

Posttraumatic Stress Symptom Profiles of Battered Women: A Comparison of Survivors in Two Settings

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This study sought to develop a profile of posttraumatic stress symptoms experienced by battered women and to explore differences among subsamples. Two groups of survivors from five states were compared: 159 who had obtained help at domestic violence programs (DVP) and 33 who had obtained help at other types of programs (NDVP). They completed three self-report measures of posttraumatic stress and a fear questionnaire. Sixty percent of the women in the DVP group and 62% in the NDVP group met criteria for a diagnosis of posttraumatic stress disorder (PTSD). The most common symptoms were: nightmares, intrusive memories of the abuse, avoiding reminders of it, and hyperarousal. DVP women experienced a variety of symptoms more frequently. Group differences in PTSD symptomatology were not present after statistically controlling for severity and frequency of the violence and length of time since the abusive relationship.

Posttraumatic stress disorder (PTSD) among help-seeking battered women is quite common, with rates ranging from 40% to 84% ($M = 56\%$) (Astin, Lawrence, & Foy, 1993; Cimino & Dutton, 1991; Gleason, 1993; Houskamp & Foy, 1991; Kemp, Rawlings, & Green, 1991; Lenau, 1990). Although information about the prevalence of PTSD in battered women may be useful, the description of specific PTSD symptoms is likely to be even more useful. Developing specific symptom profiles has several advantages. First, knowing what aspects of PTSD are characteristic of battered women and other trauma groups can help define the disorder more clearly. The definition of the disorder is relatively new and is evolving (Herman, 1992). In particular, little is known about the impact of prolonged trauma perpetrated by a significant other.

Second, battered women may benefit directly from learning of symptoms commonly experienced by other battered women. Those with PTSD sometimes think they are "going crazy." Practitioners who share information with battered women on the prevalence of specific symptoms may reduce any anxiety and sense of powerlessness arising from the disorder itself.

Third, practitioners may need to be better informed of the specific nature of the symptoms. Those with anxiety disorders may be less likely to disclose their symptoms (cf. Shapiro, Skinner, Kessler, Von Korff, German, et al., 1984), probably because awareness and discussion of the symptoms themselves can evoke anxiety. Practitioners need to be aware of symptoms that battered women are likely to have, especially if those symptoms are not readily apparent and yet interfere with functioning. Knowledge of specific symptoms may therefore prevent the misdiagnoses that sometimes occur of women suffering from PTSD (Brown, 1986; Rosewater, 1985).

Finally, the pattern of symptoms may indicate the type of interventions needed. For example, a predominance of avoidant symptoms (e.g., avoiding situations associated with the abuse) may lead to one form of intervention, whereas a predominance of intrusive symptoms (e.g., nightmares and flashbacks) may lead to another type.

One review of the literature showed that there was a fairly good fit between battered women's characteristics and the major indicators of PTSD as currently defined (Woods & Campbell, 1993). However, in most cases the studies reviewed provided only indirect evidence for PTSD indicators. More research with battered women is needed to establish direct evidence of PTSD symptoms using multiple measures of PTSD and related constructs.

This study compared two groups of battered women on three measures of posttraumatic stress and a fear questionnaire. The fear questionnaire was used to explore the possibility of the generalization of trauma effects. One of the groups comprised women who obtained help at domestic violence agencies for shelter and/or counseling. The other group comprised women who obtained help at one or more nondomestic violence programs. Comparisons were also made on the severity of abuse and injuries and levels of depression and self-esteem.

Battered women seeking help at domestic violence agencies were expected to have experienced more severe violence, as previous studies have found (Washburn & Frieze, 1980; Wilson, Vercella, Brems, Benning, & Renfro, 1992). As a result, they were expected to experience symptoms of PTSD more frequently because violence severity has been related to PTSD in other studies (Kemp et al., 1991; Lenau, 1990). The frequency of violence has also been associated with the intensity of PTSD symptoms (Astin et al., 1993).

A potential benefit of this analysis is that practitioners from different settings may learn that they are working with survivors with very different experiences of the abuse and its effects. Two studies found that battered women could be clustered into groups according to the types of violence they experienced and the apparent causes for it (Follingstad, Laughlin, Polek, & Rutledge, 1991; Snyder & Fruchtman, 1981). Some of the controversies in the field may be resolved through the recognition of these differences.

