantiation of these goals, we present a set of five interconnected studies (See Figure 1): a systematic review on psychological IPV, identifying the current state of prevalence rates, measures and interventions in this context (Chapter I); the validation of a comprehensive screening tool to identify psychological IPV in Portugal (Chapter II); an investigation into the impact of this phenomenon on mental health, through a quantitative cross-sectional study (Chapter III); an exploration of the stages of leaving psychologically abusive relationships, using qualitative methodology (Chapter IV); and an intervention protocol specifically tailored to addressing psychological IPV (Chapter V). Apart from the integrative introduction and conclusion of this dissertation, each chapter embodies an independent part of the research, which has been published in a peer-reviewed scientific journal or submitted for publication.

Figure 1

Layout of Chapters.



Chapter I is a qualitative synthesis, which summarizes the lack of consensus regarding the screening tools and the prevalence rates of IPV across studies, as well as the types, length, content, and effectiveness of interventions in the context of psychological IPV. Given that strong support for the effectiveness of interventions in IPV is missing, this summary aims to expose the gaps regarding psychologically abused victims, and the alarming absence of studies concerning interventions for male victims. The systematic review summarizes IPV interventions that have a baseline measure of psychological IPV, and provides a clear overview of their effectiveness, regardless of gender. To accomplish this goal, randomized controlled trials (RCTs) that assess psychological IPV and describe interventions targeting IPV victims were analyzed. This section ends by underlining some limitations of the current studies and suggesting guidelines for further research in this area.

Informed by this systematic review, Chapter II aims to promote a response to the lack of agreement on standard measures of psychological IPV and the threshold at which acts can be considered harmful. The study confirms the factor structure of the PMWI-SF in a Portuguese sample and analyzes its psychometric properties, in order to prepare the ground for the empirical

work reflected in Chapter III. The translation was adapted in the sense of being gender-neutral and was applied to men and women for evaluation of their experiences of psychological IPV. The results presented here refer to the women's validation. While the men's validation has also been tested and confirmed, we are currently collecting further data in order to increase the sample size for future publication purposes. Five hundred and six women filled out the e-survey, including the assessment of IPV and psychopathology. Sociodemographic characteristics, construct validity, and internal consistency were analyzed, and a cut-off for the PMWI-SF was established. We went further than the original version, since we proposed a cut-off for discriminate severe levels of psychological IPV and added confirmatory factor analysis, which provides a robust statistical framework. The clinical and research implications of these methodological improvements are highlighted.

In order to promote a deeper understanding of psychological IPV victimization, a mixed methodology design was adopted, involving the integration of quantitative and qualitative data to fully capture the phenomenon in its multiple facets. For accomplishing this goal, we developed the research in two sequential stages, planning a quantitative study, in the first phase (Chapter III), followed by a qualitative study (Chapter IV).

Thus, in Chapter III we explore the adverse effects of psychological IPV in both genders, through a cross-sectional study design, using the screening tool proposed in the previous chapter. This study examines the prevalence and independent impact of psychological IPV on mental health. The initial sample comprises 661 college students from a Portuguese public university, who completed an e-survey. Statistical analysis focused on a subsample (n = 364), 23% of which were men, after removing cases of physical and/or sexual abuse. This study draws on quantitative data and makes three distinct contributions to understanding the characteristics of psychological IPV in a mixed sample of college students. First, it moves away from a feminist framing, to highlight the symmetric and bidirectional nature of abuse in this context. Second, it explores the unique impact of psychological IPV on mental health, in a subsample of victims without self-reported physical or sexual abuse. Third, it uses the first comprehensive tool specifically validated to asses psychological IPV in the Portuguese context. The aims of this paper are to 1) verify the association between sociodemographic factors and psychological IPV; 2) explore the prevalence and symmetry of gender and the bidirectionality of psychological victimization; and 3) verify if psychological IPV is a predictor for mental health issues, specifically post-traumatic stress symptoms, depression, and anxiety. This chapter provides an empirical

basis to recognize the unique and serious impact of psychological IPV on mental health, and recommends screening psychological IPV as part of the clinical routine, developing a gender-inclusive approach to victimization.

Complementarily, Chapter IV describes the specificities of moving on from psychologically abusive relationships, through a qualitative approach. An inductive content analysis, using QSR Nvivo10, was selected to explore the narratives of 20 college women with a history of psychological IPV, with and without PTSD. The goal was to provide a comprehensive understanding of the stages of readiness to leave psychological IPV. Accordingly, the purposes of this study were to explore the particular process of leaving psychological IPV in college women, as well as the effects in the aftermath of psychological IPV on those who developed PTSD and those who did not. Although the invitation to participate in the study was extended to men, the degree of adhesion did not allow their integration in this study, since only two individuals, with different sexual orientations, were available to share their narratives of the psychologically abusive relationships. This chapter provides information about the mechanisms and non-sequential stages of psychological IPV and their relevance to legal and clinical settings.

Chapter V suggests a gender-neutral intervention protocol for psychological IPV, informed by the preceding chapters. Since Forgiveness Therapy was the only evidence-based model tested so far, we developed the first CBT (Cognitive Behavioral Therapy) model specifically tailored for psychological IPV, entitled IMPACT (Intervention Model for Psychological Abuse & Cope with Trauma). The protocol derives from the third wave of CBT, based on using mindfulness techniques to recover from traumatic past experiences by fully living in the present. We expect that IMPACT will add the foundations to test the effectiveness of interventions, with several implications for practice, given the lack of specific protocols for coping with the aftermath of psychological IPV.

The discussion and final remarks of this dissertation offer an integrated reflection of the findings, in light of the contributions of the studies to the field, as well as their limitations and theoretical, methodological, and practical implications. Additionally, empirically-informed recommendations are highlighted, and challenges for future research are explored.

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CHAPTER I

REVEALING THE GAPS ON INTIMATE PARTNER VIOLENCE: A SYSTEMATIC REVIEW OF INTERVENTIONS[5]

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CHAPTER I

REVEALING THE GAPS ON INTIMATE PARTNER VIOLENCE:

A SYSTEMATIC REVIEW OF INTERVENTIONS

Abstract

Psychological intimate partner violence (IPV) is the most pervasive form of abuse reported for men and women. However, little empirical evidence is available regarding the effectiveness of interventions in this context, thus deserving further attention. To our knowledge, this qualitative synthesis is the first of its kind. The purpose is to summarize IPV interventions that have a baseline measure of psychological IPV, and provide a clear overview of their effectiveness, regardless of gender. Scopus, Web of Science, PubMed, PsycINFO and PsycARTICLES were surveyed by two independent researchers and expanded by hand search. Randomized controlled trials (RCTs) that assess psychological IPV and describe intervention targeting IPV victims were analyzed. The effectiveness in mental health, safety, and/or well-being varied according to the type, content, and length of the interventions. Generally, psychological individual interventions were more effective than group or advocacy interventions. Of the 12 included studies, only one was designed specifically for psychologically abused victims, and no data concerning RCTs with male samples came up in the search results. Stronger support for the effectiveness of interventions in IPV is missing. Moreover, there are gaps in the literature regarding clear definitions, specific screening tools and interventions for psychologically abused victims, and an alarming absence of studies concerning interventions for male victims.

Keywords: Psychological intimate partner violence, intervention, systematic review.

Introduction

In the context of Intimate Partner Violence (IPV), physical abuse and victimization of women are the most explored and visible expressions of aggression. However, psychological IPV represents the most self-reported form of IPV, with the highest rates of victimization regardless of gender (Ybarra, Espelage, Langhinrichsen-Rohling, & Korchmaros, 2016). A possible definition describes psychological IPV as acts of criticism, verbal aggression, isolation, and/or domination of a partner (O'Leary, 1999). It often occurs in the early stages of a relationship and can predict future physical aggression (O'Leary & Slep, 2003).

The meta-analysis conducted by Carney and Barner (2012) found prevalence rates of 40% of women and 32% of men reporting expressive aggression (e.g., swearing) and 41% and 43% reporting coercive control (e.g., tactics of isolation and threats of harm). In our country, the Portuguese Association for Victim Support (APAV), revealed that 85% of the official data from IPV derived from female victims (*Annual Report of Internal Security*, 2016), of which 32% were cases of psychological IPV (APAV, 2016a). Nevertheless, male victims of IPV increased by 15% between 2013 and 2015 (APAV, 2016b), which might be due to men feeling less embarrassed by asking for formal help. In most cases, fear, shame, and revictimization from family and the judicial system has stopped these victims from disclosing the abuse (APAV, 2016b). Only recently, APAV launched a campaign to raise public awareness of the issue that men are also victims of IPV, including controlling behaviors and jealousy. Despite this recent effort, the Portuguese legal system seems far from prepared to respond to male victimization, and the first shelter for men is only expected to be launched in the autumn of 2016, in a one-year pilot project.

The baseline assessment of psychologically abusive behaviors seems important to allow more accurate predictions, as it seems that more signs of psychological IPV predict subsequent physical aggression (Salis, Salwen, & O'Leary, 2014). On the other hand, physical IPV is substantially less frequent than psychological IPV (Salis et al., 2014). This means that there is an overwhelming rate of psychologically abused victims without physical or sexual violence that need to be identified and treated. In the legal context, psychological IPV is considered a criminal act in Portugal, under the terms of Article 152 of the Penal Code. Only recently, The Serious Crime Act 2015 in the United Kingdom created a new category of offense for controlling or coercive behavior in the context of an intimate relationship (Section 76, 2015). In the USA, there is a growing tendency, in several states, to criminalize this type of IPV, although it may not be enough

on its own to support a domestic violence action. Therefore, it's an area that requires more empirically validated data to inform policies.

In terms of the impact of psychological IPV on the victims' wellbeing, it is associated with chronic mental and physical consequences (Coker et al., 2002), and can cause serious stigma regardless of the victim's gender (Eckstein, 2016). The majority of victims report this form of IPV as having the most detrimental consequences on their emotional wellbeing, even when it co-occurs with physical aggression. It should be noted that psychological IPV is a strong predictor of poorer health, similarly to that which results from physical violence alone, however, it also has serious negative outcomes that are distinct from physical violence (Bogat, Garcia, & Levendosky, 2013; Montero et al., 2011; Pico-Alfonso et al., 2006). Thus, early identification of psychological IPV is crucial for diminishing its consequences on mental health for both female and male victims, and for preventing the escalation to physical forms of aggression (Coker et al., 2002).

Overall, this evidence points to the need for more sensitive research on IPV. The existing literature was primarily focused on the definition, measurement, and comprehension of the construct, and emphasizes the theoretical framework and the consequences of IPV. Nevertheless, little attention has been given to systematizing the effectiveness of interventions in this field, in order to guide professionals through evidence-based treatments (Bogat et al., 2013). A deeper understanding of psychological IPV and victimization of men is required, and it has been recommended that researchers in this area routinely assess its impact and formulate effective interventions (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006).

Therapeutic interventions in IPV often consist of general protocols that target the co-occurrence of several forms of abuse, focused on responding to crisis situations and transition moments, especially in medical emergencies or shelters. Advocacy interventions are usually made in large groups with protocols based on safety plans and empowerment, whereas psychological interventions seem to be scarcer, probably because they are more expensive, requiring more time and specialized resources. It is critical to analyze the effectiveness of interventions in the light of the emerging conceptualization of psychological IPV, either as a single manifestation of violence or in the context of co-occurrence of other forms of IPV. To our knowledge, this is the first systematic review focused on how psychological IPV is embodied in IPV interventions. With this purpose, the present review seeks to bring together accurate data concerning IPV interventions and their outcomes, including psychologically abused victims regardless of gender, in order to contribute to the improvement of guidelines that may potentially be useful for clinical and legal practices.

Method

Search Strategy

Scopus, Web of Science, PubMed, PsycINFO, and PsycARTICLES were surveyed by two independent reviewers using the following MeSH terms and/or keywords: psychological abuse, emotional abuse; dating, intimate partner, spouse; intervention, therapy, psychotherapy. These keywords allowed for 18 combinations (Table 1). In addition, related studies, references from analyzed papers, and specialized journals in violence were hand searched in order to find new potential studies. The same strategy, procedure, and filters were used with all databases: each of the 18 combinations was run, and was refined by title, abstract, and keywords; type of document (only articles); and language (English, French, Spanish and Portuguese). The results were exported to Endnote's reference manager.

Table 1

Search terms (A-H) and combinations (1-18) in databases.

A.	Psychological abuse	C.	Dating	F.	Intervention
B.	Emotional abuse	D.	Intimate partner	G.	Therapy
		E.	Spouse	H.	Psychotherapy
1.	**A** and **C** and **F**	7.	**A** and **C** and **H**	13.	**B** and **C** and **G**
2.	**A** and **D** and **F**	8.	**A** and **D** and **H**	14.	**B** and **D** and **G**
3.	**A** and **E** and **F**	9.	**A** and **E** and **H**	15.	**B** and **E** and **G**
4.	**A** and **C** and **G**	10.	**B** and **C** and **F**	16.	**B** and **C** and **H**
5.	**A** and **D** and **G**	11.	**B** and **D** and **F**	17.	**B** and **D** and **H**
6.	**A** and **E** and **G**	12.	**B** and **E** and **F**	18.	**B** and **E** and **H**

Inclusion Criteria

The American Psychological Association (APA) criteria for evaluating treatment guidelines promulgates systematic reviews of RCTs as an important step to validate conclusions from research on intervention, defining RCTs as the most rigorous way of evaluating treatment efficacy, as "they are the most effective way to rule out threats to internal validity in a single experiment" (APA, 2002, p. 1054). On the basis of those criteria, only this experimental methodology was considered, in order to reduce the unbiased predictions of effect sizes.

Thus, RCTs describing treatment programs targeting victims of IPV were included, dated up to June 2016. The studies had to present a psychological IPV measure at baseline and

describe the outcomes of the intervention, regardless of gender. Studies that only considered a total score of IPV or weren't RCTs were excluded.

Quality assessment

The studies were assessed using structured guidelines from The Cochrane Collaboration's tool for assessing risk of bias (Higgins et al., 2011). Two independent reviewers rated each study as low, high, or unclear risk of bias, based on a set of bias sources: random sequence generation, allocation concealment, blinding of participants and researchers, blinding and/or incomplete outcome data, selective reporting, and other potential bias. The PRISMA statement guidelines (Liberati et al., 2009; Moher, Liberati, Tetzlaff, & Altman, 2009) were followed to identify, screen, and describe the protocols used.

Data extraction

A data extraction sheet was developed in order to analyze the papers (based on the Cochrane Review Group's data extraction template), using a common structure for the data extraction: source (authors, year and country), type of intervention, setting and participants, intervention description and main goals, control group, outcome measures, and follow-up. The authors were contacted whenever necessary for additional information.

Data analysis

Since it is more informative to report effect sizes instead of *t*–values, *F*–values, or *p*–values, the effect sizes were reported for all studies, providing meaningful information about each outcome. When effect size measures were not reported in the included articles, they were calculated and added to the results section (Cohen, 1988). When mathematically possible, the Cohen's *d* measure is reported, in order to homogenize, standardize, and compare the magnitude of results. According to Cohen (1988), the following criteria were adopted: "small, d = .20," "medium, d = .50," and "large, d = .80" effect sizes.

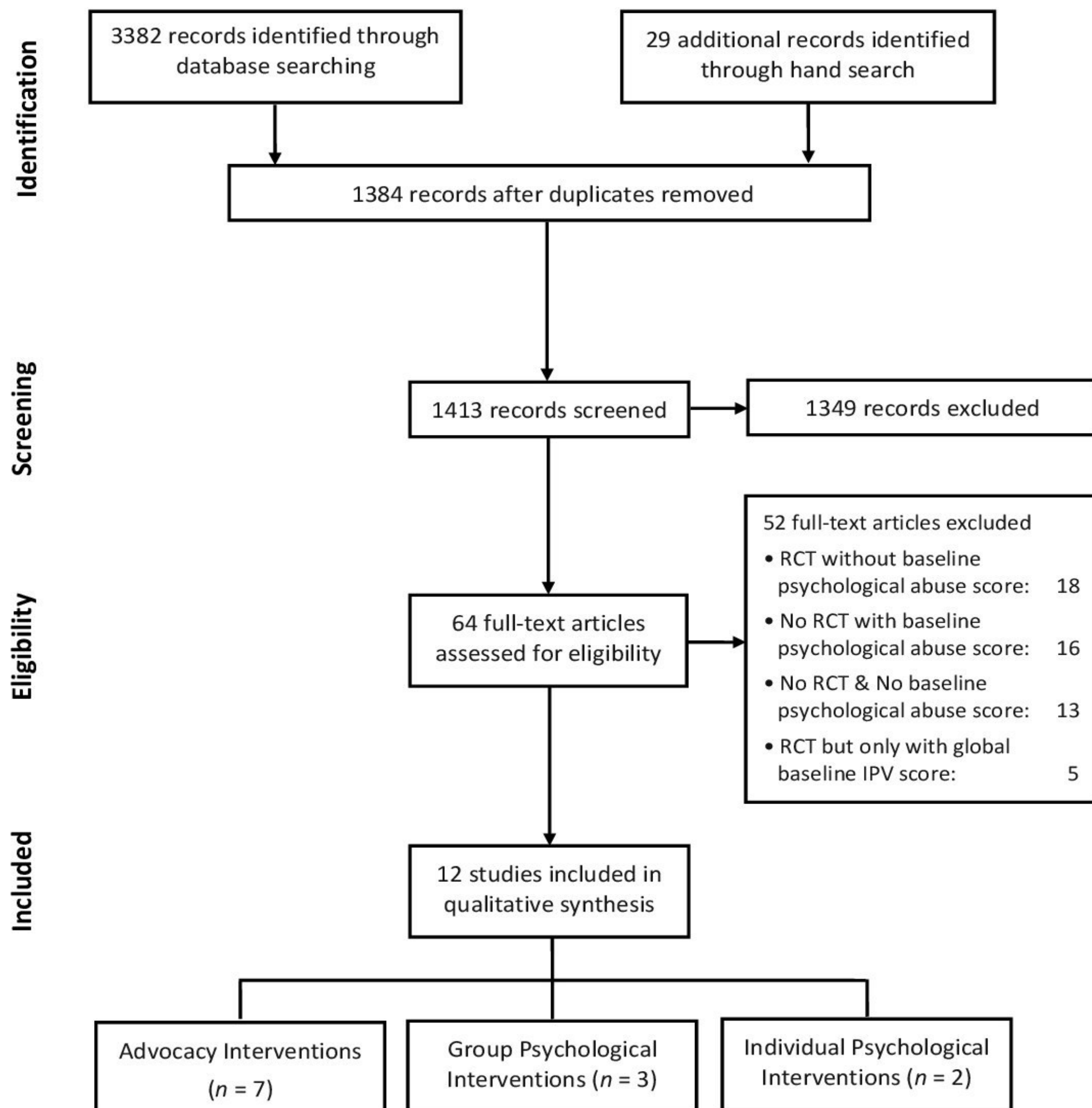
Results

The searches identified 3382 records, which were reduced to 1384 after removing duplicates: Scopus (n = 887), Web of Science (n = 432), PubMed (n = 32), PsycInfo (n = 30), and PsycArticles (n = 3). The hand search identified 29 additional articles. A total of 1413 studies were screened by title and abstract to assess whether the contents were likely to be within the scope of the review. This process led to the exclusion of 1349 studies, and 64 were assessed for eligibility. After a full text evaluation, 52 were excluded due to reasons that can be consulted in

Figure 2. As a result, 12 studies remained and were selected for subsequent data extraction and integration into this qualitative synthesis. The great majority were from the USA (*n* = 8), followed by China (*n* = 2), Australia (*n* = 1), and Peru (*n* = 1). Although this search did not exclude interventions targeting men as victims of IPV, the results found only female victims. A comprehensive summary of the included studies evaluating psychological IPV in RCTs for victims of IPV can be found in Table 2.

Figure 2

Search strategy flowchart.



Note: The search process is demonstrated describing all steps.
RCT (Randomized controlled trials).

Table 2

Summary of included studies for women experiencing Intimate Partner Violence (IPV).

Source & Type	Setting & Participants	Intervention & Main Goals	Control	Outcome Measures & Follow-up	Bias
(Cripe et al., 2010) Peru ***Advocacy Intervention***	220 pregnant women abused between 12 and 26 gestational weeks in a referral public hospital for high risk obstetric cases in Lima, between January and July 2007. **Eligibility**: Spanish-speaking, IPV+ in the past 12 months, 18 - 45 years old.	EG: 110 women were in an **Empowerment Intervention** conducted by a social worker with supportive care, empathic listening, education about violence and safety plans (individual session of 30 minutes), plus brochure with safety plan and referral card of community resources. Women could discuss pros and cons of leaving the offender, report the abuse, or request protection. **Goals:** increase in the health quality of life, safety behaviors and community resources.	CG: 110 women with **standard care**, wallet-size referral card listing agencies that provide IPV services (legal, social services, and law enforcement). No counseling, advocacy, education, or other services were offered.	Initial IPV evaluation was provided by AAS. The frequency and severity of physical, sexual and **psychological abuse** was assessed using CTS2 at baseline. Post intervention abuse information was not provided. Outcomes are health-related quality of life (SF-36), safety behaviors adopted (safety behaviors checklist) and use of community resources (community resources assessment). 10 Women in the EG and 6 in the CG were lost in the follow-up.	Low risk
(DePrince et al., 2012; 2012b) USA ***Advocacy Intervention***	236 women with police-reported IPV in Denver between December 2007 and July 2008 **Eligibility**: adult women as victims, English-speaking, with valid contact information, involving nonsexual IPV	EG: 79 women were in a **Community-Coordinated Outreach Program Victim-focused,** with community-based advocates that offered confidential, flexible and individualized support and services by phone call, based on both legal and victim needs **Goals:** Evaluate the impact of intervention on psychological distress and victim safety (DePrince et al., 2012a) and to increase victims' engagement with prosecution tasks (DePrince et al., 2012b).	**CG:** 50 women with **treatment-as-usual** under the old system: referrals offered during phone contact with system-based advocates.	Participants were interviewed 3 times over a 1-year period: within 26 (median) days since police-reported IPV, 6 and 12 months later. Primary outcomes included psychological distress: post-traumatic stress disorder (PDS) depression (BDI-II) and fear appraisals (TAQ). Secondary outcomes included victim safety: services usage, physical, sexual and **psychological revictimization** (CTS2) and stage of change (2012a).In another paper (2012b) with the same sample, authors reported the impact on the ability of victims to engage and participate in the tasks of charges against their abusers. 13 women in the GE and 11 in the CG were lost in the follow-up.	Unclear risk
(Gillum et al., 2009) USA ***Advocacy Intervention***	41 women were in a primary healthcare clinic, Baltimore, Maryland, during fiscal year of 2005 **Eligibility**: women > 18 years old, IPV + in the past year.	EG: 21 women received a **Clinic-based Intervention** that consisted of a personalized counseling session about safety—promoting behaviors, goal setting, and individual needs—and six telephone counseling sessions (average duration of 20 minutes) over a 3-month period by a trained community health worker **Goals:** assess the effect of a clinic-based telephone intervention on women's engagement in safety-promoting behaviors and access to community resources.	CG: 20 women in the control group received health information brochures, a list of community resources, and a monthly telephone call to confirm contact information in order to ease the follow-up.	Women were screened for recent IPV (past year) by PVS and PAS –for type and severity of physical and **non-physical abuse**. After the initial interview, participants in the GE received six phone calls during 3 months (at weeks 1, 2, 4, 6, 8 and 10) and all participants were again interviewed at a 3-month follow-up. Outcome measures: level of risk for lethal harm (DA2), stages of change (scale), safety promoting behavior (checklist), frequency of access to community resources, chronic pain (grade questionnaire), fatigue (brief fatigue inventory), depressive symptoms (CES-D), perceptions of mood disorders, and PTSD (DTS). 2 women were lost in the follow-up.	Unclear risk
(Hegarty et al., 2013) Australia ***Advocacy Intervention***	272 women were in health-care clinics, in Victoria, between January 2008	GE: 137 patients received a **WEAVE Project,** 1 to 6 sessions of counseling from family doctors (*N* = 25) based on the Psychosocial Readiness Model to women	CG: 135 patients received **usual care** if they presented to their doctor	Data was collected by a postal survey at baseline, 6 and 12 months post-invitation. Women completed an IPV measure (CAS) for physical and **emotional abuse** at baseline. Primary outcomes were quality of life	Low risk

	and January 2010. **Eligibility**: female patients who screened positive for fear of a partner in past 12 months in a health and lifestyle survey.	identified through IPV screening. Patient-centered care promotes active listening, motivational interviewing and problem-solving techniques **Goals:** Testing benefits on quality of life, safety planning/ behavior, and mental health.	(n=27) with concerns during the trial period. All women received a list of resources (with the surveys).	(WHOQOL-BREF), safety planning and behavior, and mental health (SF-12). Secondary outcomes included depression and anxiety (Hospital Anxiety and Depression Scale); women's report of their safety and that of their children, and comfort to discuss fear. 41 women in the GE (30%) and 35 in the CG (26%) were lost in the 12-month follow-up.	
(Sullivan et al., 1992; 1994; 1999) USA ***Advocacy Intervention***	278 women from a domestic violence shelter in a Midwestern city **Eligibility**: stayed at least 1 night at the shelter and intended to stay in the vicinity.	EG: 143 women received **Advocacy services,** 4 to 6 hours per week, for the first 10 weeks post shelter to facilitate access to the community resources they needed to reduce their risk of future violence from their abusive partners. Advocates were female undergraduates **Goals:** improve community resources, social support and life satisfaction, and decrease re-abuse.	CG: 135 women **without intervention** were not contacted again until their next interview.	Participants were interviewed 6 times over a period of 2 years: immediately upon their exit from the shelter, 10 weeks thereafter and 6-, 12- and 24-month follow-up. Outcome variables were physical abuse (CTS), **psychological abuse** (IPA), quality of life (7 points scale with 9 areas), depression (CESD-D), social support (9 items), and effectiveness and difficulty in obtaining resources. Retention rate averaged 95% over the 2 years.	Unclear risk
(Tiwari et al., 2010; 2012) China ***Advocacy Intervention***	200 Chinese women in a community center in Hong Kong recruited between December 2006 and June 2009. **Eligibility**: women 18 years or older, IPV+.	EG: 100 women received **Empowerment** in a one-to-one interview of 30 minutes including protection, choice-making, and problem-solving skills based in Dutton´s Empowerment Model and **Telephone Social Support** based on Cohen´s Social Support Theory with 12 scheduled weekly telephone calls and 24-hour access to a hotline. **Goals:** improve mental health.	CG: 100 women received **usual community services** including child care, health, social, educational, and recreational services.	Data was collected at baseline and at 3 and 9-month follow-ups. Women were screened for IPV using C-AAS. Primary outcome was related to changes in depressive symptoms (C-BDI-II) and secondary outcomes were related to changes in IPV (C – CTS2) including physical, sexual, and **psychological abuse**; health-related quality of life (SF-12), social support (ISEL), safety-promoting behaviors, and utilization of health services. No subjects were lost in the follow-up.	Low risk
(Tiwari et al., 2005) China ***Advocacy Intervention***	110 pregnant women in pre-natal clinic of a public hospital in Hong Kong between May 2002 and July 2003. **Eligibility**: women over 18, <30 weeks gestation attending first pre-natal session, IPV+.	EG: 55 women received **Empowerment** specially designed for Chinese abused pregnant women administered by a midwife with a master's degree in counseling. An individual interview lasted about 30 minutes with advice on safety, choice making, problem solving, and empathic understanding, plus an informative brochure. **Goals:** reduce IPV; improve health status.	CG: 100 women received **standard care** after enrolment, a wallet-sized card of community resources (e.g., shelter hotlines, law enforcement, and social services.	Screening for IPV was made using the C-AAS. Data was collected at the study entry and after six weeks postnatal. At the time of enrolment CTS2 for physical, sexual and **psychological abuse** (primary outcomes); demographics and health-related quality of life (SF-36) were collected. Final outcomes were obtained in the six weeks postnatal follow-up by telephone, including CTS2 and secondary outcomes—Quality of life (SF-36) and Postnatal Depression (EPDS). 4 women (EG) were lost in the follow-up.	Low risk
(Gilbert et al., 2006) USA ***Psychological Group Intervention***	**34 women** in a methadone treatment between June 2003 and February 2004. **Eligibility:** were aged 18 or more, met IPV and drug use criteria	EG: 16 women received a **Relapse Prevention and Relationship Safety (RPRS),** 11 group sessions plus 1 individual session based on social cognitive and empowerment theories (communication, negotiation skills). **Goals:** reducing IPV and drug use among women on methadone.	CG: 18 women received one-session of **informational control (IC) condition:** 1hr didactic presentation of referral sources to address IPV.	Participants were analyzed at baseline and at the 3-month follow-up in all variables. Primary outcomes: IPV for physical, sexual, and **psychological abuse** (CTS2); drug and alcohol use (questionnaire). Secondary outcomes: depression (BSI), PTSD (PCL-C), and Sexual risk behavior - HIV (SRBQ).Retention rate at the 3-month follow-up was high with 91% of women (n=31) completing interviews.	Low risk
(Graham-Bermann & Miller, 2013) USA	181 mothers plus children in the community **Eligibility:** exposed to IPV	EG: 61 (M+C) versus 62 (CO) received Moms' **Empowerment Program** (MEP), 10-week, group intervention to discuss fears	CG: 68 women were in a **waiting list** in comparison to the other	3 conditions: mother-plus-child intervention (M+C), child-only (CO), and wait list (CG). Physical, sexual, and **psychological IPV** (CTS, SVAWS) were evaluated at baseline. Outcome	Unclear risk

