INTIMATE PARTNER VIOLENCE AND THE BLACK AND MINORITY ETHNIC COMMUNITY

by

Sohbia Binit Shoaib

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Abstract

Thiara (2005) stated that the development of research on ethnicity and Intimate Partner Violence (IPV) have generally been problematic, couched in stereotypical assumptions rather than being explored in detail or given centrality. Therefore, the aim of this thesis is to examine IPV within Black and Minority Ethnic (BME) communities with a particular focus on the South Asian community.

The original aim of Chapter one was to present a conceptual literature review exploring treatment for BME victims of IPV. However, limited studies were found and, consequently, a generic review of treatment on IPV victims is presented. In total, nine studies were examined, seven studies did not examine ethnic differences and findings suggest that interventions are more effective when there is a combination of CBT and advocacy service in reducing psychological effects and re-abuse. Looking at interventions on an individual level (Chapter 2), it was also found that in work with a female BME paranoid schizophrenic patient who had suffered from IPV, CBT was effective in reducing the distress she was experiencing from her delusion's and psychotic beliefs. In addition, a number of risk factors were identified within the assessment stage, which were similar to those found in previous research, indicating the likelihood of the patient becoming a victim of IPV.

Chapter three provides a critique of the CTS-2, particularly focusing on its cultural applicability in assessing IPV within South Asian communities. The review highlights that the instrument remains the most paramount empirically based guided tool in IPV. Therefore, the CTS-2 was used in the empirical research presented in Chapter 4 to investigate whether differences exist in rates of IPV in South Asian and non South Asian participants. The study found high levels of severe physical violence and associations between participants' beliefs and their use of violence within relationships. The research findings contribute to current knowledge and understanding of IPV.

For my mother

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Thank you

"Women and children are often in great danger in the place where they should be safest: within their families. For many, 'home' is where they face a regime of terror and violence at the hands of somebody close to them – somebody they should be able to trust. Those victimised suffer physically and psychologically. They are unable to make their own decisions, voice their own opinions or protect themselves and their children for fear of further repercussions. Their human rights are denied and their lives are stolen from them by the ever-present threat of violence".

(UNCIEF, 2000, p. 2)

"Domestic violence causes far more pain than the visible marks of bruises and scars. It is devastating to be abused by someone that you love and think loves you in return."

(Dianne Feinstein, p.1)

"The effects of domestic violence are far-reaching...it speaks many languages, has many colours and lives in many different communities."

(Sandra Pupatello, p.1)

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Abbreviations

APA: American Psychiatric Association

ASSIA: Applied Social Sciences Index and Abstracts

BCS: British Crime Survey

BME: Black and minority ethnic

BPS: British Psychological Society

CASP: Critical Appraisal Skills Programme

CBT: Cognitive Behavioural therapy

CDSR: Cochrane Database of Systematic Reviews

CENTRAL: Cochrane Central Register for Controlled trails

CF: Confounding factors

CI: Confidence Interval

CPA: Care Programme Approach

CPN: Community psychiatric nurse

CTM: Clinical team meetings

DAIP: Domestic Abuse Intervention Project

DARE: Database of Abstracts of Reviews of Effectiveness

DBT: Dialectal Behaviour Therapy

HDU: High dependency unit

HTA: Health Technology Assessment Database

IPV: Intimate partner violence

NHS EED: NHS Economic Evaluation Database

NHS: National Health Service

OR: Odds Ratios

RCT: Randomised control trial

WHO: World Health Organisation

Introduction

Historically the family is valued as a safe haven. The one place we can be assured we will be cared for and protected from what sometimes can be a hostile world. Unfortunately, evidence would suggest that this is not always the case (e.g. Fikree, Razzak & Durocher, 2005; Graham-Kevan & Archer, 2005; Johnson, 1999). In the 1970's intimate partner violence (IPV) started to gain attention with the aid of the women's movement who focused on female victims, women's rights and feminism. Similarly, in the 1990's due to masculism and men's movements the problem of IPV against men started to gain significant attention (Hamel & Nicholls, 2007). Due to these movements and a growing amount of research over the past three decades, IPV is now widely recognised as a serious problem (for review, see Dulmus, Ely & Wodarski, 2004; Langhinrichsen-Rohling, 2005). The growing public awareness led to the introduction of legislation attempting to protect victims (Sheikh, 2001). In spite of sustained evidence to raise public awareness and develop a number of approaches for assessment and treatment, IPV is still a serious problem and is on the increase (United Nations Development Fund for Women [UNIFEM], 2003).

Rationale for Thesis

Thiara (2005) stated that the development of research on ethnicity and IPV have generally been unvoiced resulting in issues of Black and Minority Ethnic (BME) communities being marginalised, silenced and made invisible. Where they have appeared, this has often been problematic couched in stereotypical assumptions to illustrate the oppressive 'cultural' practices of particular communities rather than being explored in detail or given centrality. An emphasis on the need to mainstream minority issues has often led to either invisibility or greater scrutiny of those communities (for review, see Batsleer et al., 2002; Rai & Thiara, 1997).