Future reports will focus on testing hypotheses regarding risk factors and buffers for PTSD with this sample. The hypothesis tested in this study is that battered women seeking help at domestic violence programs will have more frequent symptoms of PTSD and that these symptoms can be explained statistically by the frequency and severity of the violence they experience. The primary purpose of the study, however, is descriptive and seeks to answer the question: What are the specific symptoms of PTSD in a sample of help-seeking battered women and two subsamples? The secondary purpose is to derive implications that these symptom profiles might have for evolving definitions of PTSD and for interventions for battered women.

METHOD

Sample

The domestic violence survivors were recruited for the study from a variety of sources. Data from 192 respondents were used in the analysis. One hundred forty-four of the respondents were recruited from 18 shelter programs in five states in the northwest, midwest, northeast, and south. Twenty of the women had obtained help at the victim support program of a prosecutor's office. Eighteen were recruited through the newspaper. Ten were partners of men who had been in a special treatment program for men who batter. Seven women were in group counseling, two were in individual counseling and two were referred by other participants. Eleven respondents were excluded because they had not obtained help at any agency and their small number precluded statistical analysis.

Of the 220 questionnaires requested by the shelters, 65% were completed and returned. The return rates ranged widely across shelters from a high of 100% in two shelters to a low of 10% in one. The exact refusal rate by women recruited by DVP staff is unknown because the questionnaires were administered by program staff who did not always record the refusal rate. A contact person at a shelter with a very low response rate said that the questionnaire was too long. Three other shelters asked for more questionnaires because they had extremely high acceptance rates and found that the use of the questionnaire was helpful to the women.

Of the women at the prosecutor's victim support unit who were given flyers or sent a letter about the study, 23% completed a questionnaire. Of the women whose partners had previously been in treatment and were sent a letter about the study, 12% completed a questionnaire.

The source of recruitment did not always indicate the type of help the women had received. For example, some women responding to the newspaper ad or going to the prosecutor's office had obtained help at a domestic violence program in the past. Thus, questionnaire responses about help-seeking were used to divide the sample into two groups: 159 who had obtained help at a shelter-based program and 33 who had obtained help elsewhere. Responses were to the question: "What help have you received or are you receiving?" Based on information from the contact persons at the shelters, we knew that all those who were sheltered also received individual and/or group counseling. Not all those going to shelter-based programs, however, had been sheltered there. For example, a woman might be in a shelter-based support group 1 or 2 years after leaving her partner but had never been a shelter resident. We could not clearly distinguish between these two groups based on our questionnaire data. Research by others indicates that violence severity and learned helplessness decrease significantly in a linear fashion across each of three samples, in this order: sheltered women, support group but not sheltered, and abused but not help-seeking (Wilson et al., 1992). One study found no significant difference in PTSD rates between sheltered and nonsheltered women recruited from the same agency (Gleason, 1993). What the women in a domestic violence program had in common in this study was a willingness to admit to themselves and to others that they were seeking help at a domestic violence program.

Many of those seeking help at nondomestic violence programs were in individual therapy in private practice (30%) or in an unspecified setting (24%). Some specified that they were attending a 12-step program (21%), or receiving help at a family service agency (9%) or mental health center (6%). In addition to individual therapy, some were in couple's therapy (12%) or group therapy (12%). These categories of help-seeking are not mutually exclusive.