Psychological Group Intervention	during the past year, with a child between 6-12 years old.	and enhance coping, guided by a therapist, **Goals:** reduce traumatic stress and empower women after IPV.	group.	measure: traumatic stress (DSM III-R) at baseline, post-intervention, and 8 months later.	
(Kaslow et al., 2010) USA ***Psychological Group Intervention***	208 women with a low socioeconomic status, African American in a hospital affiliated to the university **Eligibility:** recent history of IPV and a suicide attempt.	GE: 121 women received a **Culturally Informed Empowerment-Focused Psychoeducational Intervention (Nia),** 10 sessions, 90-min group meetings with therapists, in accordance to the theory of triadic influence (enhance coping with stress: resiliency, problem solving, self-efficacy, creating purpose) **Goals:** examine the efficacy of Nia for reducing psychological symptomatology and IPV.	CG: 87 women received a **Treatment as usual (TAU)** referred to standard psychiatric and medical care offered by the hospital, including free weekly suicide and IPV support groups.	Participants were assessed at baseline, post-intervention, and 6- and 12-month follow-up. Outcome measures comprise levels of physical and **nonphysical abuse** (ISA) and psychological symptomatology: suicidal ideation (BSS), depressive symptoms (BDI–II), post-traumatic stress symptoms (Davidson Trauma Scale), and general psychological distress (BSI). Between the analysis and the complete treatment there were losses (EG: 121 analyzed, 86 completed; CG 87 analyzed, 45 completed).	Low risk
(Johnson et al., 2011) USA ***Psychological Individual Intervention***	70 battered women who lived in one of two shelters in a Midwestern city between 2004 and 2007 **Eligibility:** 1 incident of IPV (CTS2) and meet criteria for IPV-related PTSD/ sub threshold PTSD	EG: 35 women received a **HOPE** (Helping to Overcome PTSD through Empowerment), which is a cognitive-behavioral treatment for PTSD shelter-based informed by Herman´s multistage of recovery (cognitive restructuring, skill building) applied by 6 therapists, maximum of 12 sessions **Goals**: explore the acceptability, feasibility, and initial efficacy of HOPE.	GC 35 women received **standard shelter services (SSS):** case management, supportive environment, educational groups (parenting and support) were offered at the shelter.	Primary outcome measures: IPV - **psychological aggression**, physical assault and sexual coercion by CTS2 - and PTSD (CAPS). Secondary outcomes included depression (BDI), empowerment (PPS-R), resource loss (COR-E), and social support (ISSB). Retention rates for each follow-up post-shelter are: 97.1% at 1-week, 94.3% at 3 months and 94.6 at 6-months.	Low risk
(Reed & Enright, 2006) USA ***Psychological Individual Intervention***	20 emotionally abused women from the community in a Midwest city **Eligibility:** experienced spouse, psychological abuse, without physical abuse, and permanently separated from partners for 2 or more years.	EG: 10 women received **Forgiveness Therapy (FT):** defining forgiveness, examining psychological defenses, anger, shame, and cognitive rehearsal; work in forgiving, grieving the pain, reframing the abuser, exploring empathy and compassion, practicing goodwill, finding meaning in suffering, and considering a new purpose for life **Goals:** Testing the impact of FT on depression, anxiety, and post-traumatic stress after emotional abuse.	CG: 10 women received an **alternative treatment** (AT) that focused on anger validation, assertiveness, and interpersonal skill building.	Participants were included if they score 41 or above in **Psychological Abuse** Survey and showed at least 3 symptoms of PTSS checklist. Women in two conditions received weekly 1-hr of individualized therapy sessions (*M* = 7.95 months, *SD* = 2.61) by a trained psychiatric nurse based on written protocols. Outcome measures at pre-test, post-test and follow-up (*M* = 8.35 months, *SD* = 1.53): depression (BDI II), anxiety (STAI), post-traumatic stress (PTSS checklist), self-esteem (CSEI), forgiveness (EFI), environmental mastery scale, finding meaning in suffering, story measure. No losses were found in the follow-up.	Low risk

Abbreviations:
AAS: Modified Abuse Assessment Screen
BDI II: Beck Depression Inventory II/ C-BDI II: Chinese version
BSI: Brief Symptom Inventory
BSS: Beck Scale for Suicidal Ideation
C-AAS: Chinese Abuse Assessment Screen
CAPS: Clinician-Administered PTSD Scale
CAS: Composite Abuse Scale
CTS2: Conflict Tactics Scale, Form R; C-CTS2: Chinese version
CES-D: Center for Epidemiologic Studies-Depression Scale
COR-E: Conservation of Resources-Evaluation
CSEI: Coopersmith Self-Esteem Inventory
EFI: Enright Forgiveness Inventory
EPDS: Edinburgh Postnatal Depression Scale
ISA: Index of Spouse Abuse
IPA: Index of Psychological Abuse
ISEL: 12-item Interpersonal Support Evaluation List
ISSB: Inventory of Socially Supportive Behaviors
PAS: Partner Abuse Scale
PCL-C: PTSD Checklist - Civilian
PDS: Post-traumatic Stress Diagnostic Scale
PPS-R: The Personal Progress Scale Revised
PVS: Partner Violence Screen
SF-12: 12-item Short Form Health Survey
SF-36: Short Form Health Survey
SRBQ: Sexual Risk Behavior Questionnaire
STAI: State-Trait Anxiety Inventory
SVAWS: Severity Violence Against Women Scale
TAQ: Trauma Appraisal Questionnaire
WHOQOL-BREF: World Health Organization Quality of Life Brief Form

Screening

Conflict Tactics Scale-Revised (CTS2; Strauss, Hamby, Boney-McCoy, & Sugarman, 1996) was the tool most commonly used to screen psychological IPV, being used in seven (58%) of the included studies, and is considered to be a broader research instrument to evaluate IPV. It measures the type, frequency, and severity of physical assault, injury, and psychological and sexual aggression. The instruments used by each study can be consulted in Table 2.

Prevalence

Psychological IPV was the most prevalent form of IPV reported at baseline across all studies (Table 3), with rates between 27% and 100%, followed by physical assault, sexual coercion, and injury, regardless of the context in which the research was conducted. Some studies report prevalence (%), while others describe mean (*M*) and standard deviation (*SD*).

Intervention Type

Seven (58%) of the selected studies are *advocacy interventions*, working to ensure access to resources and improve health and/or legal responses, carried out by social workers (Cripe et al., 2010; Tiwari et al., 2010; 2012), community-based advocates (DePrince, Labus, Belknap, Buckingham, & Gover, 2012a; DePrince, Belknap, Labus, Buckingham, & Gover, 2012b), community health workers (Gillum, Sun & Woods, 2009), family doctors (Hegarty et al., 2013), female undergraduates (Sullivan, Tan, Basta, Rumptz, & Davidson,1992; Sullivan, Campbell, Angelique, Eby, & Davidson, 1994; Sullivan, & Bybee, 1999), or a midwife with a master's degree in counseling (Tiwari et al., 2005). Three (25%) studies refer to *psychological group interventions*, in which a therapeutic process is developed by female research assistants (Gilbert et al., 2006) or by therapists (Graham-Bermann & Miller, 2013; Kaslow et al., 2010). Two (17%) studies report *psychological individual interventions* with therapists (Johnson, Zlotnick, & Perez, 2011) or a psychiatric nurse (Reed & Enright, 2006).

Intervention Length

Generally, *advocacy interventions* were briefer, oscillating between one 30-minute individual session of empowerment (Cripe et al., 2010; Tiwari et al., 2005), advocacy by phone call (DePrince et al., 2012a, 2012b), or a combination of both (Gillum et al., 2009; Tiwari et al., 2010, 2012). More intensive advocacy programs are proposed by Sullivan and collaborators (1992; 1994; 1999), in which services were provided for four to six hours per week in the first 10 weeks post-shelter, and by Hegarty and collaborators (2013), where patients had one to six sessions of counselling with family doctors. *Psychological group interventions* were longer, taking 11 sessions (Gilbert et al., 2006) or 10

Table 3

Summary of the prevalence rates found in the 12 studies analyzed in the systematic review.

Location	Authors	Prevalence of IPV
Health care settings (50%)	(Cripe et al., 2010)	**EG:** 42.2% of severe and 7.4% of minor psychological IPV **CG:** Similar rates were observed in this group.
	(Gillum et al., 2009)	95% (39 women) experienced nonphysical abuse; 56% (23 women) experienced physical abuse.
	(Hegarty et al., 2013)	Emotional abuse in 71 women (27%); Physical abuse in 5 women (2%).
	(Tiwari et al., 2005)	**EG:** 32% suffered from psychological abuse; 23% from physical abuse; 4% from sexual violence. **CG:** 35% suffered from psychological abuse; 20% suffered from physical abuse; 8% suffered from sexual violence.
	(Gilbert et al., 2006)	100% of women reported at least minor psychological IPV **EG:** 63% suffered severe psychological IPV; **CG:** 61% suffered severe psychological IPV.
	(Kaslow et al., 2010)	High rates of non-physical abuse: **EG**: *M*= 40.1; *SD*= 22.5; **CG:** *M*= 46.0; *SD*= 18.7.
Community (25%)	(Tiwari et al., 2010;2012)	Significant scores of psychological abuse: **EG:** *M*= 18.54; *SD*= 10.20; **CG:** *M*= 18.95; *SD*= 10.36. Physical assault: **EG:** *M*= 1.68; *SD*= 4.21; **CG:** *M*= 1.55; *SD*= 4.10. Sexual coercion: **EG:** *M*= 0.68; *SD*= 3.32; **CG:** *M*= 0.14; *SD*= 0.73.
	(Graham-Bermann, & Miller 2013)	Psychological abuse is a pervasive part in mothers' lives, including control tactics (*M*= 95.46; *SD*= 79.01) and physical threats (*M*= 45.72; *SD*= 98.13), frequently followed by sexual (*M*= 37.38; *SD*= 59.72), mild physical violence (*M*= 18.89; *SD*= 30.86), and severe violence (*M*= 11.13; *SD*= 19.08).
	(Reed & Enright, 2006)	It is the only intervention designed specifically for women who experienced psychological abuse, as such, 100% of those same women present severe psychological IPV at baseline.
Shelter (17%)	(Sullivan et al., 1992;1994; 1999)	Shows high means: **EG:** *M*= 2.73; *SD*= 0.63; **CG:** *M*= 2.27; *SD*= 0.52.
	(Johnson et al., 2011)	100% of psychological IPV in both the **EG** and the **CG**; Physical abuse: 31% in the **EG** and 34% in the **CG**; Sexual abuse: 23% in the **EG** and 24% in the **CG**.
Legal System (8%)	(DePrince et al., 2012a; 2012b)	86% of women with police-reported IPV refer to psychological abuse as the most prevalent type of IPV: **EG:** *M*= 5.61; *SD*= 3.77; **CG:** *M*= 6.38; *SD*= 3.53. Psychological abuse followed by physical aggression, and injuries.

Abbreviations: EG: Experimental group; CG: Control group; *M*: Mean; *SD*: Standard deviation.

sessions (Graham-Bermann & Miller, 2013; Kaslow et al., 2010). *Psychological individual interventions* oscillated between 12 sessions in the Johnson and collaborators (2011) study and an average of 7.95 months in the Reed and Enright (2006) study.

Intervention Content

Advocacy interventions sought to empower women, being based on supportive care, empathic listening, education about violence and safety plans, supporting the victims to achieve their goals, developing their solution skills, and providing access to community-based resources, taking into account their own individual needs. *Psychological group interventions* are based on social cognitive, triadic influence, and empowerment theories, and are designed to improve communication, negotiation skills, coping, resilience, problem solving, and self-efficacy, as well as creating a purpose in victim's lives. *Psychological individual interventions* are based on cognitive-behavioral or forgiveness therapy protocols.

Intervention Outcomes

Mental health, safety, and wellbeing.

Advocacy interventions. There is inconsistent evidence regarding the effectiveness of advocacy interventions in the improvement of mental health (e.g., depression, PTSD, anxiety), safety planning, and well-being (e.g., quality of life, accessing legal and community resources, and social support). Cripe and collaborators (2010) reported that there were no effects regarding quality of life, adoption of safe behaviors, and use of community resources after the intervention. Likewise, in the study of Hegarty and collaborators (2013), no effects were detected in terms of quality of life, safety planning and behavior, mental health, anxiety, or comfort to discuss fear after 12 months, however, medium effects were detected in the experimental group (EG) for women's safety (d = 0.62), their children (d = 0.72), and depression symptoms (d = 0.44). No effect sizes for PTSD and depression were obtained in the study of DePrince and collaborators (2012a, 2012b) one year after the initial interview. Nonetheless, small effects were found in the reduction of fear (d = 0.21), engagement with prosecution tasks (d = 0.24), and taking part in the prosecution or going to court (d = 0.15). In the study by Gillum and collaborators (2009), women in the EG engaged, on average, in 3.5 more safety-promoting behaviors, while the control group (CG) performed 0.5 less on these behaviors, revealing a large effect size (d = 1.16). Sullivan and collaborators (1992; 1994; 1999) found that women in the EG reported less depression (d = 0.20), higher quality of life (d = 0.25), and social support (d=0.46), as well as being more effective in accessing resources (d = 0.43) and obtaining community resources (d =

0.41). In the two-year follow-up, the main effects were visible in all of these variables, except for depression. Tiwari and collaborators (2010; 2012) reported that the intervention effects on levels of depression were not significantly different. A small effect size was found for perceived social support (d = 0.25) in the three-month assessment and nine-month assessment (d = 0.15), but not for health-related quality of life. The number of safety-promoting behaviors increased significantly (d = 0.54), but not for the utilization of health services. In another study of Tiwari and collaborators (2005), women in the EG had higher physical functioning (d = 0.47) after the intervention and showed significantly improvements regarding limitations due to physical problems (d = 0.32) and emotional problems (d = 0.45). However, they reported more bodily pain (d = -0.59).

Group interventions. Psychological group interventions present intermediate effectiveness. Gilbert and collaborators (2006) found that the intervention promotes a decrease in the use of any drug (d = 0.46), depression (d = 0.38), and in having sex while high on illicit drugs (d = 0.38), but not in PTSD symptoms or having multiple sex partners. In the study of Graham-Bermann and Miller (2013), the effect of the intervention was moderate in reducing PTSD symptoms in the victims (d = 0.44). Kaslow and collaborators (2010) reported that the EG showed a great decline for depressive symptoms (d = 0.46) and general distress (d = 0.43), but not for reductions in suicidal ideation or PTSD.

Individual Interventions. Effectiveness was stronger in cases of psychological individual interventions. Johnson and collaborators (2011) found that participants in the EG were significantly less likely to meet criteria for PTSD when compared to the CG (d = 0.82). Strong effects were also found for depression (d = 0.79), empowerment (d = 0.84), and social support (d = 0.78). Forgiveness therapy (Reed & Enright, 2006) presents significantly greater improvement in EG for depression (d = 0.59), trait anxiety (d = 0.77), post-traumatic stress symptoms (d = 1.14), self-esteem (d = 0.68), forgiveness (d = 1.83), environmental mastery (d = 0.58), finding meaning in suffering (d = 0.74), and new stories (d = 1.60). None of the studies reported negative or harmful effects caused by the interventions.

Revictimization

Of the 12 studies reviewed, seven (58%) provide information about the intervention's impact on preventing revictimization, varying between small and large effect sizes.

Sullivan and collaborators (1992; 1994; 1999) found that women reported less psychological (d = 0.21) and physical IPV (d = 0.44). However, the effects dissipated for

psychological IPV in the 24-month follow-up. Those who remained with their partners and were economically dependent continued to experience the highest levels of IPV. In the study of Tiwari and collaborators (2010; 2012), small effects were found concerning psychological IPV at 3 months' *(d* = 0.27) and 9 months' assessment *(d* = 0.21). No effects were found in physical assault or sexual coercion. In another study (Tiwari et al., 2005), intermediate effects were obtained. The EG reported less psychological IPV at 3 months (*d* = 0.47), and less minor physical violence (*d* = 0.48) but no effects were observed for less severe physical violence or sexual aggression. In the case of DePrince and collaborators (2012a; 2012b), both conditions were unrelated with psychological revictimization in the one-year follow-up to the report of violence by new offenders. Despite that, women in the EG reported greater readiness to leave the abuser (*d* = 0.47). Gilbert and collaborators (2006) showed large effects, suggesting the EG was more likely to report a decrease in minor (*d* = 0.82) and severe psychological IPV (*d* = 0.79), as well as minor physical or sexual IPV (*d* = 1.08), at the three-month follow-up. Furthermore, Kaslow and collaborators (2010) obtained intermediate effects for non-physical IPV (*d* = 0.63) and physical IPV (*d*= 0.57) in the EG at the 12-month follow-up. Women exhibited less severe suicidal ideation when revictimized (both physical and nonphysical IPV) after intervention. Finally, the study of Johnson and collaborators (2011) only presents a global IPV score of revictimization. The EG showed large effects in the six-month follow-up in the intent to treat (*d* = 0.90) and minimal attendance analyses (*d* = 1.40).

Discussion

The consideration of these findings legitimizes further responsiveness of formal support networks and the legal system to male victimization (Machado, Hines, & Matos, 2016) and psychological IPV, since it is a prevalent form of abuse associated with chronic health consequences and financial costs (Carney & Barner, 2012). Specific and gender-neutral screening tools for detecting psychological IPV are necessary (Thompson, Basile, Hertz, & Sitterle, 2006) for developing a better understanding of this type of violence, as well the establishment of clear definitions for the adaptation of therapies according to the different needs and subtypes of IPV victimization.

The results of this systematic review revealed that the effectiveness of interventions is related to: a) intervention type, with the psychological individual intervention being more effective; b) intervention length, with extensive protocols being more successful; c) intervention content,

with structured programs associated with strong improvements, which is the case in cognitive-behavioral treatment (Johnson et al., 2011) and forgiveness therapy (Reed & Enright, 2006); and d) being assisted by therapists, rather than non-specialized volunteers.

Advocacy interventions were typically short-term, crisis-oriented, and undertaken by non-professionals, whereas group and individual psychological interventions were implemented by therapists, and ranged from 10 sessions to an average of 7.95 months of weekly therapy. In terms of effect sizes, advocacy presents great variability, from studies without significant differences (Cripe et al., 2010; Hegarty et al., 2013) up to studies with improvements (Gillum et al., 2009; Sullivan et al., 1992; 1996; 1999; Tiwari et al., 2005) or inconclusive evidence regarding outcomes (DePrince et al., 2012a; 2012b; Tiwari et al., 2010; 2012). Moderate effectiveness was registered in psychological group interventions, with reductions in symptomatology, such as PTSD, observed in Graham-Bermann and Miller (2013) but not in other studies (Gilbert et al., 2006; Kaslow et al., 2010). Strong effect sizes were mainly found in psychological individual interventions (Johnson et al., 2011; Reed & Enright, 2006).

Overall, there is a notorious paucity of evidence-based interventions designed to address psychological IPV, what might lead to the phenomenon being incorrectly addressed in terms of selection of the appropriate intervention and the recovery from its consequences. Of the 12 studies included, only one was specifically designed to target psychologically abused women (Reed & Enright, 2006), while the remaining studies intervened in global IPV, addressing the development of a security plan, increment of safety-promoting behaviors, and the access to shelters, all of which are not proper responses to the needs of psychological abused victims.

Raise authorities' awareness concerning the specific needs of these victims and the impact of psychological IPV on mental health is crucial. Professionals should be trained to recognize signs of controlling and isolating behaviors and to promote the victim's disclosure. Appropriate attitudes could begin with intentionally ask about IPV, providing information, and showing respect for the non-linear process of leaving an abusive relationship characterized by successive relapses. Providing non-judgmental support and responsiveness to victim's needs are central skills that send the message of respect for their choices, without trying to influence their decision of staying or leaving the abusive relationship (Edwards, Dardis, & Gidycz, 2012; Machado et al., 2016). An emphasis should be placed on the ability to preserve a social support network for buffering the effects of IPV and to prevent a loss of identity (Karakurt & Silver, 2013), with a special focus on existing strengths and resources. In this context, forgiveness therapy emerges as a promising

treatment (Reed & Enright, 2006) that must be replicated against a gold standard of effectiveness, which is the case of cognitive-behavioral therapy, with the necessary adaptations to the field of psychological IPV. These therapeutic guidelines might bring valuable inputs to the improvement of IPV interventions. Interventions should prevent the progression of psychological to physical violence, taking into account that this type of IPV often predicts the development of physical IPV (O'Leary & Slep, 2003).

Finally, IPV is not merely a women's issue, since men also experience IPV (Carney & Barney, 2012, Coker et al., 2002; Douglas & Hines, 2011) marked by mutual patterns of perpetration and victimization (Bogat et al., 2013). The absence of interventions targeting male victims, revealed by this review, is alarming. The authors reinforce that the search term combinations and the inclusion criteria were not gender exclusive. Thus, the absence of RCTs that included male victims points to a gender bias in this domain of research (Carney & Barner, 2012; Dixon & Graham-Kevan, 2011) because only interventions for male perpetrators of IPV were found. At the moment, there is no evidence to sustain the gendered conceptualization of IPV that has traditionally informed intervention policies (Dixon & Graham-Kevan, 2011). The phenomenon of male victimization in the context of IPV is a somewhat neglected and controversial issue (Douglas & Hines, 2011; Schuler, 2010), which lowers the propensity of men to ask for help (Schuler, 2010). Moreover, male victims seem to have negative experiences with formal resources when seeking help, which has lasting implications for their mental health condition (Douglas & Hines, 2011). It's urgent to adopt a gender inclusive approach, creating formal responses for male victims' experiences, and screening for IPV signals independently of the victim's gender (Douglas & Hines, 2011), as well as promoting policy intervention and research in this domain (Dixon & Graham-Kevan, 2011). There is a need for gender neutral support resources and awareness campaigns, in order to allow men to identify themselves as victims and to break the wall of shame that stops them from asking for support. Professionals should be aware and be technically prepared to support victims of different types of IPV, including psychological IPV and gender-inclusive interventions.

Conclusions

In sum, this review draw attention to some alarming gaps in the in the field of IPV research, with potential implications for legal context, social services, and clinical practice. The lack of assessment through specific screening tools, the apparent neglect of psychological IPV with or without co-occurrence with other types of violence, and the nonexistence of published interventions for male victims are the prominent areas that require further exploration. Concerning the included studies, strong evidence of effectiveness for IPV interventions was only found for psychological individual therapy. Moreover, longer and more structured programs seem to be associated with stronger improvements in intervention outcomes. The results reiterate the importance of exploring the effectiveness of sensitive interventions that respond to the specific needs of victims experiencing IPV. Likewise, researchers and professionals should recognize the seriousness of psychological IPV, which must be addressed not only to intervene on and prevent the consequences it causes, but mainly to recognize the first signs of IPV and prevent the escalation to physical violence.

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CHAPTER II

SCREENING TOOL FOR PSYCHOLOGICAL INTIMATE PARTNER VIOLENCE: PORTUGUESE VALIDATION OF THE PMWI[6]

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CHAPTER II

SCREENING TOOL FOR PSYCHOLOGICAL INTIMATE PARTNER VIOLENCE: PORTUGUESE VALIDATION OF THE PMWI

Abstract

The Psychological Maltreatment of Women Inventory - Short Form (PMWI-SF) is a well-established and brief instrument for assessing psychological intimate partner violence (IPV). In the absence of a specific tool to assess psychological IPV in Portuguese women, this study sought to confirm the factor structure of the Portuguese PMWI-SF and analyze its psychometric properties. Five hundred and six women filled out the e-survey including the assessment of IPV (Revised Conflict Tactics Scales, Psychological Abuse Survey, and PMWI-SF) and psychopathology (Brief Symptom Inventory). Sociodemographic characteristics, construct validity, and internal consistency were analyzed, and a cut-off for the PMWI-SF was established. Confirmatory factor analysis for the two-factor structure (emotional/verbal abuse and domination/isolation) showed an excellent fit for the last 6 months and across the lifespan. Factors possessed good internal consistency ($\alpha \geq .70$) and test-retest reliability ($r \geq .90$). Pearson's correlation analysis revealed the PMWI factors were positively correlated with proximal variables. PMWI-SF scores demonstrated excellent differentiation between women with and without psychological IPV (AUC = .948; CI = .93-.97). The PMWI-SF cut-off score that provided the optimal balance was 32 (sensitivity = 83.8%; specificity = 91.7%). The PMWI-SF is a valid and reliable instrument for assessing the experience of psychological IPV in Portuguese women.

Keywords: Psychological intimate partner violence, PMWI, screening tool assessment.

Introduction

Psychological intimate partner violence (IPV) is the most prevalent form of partner abuse in cross-cultural studies (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006) and is defined by O'Leary (2015), including acts of criticism or verbal aggression and acts of isolation and domination of a partner. For the purpose of this study, we explored psychological IPV experienced by women with a male partner (Moreno-Manso, Blázquez-Alonso, García-Baamonde, Guerrero-Barona, & Pozueco-Romero, 2014). The consequences of prolonged IPV include complex post-traumatic stress disorder (Keeley et al., 2016), anxiety and mood disorders (Dillon, Hussain, Loxton, & Rahman, 2013; Vázquez, Torres, & Otero, 2012), and decline of self-esteem and self-identity (Matheson et al., 2015).

Concerning screening tools, the instruments tend to differ in the types of psychological items measured, due to a lack of consensus on a definition for psychological IPV. Inconsistencies in definitions among researchers have repercussions in the disparity of prevalence rates and the lack of agreement concerning what measures to use. According to Follingstad (2007), psychological IPV refers to behaviors that cross some threshold of severity and result in a certain degree of effect on the victim. To our knowledge, the levels of psychological abusive acts that distinguish between normative conflict in non-abusive relationships and severely psychologically abusive relationships, as well as whether one can adequately make these discriminations through cut-scores, remain to be established.

Ureña, Romera, Casas, Viejo and Ortega-Ruiz (2015) mentioned that psychological IPV was less researched than physical or sexual violence because it can be less objective and more difficult to evaluate than other types of violence. Psychological IPV often precedes and progresses to physical IPV (O´Leary, 2015), and has been considered to be a risk factor for physical aggression (Capaldi, Knoble, Shortt, & Kim, 2012). Therefore, the early signs of verbal aggression may provide the context for further violence. In a Portuguese sample aged between 13 to 29 years (Machado, Caridade, & Martins, 2010), psychological IPV was reported by 19.5% of the participants (n = 514) and no gender differences were found in the rates of victimization. These findings are, to some extent, higher that those found in Portuguese married couples (Machado, Gonçalves, Matos, & Dias, 2007), and suggest that IPV may constitute a serious concern among the Portuguese young adult population (Machado et al., 2010). In this context, a validated measure for identification of psychological IPV is necessary, not only for reducing its chronic consequences and providing adequate treatment, but also for preventing its progression to physical IPV.