Therefore, the aim of this thesis is to look at establishing some insight into IPV within BME communities, in particular South Asian communities'. It highlights presenting issues, such as, looking at and understanding the complex divisions which operate and shape the experiences and lives of BME communities and should be seen as an addition to existing literature. In order to meet the researcher's overall aim, the introduction will give some general background on IPV. This will include; looking at problems with defining violence between intimate partners, as well as prevalence rates, theories and effects of IPV. In order to rationalise the thesis the introduction will go on to examine IPV within BME countries and communities within the U.K.

Understanding Domestic Violence and Intimate Partner Violence

There have been conflicting views on the terminology used to define violence between intimate partners amongst different professionals from diverse theoretical perspectives (Dixon & Graham-Kevan, 2010; Graham-Kevan & Wigman, 2009). The term IPV is often used synonymously with domestic violence. Effectively, feminist scholars have been largely responsible for and successful in defining the term domestic violence. As a result, the term is associated with men being the perpetrators and women being the victim of violence within relationships (DeKeseredy, 2002). However, there is growing evidence that many victims are not actually married to the abuser, that abuse can take more than one form and males can be victims too (i.e., Archer, 1999, 2000; Langhinrichsen-Rohling, 2005; Straus, 2001, 2004, 2005, 2007), consequently, terms such as wife abuse, wife beating and battering have lost popularity. Therefore, researchers have tended to be more specific, using the term IPV to define violence between intimate partners.

At present, there is still no single agreed terminology and definition of violence between partners or violence committed by family members. In any case, the need to develop specific operational definitions has been acknowledged so that research, monitoring, prevention and intervention can become more specific and have greater cross-cultural applicability (Dwyer, Smokowski, Bricut & Wodarski, 1996; United Nations Children's Fund [UNCIEF], 2000). Despite this, most definitions share some reference to physical, psychological, sexual and economic abuse (see Table 1.1), emphasising that maltreatment can take more than one form (Dixon & Graham-Kevan, 2010). For example in the UK, the Home Office defines domestic violence as:

> *'Any incident or threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or are family members, regardless of gender or sexuality'* (Walby & Allen, 2004, p.4).

Table 1.1: *Types of Abuse and Examples of Acts.*

Type of Abuse	**Examples of Acts**
Physical abuse	Slapping, shaking, beating with fist or object, arm twisting, stabbing, strangulation, burning, kicking, choking, threats with an object or weapon and murder.
Sexual abuse	Coerced sex through threats or intimidation or through physical force, forcing unwanted sexual acts, forcing sex in front of others and forcing sex with others.
Psychological abuse	Behaviour that is intended to intimidate and persecute and takes the form of threats of abandonment or abuse; e.g., surveillance, isolation, jealousy, verbal aggression.
Economic abuse	Acts such as the denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment, etc.

Subsequently, due to the variation in terminology used within different studies, this thesis uses the terms "domestic violence" and "IPV" interchangeably when examining studies. The term used is dependent on the term used by the study. Additionally, the researcher is interested in

violence between intimate partners and not violence committed by other family members (such as, mother to child, in-laws to daughter-in-law) and therefore, the term IPV will be used to describe this interaction within the remainder of the thesis.

Prevalence of Intimate Partner Violence

Prevention of violence between intimate partners is an important public health goal as it is one of the most common crimes throughout society both nationally and worldwide (Dutton, 1992; Walby & Allen, 2004). IPV cuts across all known divisions of gender, wealth, race, caste and social class (Hague & Malos, 1993; UNIFEM, 2003). Most frequently, it happens behind closed doors, occurring in all cultures and countries (UNIFEM, 2003).

Female Victims

According to a study done by UNICEF (2000), up to half the female population of the world is subject to IPV. National studies in the U.K. estimate that six million women are affected by IPV annually (Walby & Allen, 2004). In the 1996 British Crime Survey (BCS) 1 in 4 women reported being assaulted by their partners or ex partners. A slightly lower prevalence rate was found in the 2001 BCS, with 1 in 5 women reporting they had experienced assault by a partner, perhaps due to it using more precise definitions of physical violence and excluding sexual assault. When threats, emotional and financial abuse were included, prevalence increased to 1 in 4 women experiencing IPV. When asked about the year prior to the study, 1 in 17 women reported experiencing 1 or more of the measured forms of IPV with 1 in 25 being the victim of assaults or threats (Walby & Allen, 2004). Povey and Allen (2003) found that IPV offences seem to account for; between fifth and a quarter of all disclosed violent crime, 1 in 4 of all alcohol related violence and between a third and half of all violent crime reported by women. In

addition, D'Ardenne and Balakrishna (2001) reported that women between 20 and 24 years of age are most at risk from IPV.

In the twelve month period between 2001 and 2002, on average, two women were killed every week in England and Wales by partners or ex-partners (Walby & Allen, 2004). This accounted for 20% of all murders with 78% of the victims being female. In 43% of female murders, victims were killed by partners or ex-partners (Flood-Page & Taylor, 2003).

Additionally, much of the initial research and some current research on IPV focused on female victims and supported the assumption that IPV is primarily perpetrated by men against women. However, numerous researchers view IPV as a problem for both sexes and agree that it is gender-neutral in definition and in reality (Dwyer et al., 1996; Willig, 2001).