TABLE 1. Demographic Characteristics of the Samples

	Total	DVP	NDVP	<i>t</i>
Age <i>M</i> =	34.3	33.8	36.4	-1.58
<i>SD</i> =	(8.5)	(8.4)	(8.4)	
Years in relationship	8.1	7.9	8.6	-.40
	(7.5)	(7.3)	(8.6)	
Mos. since living with man	30.1	28.9	36.5	-.80
	(46.4)	(46.0)	(49.7)	
Income per month	898	816	1,212	-2.18*
	(743)	(690)	(921)	
				χ^2
Employment	56.2%	52.2%	66.7%	2.31
Education: Less than HS	13.5%	15.1%	6.1%	
High School	26.0%	25.8%	27.3%	
At least some coll.	60.4%	59.1%	66.7%	3.56
Race: Black	4.9%	5.3%	3.0%	
Asian	0.5%	0.7%	0.0%	
Hispanic	1.6%	1.3%	3.0%	
Caucasian	91.4%	91.4%	90.9%	
Native Amer.	1.6%	1.3%	3.0%	1.48
Marital status: Single	26.8%	28.7%	18.2%	
Cohab.	4.2%	3.2%	9.1%	
Married	14.2%	15.3%	9.1%	
Remarried	8.4%	7.0%	15.2%	
Separated	25.3%	26.8%	18.2%	
Divorced	20.0%	17.8%	30.0%	
Widowed	1.1%	1.3%	0.0%	9.59

Note. DVP = served at a domestic violence program; NDVP = served at a nondomestic violence program.

* $p < .05$.

Table 1 shows the demographic characteristics of the total sample and the two subgroups. Those seeking help at domestic violence programs (DVP) did not differ significantly from those obtaining help from other sources (NDVP) in age, years in the relationship, length of time since living with partner, employment, race, or marital status. The NDVP women were somewhat more likely to be employed (67% vs. 52%, $\chi^2 = 2.31$, $p = .13$) and they had significantly higher incomes. The proportion of those still in the relationship did not differ between the groups.

For the sample as a whole, the average age of the participants was 34.3 ($SD = 8.5$). They had remained in the relationship an average of 8.1 years ($SD = 7.5$). Most of the women were white (91.4%); 4.9% were African-American; and very few were Hispanic (1.6%), Native American (1.6%), or Asian-American (0.5%). As with other help-seeking samples (Washburn & Frieze, 1980), a substantial minority had a permanent (22.6%) or severe (16.8%) injury ("major wounds, severe bleeding or burns, knocked out").

Procedures

After informed consent procedures, participants were asked to complete anonymous questionnaires. They were given the option of having a copy of their questionnaires made for their counselor or shelter staff. The women took about 1 hour and 15 minutes on average

to complete the questionnaire. Women in shelters were given the questionnaires by a staff member. Women recruited from the other sources were administered the questionnaire by the project director or a research assistant. These women were given emotional support and referrals as needed after completing the questionnaires. Each woman was offered \$10 for her participation.

Measures

Diagnostic Interview Schedule: PTSD Symptoms. The nine symptoms from the Diagnostic Interview Schedule (DIS) were used in the survey. The DIS was originally constructed and validated for large epidemiological studies of mental disorders using DSM-III diagnoses (Robins, Helzer, Ratcliff, & Seyfried, 1982). For this study, respondents were asked if any of the PTSD symptoms had been experienced because of abuse from their partner or ex-partner. As in the original schedule, four of the symptoms were combined to create two indicators, resulting in a total of seven indicators for making the diagnosis. Also as in the original schedule, questions were asked regarding: the length of time between the traumatic event (the last occurrence of abuse) and the beginning of any symptoms, the last occurrence of symptoms, and symptom duration. Substantial agreement, at levels similar to other diagnoses, has been shown between psychiatric and lay interview diagnoses of PTSD using the DIS (Breslau & Davis, 1987). More conservative estimates of PTSD have been found with diagnoses derived from self-report questionnaires similar to the one used here (Houskamp & Foy, 1991).

Impact of Event Scale. This 15-item self-report scale has two subscales: intrusive (recurrence of disturbing thoughts, ideas, dreams) and avoidant (emotional numbness, avoiding situations related to the event). Responses are given on a four-point scale from "not at all" to "often." Horowitz and his associates report high levels of concurrent and "known groups" validity (Horowitz, Wilner, & Alvarez, 1979; Horowitz, Wilner, Kaltreider, & Alvarez, 1980). It is highly associated with the SCID-R diagnosis of PTSD in rape victims (Resnick, Riggs, Veronen, & Saunders, 1989), battered women (Lenau, 1990), and combat veterans (McFall, Smith, Rozsell, Tarver, & Malas, 1990). Although there is some correlation between the two subscales, factor analytic studies support their independence (Zilberg, Weiss, & Horowitz, 1982). The internal reliability of the scales has ranged from .78 to .92 (Horowitz et al., 1979; Zilberg et al., 1982). The internal reliability coefficients for this study ranged from .78 to .90. Normally, symptoms are reported for the past week. For this study, two other time frames were added: "during your relationship with your partner" and "while separated" (if applicable). The referent phrase for the trauma was "all the abuse you experienced from your partner."