In Portugal, IPV is measured as a single overarching construct among researchers, and only general scales are used to measure physical, sexual, and psychological IPV, resulting in losses in accuracy and a limited coverage of behaviors specific to psychological IPV (Carney & Barner, 2012). To sum up, it is crucial to validate a screening tool to measure psychological IPV comprehensively, given the lack of a suitable measure for Portuguese women. The national attempt to measure psychological IPV was the Revised Conflict Tactics Scales (CTS2; Alexandra & Figueiredo, 2006). This questionnaire assessed all dimensions of IPV, including psychological, physical, and sexual items. Despite being widely used, it is criticized for its generality, limited coverage of psychological items, lack of comprehensiveness, and absence of control/dominance items (Tolman, 1999). Until now, no instruments were available to specifically measure the psychological dimension of IPV in Portugal, as the psychometric properties of these tools were not tested. In fact, tools for assess psychological IPV alone are preferable for validation among a Portuguese population, given their inclusion of a more extensive scope of psychological IPV acts. After pondering the strengths and limitations of several assessment tools (Thompson, Basile, Hertz, & Sitterle, 2006), including the Subtle and Overt Psychological Abuse Scale (Jones, Davidson II, Bogat, Levendosky, & von Eye, 2005) and the Multidimensional Measure of Emotional Abuse (Murphy & Cascardi, 1999; Murphy & Hoover, 1999), we chose the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1989) for Portuguese validation of the participant's exposure to psychological IPV. The PWMI was designed to provide a brief, but reliable and valid measure, and is well known as a comprehensive instrument in the field of psychological IPV.

In order to evaluate the PMWI, we used the Portuguese version of the CTS2 (Alexandra & Figueiredo, 2006) and we had translated into Portuguese the Psychological Abuse Survey, a checklist which specifically addresses psychological IPV (PAS; Reed & Enright, 2006; an adaptation from Follingstad & Dehart 2000; Follingstad, Rutledge, Berg, Hause, & Polek 1990; Sackett & Saunders, 1999). The PAS was selected to integrate the screening protocol, since it determines a cutoff point from which psychological IPV can be considered persistent in a relationship.

The validation of a comprehensive and systematic tool for psychological IPV in this culturally-specific context is a step toward the pursuit of the following goals: a) providing a means for early identification of the perpetrative behaviors that can be targeted for intervention; b) increasing public awareness and funding for prevention campaigns; c) preventing the progression to other forms of IPV;

d) informing intervention programs about methods for the reduction of symptoms and the enhancement of global functioning; e) improving the knowledge related to etiology, prevalence rates, risk factors, and consequences; f) facilitating cross-country comparative studies with the same assessment tool; and g) allocating resources and appropriate support in health care settings (Collett & Bennett, 2015; O'Doherty et al., 2013).

The initial study of the PMWI (Tolman, 1989) was administered to 207 battered women recruited from a domestic violence program and 407 men who batter. The main purpose was to assess the non-physically abusive behaviors exhibited by male offenders and to develop a measure for psychological IPV. Based on 58 items, an exploratory factor analysis revealed two factors: dominance/isolation and emotional/verbal abuse (Tolman, 1989). Later, the inventory was validated (Tolman, 1999), and a 14-item short version was developed, maintaining the two-factor structure. The PMWI is a well-established tool for measuring psychological IPV in a simple and easy way, representing a comprehensive scope of psychological IPV items (PMWI; Tolman, 1989; 1999). This screening tool shows good psychometric properties and is translated into several languages, facilitating the cross-country comparison of results. However, Tolman (1999) noted that: "a comparison of psychologically maltreated nonbattered women with women who have not been psychologically maltreated would provide stronger evidence of criterion validity (...) further research is necessary to determine what levels of psychological maltreatment distinguish abusive and non-abusive relationships" (p. 33).

Our study is the first to answer the above questions. Specifically, we are interested in comparing the responses of non-victims with victims of psychological IPV, without self-report of physical or sexual IPV, and to determine serious levels of psychological IPV victimization through the validation of a specific instrument to evaluate psychological IPV in Portugal. The main goal was to confirm the factor structure of the Portuguese version of the PMWI-SF and analyze its psychometric properties, both for psychological IPV in the last six months, and history of psychological IPV across the lifespan. A secondary goal was to establish an optimal cut-off point and to determine whether the PMWI-SF is able to screen for serious levels of psychological IPV.

Method

Participants and Data Collection

Five hundred and six female college students completed the e-survey. The age of respondents ranged between 18 and 55 years old, with an average age of 24. University-based samples are

typically within the high-risk group of those under 25 years old, where the first manifestations of psychological IPV occur and gain expression (Carney & Barner, 2012). Thus, we employ a student sample to maximize the probability of screening for psychological IPV, in the absence of other forms of IPV, which are generally detected later in marriage or cohabitation. We have conducted the analysis with and without the "outliers", defined as "the participants who fell outside the young adult range". The conclusions of statistical analyses did not change when these data points were removed from the data set, since they were few such cases. For this reason, we decided to maintain the answers of these participants.

Table 4 shows the sociodemographic data. Women that were over the age of 18, had been in intimate partner relationships, and spoke Portuguese were included in the study. If a participant had not been in an intimate relationship within the last 6 months and/or across lifespan, she was instructed to select "not applicable", and the response was not considered in the analysis. Participants agreed to respond after having been briefed about the voluntary nature and the aims of the study. We shared the following information with participants at the beginning of the e-survey: To ensure that we started with a clear conceptual basis, a brief definition of intimate relationship was provided ("An intimate relationship can be defined as an interpersonal bond developed in the context of dating, marriage, or cohabitation"). Then, we informed participants about the general goal of the e-survey. We intentionally avoided referring to the topics "abuse", "violence", or "maltreatment" because we understand that they could precondition the responses, prevent spontaneous answers, and introduce bias ("In this study, we are interested in exploring some aspects of intimate relationships in college students. Please respond honestly according to your own experiences."). The privacy of responses was also guaranteed ("Your responses will remain anonymous and the results will be kept confidential.").

Following the approval of the Ethics Committee at the University of Porto, the invitation to participate in the study was sent by interactive e-mail to all students (N = 31,352) enrolled in the three levels of education (bachelors, masters, and Ph.D.) at a public Portuguese University, in the 2014/2015 academic year. According to the official records, 54% of these students were females (n = 16,930). Considering the undelivered emails rejected by the server (11%), a response rate of approximately 9% was obtained. To ensure confidentially and anonymity, an identity code was provided to participants. Informed consent was obtained.

Table 4

Sociodemographic data for total sample (N = 506), absence of any kind of IPV (n = 268; non-abused) and presence of psychological IPV, without physical or sexual IPV (n = 120; abused).

	Total sample	Non-abused	Abused
	N = 506	*n* = 268	*n* = 120
M (SD)			
Age (years)	23.47 (5.37)	23.89 (4.76)	23.78 (5.03)
Relationship duration (years)	4.3 (2.2)	3.8 (1.8)	4.4 (2.1)
n (%)			
Marital status			
In a relationship	341 (67.4)	162 (60.4)	86 (71.7)
Single	122 (24)	78 (29.1)	24 (20)
Married/cohabitating	40 (8)	28 (10.5)	10 (8.3)
Divorced/separated	2 (0.4)	0 (0)	0 (0)
Widowed	1 (0.2)	0 (0)	0 (0)
Academic level			
Bachelor	222 (43.9)	118 (44.0)	49 (40.8)
Master	250 (49.4)	142 (52.9)	62 (51.7)
Ph.D.	34 (6.7)	8 (3.1)	9 (7.5)
Employment situation			
Student	408 (80.6)	201 (75)	99 (82.5)
Student worker	98 (19.4)	67 (25)	21 (17.5)
IPV history (CTS2)			
1.	268 (53.0)	268 (100)	0 (0)
2.	120 (23.7)	0 (0)	120 (100)
3.	118 (23.3)	0 (0)	0 (0)

Note: 1. Absence of IPV; 2. Psychological IPV without physical and/or sexual IPV; 3. Psychological IPV with at least one item of physical and/or sexual IPV

The e-survey maximizes the number of potential respondents and consists in a structured questionnaire, which can be completed in less than 15 minutes, with items from all instruments combined. We chose this method since the target participants' use computers and the internet

on a daily basis, allowing time and cost savings. The method also allows an improvement in the levels of accuracy in data collection, through the automatic recording of participants' responses in the e-survey platform, and the possibility of downloading an Excel-compatible file. As an additional benefit of using electronic surveys regarding IPV, we could refer to the privacy it provides, which may have been helpful in reducing social desirability bias, as revealed by the study of Follingstad and Rogers (2014). For the test-retest part of the study, we sent a new invitation two weeks later. Test-retest reliability was assessed for 50 of these women, and the same participant identification code was required to create paired cases.

Procedure

Back-translation. The PMWI-SF was first translated into Portuguese from English and then back-translated by two independent bilingual investigators, in order to maximize the conceptual equivalence. Misconceptions were clarified until a first version was approved by the research team. After that, cognitive debriefing was carried out with 14 women and small adjustments were made, resulting in a final version.

Measures

Psychological Maltreatment Women Inventory-Short Version. (PMWI-SF; Tolman, 1999). Fourteen items inquired about psychologically abusive actions that women may or may not have experienced within an intimate relationship. The 14 inventory items can be consulted in Table 5. The items were divided into 2 dimensions: Emotional/Verbal (items 1–4; 11–14) and Domination/Isolation (items 5–11), with response options on a 5-point Likert scale, ranging from never (1) to very often (5), for the last six months and across the lifespan, with higher scores indicating more psychologically abusive experiences.

Revised Conflict Tactics Scales. (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Portuguese version by Alexandra & Figueiredo, 2006). The IPV related-questions were collected from three subscales (psychological aggression, physical assault, and sexual coercion). Women responded with reference to the number of occurrences during the last year, on an 8-point Likert scale. Higher scores indicated higher frequency of abusive acts in the preceding year. The instrument estimates the prevalence, chronicity, and severity of the different forms of IPV. The Cronbach's alpha for this study was .97, taking into account all the items from the three subscales. The results from the validation study demonstrate that the Portuguese version of the CTS2 scales

demonstrated good psychometric properties (Alexandra & Figueiredo, 2006), including applicability to Portuguese college samples (Fonseca, 2016).

Table 5

Items of the Psychological Maltreatment of Women Inventory-Short Form (PMWI-SF).

1. My partner called me names.
2. My partner swore at me.
3. My partner yelled and screamed at me.
4. My partner treated me like an inferior.
5. My partner monitored my time and made me account for my whereabouts.
6. My partner used our money or made important financial decisions without talking to me about it.
7. My partner was jealous or suspicious of my friends.
8. My partner accused me of having an affair.
9. My partner interfered in my relationships with other family members.
10. My partner tried to keep me from doing things to help myself.
11. My partner restricted my use of the telephone.
12. My partner told me my feelings were irrational or crazy.
13. My partner blamed me for his problems.
14. My partner tried to make me feel crazy.

Note: Items are grouped into two subscales. The 7-item Emotional/Verbal subscale consists of items 1-4 and 12-14. The 7-item Dominance/Isolation subscale consists of items 5-11.

Psychological Abuse Survey. (PAS; Reed & Enright, 2006; an adaptation from Follingstad & Dehart, 2000; Follingstad et al., 1990; Sackett & Saunders, 1999). This checklist assessed the experience of psychological IPV during women's lifetimes. The 16 items covered eight abusive categories (criticizing behavior, ridiculing of traits, jealous control, purposeful ignoring, threats of abandonment, threats of harm, threats to damage personal property, and fear of abuse). The frequency was measured by a Likert scale, ranging from 1 (never) to 8 (daily). Total scores of 41 or above are considered a serious pattern of psychological IPV based on clinical expertise (Dutton & Painter, 1993; Reed & Enright, 2006; Sackett & Saunders, 1999). The existence of a threshold for a high level of psychological IPV provided valuable information for the statistical determination of a cut-off for the PMWI. The original version of the PAS intends to create a checklist of symptoms based on a

theoretical structure informed by clinical practice, and no information about psychometric properties is available for the original version (Reed & Enright, 2006). We translated the checklist into Portuguese for the first time, and found good internal consistency with the current audience (Cronbach's α = .925).

Brief Symptom Inventory. (BSI; Derogatis & Melisaratos, 1983; Portuguese version by Canavarro, 1999). BSI is a 53-item self-report inventory, using a 5-point Likert scale (0 = "not at all" to 4 = "extremely"), in which participants rate the occurrence of each psychological symptom in the past week, with higher scores indicating a higher degree of psychopathology. The Global Severity Index (GSI) captures the intensity of psychological distress. The psychometric characteristics of the Portuguese version allow for the application of the BSI with safety, functioning as a good indicator of psychopathological symptoms given its good indexes of validity and reliability (Canavarro, 1999). The BSI dimensions and indexes in college samples (Fonseca, 2016) do not differ significantly from the data referring to the original validation study in Portuguese samples (Canavarro, 1999). The Cronbach's alpha for this study was .98.

Data Analysis

IBM SPSS 21 was used to analyze the data, except for CFA, which was executed using AMOS. The sociodemographic characteristics were reported by descriptive statistics. The psychometric characteristics of the PMWI-SF for the last 6 months, and across the lifespan, were investigated through construct validity (CFA, known-groups method, and convergent validity analysis) and test-retest consistency. The theoretical model proposed by Tolman (1999) was tested through CFA considering the two-factor model (Emotional/Verbal and Domination/Isolation). Model fit was assessed with χ^2 statistics, Comparative Fit Index (CFI), and Root Mean Square Error of Approximation (RMSEA). Model fit is considered good when the chi-square value divided by the degrees of freedom (CMIN/DF) is below 5, the CFI is ≥0.90, and the RMSEA is near or below 0.06 with the upper limit at or below 0.08 (Hu & Bentler, 1999). Pearson's correlation was executed to test convergent validity, which is sustained if PMWI-SF factors were found to be correlated with other measures of psychological IPV. The magnitude of correlations was considered small (≤ .30), moderate (.30–.50), or large (≥ .50). Known-groups technique was conducted to discriminate between the group of women known to have a history of psychological IPV, in the absence of physical or sexual IPV, and non-abused women. Internal consistency was evaluated using Cronbach's alpha coefficient. Lastly, we conducted receiver

operating characteristic (ROC) analyses to assess the accuracy and predictive value for the version across the lifespan of the PMWI-SF, in order to identify a cut-off score capable of discriminating between women with a history of psychological IPV and non-abused women.

Results

Pilot Version

Fourteen native Portuguese-speaking women, who were in psychotherapy after psychological IPV, in the absence of physical or sexual IPV, completed the inventory. The average time of response was 3 minutes (*SD* = 2 minutes). Cognitive debriefing was conducted with participants to confirm the comprehensibility of the pilot Portuguese version. Items were evaluated as simple and objective in detecting psychological IPV, and the target group considered the length of the inventory to be adequate.

Validation of the Portuguese PMWI-SF

Sample. Five hundred and six women answered the e-survey, and no missing data were detected, as submission was only possible after answering all of the questions. No floor or ceiling effects were observed.

Construct validity. CFA for the PMWI-SF, in the last six months and across the lifespan, was performed following the Hu and Bentler (1999) criteria for the CFI and RMSEA. Based on the original PMWI-SF study design (Tolman, 1999), the first model tested a two-factor solution for the last six months (Figure 3) in which items were divided into two intercorrelated dimensions (Emotional/Verbal (EV) and Domination/Isolation (DI)). The second model (Figure 4) sought to verify whether the same factor structure was maintained for history of psychological IPV across the lifespan. Correlated errors for pairs of items of the same dimension were allowed in the final model. Indices for the original two-factor model of the PMWI for the last 6 months [χ^2_{66} = 235.315; p<.01; CFI = .942; RMSEA = .077 (90% CI .067–.088)] fit the criteria indexes of CMIN/DF less than 5, CFI > .90, and RMSEA < .08. The CFA for the PMWI across the lifespan also presented a good model fit, with CFI = .970 and RMSEA = .072 (90% CI .061–.082) and CMIN/DF less than 5 (χ^2_{63} = 211.973; p<.01). Both models were supported by the data, with good fit indexes indicating that the original structure fit the Portuguese sample well. Standardized factor loadings for both models are shown in Table 6. All item loadings were statistically significant (p< .05) and with loading values >. 40.

Figure 3

Standardized regression weights of factor loadings in Model 1 for PMWI-SF last 6 months.

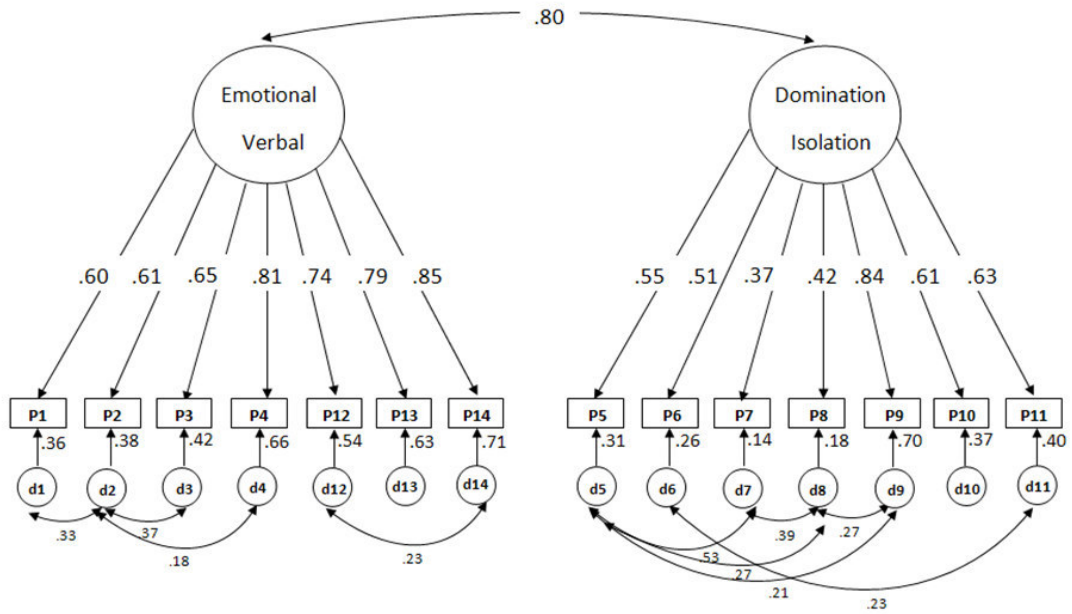


Figure 4

Standardized regression weights of factor loadings in Model 2 for PMWI-SF across lifespan.

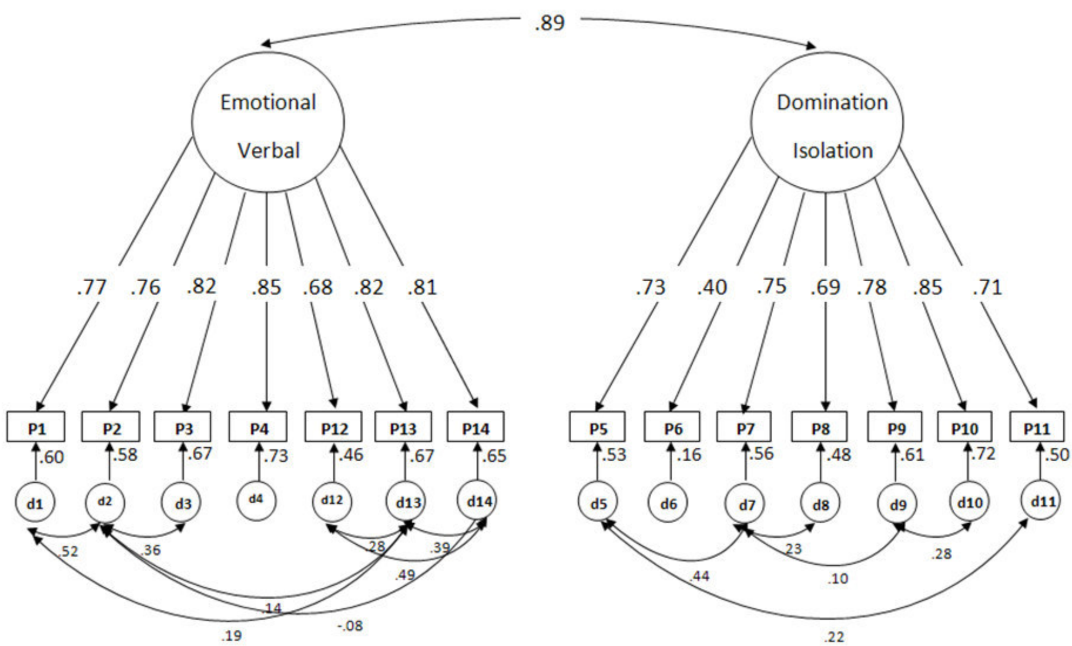


Table 6

Item loadings, means, standard deviations and sensitivity for two-factor model.

	Factor	Last 6 Months				Across Lifespan			
		Λ	*M*	*SD*	Range	λ	*M*	*SD*	Range
PMWI 1	EV	.602	1.24	0.64	1-5	.775	1.64	1.08	1-5
PMWI 2	EV	.615	1.35	0.71	1-5	.761	1.77	1.12	1-5
PMWI 3	EV	.646	1.69	0.91	1-5	.821	2.17	1.23	1-5
PMWI 4	EV	.809	1.33	0.82	1-5	.852	1.94	1.30	1-5
PMWI 12	EV	.735	1.32	0.81	1-5	.681	1.75	1.21	1-5
PMWI 13	EV	.793	1.26	0.74	1-5	.818	1.84	1.29	1-5
PMWI 14	EV	.845	1.27	0.78	1-5	.805	1.79	1.27	1-5
PMWI 5	DI	.554	1.57	0.97	1-5	.729	2.16	1.35	1-5
PMWI 6	DI	.512	1.10	0.47	1-5	.398	1.19	.66	1-5
PMWI 7	DI	.375	1.87	1.07	1-5	.745	2.58	1.36	1-5
PMWI 8	DI	.425	1.15	0.55	1-5	.691	1.66	1.16	1-5
PMWI 9	DI	.837	1.16	0.54	1-5	.779	1.61	1.15	1-5
PMWI 10	DI	.605	1.18	0.62	1-5	.847	1.78	1.27	1-5
PMWI 11	DI	.635	1.06	0.38	1-5	.705	1.37	0.90	1-5

λ: loading, *M*: mean; *SD:* standard deviation

Convergent validity. Pearson correlation coefficients were performed to analyze convergence between the PMWI-SF scores (for 6 months and across the lifespan) and related instruments (CTS2 subscale of psychological aggression and PAS) and psychological symptoms (GSI). All correlations were moderate to strong (Table 7), except for psychological symptoms, with low to moderate correlations.

Known-groups validity. According to Arias and Pape (1999), it is difficult to recruit a sample of women who are known to experience only psychological IPV. Tolman (1999) also reflects about the barriers to validate a measure of psychological IPV based on a known-groups method assuming that there is no "gold standard" for determining whether someone is experiencing psychological IPV other than their subjective global report*: "even some women who report frequent and pervasive acts of maltreatment do not necessarily label themselves as psychologically maltreated"* (Tolman, 1999, pp. 33-34) or label their partners as psychologically abusive (Follingstad & Rogers, 2014). To overcome these challenges, we conducted an interrater

reliability analysis using the Kappa statistic, and evaluated the agreement rate to determine the consistency among two categorical variables: the self-reported psychological IPV items and the direct question "Have you been psychologically maltreated by an intimate partner?". The interrater reliability was found to be Kappa = 0.61 ($p < 0.001$), indicating substantial agreement (Cohen, 1960), with an 84% score.

Table 7

Convergent validity between the PMWI dimensions (DI/EV), PAS, CTS2 psychological aggression and GSI for the last 6 months (6M) and across lifespan (AL).

	PAS	CTS2	GSI
PMWI_DI_6M	.302**	.334**	.192**
PMWI_EV_6M	.376**	.476**	.282**
PMWI_6M Total	.383**	.462**	.271**
PMWI_DI_AL	.795**	.610**	.500**
PMWI_EV_AL	.846**	.671**	.535**
PMWI_AL Total	.871**	.681**	.549**

** p<.001

To determine that the participants who had experienced psychological IPV had only experienced psychological IPV we created composite measures from the CTS2: absence of any kind of self-reported IPV (n = 268), self-reported psychological IPV without physical and/or sexual IPV (n =120), and self-reported psychological IPV with at least one item of physical and/or sexual IPV (n = 118). After that, two subgroups of women were compared using Multivariate Analyses of Variance, based on those composite measures of CTS: presence of psychological IPV, without physical or sexual IPV (n = 120), and absence of any kind of IPV (n = 268). The multivariate analyses indicates differences between groups on EV and DI subscales, for the last six months (Wilk's Λ = .97, $F(2,385) = 5.81$, p=.003), and across the lifespan (Wilk's Λ = .49, $F(2,376) = 195.18$, p<.001). Univariate analyses showed that, for each subscale (EV and DI), the scores are significantly highest among psychologically abused women, and lowest among those in non-abusive relationships for both periods, during the last six months and across the life span.

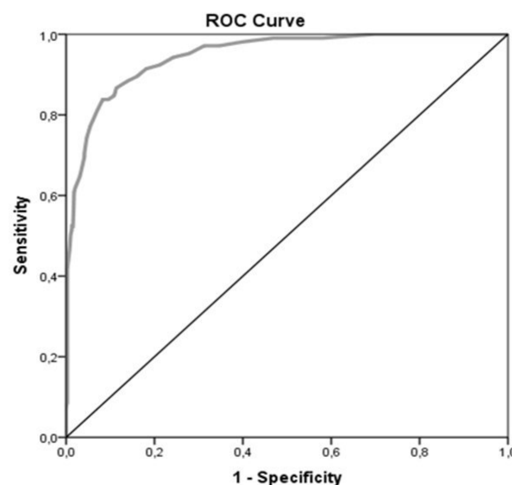
Internal consistency and test-retest reliability. The internal consistency of the Portuguese PMWI-SF indicated that the version can be used reliably for Portuguese women. The Cronbach's alpha for the entire scale for six months was .942, while the EV and DI subscales

were .902 and .865, respectively. For the PMWI-SF across the lifespan, the entire scale was .888, while the EV and DI subscales were .934 and .886, respectively. The test-retest reliability was evaluated by administering the scales twice to a sub-group of 50 participants after a two-week interval. Using the interclass correlation coefficient (ICC), the entire scale showed excellent stability across the two administrations two weeks apart, both for the last six months (ICC = .997) and across the lifespan (ICC = .998).

Criterion validity. Last, we were interested in identifying a cut-off score for the PMWI across the lifespan, to assess the accuracy and predictive value of the inventory in differentiating women identified with, and without, a history of serious psychological IPV. The average score of PMWI across the lifespan was 25 points. To determine the extent to which PMWI-SF scores can accurately identify the PAS cut-off, established as ≥ 41 by Reed and Enright (2006), we conducted ROC analyses, which examine the association between sensitivity and specificity to derive an area under the curve (AUC), indicating the extent to which a measure distinguishes between positive and negative cases. The ROC curve is displayed in Figure 5. PMWI scores demonstrated excellent differentiation between women with, and without, psychological IPV. The AUC of PMWI-SF across the lifespan was .948 (95% CI = .926–.970). In the present sample, the PMWI cut-off score that provided the optimal balance was 32 (sensitivity: 83.8%; specificity: 91.7%), indicating that the inventory can be used to discriminate abused and non-abused women, with minimum error.

Figure 5

ROC curve graph and area under the curve (AUC) for the performance of the PMWI-SF across lifespan for detecting history of psychological IPV.