Male Victims

Data is mounting that suggests that IPV is often perpetrated by both men and women against their partner (Archer, 2000; Carney, Buttell & Dutton, 2007; Renee, Ernest, Suhasini, Raul & Charles, 2006; Straus, 2005; Whitaker, Haileyesus, Swahn & Saltzman, 2007). Evidence suggests that at least one in every 33%-40% approximately of IPV victims are men and that 1 in6 men will become a victim of IPV in his lifetime (Walby & Allen, 2004). Although a relatively small sample, Shoaib (2009) found a high rate of reported violence from her sample of 17 male students. For example, 94.1% of the male participants reported to have experienced minor physical violence and 64.7% of the male participants reported to have experienced severe physical violence. In addition, 88.2% of the male participants reported to have experienced minor psychological aggression and 41.2% of the male participants reported to have experienced

severe psychological aggression. It is also becoming recognised that perpetration of IPV by both partners within a relationship is fairly common (Walby & Allen, 2004).

However, for both male and female victims there are problems with estimating the prevalence of IPV. It is widely believed that there are a serious number of underreported cases of IPV (Walby & Allen, 2004). In addition, the trend of IPV reported depends on what data sources are used (Johnson, 2000), the definition of violence used and the context in which violence is measured (Fals-Stewart, O'Farrell & Birchler, 2004). For instance, the BCS does not address the full range of abusive behaviours and 35% of the women who completed the 1996 survey reported not being alone when they did so (Walby & Allen, 2004). Mirrlees-Black (1999) observed that where partners involved themselves in questionnaire completion reported victimisation rates were reduced by half.

Having looked generically at prevalence rates for IPV for both male and female victims, given the focus on BME communities within this thesis, it is important to understand the prevalence of IPV within BME countries generally and, more specifically, within these communities in the UK.

Intimate Partner Violence and Prevalence Rates in BME Countries

A number of BME individuals in the UK, in particular those from South Asia and Africa, originated from developing countries (Thiara, 2005). Overall it has been found that there are higher rates of IPV within developing countries (*M*=33.7%) than developed countries (*M*=26.5%; see Table 1.2; Chan, Straus, Brownridge, Tiwari & Leung, 2008). Further examination revealed that, looking overall at both developing and developed countries, more

reported violence was male perpetrated violence than female perpetrated. However, within developing countries in Asia and Africa, males perpetrated more violence than females compared to Europe and Latin American countries where females perpetrated more violence than males.

Table 1.2: *Male and Female Perpetrated Rates of Physical Assaults in Developing and Developed Countries (Chan, Straus, Brownridge, Tiwari & Leung, 2008).*

Country		**Rate**		
		Total Perpetrated Violence	**Male Perpetrated Violence**	**Female Perpetrated Violence**
Developed Country	***Asia***			
	Hong Kong (since 1997)	36.9%	26.3%	41.8%
	Singapore (since 1997)	22.4%	14.3%	26.1%
	Australia and New Zealand			
	Australia	20.1%	19.5%	20.2%
	New Zealand	25.9%	16.1%	28.4%
	Europe			
	Belgium	28.9%	27.2%	29.4%
	Germany	28.9%	37.5 %	24.0%
	Greece	35.0%	68.4 %	24.4%
	Netherlands	31.1%	35.3%	29.6%
	Portugal	17.2%	16.5%	17.5%
	Sweden	17.0%	19.5%	16.2%
	Switzerland	24.8%	28.6%	23.7%
	United Kingdom	35.8%	25.8%	37.7%
	Middle East			
	Israel	18.8%	25.0%	17.3
	North America			
	Canada	24.0%	25.1%	23.6%
	United States	30.3%	33.1%	28.7%
Overall	***Mean***	***26.5%***	***27.9%***	***24.6%***
Developing Countries	***Asia***			
	China	35.2%	40.7%	27.5%
	India	36.4%	46.9%	28.9%
	Korea	34.3%	35.3%	35.1%
	Europe			
	Lithuania	32.2%	26.0%	35.6%
	Russia	32.6%	27.5%	37.3%
	Latin America			
	Brazil	21.9%	22.1%	21.8%
	Mexico	44.4%	34.3%	46.6%
	Africa			
	South Africa	33.0%	33.3%	28.6%
	Tanzania	33.1%	37.2%	29.2%
Overall	***Mean***	***33.7%***	***38.3%***	***32.2%***

No comparison rates could be found within the literature for male and female perpetrated violence in some South Asian (e.g., Bangladesh & Pakistan) and African (e.g.,., Kenya, Uganda, Zimbabwe) developing countries. However, numerous sources report female IPV victim rates that are higher in developing countries than in developed counties (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006; South Asia Regional Campaign, 2009; UNICEF, 2000; WHO, 1999). A UNICEF (2000) study found that South Asian countries (defined as Bangladesh [72%], India [45%] and Pakistan [90%]) had the highest rates of victims of IPV compared to other countries (see Table 1.3).