Posttraumatic Stress Scale for Family Violence. Most measures of PTSD are designed to measure the impact of a single event. Some are derived from general measures of anxiety or psychopathology, like the SCL-90 or the MMPI. Still other measures, like the DIS and the Impact of Event Scale (IES), leave out or minimize the hyperarousal dimension that is included in the DSM-III-R definition. Because of the weaknesses of other scales, a measure was constructed for this study based on the 17 criteria of the DSM-III-R. The items are listed in Table 3. The time frame was purposely broad and the words "trauma," "stress," and "anxiety" were not used. The introduction asked participants: "As a result of any of your partner's verbal or physical abuse of you, please circle how many times you had each of the following problems." The response categories were: never, 1-2, 3-11, 12-

24, 25-36, 37-50, 51-100, and over 100. These categories have the advantage of being less subjective than those used in other scales, e.g., "rarely," "sometimes," "often."

Factor analysis (principal component, varimax rotation) revealed three factors accounting for 66% of the variance. An "avoidant" factor included three items (5, 6, 7) with an internal reliability (alpha) of .79. A combined "intrusive/hyperarousal" factor included items 1-4 and 15-17, with an internal reliability (alpha) of .87. A third factor reflected numbing of affect and detachment from others, plus difficulty sleeping, irritability, and difficulty concentrating (items 8-14). Its internal reliability (alpha) was .92. It correlated the highest with the Beck Depression Inventory ($r = .43, p < .001$). Internal reliability (alpha) for the entire scale was .94.

Concurrent validity was shown by significant, positive correlations with the subscales of the IES. The correlation was highest between the total score of the scale and the IES intrusion scale ($r = .58$). The correlation was also moderately high ($r = .50$) between the "intrusive/hyperarousal" subscale and the intrusion subscale of the IES, a similar but not identical construct. The correlation was somewhat lower between the corresponding avoidant subscales ($r = .29$).

Marks Fear Questionnaire. The five-item Agoraphobia Scale and five-item Social Phobia Scale from this questionnaire were used (Marks, 1987). For each phobia-related situation, responses were given on an eight-point scale from 0 ("would not avoid it") to 8 ("always avoid it"). The scales successfully discriminate agoraphobics and social phobics from each other and from other diagnostic groups (Marks, 1987). In addition to the usual form of the questionnaire, we asked respondents their reactions to the situations prior to meeting the partner who abused them. Retrospective reports, typically of questionable reliability, are likely to be more reliable for these women because the beginning of the relationship would provide a clear memory marker. The internal reliability coefficients for the scales ranged from .76 to .79.

Beck Depression Inventory. This inventory consists of 21 items, each item listing a range of severity of symptomatology. The symptoms cover many aspects of depression, including somatic complaints, guilt, pessimism, and indecisiveness. Respondents are asked to describe the way they "have been feeling the past week." The validity of the scale is based on ratings of experienced clinicians, and previous split-half reliability was .86 (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The internal reliability coefficient with the sample of this study was .91.

Rosenberg Self-Esteem Scale. This is a commonly used, 10-item measure of self-esteem. First developed for use with adolescents (Rosenberg, 1979), it has been widely used with adults, including victims of violence (Myers, Templer, & Brown, 1984). We used a version with a four-point response format: strongly agree, agree somewhat, disagree somewhat, and strongly disagree. Several studies support the construct and concurrent validity of the measure (Fleming & Courtney, 1984; Myers et al., 1984; Rosenberg, 1979). Previous studies report an internal reliability coefficient over .80 (Fleming & Courtney, 1984). Besides the usual measure that tapped current self-esteem, we administered one with the time frame "just before I met my partner." Both the current and past measures of self-esteem had an internal reliability coefficient of .92.