Discussion

This study was a response to the lack of agreement on standard measures for psychological IPV, and the threshold from which acts can be considered psychologically harmful (World Health Organization, 2013). Therefore, this was the first study to analyze the psychometric properties of a tool for psychological IPV among Portuguese women and propose an average score of the PMWI-SF across the lifespan (25 points) and a cut-off for severe levels of psychological IPV (32 points). We went further than the original version by adding CFA, which provides an appropriate statistical framework to: 1) assess the validity and reliability of each item; 2) examine factor loadings; 3) test the correlations among the factors; 4) advance an index of their connectivity; and 5) choose a good-fitting model, rather than only providing a global assessment. In addition, we were interested in the screening of psychological IPV, in the absence of physical or sexual IPV, not only in the last six months, as in the original version (Tolman, 1999), but also across the lifespan, to detect the long lasting consequences on mental health (Lacey, McPherson, Samuel, Sears, & Head, 2013). As a result, stronger correlations were found between the PWMI-SF across the lifespan and psychological symptoms (IGS), where the costs of extended IPV are more visible than in the last six months.

For clinical and legal purposes, the establishment of a mean score for psychological IPV, and the determination of a cut-score, which can distinguish the line between non-abusive and abusive relationships, provides the opportunity for providers and therapists to detect signs of psychological IPV among couples, so as to better prevent and intervene in those cases. From the intervention point of view, the differentiation between behaviors reported in the last 6 months vs. life time experiences allows for detection of the impact of recent vs. long-standing exposure and a serious pattern of psychological IPV (Follingstad & Rogers, 2014), as well as their cumulative effect on mental health, self-esteem, and overall functioning, by adapting protocols based on a comprehensive assessment.

Moreover, it helps to support decisions in official reports and courts. While causal relations cannot be established through the interpretation of the scores, the tool provides the opportunity to screen for life time psychological IPV vs. psychological IPV in the last 6 months, and, thus, guide clinical decisions, helping in the conceptualization of the roots of symptoms and informing the determination of clinical diagnostics and treatment choices. Additionally, it can guide scientific research, providing the possibility of establishing criteria to justify statistical decisions, such as the mean range of psychologically abusive behaviors and the definition of a threshold which divides healthy and unhealthy intimate relationships.

With the Portuguese validation of this comprehensive instrument for psychological IPV, we are a step closer to the pursuit of the goals set out in the introduction. Specifically, the foundations for increased conceptual and empirical knowledge about the phenomenon are established, and we hope to contribute to the application of this tool in the areas of prevention, intervention, public awareness, comparison of parallel studies, and allocation of resources and funding (Collett & Bennett, 2015; O'Doherty et al., 2013).

This study supported prior research findings (Fernandez-Fuertes & Fuertes, 2010; Ureña et al., 2015) that psychological IPV is a less documented form of violence that defines many relationships, in which IPV occurs before marriage or cohabitation. As a result, assessment and intervention regarding psychological IPV may prevent the escalation to physical IPV and persistent forms of violence (O´Leary, 2015).

Our goals, with the validation of the PMWI-SF, were to provide a screening tool for prevention and detection of psychological IPV, and thereby help young adults to recognize and be aware of psychologically abusive behaviors (Ayala et al., 2014). Further research may include other sources of information, incorporating a more representative sample, and a longitudinal study to detect changes over time and to test for the potential presence of an emerging pathway of psychological IPV, in the early stages of dating. Moreover, further investigation should include men's assessment, giving visibility to the phenomenon of men's victimization and deconstructing the patriarchal paradigm of men as exclusively perpetrators and women as exclusively victims. The determination of whether or not psychological IPV is bidirectional in nature, the exploration of potential gender differences in reactions and self-perceptions of harm, and the identification of specific patterns or clusters of psychological IPV (Follingstad & Rogers, 2014) are also needed. An important limitation to this study is the self-report nature of the data, which only allows the assessment of individual perceptions based on the recall of past experiences, rather than accessing totally accurate information (Follingstad & Rogers, 2014).

In conclusion, the PMWI-SF revealed good psychometric properties, both for detecting psychological IPV in the last six months, and across the lifespan, being an effective and brief tool for screening Portuguese women. It should be used in clinical and research settings to detect early signs of psychological IPV, allowing a cross-country comparison of data and improving decision making in cases of potentially abusive relationships.

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CHAPTER III

CLINICALLY SPEAKING, PSYCHOLOGICAL ABUSE MATTERS[7]

[7] The present chapter was published in 2016 in the Journal Comprehensive Psychiatry (Impact Factor: 2.043, Quartile 1)

CHAPTER III

CLINICALLY SPEAKING, PSYCHOLOGICAL ABUSE MATTERS

Abstract

The adverse effects of intimate partner violence (IPV) on mental health are well-established, except in the cases of psychological IPV and men's victimization. This research study examines the prevalence and the independent contribution of psychological IPV on mental health for both genders. The initial sample comprises 661 college students from a Portuguese public university, who completed an e-survey. Statistical analysis focused on a subsample (n=364), 23% of which were men, after removing cases of physical and/or sexual IPV. A total of 75% of men and 72% of women reported lifetime psychological victimization and no differences were found for sociodemographic factors, including gender. However, women reported significantly more instigations of psychological abusive acts (OR = 5.41, 95% CI = 1.88-15.55). Multivariate linear regression models revealed that post-traumatic stress symptoms—PTSS (β = .51; p < .001), depression (β = .34; p < .001) and anxiety (β = .22; p < .001)—were predicted by psychological IPV. The strongest relationship was established between psychological IPV and PTSS, and the final model accounts for 28.6% of the variance (F(6,357) = 23.86, p < .001). This article provides an empirical basis to recognize the unique and serious impact of psychological IPV on mental health, and recommends screening psychological IPV as part of the clinical routine, developing a gender-inclusive approach, and implementing evidence-based protocols tailored to the needs of these victims.

Keywords: Psychological intimate partner violence, gender symmetry, post-traumatic stress disorder; depression, anxiety.

Introduction

Until recently, a unidirectional model of women victimization was assumed, disregarding the reciprocal nature of intimate partner violence (IPV) defined as a range of psychological, physical, and/or sexual coercive acts perpetrated by a partner [1]. In fact, the latest systematic review on IPV [2] concluded a pattern of gender symmetry, characterized by similar rates of victimization among men and women. According to the World Health Organization [3] almost one third of women have experienced IPV across their lifespans but the same data are not available for men. An emerging body of research reveals similar rates of perpetration and victimization for men and women and the co-occurrence of both roles in the dyad [2,4,5,6] especially when it comes to community-based samples of young adults where the manifestations of violence are situational [7].

The affective disorders linked to IPV are well established and cover increased risk of post-traumatic stress symptoms [8], anxiety [9], depression [10], and comorbid symptoms [11, 12]. Surprisingly, little is known about the single contribution of psychological IPV to mental health and its related correlates, since studies have typically focused on physical aggression, global IPV scores [10], and women's victimization.

Although a unanimous definition has not been reached, psychological IPV can be categorized into two domains [13, 14]: emotional/verbal (e.g., name-calling, swearing, yelling and screaming) and domination/isolation (e.g., monitoring time and activities, jealousy or suspiciousness). In the etiology of physical expressions of violence, psychological IPV frequently starts with subtle behaviors and gradually augments in frequency and intensity to acts of control [15]. Psychological IPV has the highest rates of perpetration and victimization as shown in a recent representative epidemiological study in the U.S. with a sample of youth for both genders [16] and the prevalence is overwhelming, standing between 70% and 80% across studies [7]. In Portugal, psychological IPV is also the most reported type of IPV with rates of 54% for women and 61% for men [17] and traditionally is measured by the Revised Conflict Tactics Scales (CTS2), which assesses all dimensions of IPV. However, the greatest limitation of the CTS2 is the lack of adequacy and specificity in measuring psychologically abusive acts. The subscale includes only eight items not comprehensive and sensitive enough to capture the diversity of manifestations of psychological IPV [18]. For this reason, we decided to validate the first specific tool to evaluate psychological IPV in Portugal [19] the Psychological Maltreatment Inventory (PMI), which is a specific and comprehensive tool for measuring psychological IPV with good psychometric properties used widely in the world. Until now,

the absence of a consensual definition and screening tool for psychological IPV has affected the comparison of prevalence rates between studies [7, 15].

Results of a longitudinal study revealed a pattern of non-recovery from PTSD, anxiety, and depression in women exposed to psychological IPV alone [20]. Similarly, Pico-Alfonso (2005) found psychological IPV to be the major predictor of post-traumatic stress disorder in abused women [21]. Psychological IPV is associated with higher levels of emotional distress and can be more damaging to mental health than other forms of IPV [10] even after leaving the abusive relationship [22]. Thus, the duration and severity of IPV are important variables to consider, with long periods of exposure and chronicity of IPV associated with worse mental health outcomes [10]. Nevertheless, few studies consider the phenomenon of abused men and recent data supports the argument that women and men experience IPV differently [23]. Furthermore, the findings encourage the consideration of structural differences related to gender in analyses of men's experiences of IPV [24]. In Portugal, the first studies are emerging [25, 26] and reveal a pattern of stigmatization, underreporting, and embarrassment among men in identifying themselves as victims and the barriers they face in formal help-seeking.

According to Clark and colleagues (2016) the majority of the 29% of men and 36% of women who reported lifetime IPV exposure in a national survey conducted in 2010 were victimized before the age of 25 years old [27]. In fact, recent studies highlight youth as both perpetrators and victims in their dating experiences [16], raising the value of prevention strategies targeted at adolescence and young adulthood, where psychological IPV first occurs and gains expression [7, 28].

This study draws on quantitative data and makes three distinct contributions to understanding the characteristics of psychological IPV in a mixed sample of college students. First, it moves away from a feminist framing to highlight the symmetric and bidirectional nature of IPV in this context. Second, it explores the unique impact of psychological IPV on mental health in a subsample of victims without self-reported physical or sexual IPV. Third, it uses the first comprehensive tool specifically validated to assess psychological IPV in the Portuguese context.

The aims of this paper are to 1) verify the association between sociodemographic factors and psychological IPV, 2) explore the prevalence and symmetry of gender and the bidirectionality of psychological victimization, and 3) verify if psychological IPV is a predictor for mental health issues, specifically PTSS, depression, and anxiety. We hypothesized similar rates of victimization regardless of sociodemographic variables, a pattern of co-occurrence with perpetration of IPV, and the

emergence of psychological IPV as a predictor of affective disorders, after controlling for sociodemographic data and variables linked to abusive relationships.

Methods

Participants and Procedures

The e-survey was completed by 661 students, 509 of whom were women aged 18-55, with an average age of 23.5 (*SD* = 5.4), 23% of the sample were men aged 18-58, with an average age of 25.6 (*SD* = 7.1). Demographic information is shown in Table 8. The data comprises information for the total sample (*N*=661) and a subsample of those after removing self-reported physical and/or sexual IPV (*n*=364).

Table 8
Sociodemographic characteristics.

	Total Sample (*N*=661)		Subsample (*n*=334)	
	N	*%*	*N*	*%*
Gender				
Men	152	23.00%	86	23.63%
Women	509	77.00%	278	76.37%
Age (Mean/SD)	24	5.9	23,47	4.98
Employment Situation				
Student	522	78.97%	292	80.22%
Student worker	139	21.03%	72	19.78%
Nationality				
Portuguese	622	94.10%	349	95.88%
Non-Portuguese	39	5.90%	15	4.12%
Marital status				
In a relationship	464	64.30%	259	71.15%
Single	168	25.42%	76	20.88%
Married	35	5.30%	19	5.22%
Living with someone	25	3.78%	9	2.47%
Other	8	1.20%	1	0.27%
Sexual orientation				
Heterosexual	598	90.47%	337	92.58%
Other	63	9.53%	27	7.44%

Participants were identified through an email invitation sent to all the 31,352 students registered in the academic year of 2014/2015 of a Portuguese public university, of which 56% were women (*n* = 17,557). The invitation contained a direct link to the e-survey. All procedures were approved by the Ethics Committee of the University.

Measures

Post-traumatic Stress Disorder Checklist for Psychological IPV. To assess the presence of PTSS in the last month, the Reed and Enright version of the Checklist [22] was used based on the 17 items listed in the DSM-IV-TR. This version of presence/absence was chosen to assure the measurement of symptoms specifically derived from the psychologically abusive relationships (e.g., "Intrusive and recurrent memories of the abusive events - images or thoughts"; "Efforts to avoid thoughts, feelings, or conversations about the psychologically abusive events"; "Hypervigilance, over watchful, protective, worried"). High scores on the PTSS checklist indicate greater severity.

Beck Depression Inventory–II (BDI-II). Participants were also administered the BDI-II [29, 30], a self-report measure of 21 items to examine the level of depression in the last two weeks. Scores can range from 0 (no depression) to 63 (high depression). Higher total scores indicate greater severity of symptoms. The Cronbach Alpha is .93 in the present study.

State Anxiety Inventory (STAI). A version of the STAI [31, 32] was also used to measure the anxiety at the current moment. This is a self-report questionnaire with items rated on a 4-point Likert scale. Scores range from 20 to 80. High values on the items correspond to high anxiety. The instrument presents high internal consistency in the current sample with an alpha coefficient of .95.

Psychological Maltreatment Inventory – Short Form (PMI-SF). The psychological intimate partner violence across lifespan was assessed with the PMI-SF [14, 19], a 14-item self-report measure with scores ranging from "never = 1" to "5= very frequently". Items are grouped into two subscales. The 7-item Dominance/Isolation subscale consists of items 5-11 and included actions such as "My partner monitored my time and made me account for my whereabouts", "My partner accused me of having an affair" and "My partner tried to keep me from doing things to help myself". The 7-item Emotional/Verbal subscale consists of items 1-4 and 11-14 and some examples included "My partner treated me like an inferior"; "My partner

told me my feelings were irrational or crazy" and "My partner blamed me for his/her problems". Responses for each item are summed to create a total score of psychological IPV and higher scores indicate more psychologically abusive experiences. The Cronbach Alpha is .94 in the present study.

The Revised Conflict Tactics Scales (CTS2). The subscales of physical assault (18 items) and sexual coercion (7 items) of the CTS2 [33, 34] were applied to assess the history of other forms of intimate partner violence other than psychological IPV, with an alpha Cronbach of .98 and .93 respectively. The instrument was scored across the lifespan (a dichotomous variable was created "This has never happened" vs. "Number of times in the past year" or "Not in the past year but it did happen before").

Questions were added in order to assess the duration of the psychologically abusive relationship and the time elapsed between the end of the relationship and the present moment. In order to examine the trigger of psychologically abusive acts, participants were asked "If you practiced at least one of the behaviors described above toward your partner, think about the last time it happened; who was the first to exhibit this behavior? 1) I did it first; 2) My partner did it first". Finally, the possibility of other previous traumas were evaluated with an open qualitative question: "Did you want to describe other(s) situation(s) that you considered potentially traumatic in your story of life?".

Statistical Analyses

Analyses were conducted for the total sample (*N*=661) and for a subsample of participants after excluding cases of physical and/or sexual IPV screened by the CTS2 (*n*=364). A univariate odds ratio was used to examine the association between sociodemographic characteristics and psychological IPV in the total sample and in the subsample without physical or sexual IPV (Table 9), and to explore prevalence, symmetry of IPV, and bidirectionality of psychological IPV by gender (Table 10).

Subsequently, in the subsample without self-reported physical or sexual IPV (*n*=364), the relationship between psychological IPV and a set of mental health symptoms (PTSS, depression, and anxiety symptoms) were tested in multivariate linear regression models after adjusting the model for sociodemographic variables (step 1) and variables related to the psychologically abusive relationship (step 2), avoiding these main confounder variables.

Results

Table 9 presents the relationship between sociodemographic factors and the presence of psychological IPV. In the total sample, and in the subsample without history of physical or sexual IPV, none of the sociodemographic factors were statistically significant when correlated with the presence of psychological IPV.

Table 9

Univariate odds ratio for the associations between sociodemographic factors and psychological IPV in the total sample and in the subsample without physical or sexual IPV.

	Total Sample (*N*=661)			Subsample (*n*=334)		
	N	OR	95% CI	*n*	OR	95% CI
Gender						
Men	152	1	-	86	1	-
Women	509	1.09	[.74-1.61]	278	.99	[.57-1.71]
Employment Situation						
Student	522	1	-	292	1	-
Student worker	139	1.16	[.71-1.90]	72	1.04	[.58-1.86]
Nationality						
Portuguese	622	1	-	349	1	-
Non-Portuguese	39	2.14	[.75-6.12]	15	1.50	[.41-5.42]
Current Relationship						
No	172	1	-	76	1	-
Yes	489	.91	[.58-1.43]	288	1.34	[.77-2.32]
Sexual orientation						
Heterosexual	598	1	-	337	1	-
Other	63	1.69	[.78-3.65]	27	2.24	[.75-6.6]
Education						
Undergraduate students	288	1	-	147	1	-
Graduate students	373	1.09	[.74-1.61]	217	1.09	[.68-1.74]

Table 10 presents the prevalence, symmetry, and bidirectionality of psychological IPV by gender. Self-reported psychological victimization was not associated with gender. To have assumed the instigation of psychological IPV ("I did it first") was positively associated with gender (women) in the total sample (OR = 1.95, 95% CI = 1.04 - 3.65) and in the subsample without history of physical and/or sexual IPV (OR = 5.41, 95% CI = 1.88 - 15.55).

For the subsample of participants without history of physical and/or sexual IPV (n=364), correlational analyses were conducted for outcome variables and predictors. Psychological IPV showed positive correlations with post-traumatic symptoms (r = .50, p < .001), depressive symptoms (r = .29, p < .001), anxiety symptoms (r = .20, p < .001), duration of the psychologically abusive relationship (r = .44, p < .001), and time elapsed after ending the relationship (r = .35, p < .001). Table 11 presents the correlation coefficients and significance levels. The correlation between predictors did not present multicollinearity.

Variables with significant correlations in the bivariate analysis were introduced as predictors in the multivariate linear regression models. Results revealed that post-traumatic stress symptoms, depression, and state anxiety symptoms were predicted by psychological IPV, after been adjusted for the remaining predictors (see Table 12). PTSS was negatively predicted by time elapsed after the end of the relationship (β = -.14; p = .024) and positively predicted by age (β = .17; p < .001) and history of psychological IPV (β = .51; p < .001).

Table 10

Prevalence, symmetry and bidirectionality of psychological IPV by gender.

	Total Sample (*N*=661)					Subsample without physical/sexual IPV (*n*=364)				
	Men		Women			Men		Women		
	N	*%*	*N*	*%*	*OR [95 % CI]*	*N*	*%*	*N*	*%*	*OR [95 % CI]*
Ψ victimization										
No	32	21.05%	94	18.47%	1	18	25.35%	61	28.11%	1
Yes	120	78.95%	415	81.53%	1.17 [.75-1.85]	53	74.65%	156	71.89%	.99 [.57-1.71]
Who did it first?										
"My partner"	107	89.17%	333	80.83%	1	67	94.37%	164	75.58%	1
"I did it first"	13	10.83%	79	19.17%	1.95 [1.04;3.65]	4	5.63%	53	24.42%	5.41 [1.88;15.55]

After having been adjusted for the main confounding variables, the full model explained 28.6% of the variance ($F(6.357) = 23.86$, $p < .001$). Depression symptoms were negatively predicted by time elapsed after the end of relationship ($\beta = -.14$; $p = .041$) and positively predicted by history of psychological IPV ($\beta = .34$; $p < .001$) in the final model. The overall model accounted for 11% of the variance ($F(6.357) = 7.36$, $p < .001$). The only predictor of state anxiety symptoms was a history of psychological IPV ($\beta = .22$; $p < .001$) and the overall model explained 5.5% of the variance ($F(6.357) = 3.46$, $p = .002$). History of psychological IPV was the strongest predictor in all models and the strongest relationship established in step 3 was found between the history of psychological IPV and post-traumatic symptoms. No other variables were significant.

Table 11

Correlation matrix for outcome variables and predictors.

Outcome Variables	1.	2.	3.	4.	5.	6.
Post-traumatic symptoms	-0,03	0,16**	-0,05	0,24**	0,13*	0,50**
Depression symptoms	0,00	0,07	-0,09	0,07	0,00	0,29**
State anxiety	0,02	0,09	-0,05	0,08	0,03	0,20**
Predictors						
1. Gender		-0,09	0,16**	0,06	0,11*	-0,01
2. Age			-0,05	0,17**	0,23**	0,03
3. Sexual orientation				-0,16**	-0,03	-0,12*
4. Duration of relationship					0,64**	0,44**
5. Time elapsed after Ψ IPV						0,35**
6. History of Ψ IPV						

**p <.05; **p<.001*

Discussion

The phenomenon of psychological IPV is based on the need for power and control, surpassing issues of gender, education, and sexual orientation. This study shows that none of the sociodemographic factors are correlated with psychological victimization. Similar to results found in the systematic review of Carney and Barner [7], the prevalence of psychological IPV is overwhelming, especially if we consider a community sample with high education, with levels of victimization ranging between 75% and 80%.

Table 12
Linear regressions for prediction of PTSS, depression, and anxiety symptoms.

		PTSS			*Depressive symptoms*			*Anxiety-state*		
Step	*Predictors*	B	SE	β	B	SE	β	B	SE	β
1	Gender (0=Men; 1=Women)	-.04	.26	-.01	.53	1.16	.02	1.03	1.47	.04
	Age	.07	.02	.16**	.13	.10	.07	.22	.12	.09
	Heterosexual (0=No; 1=Yes)	-.28	.42	-.04	-3.03	1.88	-.09	-2.11	2.38	-.05
	R^2			.028*			.012			.011
2	Gender (0=Men; 1=Women)	-.12	.25	-.02	.57	1.17	.03	.98	1.49	.04
	Age	.06	.02	.13*	.13	.10	.07	.21	.13	.09
	Heterosexual (0=No; 1=Yes)	.04	.42	.01	-2.55	1.91	-.07	-1.59	2.42	-.04
	Duration of the relation	.04	.01	.26**	.08	.05	.10	.08	.07	.08
	Time elapsed after ending	.00	.01	-.06	-.03	.02	-.09	-.02	.03	-.05
	R^2			.078**			.019			.015
3	Gender (0=Men; 1=Women)	-.02	.22	.00	.88	1.12	.04	1.24	1.46	.04
	Age	.07	.02	.17**	.18	.10	.10	.24	.13	.10
	Heterosexual (0=No; 1=Yes)	.25	.37	.03	-1.93	1.83	-.05	-1.07	2.38	-.02
	Duration of the relationship	.01	.01	.08	-.01	.05	-.01	.00	.07	.00
	Time elapsed after ending	-.01	.00	-.14*	-.05	.02	-.14*	-.03	.03	-.08
	Ψ IPV	.13	.01	.51**	.39	.06	.34**	.33	.08	.22**
	R^2		.286**			.110**			.055**	

**p <.05; **p<.001*

No gender differences were found for psychological victimization in this college sample. The absence of significant differences between men and women with regard to the levels of reported psychological IPV is in line with the paradigm of gender symmetry [5, 7, 26].

Contrary to expectations, it appears that a high percentage of women recognize their instigation of psychologically abusive acts, reinforcing the findings from Spain [4]. This perspective frames psychological IPV as a self-motivated and reciprocal process where behaviors are shaped by mutual actions, away from the traditional view of women as victims and men as perpetrators. On the other hand, men exhibited higher rates of recognition that it

was the partner who started the first psychologically abusive behaviors, suggesting the idea that the first step for those being psychologically abused is the recognition of its occurrence.

Additionally, data suggests high levels of psychopathology and the independent contribution of psychological IPV to clinical outcomes despite gender, emerging as a predictor for post-traumatic stress symptoms, depression, and anxiety [15, 21, 28, 35] among those without self-reported exposure to physical or sexual IPV. Recent findings point in the same direction, since women who had experienced only nonphysical IPV in the past 5 years were 2.06 times and 1.75 times as likely to experience minor and severe depression, respectively, in comparison with non-abused women [10]. Moreover, previous studies found high levels of PTSS (75% of the sample) and depression (54% of the sample) among women victims of IPV and 52% of the variance in depressive symptoms were explained by psychological IPV and PTSS severity [11].

The time elapsed since the end of the abusive relationship is an important variable, since the more time away from the abusive relationship, the further advanced is the pattern of recovery. It seems that as time goes by, the victim reports less post-traumatic stress symptoms and less depression. In the case of PTSS, older participants reported more symptoms. This increment may be explained because older youths spend longer time in relationships and suffer from the consequences of victimization [16].

Concerning the evaluation of previous traumas participants only wrote details about their history of psychological IPV but this is not a guarantee of the inexistence of previous traumas related with other traumatic events (e.g., childhood trauma). Nonetheless, for post-traumatic stress a checklist of symptoms specifically derived from the psychologically abusive relationships was chosen [22].

An inclusive approach toward gender is needed to understand the nature and complexity of this issue. Research guidelines must include mixed samples designs, the measurement of both victimization and perpetration, the inclusion of different contexts and actors in data collection, the inclusion of physical health indicators, and the creation of instruments that are gender neutral and/or contain the specificities of violence against men [36]. Such an approach points to the need for more qualitative data and longitudinal studies to clarify the context of these results and understand the meanings, beliefs, and judgments that participants make about psychological dating aggression.

Important implications can be drawn for clinical practice in order to develop specialized responses and services for psychologically abused men and women. The results highlight the

bidirectionality of psychological IPV, the occurrence of victimization among men, and the reporting of women's instigation. Preventive efforts must be formulated according to the paradigm of gender symmetry in IPV [5], rather than a men's perpetration approach. This perspective has important implications for prevention efforts in the field of dating violence. Programs must target teenagers and young adults of both genders, raise awareness about the early signs of IPV, promote the dissemination and use of formal help, look at offenders as simultaneously victims, and reduce the barriers faced by homosexuals and men since there are no published interventions and guidelines for men's victimization [22].

This research supports and expands the focus of previous studies by identifying the high prevalence of psychological IPV and its impact on mental health in a sample of Portuguese college students, giving voice to the perspective of IPV symmetry. The results reinforce the importance and independence of this form of IPV, confirming the need for its own theoretical models and preventive strategies. The experience of being in a psychologically abusive relationship is a strong predictor for affective disorders and the strongest relationship was found between having a history of psychological IPV and post-traumatic stress symptoms. It is essential to explore the relationship of IPV with non-physical forms of violence and reveal its independent impact on mental health.

There are important considerations about the unbalanced ratio between men and women in this sample that should be acknowledged. First, according to the University official records, the percentage of women is higher (56% of women vs. 44% of men). In addition, previous studies with college students showed that women have a higher predisposition to respond to e-surveys based on characteristics of connective selves, such as empathy or emotional closeness [37] and are more likely to engage in online activities characterized by communication and exchanging of information (e.g., access, complete, and return an e-survey) whereas men are more likely to seek information [38]. Finally, previous research suggested that men have difficult in recognize themselves as victims and take actions to disclose IPV [26].

Future research should aim to overcome the barriers of the current study. First, a consideration of the context and attitudes that motivate IPV is suggested; the frequency of abusive behaviors was measured, but not the circumstances in which these behaviors occurred and how participants developed their own views about psychological victimization. Therefore, self-reported measures should be complemented with qualitative data. Second, the comparison of results from both elements of the dyad is required in order to assess couple perceptions and

enhance the accuracy of prevalence rates. Third, prospective studies are recommended to explore the impact of pre-abuse mental health, childhood trauma experiences, and additional risk factors in the development of affective disorders in the face of psychological IPV. Four, psychopathology should be screened for and established by a mental health professional.

The generalization of results for other populations in untested since a convenience sample of college students was used and causal inferences cannot be drawn since a cross-sectional design was adopted. Specifically, some mediators could explain the results (e.g., social support, self-esteem or emotional regulation) and possible associations between psychopathology and IPV and/or over-reporting may have exacerbated the findings. Future studies should be conducted with longitudinal designs to explore the directionality and the role of the mediators [39] in the relationship between psychological IPV and mental health.