Table 1.3: *Prevalence Rates in Developing and Non Developing Countries (UNICEF, 2000).*

Country		**Percentage of Female Victims**	**Sample Size**
Developed Country	Canada	29%	12,300
	New Zealand	20%	314
	Switzerland	20%	1,500
	United Kingdom	25%	Sample size not given
	United States	28%	Sample size not given
Developing Countries	***South Asia***		
	Bangladesh	72%	Sample size not given
	India	45%	6,902
	Pakistan	90%	Sample size not given
	Africa		
	Kenya	42%	612
	Uganda	41%	Sample size not given
	Zimbabwe	32%	966

Moreover, while cultures throughout the world have dowries (i.e., money, goods or estate that a woman brings to her husband in marriage) or analogous payments, dowry murder occurs predominantly in South Asia (Nicholas & Sheryl, 2009). Dowry deaths or murders occur when husbands or in-laws continue to harass and torture the new bride to extort dowry that has not been received or an increased dowry, consequently, murdering her or driving her to suicide (Nicholas & Sheryl, 2009). In India, for example, there are close to 15,000 dowry deaths estimated per year (Banerjee, 1997). In Bangladesh, there have been many incidents of acid

attacks due to dowry disputes leading often to blindness, disfigurement, and death (Benninger-Budel & Lacroix, 1999). In addition, honour killings are prevalent in South Asian countries and occur when the perpetrator(s) believes the victim has brought dishonour upon the family or community. In Pakistan alone, more than 1,000 women each year are killed in the name of honour (Coomerasamy, 2002). The practice of early marriage is prevalent throughout the world, especially in Africa and South Asia. This is a form of sexual violence, since young girls are often forced into the marriage and into sexual relations (Ali Shah, 2001).

Given the previously reported issues of under-reporting of IPV, these figures of IPV are higher than developed countries and still suffer from underestimation. Women know that if they report a crime against them they could be subjected to further violence or they could be killed (UNCIEF, 2000). Furthermore, Archer (2002) stated that there were practical problems with obtaining representative samples of cultures (and subcultures) where patriarchal values (including the use of violence to control women) are part of the traditions of a closed community. Reports of the position of women in countries under Islamic law, such as Iran (Moin, 1998) and Pakistan (Frenkiel, 1999), indicate that women are kept in strict *purdah* (i.e., young women mainly associate with members of their family, only showing their faces to members of the family they grew up in and to their husband, they rarely travel and when they do go out in public they are chaperoned by a male family member with their face and body veiled) and the law is lenient towards husbands who have killed their wives. It would be extremely difficult to study violence towards women under such conditions.

Intimate Partner Violence Prevalence Rates and Services/Support for BME Communities in the UK

The 2001 BCS pointed to little difference in the prevalence of IPV by ethnicity (Walby & Allen, 2004). However, one would expect higher rates of IPV within some BME communities such as South Asian and African communities due to the impact of cultural influences (Dutton, 1995; discussed later in chapter 4) and rates of IPV within developing countries. Thiara (2005) reported that the reason why no significant ethnicity variation was found in the BCS 2001 was because of the serious under reporting from some BME groups. Research shows that women from BME groups, in particular South Asian women, are less likely to access services, consequently, leading them to endure abuse for longer periods (see Batsleer et al., 2002; Imkaan, 2003; Rai & Thiara, 1997; Southall Black Sisters, 1993) In addition, research shows that language (and culture) is of great importance to women who are reluctant to access or approach services considered to lack an understanding of their experiences and needs (Thiara, 2005).

Thiara (2005) found that although more BME women are accessing IPV services than in the past, mainstream services still struggle to provide an appropriate service and to adequately meet their needs. In practice, stereotypes and assumptions about culture and difference frequently shape service responses for BME women affected by IPV and not evidenced based literature. Thiara (2005) reported that feminists claim to have dealt with the issue of diversity; subsequently, few studies have been conducted which take into account ethnicity in IPV literature. Therefore, more evidence based research is needed in order to provide a better and more accurate understanding of IPV within BME communities, and more effective and appropriate services. In order to attempt to provide better services and interventions it is important to look at the theory put forward for IPV and the effect that IPV has on victims.

Explanations of Intimate Partner Violence

A number of studies have been conducted and theories put forward focusing on what causes abusive behaviours, each with their own merits and limitations. It is not within the scope of this thesis to discuss all these theories. Therefore, Table 1.4 gives a summary of the more widely recognised theories with the Feminist Theory discussed in more detail in chapter 4. It is important to note that a number of theories put forward for IPV are sociological rather than