Characteristics of Partners. Twelve items reflecting the women's perceptions of their partners' behavior, psychological characteristics, and attitudes were selected from a measure developed by Kelly and Loesch (1983). A five-point response format was used, from "strongly disagree" to "strongly agree." A factor analysis (principal component, varimax rotation) revealed three factors: jealous/controlling, quiet/depressed, and remorseful. Only

the first factor, with seven items, had a sufficiently high internal reliability coefficient (.80). Examples of items for this scale are: "My partner is jealous of the friendships I have with other people," and "My partner tries to control everyone in his life."

Expanded Conflict Tactics Scales of Aggression. The verbal aggression and physical violence scales of the widely used Conflict Tactics Scales were used. Several studies support its reliability and validity (Straus, 1990). Ten items were added to the original 16 items in order to cover nonviolent threats and sexual abuse (e.g., "made threats to leave the relationship," "drove recklessly to scare you," "verbally pressured you to have sex," "physically forced sex on you"). Three factors were derived from factor analysis (principal components, varimax rotation): psychological, physical, and life-threatening abuse. These factors corresponded to those found in other analyses (Hornung, McCullough, & Sugimoto, 1981). The internal reliabilities of these subscales were .89, .85, and .63, respectively. The two items on sexual abuse correlated highly with each other and thus were combined into a single scale for analyses. Occurrence of severe violence was defined as any of the following: beat up, choke, or strangle, threaten with knife or gun, used a knife or gun.

Injury Scale. Respondents were asked how often they suffered four levels of injuries as a result of the violence: mild (scratch, small bruise, swelling), moderate (fracture, minor burn, cuts, large bruises), severe (major wounds, severe bleeding or burns, knocked out), permanent damage (blindness, loss of hearing, disfigurement, chronic pain). The scale was developed from ratings of battered woman's injuries made by emergency room nurses (Saunders, 1980). A single five-point scale, from none to permanent injury, was constructed for any occurrence of an injury at or below each point on the scale.

Analysis

Descriptive statistics were calculated for each item and reported for each subsample. Performance of *t* tests and chi-square tests of significance was done as appropriate. Results that approached significance will be reported because the study is exploratory and the results may provide leads for future research that would otherwise be obscured by Type II errors. Even at the .05 level of significance, however an effect size analysis revealed that a fairly small effect size could be detected ($d = .29$; two-tailed; power = .80) with *n*'s of 33 and 159. With *p* of .10, the effect size was $d = .24$. Analysis of covariance was used to help explain any differences that occurred between samples. Abuse and injury in the relationship and time since the relationship were used as covariates.

RESULTS

Violence and Injury

The women in the DVP group reported significantly more frequent psychological abuse ($t = 3.48$; $p = .001$), sexual abuse ($t = 2.48$; $p = .02$), and physical abuse ($t = 3.27$; $p = .002$) on the expanded version of the Conflict Tactics Scales. In addition, more of the DVP women experienced severe violence (80% vs. 59%, $\chi^2 = 5.67$, $p = .02$). Consistent with these findings, the two groups differed significantly in the presence and severity of their injuries (overall $\chi^2 = 17.8$; $p = .001$). Only 6% of the DVP group had no injuries, compared with 27% of the NDVP group ($\chi^2 = 13.49$, $p < .001$). The DVP group was much more likely to have a permanent injury (26% vs. 9%, $\chi^2 = 4.31$, $p = .04$). They also reported their partners to be

TABLE 2. Percent Having PTSD Symptoms Based on Diagnostic Interview Schedule (DIS)

	Total	DVP	NDVP	χ^2
1. Dreams or nightmares about the abuse	75	77	65	1.49
2. Remembering the abuse even though you didn't want to	89	89	88	0.00
3. Loss in your ability to care for other people	53	52	61	0.83
4. Loss of interest in the things you used to enjoy	78	79	69	1.26
5. Feeling jumpy or easily startled	80	82	73	1.04
6. Trouble sleeping	78	80	69	1.45
7. Feeling ashamed of being alive	57	59	42	2.69*
8. Forgetfulness or trouble concentrating	78	78	77	0.01
9. Avoidance of situations or activities that reminded you of abuse	77	77	77	0.00
PTSD DIAGNOSIS	60	60	62	0.05

Note. A PTSD Diagnosis, similar to the DIS, was given if: a) symptoms 1 or 2 and 3 or 4 were present, and b) two symptoms from 5 through 9 were present, and c) symptoms lasted at least 1 month.