The findings corroborate the high prevalence of psychological victimization, the similar rates among men and women, and a pattern of co-occurrence with perpetration being a bidirectional phenomenon. Data suggests that sociodemographic factors are not associated with risk of psychological IPV or affect mental health outcomes, and could be related to a gender symmetry paradigm. However, women were more likely to report the instigation of psychologically abusive acts when asked “who did it first?” suggesting a new approach in collecting data to explore these patterns.

Our study suggests a relationship between psychological IPV and mental health more prominent than originally thought. Psychological IPV may have a strong and independent adverse effect on affective disorders, namely post-traumatic stress, depression, and anxiety symptoms, which could be affected by the severity and extent of exposure.

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CHAPTER IV

THE 'SLOW MOTION' PROCESS OF LEAVING PSYCHOLOGICAL ABUSE: A QUALITATIVE STUDY[8]

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CHAPTER IV

THE 'SLOW MOTION' PROCESS OF LEAVING PSYCHOLOGICAL ABUSE:

A QUALITATIVE STUDY

Abstract

The process of leaving physical Intimate Partner Violence (IPV) is well documented and focuses on the victims' safety. However, the specificities of moving on from psychologically abusive relationships have not yet been described. An inductive content analysis using NVIVO10 was selected to explore the narratives of 20 college women with a history of psychological IPV, with and without PTSD. Non-sequential stages of leaving were found in a 'slow motion' process, surrounding the categories of Enchantment, Awareness, Ambivalence, Detachment, Restarting, and Healing vs. Psychopathology. Findings suggest a comprehensive understanding of the stages of readiness to leave psychological IPV useful for professionals.

Keywords: Dating violence, psychological intimate partner violence, process of leaving, qualitative study.

Introduction

On the one hand, dating experiences are opportunities for establishing significant relationships and practicing behaviors and roles for future commitment (Daigle, Scherer, Fisher, & Azimi, 2016). On the other hand, it is also true that most abusive experiences begin during adolescence and young adulthood.

Being a young adult is a risk factor for Intimate Partner Violence (IPV) and research consistently shows that age is inversely related to dating violence. In fact, as age increases, the risk of dating violence decreases (Capaldi, Knoble, Shortt, & Kim, 2012) and women until the age of 24 are at the highest risk of victimization (Black et al., 2011). For these reasons, the incidence of IPV among college students becomes a new concern, unlike previous studies that concentrated their efforts on marital violence.

Recent studies report high rates of psychological victimization (Anderson, Renner, & Danis, 2012) in the absence of physical or sexual IPV (Começanha, Basto-Pereira, & Maia, 2016) involving verbal/emotional abuse (e.g., humiliation) and dominance/isolation acts (e.g., restriction) perpetrated by a current or former intimate partner. The most comprehensive data set available on the health of college students (American College Health Association - National College Health Assessment, 2012) shows that they are more likely to experience psychological IPV than physical IPV. In the field of dating violence, no significant differences were established between women in college and those women who never attended university (Coker, Follingstad, Bush, & Fisher, 2016) with similar rates of psychological victimization linked to poor mental health outcomes (Daigle et al., 2016; Estefan, Coulter, & VandeWeerd, 2016).

Walker (1991) describes the "battered women syndrome" as a subcategory of post-traumatic stress disorder (PTSD) with a group of symptoms often observed after a woman repeatedly experienced physical, sexual, and/or psychological IPV. PTSD has been associated with psychological dating violence. Specifically, Começanha and collaborators (2016) report the correlation between psychological IPV and post-traumatic stress symptoms among college students.

Despite the adverse effects of psychological IPV, an emergent group of studies takes into account the natural heterogeneity of trauma reactions and highlights the possibility of a resilient trajectory in the aftermath of potentially traumatic events such as IPV (Anderson et al., 2012). In this innovative perspective, the exposure to potentially traumatic events is a necessary, but not a deterministic condition, to the development of PTSD (Bonanno & Mancini, 2012).

Research also reveals that leaving the abusive relationship is a non-linear process (Edwards, Murphy, et al., 2012; Wiklund, Malmgren-Olsson, Bengs, & Öhman, 2010) where appraisal distortions such as denial (e.g., excusing the partner´s behavior), self-blame (e.g., perceiving themselves as responsible for the abuse) and minimization (e.g., reducing the importance of what happened) prevent women from leaving the partner (Whiting, Oka, & Fife, 2012). This explains why approximately 50% of help-seeking women return to their abusive partners (Rhatigan, Street, & Axsom, 2006) as they underestimate the severity of the early signs of IPV and perceive their alternatives within the relationship as more valuable to them than living without the partner.

Walker (1984) described the process of IPV and its increasing severity as the "cycle of violence" in which verbal abuse, intimidation, and control increase over time in the relationship until battering occurs followed by a "honeymoon" period or reconciliation, which is sustained until a new episode of tension happens with shorter periods of calm and reconciliation over time. An explanation for the intermit nature of IPV resides in the persuasive techniques used by abusers to prevent women from leaving the relationship, such as promising to change, apologizing, giving affection, and behaving themselves in a kinder manner until a new episode of IPV happens again. Many women who leave an abusive relationship eventually return to the partner and are likely to be abused again, feeding the cycle of victimization.

The process of leaving an abusive partner has been theorized using the Prochaska and DiClemente´s Transtheoretical Model of Change (1982). The model was created to explain stages of change in health-related behaviors such as stopping smoking (Prochaska, DiClemente, & Norcross, 1992) and later applied to other behaviors and situations, including battered women (Brown, 1997). According to this model, women move through predictable stages in their efforts to increase physical safety and prevent further danger. From the tendency not to recognize the need for change in the next 6 months (precontemplation), to intend to change within the next 6 months but not yet to decide to take action (contemplation), to make plans for change (preparation), to take some action to change (action), and to reinforce and sustain the desirable behavior (maintenance). Although useful, this model does not account for the lengthy and subtle process of awareness in psychologically abusive relationships where there are no physical signs of violence operating as turning points in the readiness to leave. Furthermore, this model does not explore the process of identity reconstruction and responses in the aftermath of IPV.

Most research has been conducted with women who have come to the attention of the legal system and/or shelter-based interventions, with different needs and barriers to leaving an abusive relationship that may not be applicable to the reality of all young adults (Daigle et al., 2016). Most college students, unlike battered adult women, do not cohabit, are not financially dependent, and do not have children with their partners (Edwards, Murphy, et al., 2012) and their physical safety is not compromised. Additionally, a high percentage of young adults present psychological IPV in the absence of physical and/or sexual IPV (Começanha et al., 2016). These specificities may impact the processes involved in the decision to leave the relationship with implications for the work of healthcare professionals.

Although some qualitative studies have focused on the thematic narrative analysis of the leaving processes in abusive relationships for young women (e.g., Edwards, Murphy, et al., 2012; Few & Bell-Scott, 2002; Wiklund et al., 2010), the samples include comorbidity with physical and/or sexual IPV. In addition, research has often focused on the pathway of psychopathology derived from IPV and little is known about the women´s strengths and resources and the course of identity reconstruction and recovery after the psychological IPV (Anderson et al., 2012). A comparison between women with PTSD versus asymptomatic women would be helpful in understanding the specificities of these pathways.

To our knowledge, this is the first qualitative research to explore specifically the process of leaving psychological IPV in women´s own words, in the absence of other forms of dating violence, namely physical and/or sexual IPV. In fact, the nature of the IPV experienced may have a different impact on the women´s reactions and functioning. Accordingly, the purposes of this study were to qualitatively explore (1) the particular process of leaving psychological IPV in college women and (2) the aftermath of psychological IPV on those who developed PTSD and those who did not develop it.

Method

Participants

Inclusion criteria involved be female, college student at the University of Porto aged 18 years or more, heterosexual, with a history of psychological IPV that had occurred in the absence of physical and sexual IPV, and separated from their partner for at least one year. The sample includes 20 participants, 10 women with history of psychological IPV who developed PTSD in the aftermath of this experience, and 10 women without this diagnosis.

Data Collection and Screening Measures

Data related to the characteristics of the relationship included the age of the women when the relationship began, the duration of the relationship, the duration of the abusive psychological acts, and the interval of time between the end of the relationship and the writing of the narrative.

Women who identified themselves as psychologically abused were screened based on their responses to the short version of the PMWI – Psychological Maltreatment Women Inventory (Tolman, 1999; Portuguese version, authors, under review). The inventory is adequate and specific for measuring psychological IPV and contains 14 items grouped into two subscales using a 5-point Likert scale ranging from 1 (never) to 5 (very frequently). The items ask about verbal/emotional abuse ("My partner treated me like an inferior"/"My partner tried to make me feel crazy") and dominance/isolation abuse ("My partner monitored my time and made me account for my whereabouts"/ "My partner was jealous or suspicious of my friends"). Responses for each item were summed to create total scores with higher scores indicating greater exposure to psychological IPV. Women with 32 points or above in this screening measure were included in the study. This cut-off is considered a high level of psychological IPV (authors, under review).

The subscales of physical assault (18 items) and sexual coercion (7 items) of the CTS2 – Revised Conflict Tactics Scale (Alexandra & Figueiredo, 2006; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) were applied to exclude comorbid cases with physical and/or sexual IPV across the lifespan.

Participants also completed the Post-Traumatic Stress Disorder Checklist based on the 17 items listed in the DSM-IV-TR. This checklist was specifically formulated to access the consequences of psychological IPV (Reed & Enright, 2006). Examples of items include "Efforts to avoid thoughts, feelings, or conversations about the psychologically abusive events" and "Intrusive and recurrent memories of the psychologically abusive events – images or thoughts". Of the 20 college students, 10 presented clinical levels of PTSD derived from the psychologically abusive experience and 10 were asymptomatic for this diagnosis. The most reported symptoms included: intrusive and recurrent memories, flashbacks, and distressing dreams of the psychologically abusive events, avoidant behaviors, hyperarousal, and feelings of detachment or estrangement from others

Procedures

Advertisements were placed in canteens, residences, and libraries to invite participation. The study was also published on the web site of the Health Center of the University. Following

institutional review board approval by the Ethics Committee of the University of Porto, written consent was obtained and anonymity was assured. After the application of screening measures and selection of eligible participants, each participant was asked whether they agreed to be quoted in published reports and a copy of the informed consent was given to them. The recruitment was stopped when we reached 10 participants with history of psychological IPV who developed PTSD in the aftermath of this experience and 10 participants without this diagnostic. This sample size allowed the data saturation. Free psychological counseling was provided to all potential participants regardless of whether or not they met criteria for participating in the present study.

A narrative prompt about women´s leaving processes from psychological abusive relationships was created to elicit the responses: 'We are interested in hearing about your psychological abusive dating story. Please describe in detail the history chronologically up to the present. How was your relationship at the beginning? When did you realize that you were being psychologically abused? Would you identify particular events that caused a change in how you viewed and/or dealt with the situation? How did the end come about? What was it like leaving the relationship? After this experience can you please describe in detail what has changed and what has remained the same in the way you perceive yourself, others, and the world? How does it shape your view of future relationships?' Before and after the written narrative, referral services were available.

The narratives were written on each participant's laptop in their mother tongue, Portuguese, and then collected by a research collaborator. Selected quotations were translated into English by a bilingual translator to present in this paper. On average, the length of written responses to the open-question was 826 words (*SD* = 223 words).

Data Analysis

An inductive content analysis using NVIVO10 was used for data coding and analysis in a "bottom-up perspective driven by what is in the data, which means that the codes and categories derive from the content of the data themselves" (Braun & Clark, 2012, p. 58) giving voice to the experiences and meanings as reported by the participants.

Each written response was independently content-analyzed by 2 coders, using NVIVO10 software. The coders had experience in qualitative analysis, knowledge of dating violence, and at least 10 years of practice in clinical psychology. Coding was supervised by the Project Coordinator.

A six-phase approach to content analysis was adopted, as suggested by Braun and Clarke (2012) assuming a post-positivist-oriented qualitative research (Ponterotto & Grieger, 2007) based on realist knowledge (Willig, 2012). First, coders independently read the women´s narratives to familiarize themselves with the data. Second, an initial codebook was created based on information relevant to answering the research questions. The primary unit of analysis was 'each independent idea'. To ensure the validity of the emerging categories, the Project Coordinator and researchers coded the initial narratives separately, identified patterns and diversity within and across groups (asymptomatic for PTSD vs. with diagnosis of PTSD), and then discussed their findings and labeled the key categories. Third, the codes were combined into categories and discussed individually with the Project Coordinator. Similarities and differences in the responses lead to the saturation of categories (i.e., the narratives were not eliciting new categories). Four, potential categories were reviewed to ensure that they captured the data set and divergences between coders were arbitrated and discussed with the Project Coordinator until consensus was obtained. Five, mutually exclusive categories were defined and named, several sub-categories were formulated and data extracts were selected to further illustrate lived experiences. Six, the report was produced to provide the story about the data based on the analysis. Following the guidelines proposed by Ponterotto and Grieger (2007), for each category, a thick description grounded in examples was provided.

Credibility was established through peer debriefing and the assessment of the interrater reliability (κ = 0.91; confidence interval 95%, 0.90–0.92). An independent researcher coded a random subset (32% of the sample narratives) and agreement occurred in 91.3% of the narratives, indicating strong consensus. Another check on qualitative trustworthiness was done to account for bracketing, that is the personal influences and backgrounds of the researchers that could influence how they view the data, which are included in memos and discussed. Before writing the paper, the results were returned to narrators in order to review and support the summary of data. Participants were asked to evaluate whether they reflected themselves in the categories and indicate how that could be the story of their lives. Women confirmed the accuracy of their processes of change, especially the non-sequential movement between stages and the return to previous stages of thinking and functioning before the consolidation of change.

Results

Demographics and relationship characteristics

Participants were Caucasian (*N* = 20) with an average age of 23.45 (*SD* = 1.33). When the relationship began, women had an average age of 16 (*SD* = 1.86) and the average length of the relationship was 4.23 years (*SD* = 2.56), with an average duration of abusive psychological acts of 3.15 years (*SD* = 0.66). The interval of time between the end of the relationship until the written narrative was 2.13 years (*SD* = 1.78).

Qualitative findings

Inductive content analysis allowed understanding of non-sequential stages of leaving psychological IPV in a 'slow motion' process over time surrounding the categories of Enchantment, Awareness, Ambivalence, Detachment, Restarting, and Healing vs. Psychopathology. The processes described may occur simultaneously or in a variety of combinations in the movement through stages. In this process, women may experience relapses moving backwards to previous stages until completing consistent change. The categories found were shared by the two groups of women, with and without PTSD, except in the last stage. In the aftermath of psychological IPV, the categories diverge between women asymptomatic for PTSD (Healing category) and those with PSTD (Psychopathology category).

Enchantment

According to the narratives, at this stage, women report a perfect relationship and did not recognize the abuse as it started, were highly committed to their relationships, and experienced no ambivalence about the decision to stay or leave the partner.

"At first we are the best in the world. He asks for our opinion on just about everything. What we say is always well received and is always accepted, and all our wishes are granted. That is, if we want to go shopping we go, if we want to go walking we go, and everything is as we want. It is all perfect, it is like living in a fairy tale".

They idealized the relationship and overvalued the positive traits of the partner. Positive quotes included: "He was so handsome. All the girls wanted to date him and I was happy to be his girl"/ "It seemed that he would look after me, he was so supportive and caring"/ "When I met him he gave me lots of attention, he was so kind"/ "He was always there for me and he wanted to know everything about me, my friends, and my family".

A future together was envisioned with great hope and positive emotions related to their partner were described ("He made me feel so beautiful"/ "We enjoyed being together and I really believed he was the one"). Signs of emotional dependency on their partner were reported and women saw themselves as having something important to lose ("I didn't want to be alone and I appreciated his company").

Cognitive distortions were used in order to cope with the first signs of discomfort in the relationship, to reduce its impact, and to escape from negative feelings. Denial ("all I saw was my love for him"), minimization ("I simply did not identify my relationship with the word abuse") and blame ("I always ended up feeling responsible for what happened"), helping to excuse the partner´s behavior. Examples of behaviors involve jealousy and control. However, women confounded these signs as clues of affection for the partner. They tried to feed the fantasy of a healthy relationship and to avoid conflict or to handle it peacefully despite the first signs of objectification from their partner.

Social withdrawal increased but this was seen as an opportunity to spend more time with the partner ("He used to say that we only needed each other and it sounded romantic to me"). Table 13 aims to integrate and enhance a detailed description of the findings for the Enchantment category.

Table 13

Non sequential stages of leaving psychological IPV: quotes depicting the category of Enchantment.

Subcategories	Example quotes
Lack of recognition of abuse	"I thought it was the best relationship I ever had".
High commitment	"For me he was the only boy on the face of Earth"
No ambivalence stay/leave	"Everything seemed perfect... I didn't plan to break up"
Overvalued partner qualities	"He just seemed so protective, so loving"
Positive emotions	"He made me feel happy and loved"
Plans for a future together	"He talked me about getting married and having a family"
Emotional dependency	"I could no longer imagine my life without him"
Denial, minimization, blame	"He never hit me. So, it wasn´t abuse", "I provoked him"
Avoidance of conflict	"I would do anything to avoid a fight"
Social withdrawal	"We spent all our free time together"

Awareness

The women began to reevaluate their relationships, recognized them as psychologically abusive and found the abuse less acceptable:

"There is a proverb that says: 'When the alms are too much, the poor will be suspicious'. I think it applies well in this case: when everything is all right and seems to get better, the first discussion happens. Something happens to start a disagreement, no matter how insignificant the matter is, he starts to yell and scream at me. The first thing you think is that he's having a bad day and you understand. After that, he apologizes and you think everything will go back to normal. But no, this is the starting point for everything to get worse and worse ... After the first argument comes indifference and what you want no longer matters."

The pros and cons of leaving were weighted. Clues about the abusive nature of the relationship included verbal/emotional abuse ("he compared me with other girls and saw them as being better than me. I felt diminished and worthless as if I were nothing") and control/dominance abuse ("That was when it really started to become clear to me that I was being controlled in some sort of way. Things like 'that dress is a little bit too short' or 'You look better without your makeup on'").

The conflicts increased when the woman tried to affirm her individuality and stopped relinquishing herself in an effort to please her abuser ("It's almost as if you were a pet, your owner had bought you and you had to obey for things to go well (...) and the worst of it is that we are so manipulated that we begin to think that we have done something wrong, that we are doing things badly and that we have to improve in order to please him and get back the perfect relationship").

Jealousy about the time spent with friends and family was described as an attempt to isolate the women, to induce blame and to accuse them of supposed infidelities ("I began to attend progressively fewer classes, to stop seeing the few friends I still had, and to live exclusively for him. Even so, he accused me of infidelity. That was when I came to realize how jealous and possessive he was").

This jealousy served as an excuse for the partner to betray the woman and blame her for it ("He told me: 'if you had given me attention instead of going out with your friends I wouldn't have had the need to seek outside affection.' It was like he was punishing me by transferring affection to someone else to make me jealous"/ "Maybe I was no longer useful and he was looking for someone else to dominate in the same way").

This stage could be divided into two moments: nondisclosure and disclosure. In the initial phase of nondisclosure, women recognized the relationship as abusive but they were unwilling or unable to disclose the abuse to another person. This sub-stage is marked by the subjective barriers of embarrassment, shame, guilt, and fear of judgmental attitudes, coupled with love and dependency on the partner. In the advanced phase of informal disclosure, women are open to feedback from friends and family, they seek emotional support, and they replace self-blame with partner-blame as a cause of the abuse ("She told me that I had done nothing wrong and no one deserves to be treated like this. Hearing someone important to me saying that it wasn´t my fault was really important"). None of the women were seeking formal help at this stage. Table 14 summarizes the findings for the Awareness category, operationalizing the subcategories and giving sample quotes.

Table 14

Non sequential stages of leaving psychological IPV: quotes depicting the category of Awareness.

Subcategories	Example quotes
Reevaluation of abusive clues	"Some signs that I possibly didn't read at first became more clear"
Emotional and verbal abuse	"I started to feel inferior (...) inadequate"
Dominance and control	"It started to dawn on me that I was been controlled"
Self-affirmation and conflict	"I always put him first in order to please him"
Jealousy	"He accused me of having an affair with my best friend"
Blaming	"In his head, everything was my fault including all his problems"
Betrayal	"I found out he was dating other girls"
Barriers to nondisclosure	"I was afraid of hearing: why you just don't leave?"
Disclosure and support	"Talking about how I felt helped me to consider changes"

Ambivalence

Based on the hope that the partner would change, women reconsidered the relationship and several reconciliations were reported despite the increased cost of maintaining the relationship. This hope fueled the cycle of violence and the escalation of behaviors that became more frequent and severe ("His ego was inflated, he felt superior, and he humiliated me"). Abusive behaviors such as promising change, minimizing the severity of abuse, blaming the

victim, and creating social isolation discouraged the leaving process ("He always had an answer for everything and I was disarmed"). At this stage, the ambivalence between the insights into abuse and the contradictory feelings that often led to relapse and the return to the abusive relationship was noticeable:

"At that time he was like an addiction for me. Like a drug ... At first I was in heaven and then I was aware that was bad for me but I just couldn't stop ... I just didn't know how to stop..."

This was a time of doubt and rolelessness during which the women were not the person they were before psychological IPV, and they had yet to transform into something different ("I felt like a fraud. Could love be something so toxic that we lose our own identity?").

This is a slow process during which the women moved backwards and forwards, often with regression to previous stages. At this stage, there were no reports of objective turning points marked by physical aggression ("If he had hit me, I would have recognized it as violence. I would not even fall in love with him. But, in my case, there was no physical violence, it was a 'slow motion' process where I started to wonder if I was going crazy").

A summary of the subcategories and quotes related to the Ambivalence category can be found on Table 15.

Table 15

Non-sequential stages of leaving psychological IPV: quotes depicting the category of Ambivalence.

Subcategories	Example quotes
Hope partner would change	"He was sorry, apologized and promised he would change"
Reconciliations	"So I forgave him and tried once again"
Escalation of abuse	"I didn´t realize that it was going to lead to something worse"
Contradictory feelings	"Deep down I knew it was unhealthy but he still meant a lot to me"
Doubt and rolelessness	"I no longer knew who I was or what I wanted to be"
'Slow motion' process	"He did everything so cleverly that I just didn't realize"
Move forward and back again	"I go back because it was the only way I knew. It´s a warped thing"

Detachment

Women disengaged from the relationship as they realized that the partner would never change and they became tired of the situation ("It is a complete illusion, things do not change and never return to what they once were. I realized that I had to continue my life without him.").

Behavioral and emotional distance from the abusive partner was initiated and it was a struggle not to return to denial and fantasy. Actions such as no longer seeing, talking, or getting news from their partner (personally, by telephone, or internet) were reported. Creating geographical distance from the partner and becoming inaccessible were also described at this stage. Women struggled to break the emotional bond with the partner and reframed the situation reaching a new understanding of old information ("He made me feel like I needed him, that I couldn´t manage or cope without him, and, over time, I lost everybody else around me. I understand why a lot of people go back. It is because it´s the only way they know and it´s a warped thing, but it happens").

In this phase, social networking was reported as an important factor in taking action, in dealing with the grief, and in becoming disengaged from the abusive partner. An integration of the results found can be consulted at Table 16.

Table 16

Non sequential stages of leaving psychological IPV: quotes depicting the category of Detachment.

Subcategories	Example quotes
Realism replaces hope	"I understood that things were not going to change"
Distance from partner	"I changed my phone number and deleted him from Facebook"
Struggle to not go back	"Leaving was one of the hardest things I've ever done in my life"
Reframing old information	"Maybe he had a certain sociopathy that lead him to control me"
Bad overweighs the good	"The pain of staying had become much greater than the fear of leaving"
Importance of social support	"Hearing my Mom saying that I had the right be happy was important"

Restarting

The old patterns of minimization of abuse began to be replaced by new roles of affirmation and reconnection with others and of moving beyond the social isolation. The attempt to reestablish and build autonomy and social support networks, shifting self-priorities, developing

new interests, groups, and activities were described during this stage. An effort to restore the feeling of agency and freedom was described and women tried to invest their time and energy in their capacity to make choices. The challenge of improving their physical appearance and taking care of themselves was also described (e.g., exercising). Social support was reported as a buffer for the impact of psychological IPV and a help in the consolidation of change. A comprehension account of these findings can be found in Table 17.

Table 17

Non sequential stages of leaving psychological IPV: quotes depicting the category of Restarting.

Subcategories	Example quotes
Attempt at self-affirmation	"I'm tried to make my own choices"
Reconnection with self/others	"After all, they were always there but now I started to see them"
Effort to build autonomy	"I allowed myself to feel free"
Shifting self-priorities	"I've learned to invest my time and energy in what matters to me"
Raising interests/activities	"I rediscovered what makes me laugh"
Social support - consolidation of change	"Their support was crucial in getting back to my real self"

Healing vs. Psychopathology

Table 18 summarizes the findings for the category of Healing present in the narrators asymptomatic for post-traumatic stress (n = 10). These women described how they viewed themselves and others, away from the framework of abuse. Behavioral coping demonstrated the capacity for self-efficacy and environmental mastery in defining and achieving personal goals. They described a deeper appreciation of life along with new directions and priorities. Satisfaction with social support from family members, relatives, friends, and the sense of belonging and bonding were reported. They described positive self-perception, the achievement of psychological and physical well-being, self-affirmation, interpersonal assertiveness, and validation of personal needs and desires. They learned to let go of those who brought them down and to surround themselves with those who bring out the best in them. Autonomy and power were balanced with new attachments in which women learned to recognize healthy relationships, to know who treats them well and who deserves their attention and trust:

"Fortunately in my case, and I hope that in the majority of cases, there is someone who makes us see that we continue to be the same person we were. Things just changed because the one who was going to be our opportunity for happiness was our opportunity to realize that the important thing is to like ourselves and to only allow into our lives someone who treats us well. We learn to have sufficient strength and courage and not to allow abusive people be part of our lives".

Table 18

Non sequential stages of leaving psychological IPV: quotes depicting the category of Healing.

Subcategories	Example quotes
Behavioral coping	"I define my goals and how to achieve them"
Environmental mastery	"I feel capable of doing things for myself and doing them well"
New directions and priorities	"When I want something I have the right to fight for it"
Satisfaction with support	"I surround myself with people who bring out the best on me"
Well-being	"I feel good in my own skin!"
Validation of personal needs	"When I have to say NO I say it without apportioning blame"
Let go past hurts	"Things happened that way. I already accept it as something in the past"
Autonomy and attachments	"I like having time for myself but I also enjoy feeling connected"

Participants with post-traumatic stress (n = 10) reported a fragmented memory and a present shaped by the experience of psychological IPV, living, and coping with its consequences:

"He got on with his life while my life is stalled and I am destroyed by this pain. I feel bad about myself; I lack self-love; I have no trust or self-esteem; I isolate myself a lot; I no longer feel good in social interactions; deep down I lost myself, I stopped smiling. Even today, I cry many nights not because of him, but because of the woman I became".

The majority of this group reported chronic health problems such as the typical symptoms of PTSD (e.g., suffering from nightmares and flashbacks), chronic pain, a range of physical complaints and mental health problems (e.g., low self-esteem):

"A lie, often repeated, begins internalized as a truth in your heart. It erodes your self-esteem ... And even if you know rationally that it is not true you lose touch with reality. The weight of guilt is so great that it begins to take root in your identity."

Difficulties in emotional regulation, overreacting, and susceptibility to stress were also described. The abuse had a negative impact on the perceptions of intimate partners. Women distrusted men and had "no plans to engage in a new relationship". At this stage, women turned to therapists for formal support. Table 19 summarizes the findings for the Psychopathology category.

Table 19

Non sequential stages of leaving psychological abuse: quotes depicting the category of Psychopathology.