Table 1.4: *Bell and Naugle (2008) Summary Table of IPV Theories (p.1098).*

IPV Theory	Literature Cited	Variables of Interest	Theoretical Limitations
Feminist theory	Dobash & Dobash (1977), Walker (1979), Yllo & Bograd (1988)	Female inequality; power imbalances between sexes; sexism stemming from society's patriarchal beliefs	Mixed empirical support; fails to explain IPV in same-sex couples; limited impact on IPV prevention/ treatment; restricted flexibility in accommodating novel IPV findings; limited scope.
Power theory	Straus (1976), Straus (1977), Straus et al. (1980)	Family conflict, social acceptance of violence, gender inequality, societal beliefs about IPV.	Mixed empirical support; restricted flexibility in accommodating novel IPV findings; limited impact on IPV prevention/ treatment; limited scope.
Social learning theory	Mihalic & Elliott (1997), Kalmuss (1984), O'Leary (1988)	Family conflict; modelling; reinforcing consequences of aggression; sex-role characteristics.	Mixed empirical support; limited impact on IPV prevention/treatment; limited scope.
Background/ situational model	Riggs & O'Leary (1989), Riggs & O'Leary (1996)	Background = abuse & aggression history; psychopathology; social acceptance of violence; arousability; aggressive personality characteristics Situational = interpersonal conflict; substance use; relationship satisfaction; intimacy levels; problem-solving skills; violence expectancy beliefs; communication style.	Limited impact on IPV prevention/ treatment; somewhat restricted in scope
Borderline personality organization and assaultiveness theory	Dutton (1995)	Insecure attachment and shaming during childhood/adolescent development.	Limited empirical support; limited impact on IPV prevention/treatment; restricted flexibility in accommodating novel IPV findings; limited scope.
Developmental model of batterer subtypes	Holtzworth-Munroe & Stuart (1994), Holtzworth-Munroe & Meehan (2004)	Genetic/prenatal factors; early childhood family experiences; peer experiences; attachment to others; impulsivity; social skills; attitudes toward women & violence.	Restricted flexibility in accommodating novel IPV findings; limited scope.

psychological in nature. Additionally, Bell and Naugle (2008) noted that these single-factor theories are limited in two ways; (1) current theories fail to adequately capture and address the complexity of variables implicated in IPV episodes and (2) the extent to which these theories have successfully impacted IPV prevention and treatment programs have been limited. Therefore, models which draw upon the most useful aspects (i.e., which help inform IPV interventions) of all approaches such as the integrative approach and Bell and Naugle's (2008) contextual framework are discussed.

Integrated Perspectives

There has been increasing consideration that an integrated perspective may provide the best way to address IPV (Mauricio & Gormley, 2001). Based on Bronfrenbrenner's (1979) ecological systems theory, one such model was presented by Dutton (1995) which consists of four interactive levels (see Table 1.5), with the influence of each level on violent behaviour being

Table 1.5: *Four Interactive Levels (Dutton, 1995).*

Level 1: Macrosystem.	Consists of the broad cultural attitudes and beliefs regarding women and domestic violence that are held by the society of the perpetrator. This includes the influence of patriarchy and any social/cultural views that explicitly or implicitly endorse male aggression towards, and their power and control over women.
Level 2: Exosystem.	Consists of social structures that have influence over the context in which the abuse is occurring. This would include work groups, friendships and any social circles that connect the perpetrator and his family to the society in a broader context.
Level 3: Microsystem.	Concerns the immediate environment the abuse takes place, for example the family environment.
Level 4: Ontogenetic.	Considers the individual characteristics of the perpetrator that are considered relevant in the context of their domestic abuse. This might include their development history, ability to manage emotions, and social skills among other things.

dependant on the specific features of the other levels. The ecological model suggests any intervention with perpetrators of domestic violence should allow consideration of all levels and how each level relates to the others.

Despite there being a number of established risk markers for IPV, research suggests perpetrators are not a homogenous group with a single profile whose abuse can be predicted by the same factors (Dixon & Brown, 2003). Efforts have been made to identify typologies of perpetrators (Johnson, 1995) in the hope of improving risk prediction, understanding the origins of violence and identifying any differences in treatment needs and treatment responsivity. Johnson (1995) put forward a behavioural typology that was consistent with both feminist research and general population findings. He put forward two typologies, Common Couple Violence (CCV) and Patriarchal Terrorism (PT). From conducting further research Johnson (1999) reclassified his categories on the bases of individuals' and their partners' use of aggression, and added two new categories (see Table 1.6).

Table 1.6: *Johnson (1999) Typology.*

Common Couple Violence (CCV).	When one or both members of the relationship use non- controlling physical aggression.
Patriarchal Terrorism (PT) was renamed Intimate Terrorism (IT).	When the respondents' use controlling aggression and their partner uses either no physical aggression or non-controlling aggression.
Violent Resistant (VR).	When a partner of an IT uses non-controlling physical aggression.
Mutual Violent Control (MVC).	Essentially both partners fighting for control.

Graham-Kevan and Archer's (2005) study's findings suggest that Johnson's (1999) typologies have some utilities. However, Graham-Kevan (2007) found Johnson's (1999) study to be sensitive to reporting and sampling effects. Graham-Kevan (2007) suggested that future studies

should refrain from using stratified sampling techniques to study sex differences unless such techniques include comparable samples from men and women.