* $p < .05$.

violent with more people outside the family ($M = 3.0$ vs. 2.0 ; $t = 2.56$; $p = .01$) and to be more jealous/controlling ($t = 2.65$; $p = .01$).

Depression and Self-Esteem

The two groups did not differ in their levels of depression or in their past or current levels of self-esteem.

Traumatic Stress Symptoms

DIS-PTSD Scale. Table 2 shows the symptoms reported for the DIS. Intrusive memories of the abuse were the most common problems for both groups, affecting almost 90% of the women. About three fourths of the entire sample experienced a variety of other symptoms, including avoiding reminders of abuse, hyperarousal (feeling jumpy), and nightmares about the abuse. Rates were higher for the DVP group for seven of the nine symptoms but only one difference was statistically significant. More of the DVP women reported "feeling ashamed of being alive." Sixty percent of those in the DVP group and 62% in the NDVP group met the diagnostic criteria for PTSD. The total number of symptoms tended to be higher in the DVP group ($M = 5.6$ vs. 5.0 ; $t = 1.28$; $p = .056$). This difference between the groups was not significant when controlling statistically for abuse frequency and level of injury ($M = 5.5$ vs. 5.3 ; $F = .82$, $p = .36$).

The recency and chronicity of PTSD-DIS symptoms did not differ between the groups. About 60% in each group had symptoms lasting over 6 months (DVP: 59.2%; NDVP: 65.4%). Both groups experienced their last symptoms 2-4 weeks before the survey. There was a marginally significant tendency for a delayed onset of symptoms in the NDVP

group; 16% had a symptom delay of 6 months or more, compared with 7% of the DVP group ($\chi^2 = 2.5$; $p = .06$).

PTSD Scale for Family Violence. Table 3 shows the frequency of PTSD symptoms based on DSM-III-R criteria. As with the PTSD-DIS measure, intrusive memories of the abuse were the most frequent problem. Amnesia for abusive episodes was reported the least frequently. All of the symptoms were reported more frequently by the DVP group. About 1 of the 17 item-by-item comparisons would be expected to be significant by chance alone ($p = .058$). However, nine of them were significant, indicating that the results were not due simply to the number of comparisons tested. The largest differences were for amnesia for the abuse, withdrawal from important activities, and being overly alert. Using the total scale score, there was a significant difference between the two groups, with the DVP group showing more frequent symptoms. When statistically controlling for the time since the relationship or for injuries and abuse frequency, the difference was no longer sig-

TABLE 3. Help-Seeking Groups Compared on DSM-III-R Post-Traumatic Stress Scale for Family Violence

Items	DVP	NDVP	<i>t</i>
1. Unpleasant memories of the abuse you can't keep out of your mind	56.9	38.5	2.52*
2. Upsetting dreams about the abuse	28.2	21.8	1.04
3. Suddenly acting or feeling as if the abuse was happening when it wasn't	18.1	17.3	0.16
4. Very upset when exposed to something reminding you of the abuse	35.8	28.9	1.02
5. Trying to avoid thought or feelings associated with the abuse	43.4	33.5	1.35
6. Trying to avoid activities or situations that remind you of the abuse	39.3	26.7	1.78*
7. Not able to remember important parts of abusive episodes	21.9	12.0	2.53**
8. Much less interest in important activities since the abuse	25.8	12.7	2.71**
9. Feeling detached from others since the abuse	37.2	29.9	1.03
10. Not having your normal range of feelings since the abuse (for example, not able to have loving feelings)	39.4	26.7	1.77*
11. Since the abuse, having a sense that you do not have long-range plans	31.5	27.6	0.54
12. Difficulty falling or staying asleep	41.5	25.4	2.32*
13. Irritability or outburst of anger	42.5	32.9	1.29
14. Difficulty concentrating	45.5	32.7	1.70*
15. Being overly alert	41.6	24.2	2.56**
16. Very easily startled	43.7	28.8	2.08*
17. When near something or someone that reminds you of the abuse, you have a physical reaction, such as shaking or sweating	35.0	26.7	1.16

Note. Response categories for the frequency of each problem were as follows: Never, 1-2, 3-11, 12-24, 25-36, 37-50, 51-100, Over 100 times. Midpoints were used to calculate the above means.