Subcategories	Example quotes
Coping with the consequences of psychological IPV	"I still suffer from nightmares and I wake up thinking he's there"
	"Since then I feel severe back pain"
	"If I see someone like him my heart races"
	"My self-esteem is destroyed"
	"I've always been optimistic but from now on I don't know if I'm going back to be the girl I was before"
Emotional dysregulation	"I react disproportionally as if I have no control over my emotions"
Susceptibility to stress	"I'm always nervous"
Impact on future relationships	"I don't trust them", "I don't want to go through the same thing again"
Considering formal help	"I'm thinking about going to a psychologist"

Discussion

The narratives of this study provide comprehensive data about the women´s understanding of living with, leaving behind, and healing from a psychologically abusive relationship. An inductive methodology was adopted in order to give voice to the idiosyncrasies of in-depth processes as described by the narrators. In this perspective, women are the experts on their experience and on their ability to change.

As pointed out by Wiklund and collaborators (2010) leaving the abuse is not a straightforward process followed by chronological stages, but rather a movement of ups and downs and oscillations back and forth, in a variety of paths towards sustainable change. This is why the movement between stages is more informative than the stages themselves. Initial

distortions include denying that the partner meant to be abusive, feeling responsible for the abuse, or minimizing the severity or frequency of abusive acts (Whiting et al., 2012). These appraisals may prevent women from seeing the real impact of the psychological IPV in the erosion of their self-worth. However, the minimization can fulfil an important role in dealing with IPV (Bogat, Garcia, & Levendosky, 2013) and many women 'forget' situations that are too emotionally painful and they enter a dissociative state (Walker, 1991).

Therefore, the professionals do not need to feel discouraged when women decide to return to the abusive relationship because is a natural part of the process. If they understand the process of leaving psychologically abusive relationships, they will be more able to target their interventions and help their clients. In this movement of change, it is essential not to overload the women with information or to ask questions that are not applicable to women who are psychologically abused. In the majority of these cases, physical safety is not compromised and young women do not engage in typical protocols to increase their safety (e.g., making an escape plan, hiding knives and potential weapons, preparing a bag and documents to escape, getting to a shelter, and/or accessing a protective order).

One interesting finding is that as the women consolidated their changes they moved from a partner-centered discourse ("He") to a self-centered discourse ("I"). In this process, many abusive partners interpret the woman's independence as abandonment and often stalk her with unwanted phone calls, visits, and promises to change. These behaviors can produce ambivalence in the process of leaving (Walker, 1991). This is why it is important to provide individualized psychotherapy through the different stages of this help-seeking process. In planning such interventions, is essential to tailor therapeutic techniques to the particular needs and to the women´s levels of readiness to change, emphasizing the personal strengths and resources they already have.

The key findings of this study offer qualitative information to increase the knowledge and training of professionals to intervene competently in psychological IPV. The first routine component of any treatment plan should be to ask for the history of IPV with simple and open-ended questions, to assess the woman's current support network, to evaluate the potentially negative consequences of IPV including post-traumatic stress symptoms, to take into account the stage of change in which the woman is currently, and to adapt the therapy accordingly. For example, it is possible to overcome the ambivalence stage by using motivational interviewing

(Shorey, Tirone, Nathanson, Handsel, & Rhatigan, 2012), where the idea of changing the partner's behavior is progressively abandoned and the woman starts to change herself.

The intervention should go beyond the recovery from the consequences of IPV and relapse prevention by focusing on the improvement in resilience, protective factors and positive experiences at each particular stage of change. A collaborative and nonjudgmental approach must be adopted to build trust and to encourage women to disclose (Walker, 1991). It is important to provide information about the mechanisms and non-sequential stages of psychological IPV, the dynamics of the cycle of abuse and their health costs, to give the message that the abuse was not the woman's fault, to offer community resources, and to promote the reestablishment of the social network. These are crucial tasks in the process of change.

Since women have a history of invalidating interactions marked by rejection, criticism, and disrespect for their personal worth (Bogat et al., 2013) interventions must target the management of emotional arousal. Emotional regulation following psychological IPV may represent a key therapeutic goal increasing the tolerance to distress and self-efficacy by the recognition, comprehension, and management of emotions and their relationship to old patterns of functioning (Goldsmith, Chesney, Heath, & Barlow, 2013). In this task, initial sessions may be difficult to manage, especially when therapist tries to desensitize the pain or the woman is re-experiencing the trauma (Walker, 1991).

In this study, we understand that the quality of social networking is a facilitator of change. The protective role of perceived social support is a significant aspect in regaining a sense of identity and empowerment and may encourage active coping among women. Formal social support systems (e.g., mental health counseling) and informal networks (e.g., family and friends) are particularly helpful in recovery. Providing opportunities to speak, validate, and reframe their stories are chances to increase the self-efficacy and resilience instead of reinforcing the consequences of abuse (Anderson et al., 2012). At this level, a qualitative study (Edwards, Dardis, & Gidycz, 2012) described the most and least helpful reactions of confidents (i.e. those in whom the women confided) among college students. Responses offering good advice as a result of their disclosures were reported as being the most helpful (e.g., "My friends told me not to talk to him for a couple of days so we could both cool down"), the opportunity to talk about it, to receive emotional support, to rationalize the partner´s behavior, and to provide a neutral perspective. The least helpful responses included encouraging the dissolution of the relationship, providing bad advice (e.g., "Some friends said not to do anything"), not understanding, and

joking about the experience. The majority of the participants were much more likely to disclose to informal supports, especially friends, than to formal support services. Minimization was the most frequent reason for nondisclosure of abuse.

In the analysis and presentation of data, a dichotomized vision of narrators as primarily "helpless victims" or "strong survivors" from psychological IPV was avoided (Wiklund et al., 2010, p. 222) opting for an integrated vision that allows a more holistic sense of self (Allen & Wozniak, 2010). This perspective does not invalidate the recognition that the exposure to dating IPV may interrupt normal developmental processes including a stable self-concept and the development of agency in the context of secure relationships (Bogat et al., 2013). The trauma does not just affect the present but it also leaves prolonged effects on self-appraisal and on future relationships (Whiting et al., 2012). The narratives illustrated such interruptions through citations as being trapped or unable to change in ways that prolong the crisis and impede growth. These experiences affected the women's basic identity and the way they view and interpret others (e.g., fear, distrust, and isolation), the world (e.g., as dangerous and insecure), and the future (e.g., difficulty in interpersonal relationships and intimate commitment).

Post-traumatic stress symptoms are long-term consequences found in one of the groups exposed to psychological IPV. Daily humiliation and control were internalized in self-perception with an impact on self-esteem, existential distrust, and feelings of worthlessness (Wiklund et al., 2010). Actually, women with PTSD began their movement through a life without abuse (Restarting category) but to recover from the consequences of psychological IPV (Psychopathology category) is a challenge that needs to be overcome for Healing to take place. The intervention approach should take into consideration the diagnosis and the particular needs of these women, helping them in the transition from Psychopathology to Healing, through a process of recovery.

Until recently, most of the studies focused on the process of leaving but not on the aftermath of the experience. How did women describe the process of recovery after an abusive IPV experience? What strengths and resources are helpful in this process? Understanding the personal factors such as strength and resources in the aftermath of psychological IPV in order to enhance resilience can empower women in their process of change. In this perspective, intervention should facilitate the transition from a narrative embedded in trauma toward a new sense of identity, well-being, and strength. Conceptualizing the leaving process in this way requires not only consideration of the detachment from the abuse, but, above all, the

reconstruction of affective and cognitive processes so that women no longer define themselves in terms of past trauma (Allen & Wozniack, 2010).

The qualitative findings of this study reinforce the importance of developing early dating violence prevention programs to raise awareness about psychologically abusive acts and the risks to mental health. Increasing awareness in teenagers can help them to recognize and avoid abusive adult relationships. In Portugal, the project “Fair Play in Dating” is a joint initiative between the Portuguese Institute of Sport and Youth and the Portuguese Association for Victim Support (APAV) where young volunteers receive training to organize preventive sessions in schools about date violence.

Daigle and collaborators (2016) claim that little empirical data is available regarding the effectiveness of programs on university campuses, specifically the number of victims and offenders, the level of awareness of preventive strategies, or the training of professionals. However, bystander intervention is a promising area for prevention. Bystanders are “those who witness high-risk situations but are not themselves directly involved as either the victim or perpetrator” (Daigle et al., 2016, p. 390). Bystander behavior programs can train students to recognize these situations and to develop tactics to intervene, interrupt, or prevent IPV among their peers.

Future research can explore the differences in the basis of the paths of Psychopathology (women with PTSD) vs. Healing (women asymptomatic for PTSD) including: (1) facilitators of resilience, (2) satisfaction with social supports and resources, (3) readiness to disclose the abuse and express dissatisfaction with the relationship, (4) attachment style in romantic relationships and levels of emotional dependency on their partner, (5) factors associated with the readiness to leave and stop the cycle of abuse, (6) impact of geographical distance from the partner vs. prolong the contact with the abuser, (7) perceived increase in severity of abuse and readiness to recognize the signs of abuse, and (8) to be aware of the relationship between psychological IPV and the costs to health. These differences can represent important indicators for coping with the process of recovery. Future studies should also consider the process of leaving psychologically abusive relationships from the perspective of male victims. Previous research shows that men ask for support less often and face barriers such as shame and embarrassment in the help-seeking process (Machado, Hines, & Matos, 2016). Dyadic analysis of the narratives would be important to compare both perspectives of the relationship. The impact of control and dominance behaviors perpetrated through information communication technology is a promising new

direction for investigation. Additionally, understanding the specific impact of betrayal (Goldsmith et al., 2013) on the process of leaving and the consequences on mental health (e.g., self-esteem) is another suggestion for additional work.

Conclusion

Leaving psychological IPV is a 'slow motion' process requiring multiple attempts and reconciliations before a definitive separation. Professionals should evaluate the degree of readiness to leave and respect the women´s timeline considering multiple factors such as the steps women have taken to leave and their strengths and resources, rather than simply asking whether they intend to leave. Implications for practice include the consideration of movements between the phases of Enchantment, Awareness, Ambivalence, Detachment, Restarting, and Psychopathology vs. Healing, to better help these women. Professionals should provide both emotional and informational support and express empathy through an authentic attitude avoiding judgment and criticism about women's decisions.

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CHAPTER V

SPECIFIC APPROACHES FOR PSYCHOLOGICAL IPV:

PROTOCOL FOR A RANDOMISED NON-INFERIORITY TRIAL[9]

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CHAPTER V

SPECIFIC APPROACHES FOR PSYCHOLOGICAL IPV:

PROTOCOL FOR A RANDOMISED NON-INFERIORITY TRIAL

Abstract

According to a recent systematic review developed by our team, specific therapies for psychological IPV (intimate partner violence) are missing and FT (forgiveness therapy) is the only evidence-based model tested so far. In this context, IMPACT (intervention model for psychological abuse & cope with trauma) emerges as the first CBT (cognitive behavioural therapy) specifically tailored for psychological IPV. The protocol derives from the third wave of CBT based on mindfulness techniques to recover from traumatic past experiences by fully living in the present. This study is a randomised non-inferiority controlled trial with blinded assessment. Our aim is to determine whether the new CBT experimental treatment (IMPACT) is non-inferior to the comparator FT for participants with a history of psychological IPV. Methods: The eligible participants are recruited from a Portuguese academic health centre, separated from their partner for at least two years, and screen positive for psychological IPV and PTSD (post-traumatic stress disorder). They will then be randomised to either IMPACT or FT and receive 18 weekly sessions of individual therapy by trained clinical psychologists. We hypothesised that IMPACT would be non-inferior to FT in reducing PTSD (primary outcome), anxiety, depression and the repetition of the story as a victim of abuse, and that it would increase environmental mastery and self-esteem (secondary outcomes) assessed at baseline, post-treatment and at 6-month follow-ups. Non-inferiority will be established if the evidence suggests that the efficacy of IMPACT is no more than 4 units in PTSD compared to FT. With 15 participants in each group (allowing for the attrition of three in each group), and a standard deviation of 3.16 within a group, the study would have 80% power to reject the null hypothesis that FT is superior to IMPACT. IMPACT will add empirical evidence to support the effectiveness of psychological IPV interventions, with implications for clinical and legal practices.

Keywords: Psychological intimate partner violence, post-traumatic stress, cognitive behavioural therapy, mindfulness, randomised non-inferiority trial.

Introduction

In this chapter, we present our rationale for intervention based on adaptations of evidence-based therapies for intimate partner violence (IPV) with insights from the specificities of psychological IPV. The study illustrates specific exercises that can be used between sessions to promote inner discovery, meaning-making and integration.

Often unrecognised, psychological IPV is the most prevalent form of abuse, causing serious and prolonged post-relationship functional impairments. Acts of criticism, humiliation, control, jealousy, isolation, disregard and threats of abandonment tend to increase over time and precede signs of physical violence. This emotional experience contributes to survivor's guilt, powerlessness and a poor sense of self-worth. Psychologically abused individuals predominantly present discourses of self-blame, positioning themselves as primarily responsible for abuse, reporting utterances such as the following ones: 'not knowing different', 'letting it happen' and 'attracting and choosing abuse'.[1]

As a result, anxiety, depression, low self-esteem and post-traumatic stress symptoms may arise and persist chronically, long after leaving the abusive relationship.[2] Other consequences that can derive from exposure to psychological IPV include an increased use of alcohol, drugs, somatic complaints and an increased risk of suicidal ideation.

This is particularly alarming if we consider that psychological IPV is: 1) at least as strong a predictor of poor health as physical violence alone;[3] 2) the major predictor for post-traumatic stress disorder in abused samples;[4] and 3) associated with the greatest risk of re-victimisation.[5]

Despite the fact that survivor's reports of psychological IPV in Walker's book[6] are identified as their worst battering experience, we conclude that there is a lack of empirically validated treatments. This happens because efforts mainly focus on reducing physical and sexual IPV in shelters and in medical emergencies, where psychological IPV is considered to be a minor threat.

Trauma can affect survivor's identity and inner experience, often exposing clients to unexplored sensations, cognitions and emotions. This conflict can significantly disrupt the tendency to self-actualisation, giving place to ineffective pathways which hamper higher levels of consciousness.[7] Previous studies have revealed that the prevalence of PTSD (post-traumatic stress disorder) is elevated even after participation in exposure cognitive behavioural therapies.[8] Therefore, an exclusive therapeutic focus on the traumatic experience should be avoided to the extent that it can emphasise fragmentation of the self, thus reinforcing limited processing and cognitive distortions.[9] Rather than being guided by symptoms, the approach calls for collaborative

work between therapists and their clients in the exploration of their strengths and skill building. In this context, counsellors see themselves working with clients in a quest to reconnect them with their potential identities[10] and to move forward with their lives. This promotes the possibility of helping survivors become more empowered in the reformulation of their symptoms and experiences as opportunities for self-knowledge, authenticity and inner transformation.[11] This model aims to facilitate stability in post-relationship abused persons, and once the decision to leave has been made, to support people's efforts and reinforce the survivor's hopes for their future. It will thus become the new norm, which is referred to in Paula Sequeira's[12] presentation as the 'refreeze phase' of recovery.

CBT (cognitive behavioural therapy) has made significant improvements over the last decade to help survivors deal with the adverse effects of IPV, whether crisis-oriented;[13] or after leaving an abusive relationship.[14] According to a recent systematic review,[15] individual CBT is more effective than group or advocacy interventions, reducing the adverse effects of IPV on mental health and promoting well-being. However, therapeutic interventions are usually integrated in global IPV protocols, neglecting the particular impact of different types of IPV on individuals' health. Therefore, the evidence that can be drawn from these studies is still weak, given the lack of research on psychological IPV in contrast to physical or sexual violence.

In fact, Começanha and colleagues[16] point out that only one empirical study in the field of the FT (forgiveness therapy)[17] was specifically designed to deal with psychologically abused women, but no published interventions were found for male survivors. FT is an empirically validated treatment for psychological IPV recovery based on the Enright Process Model of Forgiveness. Despite the value of this study, its applicability is compromised given that: 1) only a minority of therapists are trained in Enright's model of forgiveness, in comparison to CBT strategies; 2) it focuses on dealing with the aftermath of abuse, whereas CBT gives transversal skills to deal with life; 3) it has not been compared with a bona fide option; 4) the design of the study introduces a confirmatory bias of the authors' own purpose, since a one-tailed matched-pairs t test was used; and 5) the protocol was not gender-neutral, and excluded male victims.

Aiming to improve research and practice in this area, IMPACT (intervention model for psychological abuse & cope with trauma) emerges as the first CBT programme specifically tailored for individuals with a history of psychological IPV, in the absence of physical and/or sexual IPV, and as an alternative to FT. To our knowledge, no study has been developed to demonstrate the effectiveness of CBT to cope specifically with psychological IPV. Mindfulness

techniques[18] are introduced to promote self-awareness in the present moment, to reconnect feelings, thoughts and sensations at this moment, rather than staying in the past.

The purpose of this trial is to find out whether the new individual CBT (IMPACT) is not worse than active control FT for post-relationship psychologically abused survivors. We hypothesised that IMPACT would be non-inferior to FT in reducing PTSD (primary outcome), anxiety, depression and the repetition of the story as a victim of abuse, and that it would also increase environmental mastery and self-esteem (secondary outcomes). For that, and following the CONSORT (consolidated standards of reporting trials) guidelines for non-inferiority randomised control trials,[19] we considered comparing the active control of Reed and Enright to an alternative treatment to check whether it is not below the pre-stated non-inferiority margin, following the guidelines of D'Agostino, Massaro and Sullivan.[20] To guide future studies and our presentation, we designed an adapted checklist of CONSORT guidelines to report the study protocol, integrating general items to conduct a randomised controlled trial and specific items for non-inferiority and behavioural trials, as shown in Table 20.

Table 20

Adapted CONSORT checklist to report the study protocol.

Section		Checklist item	Page
Title and abstract			
	1a	Identification as a randomised trial in the title, specifying that the trial is a non-inferiority or equivalence trial.	
	1b	Structured summary of trial design, methods and conclusions. In the abstract, description of the experimental treatment, comparator, care providers, centres and blinding status.	
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale, including the rationale for using a non-inferiority or equivalence design.	
	2b	Specific objectives or hypotheses, including the hypothesis concerning non-inferiority or equivalence.	
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio.	
	3b	Important changes to methods after trial commencement (such	

Section		Checklist item	Page
		as eligibility criteria), with reasons.	
Participants	4a	Eligibility criteria for participants (detailing whether participants in the non-inferiority or equivalence trial are similar to those in any trial[s] that established efficacy of the reference treatment).	
	4b	Settings and locations where the data were collected. When applicable, eligibility criteria for centres and those performing the interventions.	
Interventions	5	The interventions for each group, with sufficient details to allow replication, detailing whether the reference treatment in the non-inferiority or equivalence trial is identical (or very similar) to that in any trial(s) that established efficacy and how and when they were actually administered. Precise details of both the experimental treatment and comparator. Description of the different components of the interventions and, when applicable, descriptions of the procedure for tailoring the interventions to individual participants. Details of how the interventions were standardised. Details of how adherence of care providers to the protocol was assessed or enhanced.	
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed, detailing whether the outcomes in the non-inferiority or equivalence trial are identical (or very similar) to those in any trial(s) that established efficacy of the reference treatment (and, when applicable, any methods used to enhance the quality of measurements (e.g., multiple observations, training of assessors).	
	6b	Any changes to trial outcomes after the trial commenced, with reasons.	
	7a	How sample size was determined, detailing whether it was calculated using a non-inferiority or equivalence criterion and specifying the margin of equivalence with the rationale for its choice.	

Section		Checklist item	Page
Sample size	7b	When applicable, explanation of any interim analyses and stopping guidelines (and whether related to a non-inferiority or equivalence hypothesis). When applicable, details of whether and how the clustering by care providers or centres was addressed.	
Randomisation			
Sequence Generation	8a	Method used to generate the random allocation sequence.	
	8b	Type of randomisation; details of any restriction (such as blocking and block size). When applicable, how care providers were allocated to each trial group.	
Allocation Concealment Mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers or central telephone), describing any steps taken to conceal the sequence until interventions were assigned.	
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions.	
Blinding	11a	If done, who was blinded after the assignment to interventions (for example, participants, care providers, those assessing outcomes) and how. When relevant, how the success of blinding was evaluated. Whether or not those administering co-interventions were blinded to group assignment.	
	11b	If relevant, description of the similarity of interventions. If blinded, method of blinding and description of the similarity of interventions.	
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes, specifying whether a 1- or 2-sided confidence interval approach was used.	
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses. When applicable, details of whether and how the clustering by care providers or centres was addressed.	

Section		Checklist item	Page
Additional evidence-based behavioural guidelines[21]			
Training and supervision of therapists		Background training and professional credentials of the study providers and the specific procedures that were used to train providers to uniformly conduct the treatments.	
		Type, duration and form of supervision of treatment providers, and the existence of videos of random samples of therapy observed and commented upon.	
Treatment		Treatment allegiance or preference of patients and providers, allowing for the examination of a source of bias.	
		Treatment delivery to test whether a given intervention was administered according to the plan and whether it was inadvertently delivered to the study's control or comparison group.	
Client's adherence to treatment		Whether or not patients enacted the treatment recommendations (e.g., did participants read or complete homework assignments?). Use both self-reported and objectively measured evidence of adherence rather than being inferred from outcomes.	

Methods

Trial Design

This study is a randomised, non-inferiority clinical trial, with an allocation ratio of 1:1. The purpose of non-inferiority studies is to demonstrate that a therapy is no worse than another one, where the use of a placebo is unethical.[22] The reason for testing non-inferiority was that it was hypothesised that IMPACT is no worse than FT. Also, it has important process benefits since CBT is better disseminated among therapists, thereby allowing for savings on costs related to training therapists and promoting global coping strategies to deal with life that are not confined to the experience of psychological IPV. Therefore, we hypothesised that IMPACT will not have inferior outcomes to FT in the treatment of psychological IPV consequences.

Participants

Following the same inclusion criteria for the reference treatment,[23] the eligible participants have been separated from their intimate partner for at least two years prior to enrolment and

they screen positive for psychological IPV (at least three categories with a minimum score of four) and PTSD (minimum of three symptoms).

Individuals are excluded from participation if they are currently in an abusive relationship, have a history of physical abuse in childhood and/or a history of comorbidity with other IPV types.

Participation in this study is voluntary and free of costs. College students adhere to the study by responding to the massive divulgation through the institutional mailing list and flyers. It is guaranteed that, prior to the assignment, the participants: a) are informed and fully understand the goal of the study, b) are aware that participants in each condition will be subject to treatment, and c) will sign an informed consent. Treatment protocols are administered in private soundproof cabinets in a therapeutic setting at the medical centre of a public university.

Interventions

Intervention consists of 50-minutes of 18 individual weekly sessions of IMPACT or FT. Before beginning the sessions, standardised training will be provided to therapists by the head of the investigation. Training comprises 30 hours of theoretical background, instructional modelling and role-play practice. In order to assure therapists' adherence, a written protocol with clear procedures and techniques for each session is individually provided and randomised sessions were analysed by an independent investigator. Weekly supervision sessions with therapists will be scheduled. According to Davidson and colleagues, different treatments should be delivered by different research staff so that treatment contamination can be minimised.[24] Thus, two therapists will ensure the implementation of CBT protocol and the other two will ensure the FT protocol. The four therapists enrolled in interventions have master's degrees in clinical psychology and a minimum of ten years' full-time experience as therapists. A patient's adherence to treatment will be assured by using self-reported and objective measures.

Active Control Comparator: FT

Intervention is structured according to four phases—uncovering, decision, work and discovery—following the model provided by Reed and Enright.[25] A workbook organised in units contains instructions for the therapists, material to work on during sessions, and provides homework, according to the original intervention protocol. Sessions start with an introduction to the new unit and a discussion of its core principles, followed by an overview of the journaling

questions and client reflection on unit principles. Clients must read the unit between sessions and answer journaling questions that will be reviewed with the therapist in the following session.

Unit 1 is an introductory session dedicated to the definition of forgiveness and to its distinction from the concepts of condoning, excusing, pardoning, forgetting and reconciling. In this unit, the client is invited to share the story of psychological IPV, which will be used as a baseline to understand the current perception of the offense, as well as the initial validation of the negative consequences of the abuse. The four phases of the Enright's forgiveness process[26] start in the next session: uncovering (examining the injustice of the abuse, units 2–6), decision (considering forgiveness as an option, unit 7), work (doing the work of forgiving, units 8–12) and discovery (find meaning in suffering, units 13–17). The process starts with the analysis of psychological defences and abuser-inculcated shame and self-blame, and it is then followed by understanding anger, cognitive rehearsal, committing to the work of forgiving, grieving the pain and the losses of the psychological IPV, reframing the former abusive partner, exploring empathy and compassion, practising goodwill, finding meaning in suffering, and considering a new purpose in life.

Experimental Treatment: IMPACT

IMPACT is a third generation CBT programme developed for this study by Começanha and Maia, which focuses on goals and strategies adapted from pre-existing interventions on global IPV, which have proven to be effective, in combination with mindfulness techniques.

Mindfulness is defined as a process where attention is intentionally turned to the present moment with an internal non-judgemental attitude.[27] In 1975, Kabat-Zinn introduced the MBSR (mindfulness-based stress reduction) programme at the Centre for Mindfulness in Medicine, Health Care and Society of Massachusetts,[28] with a rigorous structure and a precise protocol that integrates principles of the practice of mindfulness, body exercises of yoga and psychological approaches to reduce stress and promote emotional growth. The practice of awareness encourages individuals to consciously recognise sensations, emotions and thoughts as they come and go from moment to moment, rather than reacting to or ruminating on past memories or future suppositions. Exercises include exposure to internal experience, cognitive change, self-management, relaxation and acceptance, all of which are components of more traditional therapies.[29] What is transformed in the practice of mindfulness is the focus on one's moment-to-moment experiences without intentional or explicit exposure to the content or details of the

client's trauma story. Acquired mindfulness skills may promote cognitive changes, such as a sense of increased awareness, self-acceptance, self-empowerment, non-reactivity and self-care, as well as decreased rumination about traumatic events, physiological arousal and perceived stress.[30] These practices will increase the ability to focus and concentrate on one thing at a time (e.g., stay focused on breath), and when awareness is moved to a memory, internal activity or sound. This is not interpreted as a sign of failure, but as an expansion in the ability to be with whatever comes into the field of experience, non-judgementally.

The stress usually goes into an emotional imbalance dominated by feelings of anxiety, depression, grief and sadness, and which sometimes also leads to physical imbalances. The regular practice of mindfulness is a constructive and adaptive way to deal with these factors in a balanced and discerning way. Sessions include formal mindfulness practices (e.g., body scan, yoga, seated meditation), informal mindfulness to apply in everyday experiences, mindful curiosity about present experiences, and non-judgemental acceptance of one's own present moment.[31]

The programme comprises a written protocol to promote client learning and therapist adherence by following a particular structure as shown in Table 21. Participants receive mindfulness audio guides and a workbook with information to support inner exploration. No length of practice is specified in order to reduce any burden of failure.

Important implications derive from this model, including: 1) understanding how the clinical symptoms interrelate with each other, rather than being treated separately;[32] 2) reducing the unhelpful impact of behaviours, cognitions and emotions by changing the nature of the client’s relationship with them, rather than seeking to alter their content as it occurs in classic CBT;[33] 3) exploring the core negative beliefs in various situations, improving the global capacity for establishing a balanced view, and giving strength to more adaptive and realistic beliefs and rules about the self; and 4) viewing the individual's own aspects of mental activity as transient rather than immutable or as reflections of objective truth.

Table 21

Session-by-session IMPACT protocol.