Bell and Naugle (2008) Contextual Framework

Bell and Naugle (2008) put forward a contextual framework in order to improve upon former IPV theories and create a framework for investigating variables proximally related to IPV episodes (see Figure 1.1). The framework incorporates Behaviour Analytic (Myers, 1995), Social Learning (Bandura, 1971, 1973; Mihalic & Elliott, 1977) and Background/Situational theories (Riggs & O'Leary, 1996). Bell and Naugle (2008) reported several advantages to this framework; firstly it is theoretically-driven, it is flexible in integrating new findings, increases efforts for collaboration and commonalities amongst varying social science disciplines and theoretical orientations, allows for a greater idiographic analysis of IPV perpetration and lastly the framework helps improve IPV prevention and treatment programs through the identification of variables that may be more amenable to change.

Unfortunately, with it being a newer model for IPV not much empirical research has been completed to support this framework. Bell and Naugle (2008) reported that it may be impossible to design a study that adequately examines the whole framework however a unit or units can be explored and they anticipate that knowledge gained from earlier studies will guide the development of research targeted at investigating the adequacy of this theoretical framework as a whole.

As identified earlier within the thesis, in order to attempt to better services and interventions for IPV it is important to also look at the effects that IPV has on its victims.

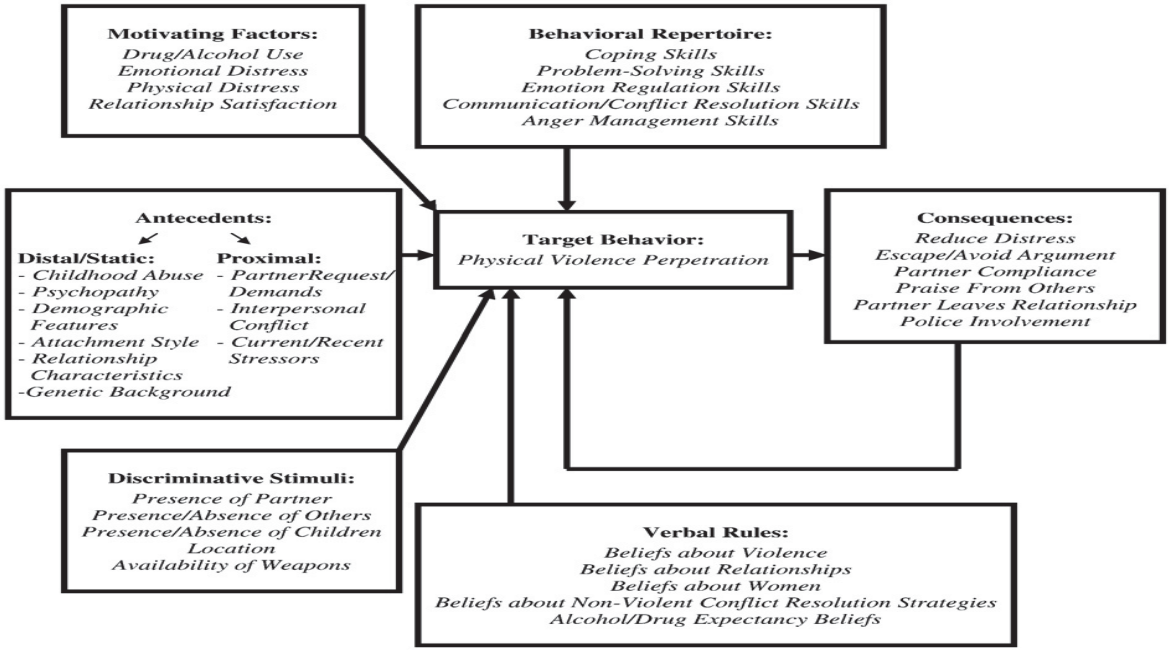

Figure 1.1: Bell and Naugle (2008) IPV contextual framework.

Effects of Intimate Partner Violence

The effects of IPV on individuals are covered in more depth in chapter 1. However, in summary, IPV is associated with a number of negative psychological and physical health consequences including post-traumatic stress disorder, low self esteem, substance abuse, depression, anxiety, physical injury, reproductive health problems, irritable bowel syndrome and chronic pain (Campbell, 2002; Golding, 1999; O'Leary, 1996; Plichta, 2004; Stark & Flitcraft, 1988; Sugarman, Aldarondo & Boney-McCoy, 1996; Testa & Leonard, 2001). Moreover, IPV not only has devastating effects on individuals and families, the financial costs are astronomical (Living with Fear, 1999). According to the Inter-Ministerial Group on Domestic Violence (2005) IPV costs the UK £23 billion a year.

Aim of Thesis

The overall aim of this thesis is to examine IPV within BME communities, first generally and then more specifically with a focus on the South Asian community. With this aim in mind, the thesis is structured into four main chapters which first consider the interventions available to victims of IPV (chapters 1 and 2) and then go on to consider how individuals at risk of either perpetrating or experiencing IPV can be identified (chapters 3 and 4).

The original aim of Chapter one was to present a conceptual literature review examining the effectiveness of treatment for BME victims of IPV. However, there were not enough articles to conduct a review and, subsequently, a generic review of treatment for IPV victims is presented in Chapter one.