* $p < .05$; ** $p < .01$.

nificant. These results are shown in Table 4. The greatest subscale difference was for the intrusive/hyperarousal subscale ($M = 44.2$ vs. 36.3 ; $t = 1.26$; $p = .10$).

Impact of Event Scale. On the IES there were no significant differences between the two groups for retrospective reports of symptoms during the relationship. However, both the intrusive and avoidant subscale scores for current symptoms (past week) were significantly higher in the DVP group than in the NDVP group (see Table 4). When statistically controlling for the length of time since the abusive relationship (with analysis of covariance), the differences between the two groups decreased but was still significant for the intrusive scale. The differences in PTSD symptom frequency also decreased when controlling for differences in abuse and injuries, but again remained significant. When controlling for both sets of covariates, however, there were no significant differences between the DVP and NDVP groups on this subscale. On the avoidant subscale either type of covariate removed the significant difference between groups.

Social Phobia and Agoraphobia

There were no significant differences on the Social Phobia Scale. On the Agoraphobia Scale, the DVP women reported an average score that was significantly higher than that for the NDVP women (see Table 5). Both groups of women scored between a normative sample and a sample of agoraphobics (Marks, 1987). The difference between DVP and NDVP groups was due primarily to three items: "traveling alone by bus or train," "walking alone in busy streets," and "going alone far from home." The difference existed after statistically controlling for abuse frequency, level of injury, and time since the relationship. The women's reports of their level of agoraphobia prior to the relationship explained the difference between the groups when the prior level of agoraphobia was entered as a covariate in the analysis.

DISCUSSION

The findings of this study suggest that practitioners in a variety of settings can expect that the majority of battered women they see will have suffered from PTSD at some time. Even

TABLE 4. Help-Seeking Groups Compared on PTSD Scale for Family Violence and Impact of Event Scale Means

	Unadjusted		Adjusted for time since rel.		Adjusted for abuse & injuries		Adjusted for all covar.	
	DVP	NDVP	DVP	NDVP	DVP	NDVP	DVP	NDVP
PTSD Scale ^a	4.67	4.10	4.72	4.24	4.64	4.44	4.67	4.61
Fam. Viol.	(1.6)	(2.0)						
	F = 2.63*		F = 1.02		F = 1.87		F = 0.36	
Intrusive	15.2	10.1	15.3	12.3	15.1	11.3	15.0	14.3
Subscale SD=	(10.0)	(10.4)						
	F = 4.6*		F = 2.8*		F = 4.3*		F = 2.1	
Avoidant	17.4	12.9	17.3	15.5	17.4	13.5	17.2	16.6
Subscale SD=	(10.9)	(11.2)						
	F = 3.8*		F = 1.2		F = 2.6		F = 0.6	

Note. DVP = served at a domestic violence program; NDVP = served at a non-domestic violence program.

^aFrequency categories converted to scale from 1 through 7.

* $p < .05$.

battered women going for help to mental health centers, family service agencies, and private practitioners are likely to be suffering from PTSD or have a history of it. Too often, their traumatic stress symptoms have been misinterpreted as chronic psychopathology (Rosewater, 1985). Many battered women may choose mental health agencies rather than DVP because their intrusive PTSD symptoms make them feel like they are "going crazy." In addition, their partners may tell them they are "crazy" or say things to invalidate their sense of reality. Mental health practitioners have a history of reinforcing this perspective by focusing on victims' intrapsychic world rather than on the external causes of their problems (Davis, 1984; Rosewater, 1985).