No.	**Outline**
Session 1	Establish a therapeutic rapport, identify personal goals for change, give an overview of treatment and topics to be covered, and explore the experience, meaning and impact of the intimate partner abuse history as illustrated in the intervention of Johnson and Zlonick.[34]
Exercises week 1	Exercises proposed for this week cover simple awareness and introduction to the body scan 6/7 times per week, once a day. The 'formal practice' includes **body scan meditation** (CD1): the ability to notice sensations and in which part of the body (e.g., feelings of tension, pain) and if any uncomfortable sensations arrive, the awareness of those feelings is kept for a little while, just staying present. The awareness is invited to focus on them, breathe into them and notice what happens (usually the feeling becomes more intense first, and as participants continue their body scan meditation and keep their focus, the feeling dissipates). The 'informal practice' consists of bringing **mindful awareness** at least once a week to some otherwise routine activity such as eating a meal.
Session 2	Improve knowledge about what is and what maintains the existence of psychological IPV and its consequences for health, and, in particular, what are its symptoms and effects according to the conceptualisation of Walker.[35]
Exercises week 2	The practice includes the training of attention and dealing with brain activity. Formal practices involve **body scan mediation** (CD1) 6/7 times per week, once a day and **sitting meditation** (10/15 minutes of daily practice) which consists of sitting in a relaxed but straight posture, using breath as the primary object of awareness. Informal practices include conscious breathing (during the day, stop in the present moment and notice the inspiration and expiration), bringing mindful awareness to some routine activities, using breathing to slow down activity during the day and being aware of how we experience and process **pleasant events** to practise positive affect (registering one event a day, that can be something as simple as noticing the sun or the experience of showering).
Sessions 3–4	To develop awareness of symptoms and stress management as Crespo and Arinero[36] proposed.
	The practice includes dealing with thoughts and introduction to yoga.

No.	Outline
Exercises weeks 3–4	For the formal practice in these weeks, **mindful yoga A** (CD2) is introduced to promote body/mind awareness and the practice of deliberate, intentional movement, alternating with the body scan (CD1). Sitting meditation is proposed on a daily basis for 20 minutes every day. **Mindful check-in** is also introduced to practise the triangle of awareness between body sensations, thoughts and emotions. Informal practice involves being aware of 'autopilot' moments and under what circumstances it occurs; the awareness and registration of how we experience and process **unpleasant events** and the reading the '9 attitudes of mindfulness': non-judgemental awareness, patience, beginner's mind, trust, non-striving, acceptance, letting go, gratitude and generosity.
Sessions 5–6	Improve mood: awareness of activities in daily routines and definition of personal areas of investment, including time for self-care.[37]
Exercises weeks 5–6	These weeks are intended to promote awareness of stress responses and the difference between responding and reacting. For the formal practice, alternation of the body scan (CD1) with yoga A (CD2) 6/7 times per week, once a day, and sitting meditation for 20 minutes every day with awareness of breathing, sensations and the body as a whole. The informal practice consists of being aware of the responses to stress during the week without trying to change the answers and situations and being aware of the blockades that may occur in stress moments. Complete the sheet, 'Stress, demands and expectations' and practise the one-minute breathing space. Complete the sheet related to daily routines for activities that 'feed or remove energy' and the sheet, 'dimension of life'.
Sessions 7–9	To gain insight into core beliefs, recognition of negative thoughts and speech, and how they interfere with self-esteem and self-acceptance.[38]
Exercises 7–9	**Sitting meditation** (CD3) is introduced and the practice is alternated with the body scan (CD1) and yoga A (CD2). The **RAIN** process is proposed to develop the capacity to deal with difficulties, when an unwanted sensation, emotion or thought is experienced. Participants are invited to practise RAIN on a daily basis or wherever they need it, to recognise what is happening in the present moment, to accept the moment to be just as it is, to investigate inner experience with kindness and non-identification with the thoughts, emotions and sensations of the body. For the **informal practice**, opportunities to practise awareness of reactions and to

No.	Outline
	explore options in responding with full attention and wisdom are encouraged, opening space to respond in the present moment. Exercises to be aware of cognitive and emotional patterns are developed, as well as the capacity to embrace their own existence.
Sessions 10–12	To deal with abuse-related activation through psycho-education concerning the development of PTSD, awareness of trauma reminders and identification of what triggers memories, flashbacks and anxiety or avoidant behaviours. Awareness and tolerance to distress are proposed, without escaping into impulsive behaviours.[39]
Exercises weeks 10–12	The body scan (CD1), yoga A (CD2) and sitting meditation (CD3) are practised on alternate days. The observation and awareness of eating patterns is encouraged and a sheet of suggestions and advices is provided for promotion of healthy choices.
Session 13	To establish emotional regulation strategies:[40] instructions about the effects of emotions on functioning, recognition and accurate expression of emotions such as guilt,[41] shame, anger, pain and resentment.
Exercises week 13	**Lovingkindness meditation** is training to deal with self-criticism and find loving feelings in oneself and others. For the formal practice, this week participants can choose between any of the three main practices experienced so far: body scan, sitting meditation and yoga A, including at least one day of lovingkindness meditation. For the informal practice, participants may choose any of the practices experienced so far (e.g., simple awareness, mindful eating, RAIN), and register their experiences.
Sessions 14–15	To develop communication skills and improve relationships and a healthy support network—train on assertiveness and how to respond to verbal aggression, affirm personal rights, obtain support and self-respect, and establish boundaries through modelling and role-playing:[42] looking in the eyes, using voice tones, showing assurance and aplomb, constructing and using believable justifications for reasonable requests.[43] Identify at least one member in the community that the client can trust and confide in. Clients are encouraged to be assertive in their social interactions and not to avoid conflict, disagreements or trauma reminders that many abused survivors avoid. Coping strategies that focus on self-empowerment such as placing oneself first, decision-making that promotes self-interest and personal happiness and standing up for one's rights are exercised.
	Mindfulness and Communication

No.	Outline
Exercises 14–15	The informal practices up until now have been focused on the intra-personal (what's happening in the inner experience) and now we begin to pay attention to the inter-personal dimension, using communication skills and noticing what happens when we bring mindfulness into the relationships. The reading of the communication styles (passive, aggressive and assertive) and an exercise of stressful communications are proposed.
Session 16	To improve problem-solving focusing on the importance of a solution-oriented attitude, as opposed to learned helpless, based on five steps: general orientation, problem definition and formulation, generating alternatives, decision-making and verification.[44]
Exercises week 16	**Yoga B (CD4)** is introduced on alternate days with body scan (without CD), sitting meditation and yoga A, 7 days a week, once a day.
Session 17	To prevent re-victimization—learning to identify abusive messages for potential perpetrators, managing unwanted contact with former partners and how to respond to harassment.
Exercises week 17	Participants are encouraged to choose the formal and informal practices of their preference and develop a personal practice during the week.
Session 18	Relapse prevention—reflection about therapy gains, newly acquired coping strategies and the importance of continuing the exercises, defining long-term goals and how to achieve them as a way of promoting confidence and continuing the progress.
Exercises Conclusion	For the formal practice participants can freely choose between any of the main practices experienced so far: body scan, sitting meditation, yoga A and yoga B and incorporate the informal practices into daily routine. The final reflection includes what participants have learned, benefits and effects of the practices in daily life, in which dimensions of life they have noticed some changes, the impact of mindfulness, the biggest difficulties and goals that have emerged from participation in the programme (including potential obstacles and strategies to overcome these obstacles).

Outcomes

Screening and outcome measures are applied after a receiving signed informed consent by an independent investigator exclusively enrolled for the assessment procedures and blind to participant assignment in three moments: baseline, post-test and 6-month follow-up. Screening measures include PTSD checklists and the Psychological Abuse Survey as used by the reference

treatment of Reed and Enright's.[45] PMI (Psychological Maltreatment Inventory) short form[46] and victimization items of CTS2 (Revised Conflict Tactics Scales)[47] are added to evaluate and differentiate different types of IPV.

Psychological Abuse Survey.[48] Screening for psychological IPV with 8 categories, namely (a) criticising, (b) ridiculing, (c) jealous control, (d) purposeful ignoring, (e) threats of abandonment, (f) threats of personal harm, (g) other threats of harm and (h) fear of abuse. Each category asks for two specific behaviours (e.g., ridiculing: 'How often did your partner tell you that you are horrible, worthless, or no good?'). Each abuse category was scored on a frequency ranging from daily (8) to never (1) following a Likert scale, which means a total score that ranged from 16 to 128. Following the procedures of the historical trial,[49] a total score of 41 or above is considered to be a high level of abuse.

PTSD checklist. Items resulting from the DSM–IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition—Text Revision) criteria for post-traumatic stress disorder. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) is currently available. Nevertheless, the criteria of the previous version were chosen in order to maintain the same inclusion criteria used by Reed and Enright.[50] The 17 items include persistent repeated experience of the traumatic event (5 items), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (7 items), and persistent symptoms of increased arousal (5 items). Participants answer *yes* (1 point) or *no* (0 points) to each item if the symptom has occurred in the last month as a consequence of a past traumatic relationship.

Outcome measures are also identical to the reference treatment, apart from Enright's Forgiveness Inventory and finding meaning in suffering. We strongly recommended punctual evaluations of mental health throughout the sessions using a brief instrument (e.g., OQ®-10.2).

Self-Esteem Inventory.[51] The adult form of the SEI consists of 25 statements where the person states 'this is like me or not like me' (e.g., 'I am a fun person'). SEI evaluates global self-esteem in the domains of the general self, social self, self and peers, and self and parents. Range of scores is 0 (low score) to 100 (high score). The Cronbach's alpha for the Portuguese version was .82.

State–Trait Anxiety Inventory.[52] STAI is a self-assessment instrument, consisting of two subscales of 20 items which assess state and trait anxiety in a Likert 4-point format. The range of scores for each questionnaire is 20 (low anxiety) to 80 (high anxiety). A Cronbach's alpha of .93 in state anxiety and .89 in trait anxiety was found in the Portuguese version.

Beck Depression Inventory–II.[53] BDI-II is a self-report measure of 21 items in a multiple four-choice format. Scores can range from 0 (no depression) to 63 (high depression). The Cronbach's alpha for a Portuguese community sample was .91.

Environmental Mastery Scale.[54] The Environmental Mastery Scale is one of six scales of psychological well-being. It consists of 14 items rated from 1 *(strongly disagree)* to 6 *(strongly agree)* and contains questions about personal mastery in daily decisions. The Cronbach's alpha for environmental scale was .68.

Story measure. The participant is invited to write a narrative about the current role of psychological IPV in their life story. According to Reed and Enright,[55] one point was given if the following categories were present for the old story: '*focuses on the power of abuser; describes self as a victim of abuse; describes abuse events but no decisions; abuse memories are resentful, repetitive, or intrusive*'. For the new story, one point was given if the narrative '*focuses on the power to choose, puts abuse in the context of other life events, describes abuse review as impetus for new decisions, and contrasts memories of abuse with ongoing personal growth*'. Both the old story (victim status) and the new story (survivor status), will be rated by two independent investigators, blinded for the study.

Randomisation

Sequence generation and allocation of participants will be performed by an independent investigator with a master's degree in psychology. Participants will be randomly assigned to IMPACT or FT using a computer random number generator and the assignment to interventions will occur according to the SNOSE (sequentially numbered opaque sealed envelopes) following Scales and Adhikari procedures.[56]

Blinding

The investigator who assesses outcomes remains blind to the intervention assignment, and at the post-test, the success of blinding will be evaluated by asking the investigator to guess the allocation to intervention.

Sample Size and Statistical Methods

Sample size is calculated using the CI (confidence interval) approach, a non-inferiority criterion, using R CRAN software (Comprehensive R Archive Network), with a two-sided 95% CI of

the difference between treatments and 80% of desire power. Sample size is determined by first examining the improvement on PTSD in the reference treatment of Reed and Enright.[57] In that study (*N* = 20), participants went from a mean of nine symptoms to a mean of two, after individual FT. Since lower PTSD is better, non-inferiority will be established if evidence suggests that the efficacy of IMPACT is no more than 4 units than that of the FT. With 15 participants in each group (allowing for the attrition of 3 in each group), and a within group standard deviation of 3.16, the study would have 80% power to reject the null hypothesis that FT is superior to IMPACT.

Determination of the margin in a non-inferiority trial is based on both statistical reasoning and clinical judgment. According to evidence, after treatment the mean difference between groups should be less than 4 symptoms in the PTSD checklist.

Conclusion

This chapter explores the possibilities for more empowered individuals through informed therapeutic interventions. We hope this protocol contributes to the empirical evidence on the effectiveness of psychological IPV interventions, improving evidence-based responses through the mobilisation of third generation CBT techniques.

To be able to ask ourselves if mindfulness is a new word for a principle that was part of the traditional cognitive and behavioural practices, without having been explicitly identified in theory, we need to summarise the psychological processes involved in mindfulness. In order to answer this question, Bishop et al.[58] proposed an operational definition of mindfulness divided into two components. The first is the intentional attention focused on the immediate experience. This allows the detection of inner events when they occur, involving the capacity to sustain attention and to choose to shift the focus of attention intentionally and flexibly when there is a distraction. The result of this practice is that the person is not caught in the automatic and unnecessary elaboration of the experience and their associations, which may lead to rumination processes. This enables a broader perspective of the experiences and releases cognitive resources to directly process a larger range of events instead of a secondary elaboration of the experience.

The second component involves the orientation of the experience, characterised by curiosity, openness and acceptance. It is the experiential openness to the reality of the present moment. It depends on a conscious decision to abandon their attempts to deny the moment as it is, and allow sensations, thoughts and feelings to be present spontaneously. It is an open attitude

towards experience. Instead of perceiving life through a filter of beliefs, assumptions, expectations and defences, a more genuine view of the experience is possible. This practice reduces avoidance strategies and repressive coping styles, thus changing the subjective context in which negative feelings and sensations are experienced, making them less threatening.

Given that strong support for the effectiveness of interventions on psychological IPV is missing, further research is crucial to provide evidence on interventions specifically targeted at psychological IPV and to clarify guidelines, bringing significant implications to practice.

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INTEGRATIVE DISCUSSION

What lobsters can teach us

"A lobster is a soft mushy animal that lives inside a rigid shell.
That rigid shell does not expand, so how can the lobster grow?

Well, as the lobster grows that shell becomes very confining,
and the lobster feels uncomfortable and under pressure.
It goes under a rock formation, to protect itself from predatory fish,
casts off the shell and produces a new one.

Eventually that shell becomes very uncomfortable as it grows,
and so it goes back under the rocks... the lobster repeats this numerous times.

The stimulus for the lobster to be able to grow is that it feels uncomfortable.

Now if lobsters had doctors, they would never grow!
Because as soon as the lobster feels uncomfortable,
goes to the doctor gets a valium, it feels fine and never casts off its shell.

So I think we have to realize that times of stress are signals for growth,
and if we use adversity properly, we can grow through adversity".

Twerski, 2009

We all have the potential for growth and the capacity to change. But, sometimes along the way, we can find ourselves stuck, struggling to find our own resources. When we emerge from the old shell, our new shell is soft and offers little protection. It can take some time before we reach our full potential and for our shell to start hardening. Just like lobsters, overcoming our limits enables us to grow. Once we discover our potential, we also gain the capacity to overcome ourselves.[10]

[10] Adapted from Mark Redwood's website, 2015

From introduction to integrative discussion

This dissertation entitled *Findings from the unexplored field of psychological intimate partner violence* (IPV) consists of a group of five chapters developed over the last three years. Together, these chapters constitute the results of a research project. As stated in the introduction, the key aims of this work were to describe the current state of the field, to explore the experiences of psychological IPV in young adults, and to suggest an intervention protocol tailored to their needs.

These aims result from the gaps identified in the literature on psychological IPV and were addressed throughout the studies. First, a systematic review was conducted in order to explore the current state of the art in the field of psychological IPV, including tested interventions (Chapter I). Theoretical, methodological, and practical concerns were summarized and taken into account for the empirical works conducted. At that stage, we tried to respond to the emergent challenges identified in the introduction. We defined as priorities, in the Portuguese context, the validation of a specific screening tool (Chapter II), the assessment of the prevalence and the impact on mental health on a sample of young adults of both genders (Chapter III), and the development of qualitative research (Chapter IV) to understand the processes underlying the quantitative findings. Based on this information, interventions in the field were suggested (Chapter V).

This integrative discussion will be dedicated to reflection on the holistic contributions offered by the chapters, once the particular discussion of each chapter has already been addressed. Additionally, we intend to discuss communalities and specificities between studies, reflecting on the extent to which they complement and inform each other. With these findings, we hope to increase the visibility of psychological IPV, recognizing its specificities as a construct with its own value, and understanding its potential contributions for legal settings and clinical practice. This section is structured around five topics, specifically: key findings, practical implications, strengths and limitations, future directions, and final remarks.

Key findings

This section addresses the field of psychological IPV in a systemic manner, providing a clear picture of the findings from the five complementary studies. Together, they aim to offer conceptual, methodological, and empirical contributions. In this summary, we analyze a group of relevant considerations that can be drawn from this work.

A solid body of conceptual and methodological foundations is needed

The use of multiple terms for a single concept is a barrier to scientific progress and scientific communication. An internally consistent set of terms to designate patterns of victimization as well as perpetration is needed. (Adapted from Hamby & Grych, 2016)

Rigor is a main criterion for any research design. However, in the field of psychological IPV, the lack of clear concepts, procedures, measures, and populations under study (Jennings et al., 2017; Winstok & Sowan-Basheer, 2015) led to inconsistencies hampering the possibility of disentangling the specific outcomes of psychological IPV as a "stand-alone" form of IPV (Barter & Stanley, 2016; Randle & Graham, 2011). In fact, the existent literature might have been undermined by conceptual and methodological shortcomings and the rates of IPV vary greatly between studies, which may have compromised the accuracy of prevalence rates and the possibility of comparative studies (Randle & Graham, 2011).

As noticed in Chapter I, the systematic review revealed gaps in the literature concerning consensual terms, screening tools, and sampling techniques. Clear procedures, in order to compare prevalence rates between studies, are needed to move this field forward.

For the purposes of this dissertation, we use the term "psychological IPV", supported by the definition of O'Leary (1999), we describe who is being studied (young adults) and show how psychological IPV can be reliably measured through the validation of a screening tool for use in the Portuguese context (Chapter II), coherent with the definition, which were important steps to interpret this work. The goal was to maximize the identification and screening of cases of psychological IPV, during the last six months, and over the lifespan, and to establish a cut-off value to identify severe levels of psychological IPV to prevent further re-victimization and mental health consequences. In the empirical studies (Chapters II–IV), we selected cases of psychological IPV, in the absence of other types of IPV, in order to make sure that we are assessing the phenomenon of concern, without confounding variables that might impact results. With this procedure, we tried to overcome a limitation found in previous research which focused on samples selected from women's shelters and/or from the legal system, in which psychological IPV was studied in co-occurrence with physical IPV, and other forms of abuse.

Data support the family conflict perspective

"Significantly, with the increase in research from the family violence perspective, the understanding of IPV has displayed a cultural shift and a growing acceptance that men and women may be both perpetrators and victims of IPV." (Randle & Graham, 2011, p. 108)

Psychological IPV is a serious pattern of abuse observable in intimate relationships and a peak is registered in adolescents and young adults. However, only recently has research begun to explore this age group (Jennings et al., 2017) finding more similarities than differences between male and female psychological IPV victimization. In community samples, rates of IPV victimization and perpetration are often equivalent, revealing gender symmetry (Randle & Graham, 2011). Likewise, our findings from the quantitative cross-sectional study (Chapter III) are consistent with this perspective and show symmetry and bidirectionality in psychological IPV victimization, in which both partners engage in psychologically abusive acts. There is a recognition that women also initiate psychological IPV. The double involvement in psychological IPV, as victim and perpetrator, is a commonly observed pattern among young people demonstrating the mutual nature of this phenomenon. In fact, understanding the dynamics of psychological IPV also requires the acknowledgement that some victims are involved in multiple roles (Hamby & Grych, 2016). As illustrated in Chapter IV, as women realized that they were victims of psychological IPV, they began to answer and to behave in an autonomous manner that could be interpreted by men as purposeful ignoring and abandonment. It is probable that, had we adopted a dyadic or interactive conceptual model (Capaldi, Knoble, Shortt, & Kim, 2012), the male version of the story would improve our understanding of how the behaviors emerge and their course, how the woman fights back, and how psychological IPV can escalate over time. In fact, literature reports a significant overlap between victimization and perpetration across all major victimization categories, including psychological IPV (Barros-Gomes et al., 2016; Daigle, Scherer, Fisher, & Azimi, 2016; Vall, Seikkula, Laitila, & Holma, 2016).

Our results do not support past trends based on a patriarchal perspective, and a new framework, grounded on the family conflict perspective seems to be more adjusted to data. However, the authoritarian political regime that has characterized Portugal for 41 years (1933–1974) gave rise to a culture of gender inequality influenced by male dominance and female subservience. In some ways, its influence has persisted in the education of more traditional families.

Psychological IPV is highly prevalent and associated with mental health costs

"Unlike physical abuse, which is often easily visible, psychological and verbal abuse can be subtle, elusive, and difficult to pinpoint. Yet, every day in America, nearly one in two teenagers who are in a relationship feel they are being threatened or pressured to act against their wishes. According to a recent study, nearly 50% of both men and women have experienced some form of psychological abuse from their intimate partners. In some respects, emotional abuse is more devastating than physical abuse because victims are more likely to blame themselves."

(Maiuro, 2015, p. V)

Several studies have focused on establishing the prevalence of IPV. However, a topic on which there has been a paucity of research is psychological IPV (Felix, Policastro, Agnich, & Gould, 2016; Maiuro, 2015), especially in young adults (Daigle et al., 2016). Moreover, previous research on psychological IPV tended to explore global psychosocial consequences rather than specific dimensions of mental health. Additionally, psychological correlates have been largely researched in women and few studies have explored the associations between mental health and male victims of IPV (Randle & Graham, 2011) despite the evidence that men and women engage in similar rates of psychological IPV (Hines, Douglas, & Straus, 2016).

Consistent with a previous systematic review (Carney & Barner, 2012), serious acts of psychological IPV were reported by 74.65% of men and 71.89% of women in our sample of young adults (Chapter III) in the absence of physical or sexual IPV. This exposure is associated with poor mental health outcomes (post-traumatic stress symptoms, depression and anxiety) which is related to the severity and extent of exposure. Interestingly, when we asked "who did it first", about the beginning of psychologically abusive acts, women report more instigation of psychological IPV and men corroborate these data (Chapter III) which reveals that women are more likely to initiate IPV, according to their own reports (Hines et al., 2016).

In this section, we will embrace the challenge of integrated the results from mixed-methods, reflecting about how effectively these combined approaches might contribute to our understanding of the phenomenon (Maxwell, 2016; Maxwell, Chmiel, & Rogers, 2015). Mixed methods are not simply the collection of quantitative (e.g., the trends and patterns) and qualitative (e.g., stories and personal experiences) data, but the integration of both, reflecting on how different approaches can deepen the understanding of psychological IPV better than an isolated form of data collection could do on its own (Creswell, 2015, p. 5).

Both the quantitative (Chapters II–III) and the qualitative (Chapter IV) findings of this dissertation show the unique impact of psychological IPV on mental health. An important reflection made by Warshaw, Sullivan, and Rivera (2013) points out that, while psychological IPV may lead to poor mental health outcomes, these reactions are not necessarily pathological, but adaptive responses to ongoing stress, protecting the person from further harm. Specifically, Chapter II revealed positive associations between psychopathological symptoms, as measured by the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI) and the Psychological Maltreatment Inventory (PMI) scores in the female sample, showing higher associations for psychological IPV across the lifespan than for the last six months, and establishing a cut-off for severe cases of psychological IPV, after removing cases of physical or sexual IPV. Chapter III shows an overwhelming prevalence in rates of psychological IPV and its detrimental effects on mental health, regardless of gender. Accordingly, previous research reveals that male victims of IPV may be as vulnerable to developing anxiety, Post-traumatic stress disorder (PTSD) and depression as women (Bonomi, Anderson, Nemeth, Rivara, & Buettner, 2013; Harned, 2001; Haynie et al., 2013; Kar & O'Leary, 2010; Sargent, Krauss, Jouriles, & McDonald, 2016; Van Dulmen et al., 2012). Furthermore, psychological IPV emerged as a predictor for post-traumatic stress symptoms, depression and anxiety in Chapter III, which justified the development of a protocol intervention to cope with these symptoms, which is presented in Chapter V. Using a mixed method perspective in the interpretation of data, Chapter IV reinforced the quantitative data presented in Chapter III, detecting points of interface concerning the impact of psychological IPV on mental health and global functioning, but also added relevant specificities of the processes of moving on from a psychologically abusive relationship by the voices of female narrators, showing the non-linear stages of psychological IPV and the different trajectories in the aftermath of abuse. This impact has already been identified in previous literature (e.g., Edwards et al., 2012; Few & Bell-Scott, 2002; Wiklund, Malmgren-Olsson, Bengs, & Öhman, 2010) but Chapter IV was the first to explore psychological IPV in the absence of other types of IPV. The findings also highlight the possibility of a resilient trajectory in the aftermath of psychological IPV and show that the exposure to a potentially traumatic event is a necessary, but not a deterministic condition, to the development of PTSD (Bonanno & Mancini, 2012). We hope that the evidence presented throughout these chapters deconstructs the pre-conceived assumptions that psychological IPV is less dangerous and has less impact on the victim (Shepherd-McMullen, Mearns, Stokes, & Mechanic, 2015) or that IPV is merely a gender issue.

Men's mental health is also affected by psychological IPV

A growing body of research has documented the significance of IPV on male victims (Machado, 2016; Randle & Graham, 2011), including the need for increased resources for the prevention of female-perpetrated IPV, and the association between psychological IPV and negative outcomes. However, there is still a scarcity of data concerning the effects of IPV from the male perspective. These effects have been widely researched for victimized women (Randle & Graham, 2011). Similarly, IPV-related services mainly target women and male-perpetrated violence against intimate partners.

Coker and collaborators (2002) and Hines (2007), studying the mental health correlates of men who sustained IPV, were among the first authors to challenge the idea that male victimization is less severe than female victimization. Similar to what was found in our work (Chapter III), the cross-cultural study of Hines (2007) showed strong associations between post-traumatic stress symptoms and male IPV victimization. Coker and collaborators (2002) highlighted the strong association between psychological IPV and depression in men. The association between psychological IPV and negative health or psychological outcomes was of particular relevance for male victims of IPV because men have been found to be more likely to experience psychological than physical forms of abuse (Coker et al., 2002). When negative psychological effects are compared between men and women after IPV victimization, findings suggest that males and females might have similar results (Randle & Graham, 2011).

In the recruitment process for this project, we observed a disproportional adherence to IPV research between male and female (23% of men vs. 77% of women), which is a pattern observed in most investigations. Still, our findings reveal that men and women did not differ by gender in health outcomes, specifically PTSD symptoms, depression, and anxiety (Chapter III). These data reinforce the results obtained from the systematic review of Randle and Graham (2011) who examined the empirical evidence on the effects of IPV in men. These outcomes suggest that men can experience significant psychological symptoms as a consequence of IPV. Associations among IPV and post-traumatic stress symptoms and depression have been documented in comparison with non-victims. Actually, findings from previous studies indicate a pattern of underreporting of IPV victimization among men, which suggests that official statistics and self-report measures may not capture accurately the real prevalence rates and symptoms among victimized men, as male reporting may be influenced by cultural and societal factors (Randle & Graham, 2011). The impact of gender-role stereotypes, norms and expectations are important dimensions when

considering male experiences of IPV. The process of masculine socialization and internalization of cultural patterns may produce a limitation in expressing vulnerable emotions that continues into adulthood (Randle & Graham, 2011) and might underlie difficulties in expressing emotions and seeking help. As stated by Machado (2016, pp. 181–182) “male victims have difficulties in labelling their experiences as violence or abuse or even identifying themselves as victims” and “suffer in silence, evaluate negatively the help-seeking services and are revictimized by the support system”, which may have created barriers to men agreeing to share their stories in response to our invitation to take part in the qualitative study.

The complexity of IPV requires comprehensive and contextualized approaches

According to Hamby and Grych (2016), a more integrated model of IPV research needs to go beyond simply assessing the frequency of abusive behaviors and documenting their associations to understand why the interconnections occur through in-depth qualitative methodologies. In this perspective, studying the processes, contexts, psychological characteristics, and situational factors of victimization can provide important contributions for prevention and intervention because they have more plasticity to change than sociodemographic risk factors such as ethnicity, gender, or income. Capturing the diversity and individual dynamics of leaving a relationship where there is psychological IPV requires a multifaceted approach, crucial to the improvement of specialized services and support systems responsive to the needs of this population.