In order to look more closely at treatment of IPV in BME individuals, a case study of an intervention with one BME female (ME) is presented in Chapter 2. This considers whether the approaches outlined in the review were applicable on an individual basis. ME is a 48 year old BME African Caribbean woman with a diagnosis of paranoid schizophrenia and history of witnessing domestic violence and experiencing IPV. Research evidence found that trauma experiences including IPV are increasingly being recognised as important in the onset and maintenance of psychosis. Thus, the severe long-term consequences of IPV are highlighted. Additionally, a number of risk factors were found within the assessment stage indicating the likelihood of ME becoming a victim and perpetrator of IPV. Therefore, it was felt that research looking at variables that may help predict IPV within BME communities needed to be explored in order to identify whether risk factors were the same as for other ethnic groups and to develop means of identifying BME individuals at risk of IPV prior to the onset. In order to avoid

assuming homogeneity between different BME groups, the focus was then narrowed to consider South Asian communities (defined as those from Bangladeshi, Indian or Pakistani ethnic communities).

One way of identifying victims and perpetrators of IPV is the use of standardised measures. However, it is important to consider whether such measures are equally applicable to BME individuals. Therefore, Chapter three presents a critique of the Conflict Tactics Scales-2 (CTS-2). As the CTS-2 is a widely used tool within the IPV field the review examines the scale in terms of its scientific properties, focusing also on its cultural applicability in assessing IPV within South Asian communities.

Chapter four presents an empirical study where the aim was to investigate whether differences exist in rates of IPV in South Asian and non South Asian participants. Furthermore, the research aimed to evaluate associations between violence and controlling behaviour. As research suggests that in the West, violence between intimate partners is reciprocal; however, research has also been put forward to suggest that societies which have more patriarchal beliefs (such as South Asian communities) will tend to have more nonreciprocal violence than reciprocal violence. Furthermore, individuals with more patriarchal beliefs will use more control tactics and violent methods within their relationship. Subsequently, 5 hypotheses were put forward and the results are discussed in terms of the current literature and implications for future research are presented.

Chapter Five is a brief discussion, which draws together the main findings from this thesis.

CHAPTER 1:

Literature Review Following a Systematic Approach:

Looking at the Effectiveness of Treatment for Victims of Intimate Partner Violence

Abstract

Aim: The systematic review aimed to look at the effectiveness of treatment for victim of IPV in BME groups. Insufficient articles led to a broadening to any ethnic group.

Method: From conducting a review and the scoping searches employed, it was found that there was a need to further explore which treatments are effective in reducing symptoms of IPV. A search was conducted on a number of electronic databases in 2008 and again in 2010. The total number of hits was 5995 identified from electronic databases, a further eight studies were identified from existing systematic reviews/ studies and one from an expert. There were 5302 that were not relevant or duplicate references that were removed from the review and two unobtainable articles. Of the remaining 101 studies, 60 failed to meet the inclusion criteria. The remaining 41 studies were quality assessed, in which 13 met the cut off of 60% or above. Four studies used secondary data and subsequently nine studies were analysed.

Results: All studies provided support that interventions for women victims of IPV were effective in reducing the effects of IPV in particular psychological symptoms. A majority of the studies reported maintaining these gains over time.

Conclusion: Findings suggest that interventions are more effective when there is a combination of CBT and advocacy service in reducing psychological effects and re-abuse. Interventions are likely to be effective when they are tailored to the individual's circumstances and stage of change. In terms of ethnicity eight of the studies did not examine ethnic differences. One of the main findings of the review was that there was limited research exploring IPV within BME communities and therefore the review suggested that more research is needed within this area.

Introduction

The issues surrounding the definition of IPV and prevalence rates have already been discussed within the introduction of this thesis. Therefore, the aim of this systematic review was to look at the effectiveness of treatment for BME victims of IPV. However, limited articles were found and this led to the broadening of the aim to any ethnic group. In order to provide a rationale for this systematic review the introduction has two objectives. These are to examine the effects of IPV on male and female victims and to examine existing systematic reviews in regards to treatment for victims of IPV.

The Impact of Intimate Partner Violence on Female Victims

Women exposed to IPV are at increased risk of injury, death, psychological and social problems (see Table 2.1; Eisenstat & Bancroft, 1999). Follingstad, Rutledge, Berg, Hause and Polek (1990) found from 72% of their 234 women participants that psychological abuse had a more negative impact than physical abuse. Additionally, a number of studies that have looked at shelter and community samples have demonstrated that the psychological effects of IPV last well beyond the end of the abusive relationship (Astin, Lawrence & Foy, 1993; Dutton & Painter, 1993; Sackett & Saunders, 1999; Woods, 2000). Follingstad et al. (1990) and Sackett and Saunders (1999) identified seven categories of psychological abuse including; criticising, ridiculing, jealous control, purposeful ignoring, threats of abandonment, threats of harm and damage to personal property.