Despite the similar rates of PTSD among women going to DVP and those seeking help elsewhere (NDVP), their symptom profiles differed in some important ways. The DVP women were more likely to have felt ashamed of being alive, and to more frequently have unpleasant memories or amnesia for the abuse, to withdraw from activities, and to have symptoms of hyperarousal. For current symptoms as measured by the IES, DVP women more frequently reported both intrusive and avoidant symptoms. Recent definitions of PTSD have removed "survivor guilt," or the shame of being alive, from the list of indicators. This study shows that survivor guilt may exist for the majority of one sample but not another. Other symptoms were more universal.

In the covariate analysis, the greater length of time since the abusive relationship helped to explain the lower frequency of symptoms in the NDVP women. In addition, the analysis revealed that a major reason for the group differences was the nature of the violence each group endured. As in other studies (Washburn & Frieze, 1980; Wilson et al., 1992), women seeking service at domestic abuse agencies were more frequently and more severely injured than comparison groups. In addition, this study showed that partners of DVP women were more likely to have been "generalized aggressors" who were violent inside and outside of the home and were the most jealous and controlling. More jealousy among partners of sheltered women was found in another study also (Wilson et al., 1992)

Symptoms of agoraphobia were also more frequent in the DVP group, but these symptoms seemed to be a continuation of the same symptoms occurring before the relationship began.

The results of this study support previous descriptions of a continuum of traumatic experiences and effects for battered women (Walker, 1991). These traumatic experiences may remain constant in severity and frequency or may change over time. Because practitioners in different settings are likely to hear about somewhat disparate types of abusers and varied traumatic effects, they may recommend different interventions. For example, social workers in shelters are much less likely to recommend couples counseling than social

TABLE 5. Help-Seeking Groups Compared on Agoraphobia Scale Means

	DVP	NDVP	<i>t</i>
1. Travel alone by bus or train.	2.53	1.63	2.07*
2. Walking alone in busy street.	2.58	1.80	1.44
3. Going out into crowded shops.	2.05	1.87	0.71
4. Going alone far from home.	2.85	1.63	2.58**
5. Large open spaces.	1.57	1.03	1.10
Total scale	2.32	1.59	1.87*

Note. DVP = served at a domestic violence program;
NDVP = served at a non-domestic violence program.

* $p < .05$; ** $p < .01$

workers in family service agencies (Davis, 1984). The perspectives of agencies or individual workers may be partly a function of the type of experiences their clients report.

Regardless of setting, the results reported here give practitioners more explicit descriptions of the impact of abuse, at least for help-seeking women. These descriptions can be shared directly with battered women. These women may find comfort in hearing their symptoms validated as common experiences of battered women and, further, that they are normal reactions to a terror-filled situation. Given the variety and chronicity of symptoms experienced by these women, comparisons with prisoners of war and victims of terrorism are often quite apt (Walker, 1984).

Beyond emotional support and experiential validation, more specific treatment methods may be required for persistent symptoms of PTSD. A wide variety of symptoms—avoidant, intrusive, and hyperarousal—are likely to exist. Dutton (1992) recommends a comprehensive assessment and treatment approach that includes safety-planning, decision-making, and problem-solving. She describes several interventions related to PTSD, some of which parallel those used with rape victims. They include helping the women to gradually reexperience the traumatic events, manage stress, express emotions (including shame, rage, and grief), and find meaning from the victimization. Unlike rape by strangers, however, the chronic nature of domestic abuse and the fact that the perpetrator was a trusted intimate greatly complicate the recovery process (Dutton, 1992). For most battered women, stress reactions are only part of the aftermath. They may also undergo cognitive changes such as paradoxical loyalty to the abuser, increased causal attributions of self-blame, and generalized mistrust. Depression is likely to arise from several sources: feeling trapped by the violence, real or anticipated losses, uncontrolled anxiety, and self-blame (Herman, 1992).

A number of limitations in this study point to some recommendations for future research. Future research should further validate the self-report methods used here or replace them with interview methods, which have the advantage of offering clarifications to respondents. Future research should also include samples of non-help-seeking women. Repeated measurement over a long period can improve our understanding of the natural recovery process and the role of formal and informal support networks. Eventually, the evaluation of specific interventions for PTSD will be needed in order to improve our ability to reduce the psychic pain that does not end when the violence ends.

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