Qualitative contributions of this work, reflected in Chapter IV, explore the non-sequential stages of leaving a psychologically abusive relationship in a ‘slow motion’ process, encompassing the categories of Enchantment, Awareness, Ambivalence, Detachment, Restarting, and Healing vs. Psychopathology. The chapter not only considers the clinical pathway in the aftermath of IPV, but also the strengths and resources (personal, social, and familial) mediating the relationship between exposure to adversity and mental health responses. A linear and direct effect does not make sense in this contextualized and dynamic approach where the complexity of variables was addressed. Leaving an abusive relationship is a process involving both forward and backward steps. In this perspective, quantitative data (Chapter III) should be informed by the processes that emerged in the qualitative study and make clear the dynamics that led to differential mental health outcomes (Chapter IV). Qualitative findings reveal that all women with and without post-traumatic stress symptoms identify the same stages of living and leaving the abusive relationship.

However, they differ in the strategies used to deal with the aftermath of psychological IPV. The asymptomatic cases describe healing processes, while symptomatic identify poor mental health and difficulties in global functioning. Such indicators should be acknowledged for clinical practice in order to foster adaptive trajectories centered on resources and the improvement of resilience (Bonanno & Mancini, 2012).

The field needs evidence-based interventions

The systematic review presented in Chapter I identified the state of the art regarding the topics of interest of this dissertation and offered the basis for drawing the remaining studies. Given the lack of interventions in this field (Barter & Stanley, 2016), and the unanswered questions about differential effectiveness, such as for whom and when treatment might be most appropriate (Pill, Day, & Mildred, 2017), we end this work with a suggestion of a gender-inclusive intervention protocol (Chapter V), since no interventions were found targeting male victims (Chapter I). As demonstrated by the systematic review, individual therapy showed considerably larger effect sizes than group therapy or advocacy (Chapter I). The data strongly support the greater efficacy of Cognitive Behavioral Therapy (CBT) and Forgiveness Therapy (FT) as compared with other protocol treatments in promoting positive psychological outcomes. The findings highlight the importance of trained therapists through gender-inclusive interventions to fit both male and female needs, using specific protocols and a robust design in order to make a clearer comparison of treatments and effectiveness, as suggested in Chapter V. Although the intervention protocol suggested in the chapter is exploratory in nature, it can contribute to new directions on evidence-based practice, achieving both clinical and research purposes.

Practical implications

This work aims to inform research, practice, and policies in a number of ways. The dissertation highlights the importance of routine screening for psychological IPV and recognizes the need to educate professionals regarding the specificities of psychological IPV and the impact on mental health in young adults of both genders, to better plan the structure and contents of prevention and intervention programs.

For screening

A recent systematic review shows that victims have low rates of initiating disclosure of IPV (Alvarez, Fedock, Grace, & Campbell, 2016). Similarly, a survey on IPV reveals that only 21% of

participants disclosed their victimization to formal services (Breiding, Chen, & Black, 2014). In fact, psychologically abusive acts have a higher probability of being undetected if not asked and the low rate of reporting may be partially attributed to the lack of screening, as persons who are asked direct questions are more likely to disclose the problem (Alvarez et al., 2016). The validation of a screening tool specific for psychological IPV in the Portuguese context (Chapter II) provides a new resource for researchers and clinicians. Therefore, professionals will be able to make the subtle forms of IPV more measurable to improve their understanding of the phenomenon.

For the forensic psychologist, the process of differential diagnosis is complex and it is hampered by the limitations of the screening tools and the existence of multiple factors that moderate the psychological impact of the abusive experience. This means that it is not possible to construct just one profile for victims of psychological IPV (Echeburúa, Muñoz, & Loinaz, 2011). Because psychological IPV does not leave external marks, it is difficult to document (Echeburúa & Muñoz, 2017) and evidence is usually collected in the form of clinical reports describing the mental health consequences of psychological IPV that corroborate the victim's report.

A screening routine is a key process to identify and assess psychological IPV because the "invisible harm" is easier to hide but it is just as associated with chronic effects on mental health as other forms of IPV (Pill et al., 2017). The simple procedure of asking for a history of IPV can help victims to increase their level of awareness since many victims do not label themselves as psychologically abused. When initially assessing the victimization history, the professional will be better able to formulate the clinical conceptualization and provide a more comprehensive diagnosis assessing the impact of victimization and, consequently be better able to perform an adequate intervention. The professional should be knowledgeable and trained on how to respond to IPV disclosure (Alvarez et al., 2016) by validating the client's experiences and feelings and by offering support. That is why it is so important to intensify the training of professionals to be aware of their own attribution errors and how their unconscious biases can impact the recognition of IPV and the quality of their work with victims (Alvarez et al., 2016; Hamby & Grych, 2016).

The findings from this dissertation are consistent with previous research indicating the symmetry of abuse, i.e., the similar prevalence rates regardless of gender (Felix et al., 2016), as well as the impact on mental health (Capaldi et al., 2012). These considerations should be kept in mind leading to a more gender-neutral approach to IPV. Moreover, Chapter IV illustrates the

slow motion process of leaving psychological IPV which requires sensitive and nonjudgmental skills from the professional in dealing with the advances and retreats of this process, without blaming the victim or pressurizing the victim to make a decision.

For prevention

"In short, few, if any, empirical findings – either process or outcome – tied to specific programs are available regarding whether intimate partner violence actually has been reduced in terms of numbers of victims or offenders, whether awareness of intimate partner violence or use of bystander interventions to interpret or prevent intimate partner violence among students was increased, or whether training personnel has improved their responses to partner abuse victims and offenders" (Daigle et al., 2016, p. 389)

Our findings point to the need to prevent psychological IPV. Indeed, late adolescence and early adulthood are sensitive periods of development within the lifespan (Gur & Gur, 2016) and one of the experiences that may impact the transition to adulthood and can increase vulnerability is the exposure to psychological IPV. In fact, literature shows that young people are at higher risk of psychological IPV, associated with mental health problems (Chapters II–IV) demonstrating the key importance of the first romantic relationships in shaping psychosocial development (Exner-Cortens, Eckenrode, Bunge, & Rothman, 2017). Additionally, experiences of psychological IPV during adolescence and young adulthood are an important risk factor for physical IPV victimization in adulthood 12 years later for both male and female participants (Exner-Cortens et al., 2017; Exner-Cortens, Eckenrode, & Rothman, 2013) and victims report psychological IPV as equally or more damaging than physical IPV (Hammock, Richardson, Williams, & Janit, 2015; Pill et al., 2017). For this reason, increasing knowledge about the sources of vulnerabilities across individuals is critical for shaping effective prevention programs with adolescents and young adults to prevent IPV from starting, to reduce victimization, and to interrupt cycles of re-victimization (Hamby & Grych, 2016).

Prevention messages in schools may offer early identification of IPV in young people maximizing peer bonding and the support that peers can offer, functioning as a protective factor against IPV (Capaldi et al., 2012) and the possibility of referral for supportive services (Barter & Stanley, 2016). Bystander interventions have emerged recently and are delivered by peers. The aim is to involve young people of both genders in identifying IPV among their colleagues and being able to look to their peers for support, being protective against IPV victimization. The

programs help in the recognition of abusive relationships and controlling behaviors and in identifying how to get support, minimizing the likelihood of victimization in adulthood. However, there is little robust evidence of the effectiveness of these programs because they are rarely evaluated (Daigle et al., 2016). Therefore, guidelines about the structure and the content of these prevention programs, aimed at reducing the high prevalence of IPV victimization and perpetration among students are needed (Daigle et al., 2016). Furthermore, the evaluation of their effectiveness will provide guidance about what contents should be included to promote long-term changes in both attitudes and behaviors (Daigle et al., 2016). The adaptation of gender-neutral language based on conflict management skills, communication skills, and emotional regulation of anger and jealousy in adolescence, before it has the change to emerge, are needed (Hines et al., 2016). Additionally, prevention programs should teach young people how to recognize and how to cope with dysfunctional interactions and how to deal with prior victimization and trauma, such as peer violence or family violence, to break cycles of re-victimization. (Hamby & Grych, 2016). In Portugal, public awareness is increasing through preventive campaigns developed by the media and by APAV (Portuguese Association for Victim Support). Moreover, programs on dating violence are emerging, such as "Fairplay in dating" and "Love you and respect you" for adolescents and "Change your course: dating violence is not for you" for college students. At the moment, our research team has a prevention program in progress with 505 students between 12 and 21 years. The main goal of the program is to evaluate the effectiveness of the "Fairplay in dating" in terms of content and outcomes.

A recent systematic review (Jennings et al., 2017) found 42 studies with data about the potential effectiveness of programs to prevent IPV in adolescents and young adults for reducing the risk of victimization. More than two-thirds of these studies were published since 2000, reflecting the emergent interest around the topic. "Safe Dates Program" and the "Fourth R: Skills for Youth Relationships Program" are some of the most well-known programs, delivered in the school and community context, and reports show effective or mixed results. Although there are still only a few studies, they hold promise for the evaluation of the effectiveness of prevention programs in this area.

For intervention

There is a lack of evidence-based treatments for psychological IPV, as long as the mental health needs of psychological IPV have been neglected, in favor of the policies to ensure the

immediate physical safety of battered victims (Pill et al., 2017). This evidence was revealed by Chapter I of this dissertation, and it has been corroborated by recent literature (Alvarez et al., 2016; Debono, Xuereb, Scerri, & Camilleri, 2016; Pill et al., 2017).

Working to increase resilience and wellbeing and to reduce individuals' vulnerability and risk is an avenue worth exploring in the ongoing mission to intervene in psychological IPV (Hamby & Grych, 2016). Training of therapists based on the development of a trusting and collaborative relationship (Pill et al., 2017), clear treatment protocols and evidence-based interventions (Dragiewicz, 2016) enhance the comparison between treatments trialed and allow for effective responses. Individual trauma-focused CBT is currently the recommended treatment of choice by the International Society for Traumatic Stress Studies and by a Cochrane review (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013).

The gender-neutral intervention protocol suggested in Chapter V provides a new intervention approach for therapists and other helping professionals designed specifically for psychologically abused persons. Additionally, it has key sections targeting the difficulties these persons typically present based on empirical research and it also highlights exercises to support and promote developmental changes that are important in enhancing decisions about health matters and quality of life. More than just reducing symptoms, the IMPACT (Intervention Model for Psychological Abuse and Cope with Trauma) aims to increase empowerment and global functioning though mindfulness techniques derived from the third wave of cognitive behavioral therapy.

Strengths and limitations

Major contributions of this dissertation included the establishment of a clear definition for psychological IPV and the Portuguese validation of a screening tool to capture a wider range of psychologically abusive behaviors, in comparison to the subscale of "psychological assault" as proposed by the *Conflict Tactics Scale* (CTS). The assessment of psychological IPV as a "stand-alone" form of IPV, enabled the researchers to disentangle the specificities of this type of IPV, in comparison with other types of self-reported IPV, as recommended by Coker and collaborators (2002). The recruitment of a sample of young adults from the community allows for the evaluation of psychological IPV in the absence of physical or sexual IPV. This differs from the usual clinical samples for which participants are recruited from shelters or from the justice system.

The consideration of both genders in the establishment of prevalence rates and mental health correlates was an attempt to overcome the patriarchal perspective on IPV, which continues to underlie and shape law and policy examining male perpetration and female victimization, without adopting a systemic lens (Knobloch-Fedders, Knobloch, Durbin, Rosen, & Critchfield, 2013). The development of contextualized qualitative research is an additional contribution of this dissertation because we do not just quantify the impact of psychological IPV (Chapter III), but we also try to understand the processes and the contexts in which it occurs (Chapter IV). This highlights that not all participants have the same experience of psychological IPV and that different factors influence the development of psychological symptoms vs. a resilient trajectory. Working with mixed methodologies was a challenge which allows the integration of quantitative self-reports with the information obtained from the narratives, and the examination of the complementarity of both methods.

The selection of the e-survey (Chapter III) as the method of collecting data presents important advantages in reducing bias response, social desirability, and potential interviewer bias, and increasing confidentiality due to the lack of face-to-face contact. The questions were related to the recent past minimizing memory distortions and difficulties in recalling the adverse events, cognitive appraisals of the events, or a desire to deny or forget the past. Chapter IV complements the data through the elicitation of a narrative prompt to understand the processes associated with living with, leaving behind, and healing from a psychologically abusive relationship. The narratives were evoked after the end of the abusive history, which prevents underreport, shame, and guilt that are usually found in the early stages of the relationship, where the behaviors are minimized and excused in order to maintain the relationship. The self-report was complemented by a previous clinical evaluation, in order to access post-traumatic symptoms and levels of psychological IPV as measured by the PMI. The detection of protective and risk factors reported in the narratives increases our understanding of the factors that potentially promote resilience. The protocol intervention suggested in Chapter V is the first one that has been specifically tailored for persons who have experienced psychological IPV based on the third wave of CBT and integrating previous interventions with other victimized populations, along with the empirical data collected from this project.

Nonetheless, some important limitations of our study should be noted. Causal inferences cannot be drawn from a correlational study (Chapter III). The findings were based on a cross-sectional design hampering the determination of causality between psychological IPV and mental

health, the establishment of a temporal sequence for these variables, or the causal mechanisms underlying psychological IPV, i.e., whether the mental health indicators were precursors/risk factors creating contextual vulnerability for IPV, a consequence/effect of IPV victimization or both (Barter & Stanley, 2016). We only know that those who report psychological IPV have more symptoms than those who do not report it. Additionally, the data relying on self-reports of symptoms may have been under or over-reported based on a convenience sample (Randle & Graham, 2011). For these reasons, findings should not be generalized to every person experiencing psychological IPV (Barros-Gomes et al., 2016).

Longitudinal studies are needed to follow children and adolescents into young adulthood in order to describe different trajectories and to improve our understanding of cause and effect, which are crucial for the detection of antecedents, consequences and cycles of victimization-perpetration (Hamby & Grych, 2016). Prospective research will allow for increased confidence in the prediction of these variables, opposed to simply associations within time. It is also important to consider to what extent the prior history of violence have contributed to these results (Hamby & Grych, 2016). This methodological improvement has a set of implications for clinical practice and research, namely the detection of an emerging pathway of psychological IPV in the early stages of dating to prevent the escalation to physical IPV since psychological IPV almost always precedes physical IPV, and the acknowledgment of the behavioral, cognitive, and emotional processes to identify ways that people can reduce their risk of being victimized based on the metaphor of "hardening the target" without "blaming the victim" (Hamby & Grych, 2016).

In Chapters II–IV, the invitation to participate was sent to all the students enrolled in the academic year 2014/2015 in a public Portuguese university. However, the sample of this study is not representative of all Portuguese college students and this affects the generalizability of the findings (Randle & Graham, 2011). On the other hand, national representative surveys among young adults are not available. Therefore, it is not possible to make a comparison between the young people in our sample and the young Portuguese population in general. Participation was voluntary which may have skewed the results by including the available participants who were interested in reporting. Our mixed-sample involved a smaller proportion of men than women and it was not possible to include men in the qualitative research due to the lack of adherence. Access to male narratives could possibly detect gender differences and signal intervention needs and differential or specific treatments.

Future directions

The work we have developed so far included a mixed method design and a sample for both sexes summarizing a group of challenges around conceptual and methodological foundations, impact on mental health, comprehension of the processes involved in psychological IPV, and interventions in the field. In this section, we share some directions for future research in the sense of amplifying the current findings and inspiring new studies to a broader knowledge in this area.

One of the great challenges is to reflect about effective strategies to include more males in the research. Previous findings reveal that psychologically abused men may not recognize themselves as victims and typically do not perceive their experiences as abuse, because violence is mainly associated with physical or sexual IPV (Machado, 2016; Randle & Graham, 2011). Moreover, stigma and shame about seeking help impede disclosure, together with an evaluation of formal services as not being helpful (Machado, 2016). Likewise, established social patterns of masculinity may seem inconsistent with viewing themselves as victims and sharing their experiences (Randle & Graham, 2011). Future research on the effects of IPV in male victims is needed, as well as the development of gender-appropriate measures for male victimization and the comparison of a sample of male victims and a sample of male non-victims, rather than comparing males with females. In-depth qualitative research and studies focusing on psychological IPV experienced by men would also be valuable since studies highlight the possibility of more adverse and long-term outcomes for men than for women (Coker et al., 2002; Exner-Cortens et al., 2017). Another topic to considerer is the inclusion of both internalized and externalized measures (e.g., Brief Symptom Inventory) when studying men who have experienced IPV because previous studies show that men typically display externalizing responses to stressful events (Randle & Graham, 2011). In this perspective, male victimization shares some communality with female victimization, but also some specificity (Machado, 2016).

Another understudied sample is LGBT individuals (lesbian, gay, bisexual and transgender) who are at increased risk of IPV, compared to their heterosexual counterparts (Felix et al., 2016; Reuter, Newcomb, Whitton, & Mustanski, 2016). In fact, most of the research data is gathered from heterosexual samples, reflecting IPV estimates and their impact on mental health, instead of the specificities of minority populations. Thus, upcoming studies must underscore the need for IPV research on same-sex couples and give consideration to prevalence rates, risk factors, and mental health outcomes (Capaldi et al., 2012). It may be the case that traditional findings

established for heterosexual youth may not be transferable to LGBT samples, given a number of singularities such as additional stigma and different role models (Reuter et al., 2016). According to Reuter and collaborators (2016) future research should explore the correlates and consequences of IPV in this specific population given the high prevalence observed in LGBT samples, together with serious outcomes and limited empirical data.

We also recommend the adoption of a gender-neutral perspective regarding psychological IPV informed by the family conflict model. The bidirectional nature and symmetry of IPV can be tested in the couple through the "dyadic concordance types", as suggested by Hines and collaborators (2016). This procedure allows for the confirmation of the presence of the overlap phenomenon and the classification of each couple in one of the following categories: male-only, female-only, or both engaged in the abusive behavior.

Self-report should be complemented by key informants and other sources close to the participant in order to obtain external validation, complement the results, and find similarities and discrepancies between reports. Also, biological markers can be used to access the physiological and biochemical changes and explore how chronic stress impacts mental functioning and emotional deregulation causing changes in cortisol levels, in hypothalamic-pituitary-adrenocortical (HPA) activity, and in the immune system.

Additionally, the establishment of clusters of psychological IPV according to an array of different categories (e.g., emotional/verbal abuse vs. control/dominance acts) will help to understand how mental health might be shaped by exposure to psychological IPV victimization, specifying which clinical symptoms are associated with different victimization profiles. Specifically, little is known about the onset and course of PTSD and complex trauma in young adults and the effects of prolonged exposure to psychological IPV in predicting the development of PTSD symptoms to make sense of individuals' experiences (Pill et al., 2017).

Longitudinal studies are needed to clarify the relationship between the occurrence of psychological IPV victimization and the development of mental problems and whether PTSD, depression, and anxiety are causes, consequences, or both. A representative sample of young adults would allow the generalization of data. Moreover, if a peak of psychological IPV is observed in young adults (Capaldi et al., 2012) then older adults should present lower prevalence rates. The utilization of the same screening protocol with young adults vs. adults from both genders will allow for testing of this hypothesis through the comparison of prevalence rates.

Given that the literature on past adversity and intergenerational transmission of abuse finds that individuals who are exposed to childhood abuse are at risk of being offenders and victims later in life (Daigle et al., 2016) it will be interesting to explore the association between these experiences and later IPV victimization and/or perpetration. To what extent do past childhood abuse, exposure to IPV in the family of origin, parental support, alcohol abuse, personality dysfunction, and internal working models contribute to additional vulnerability to IPV (Capaldi et al., 2012; Hines et al., 2016)? According to Hamby and Grych (2016) several conceptual frameworks emphasize prior violence exposure as a causal mechanism for later victimization. Research should focus on how past experiences of violence changes the person in ways that are carried into future situations creating additional risk for re-victimization. Improving the identification of modifiable risk factors can promote resilience and contribute to the development of positive functioning reversing the adverse trajectory through prevention and intervention efforts. Causal models need to be able to specify how past experiences influence future events, specifically what biological, cognitive, and emotional processes increase the likelihood of additional victimization experiences, as summarized below by Hamby and Grych (2016):

At the physiological level, exposure to chronic or repeated stress (e.g., psychological IPV) can undermine adaptive responses to events and interactions manifested by the dysregulation in the biological stress response and emotional processes involving the sympathetic and parasympathetic nervous system, neurotransmitters, and the hyperarousal of the HPA axis. This system can fail to return to baseline and became dysregulated when the person needed to engage in effective responses to later stressors impairing individual's ability to mobilize assertive behaviors, which should be the subject of future research.

At the cognitive level, the investigation of attachment and internal working models can add information about how individuals view themselves and others in close relationships. The experience of psychological IPV can disrupt the formation of secure attachment and impact positive images of the self as loveable and of others as trustworthy and responsive, creating insecurity, fear of abandonment, or jealously. Additionally, exposure to past victimization would make people especially avoidant and hyper-vigilant of future victimization.

At the emotional level, expression of feelings (e.g., anger, fear, sadness) and self-regulatory processes (e.g., modulating affect, managing impulsivity) are understudied topics in explicative

models of IPV victimization suggesting that people with a victimization history may have more difficulties in engaging in goal-directed behaviors.

As stated by Barros-Gomes and collaborators (2016) the focus should be placed on modifiable factors through intervention, increasing mental health, and preventing future victimization. For example, the variables that can mediate and moderate the impact of psychological IPV on mental health outcomes, capable of being modified through intervention programs (e.g., coping strategies, social support, self-esteem, resilience, and positive experiences) should be explored.

Future research should also extend the investment in comprehensive and contextualized methodologies that focus on the processes and richness of the stories in which the acts occurred, including how conflicts escalate to psychological IPV (Capaldi et al., 2012). For example, qualitative methodologies can reflect on the availability of resources, positive experiences, and risk factors which lead to different pathways of resilience vs. psychopathology (Bonanno & Mancini, 2012). Additionally, the understanding of the reasons reported by male victims for staying or leaving the relationship and the process of leaving psychological IPV for abused men could add relevant information to our understanding.

Concerning cyber victimization, and given that psychological IPV and violence perpetrated via technology tend to co-occur in young adults (Felix et al., 2016), research can explore the impact of categories as suggested by Wood, Barter, Stanley, Aghtaie, & Larkins (2015): emotional online abuse (e.g., hurtful comments, offensive messages); controlling behavior (e.g., using social net-working sites to control partner friends/locations/clothes); surveillance (e.g., constantly checking on what partners have been doing); and social isolation (e.g., isolating partners from friends by posting untrue messages from their phones).

Nonetheless, a beneficial use of new technologies can be self-administered computerized screening as an effective way to promote awareness among young people experiencing psychological IPV as it allows for easier disclosure and minimizes the feelings of being judged. More research is needed on how computerized screening can become the first step toward intervention (Alvarez et al., 2016). According to Barter and Stanley (2016), support may include apps (e.g., MobieG) and mobile advice services (e.g., STIRitUP) designed to assist young people to recognize and manage IPV. In Portugal, the free online game "UnLove", developed by the University of Aveiro, is a good example of an online intervention that helps young people to recognize psychological IPV.

In the dimensions of help-seeking, services, and responsiveness, although Article 152 of Portuguese law is very clear about the criminality of psychological IPV, the speeches and decisions of professionals still reveal stereotypical and traditional attitudes. Therefore, survivors' opinions about their experiences, availability of formal services/resources, and preparation of professionals, effectiveness of the criminal justice system, police responses, and implementation of the policies in real-life are needed in order to inform and improve practice. How do professionals respond to those cases? Are they receptive to training in how to respond? And, where the victims' perceptions are concerned, is formal help perceived as useful? What are the barriers faced by victims in the process of asking for help? On the one hand, it is important to evaluate beliefs, perceptions, and practices of professionals and to promote specialized training. On the other hand, it is necessary to explore the victims' perceptions of availability of formal help and their satisfaction with the help received. Future research should also explore the predictors for psychological IPV victimization and re-victimization and use that knowledge to test the effectiveness of prevention programs in adolescence and young adults and the effectiveness of intervention protocols such as the one proposed in Chapter V.

Final remarks

The work *Findings from the unexplored field of psychological intimate partner violence* has, as its main goals, to summarize the current body of research in the field, to explore the experiences of psychological IPV in young adults, and to suggest an intervention protocol specifically tailored to their needs. Accordingly, the challenges we proposed in the introduction section were accomplished through the development of a systematic review revealing the gaps relating to psychological IPV, the validation of a screening tool for detecting the subtle form of psychological IPV in the Portuguese context, the recognition of the cycles of IPV victimization-perpetration in young adults of both genders, the understanding of the complex process of leaving a psychologically abusive relationship, and the suggestion of a gender-neutral intervention protocol.

In Portugal, one of the missions of the Commission for Citizenship and Gender Equality (CIG) is to ensure the implementation of public policies against IPV. Through the V National Plan for the Prevention and Fight against Domestic Violence and Gender Violence, 2014-2017 (V PNPCVDG) the XIX Portuguese Constitutional Government Program recognizes the need to strengthen the fight against IPV, calling for coordinated action by all the entities involved and also

the participation of the society as a whole. The V PNPCVDG is aligned with the commitments made by Portugal with international organizations, specifically the United Nations, the European Union, and the Council of Europe. In fact, Portugal was the first country in the European Union to approve the Istanbul Convention on 21 January 2013, assimilating the most recent European and international guidelines on the subject. The V National Plan seeks to consolidate the work that has been developed in the area, outlining strategies for prevention, deepening procedures to more effective protection of the victims, extending the knowledge about the phenomenon, reinforcing the existing network of support structures and assistance to victims, and providing the professionals with more intensive training.

Despite the recognition that psychological IPV can impact health and global functioning and that men can also be victims, policies are mainly focused on physical violence against women, adopting a gender-based perspective grounded on the assumption that violence affects women disproportionately, according to the Istanbul Convention. Nevertheless, some changes have begun to be reflected in media content and in public prevention campaigns launched by national agencies against domestic violence, towards a more inclusive approach in civil society.

This work is founded on a constructivist paradigm (Ponterotto, 2005), based on a logic of investigation-action, which intends to impact research, practice, society, and policy and amplify knowledge through a truly comprehensive and empathic approach meeting the needs of all citizens. In this framework, an integrated action of increased public awareness, prevention, and intervention can impact individuals as co-constructors of their own changes (Machado, 2016) operating the transition from the patriarchal paradigm to the family conflict perspective, which may ultimately prevent and reduce psychological IPV. A summary of suggestions based on the principles of Applied Victimology can be found in Table 22.

Table 22

Guidelines for research, prevention, and intervention on psychological IPV.

1. Establish a clear term ("psychological IPV"), a definition (O'Leary, 1999) and categories (Tolman, 1999) to describe the phenomenon.
2. Routine screening for psychological IPV adopting standardized, reliable, and gender-neutral measures, and evaluating past traumas.
3. Implement early prevention programs for adolescents and young adults focused on malleable risk factors (problem-solving, conflict management, and assertive communication skills) involving school, peers, and community (e.g., "FairPlay in Dating").
4. Increase public awareness of the symmetrical and bidirectional nature of psychological IPV for both sexes and the possibility of co-occurrence of victim-perpetrator in the dyad anchored in the family conflict perspective.
5. Explore risk and protective factors for psychological IPV and test moderator and mediator effects.
6. Complement quantitative data with qualitative research (e.g., Leaving a psychologically abusive relationship is a slow motion process, described as backwards and forwards steps).
7. Develop randomized control trials to assess the effectiveness of interventions tailored to address the specific needs of psychologically abused persons and establish evidence-based practice.

"Don't only practice your art, but force your way into its secrets, for it and knowledge can raise men to the divine." (Ludwig van Beethoven)

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[11] Translated from the book *O Coração do Homem* [*The Heart of Man*], Jón Kalman Stefánsson, 2016.