Furthermore, Golding's (1999) meta analysis found that there were strong associations between IPV and a range of disorders. The weighted mean prevalence for victims of IPV form, depression (n=1320) was 47.6% (95% *CI* = 45.0-50.0), suicide/ suicidal ideation (n=2492) was

Table 2.1: *Effects of Intimate Partner Violence (WHO, 1999).*

NON-FATAL OUTCOMES		**FATAL OUTCOMES**
Physical health outcomes:	*Mental health outcomes:*	Suicide
Injury	Depression (see O'Leary, 1999; Pimlott-Kubiak &	Homicide
Unwanted pregnancy	Cortina, 2003; Sackett & Saunders, 1999).	Maternal mortality
Gynaecological problems	Fear	HIV/AIDS
STDs including HIV/AIDS	Anxiety (see Dutton & Painter, 1993)	
Miscarriage	Low self-esteem (see Aguilar & Nightingale, 1994)	
Pelvic inflammatory disease	Sexual dysfunction	
Chronic pelvic pain	Eating problems	
Headaches	Obsessive-compulsive disorder	
Permanent disabilities	Post traumatic stress disorder (see Astin et al., 1993;	
Asthma	Enns, Campbell & Courtois, 1997).	
Irritable bowel syndrome		
Self-injurious behaviours		
(smoking, unprotected sex)		

17.9% (95% *CI*=16.0-19.9), PTSD (*n*=817) was 63.8% (95% *CI*=60.5-67.1), alcohol abuse or dependence (*n*=887) was 18.5% (95% *CI*=15.9-21.3) and drug abuse or dependence (*n*=2057) was 8.9% (95% *CI*=6.1-12.1; Golding, 1999). Additionally, odds ratio is a measure of effect size and describes the association between two binary data values. It was found that the odds ratio in the emergency room sample was highest at 8.41 for depression and 11.49 suicide/ suicide ideation followed by decreasing rates in the general population and primary care studies, responders to advertisements and psychiatric patients. Odds ratios relating intimate violence to PTSD (QT (1) = 1.287, .25, $p < .50$) and alcohol abuse or dependence (QT (3) = 5.340, .10, $p < .25$.) were homogeneous. The study of shelter residents found a higher rate of drug abuse or dependence than did studies of emergency room patients or general populations (Golding, 1999).

Danielson, Moffitt and Caspi (1998) found from their community sample of 941 women, that those women exposed to 'any' partner violence reported significantly increased rates of mood

and eating disorders compared to those women that had not been exposed to 'any' partner violence (non-victims; see Table 2.2). Those women exposed to more severe forms of physical and sexual partner violence had increased rates of mood, eating, substance dependence and antisocial personality disorders, as well as non-affective psychosis compared to those women that had not been exposed to severe forms of IPV (Moffitt and Caspi, 1998; Pimlott-Kubiak and Cortina, 2003). The non-victims sample within this study was a suitable comparison to the victims sample, as all the participants were members of the Dunedin Multidisciplinary Health and Development Study, a representative birth cohort (*N*= 1,037; 52% men, 48% women) studied since birth in 1972–1973. The study reported data gathered when the subjects were age 21, when 92% of the living study members provided data about their intimate relationships and mental health (Danielson et al., 1998).

Table 2.2: *Risk of DSM-III-R Mental Disorders Among Female Victims and Male Perpetrators of Partner Violence (Danielson et al., 1998, p. 132).*

Female victims												
	Any Partner Violence						Severe Partner Violence					
DSM-III-R Diagnosis	Nonvictims (*N*=346) N	%	Victims (*N*=115) N	%	Odds Ratio[a]	95% CI[b]	Nonvictims (*N*=407) N	%	Victims (*N*=54) N	%	Odds Ratio[a]	95% CI[b]
Any diagnosis	133	38.4	64	55.7	2.01	1.31–3.08	162	39.8	35	64.8	2.79	1.54–5.04
Anxiety disorder	91	26.3	38	33.0	1.38	0.88–2.18	108	26.5	21	38.9	1.76	0.98–3.18
Mood disorder	75	21.7	41	35.7	2.00	1.27–3.17	92	22.6	24	44.4	2.74	1.53–4.92
Eating disorder	4	1.2	7	6.1	5.54	1.59–19.29	7	1.7	4	7.4	4.57	1.29–16.17
Substance dependence	27	7.8	14	12.2	1.64	0.83–3.24	31	7.6	10	18.5	2.76	1.27–6.00
Antisocial personality disorder	0	0.0	3	2.6			1	0.2	2	3.7	15.62	1.39–175.21
Nonaffective psychosis[c]	9	2.6	7	6.2	2.45	0.89–6.74	11	2.7	5	9.4	3.71	1.24–11.14

Note. [a]Statistical significance for the odds ratio is conveyed by a 95% confidence interval that does not include 1. [b]Confidence interval. [c]Positive symptoms of schizophrenia and schizophreniform disorder.

Studies have also explored the effects of abuse on pregnant women (Cokkinides & Coker, 1999; Newberger, Barkan & Lieberman, 1992; Stewart & Cecutti, 1993). Apart from experiencing the effects that are described above a meta-analysis found that women abused during pregnancy are

significantly more likely to give birth to low birth weight infants (Murphy, Duchnick & Vuchinich, 2001).

The Impact of Intimate Partner Violence on Male Victims

Even though female victims of IPV are more likely to be injured, male victims of IPV also sustain injury (Cascardi, Langhinrichsen, & Vivian, 1992). For instance, Makepeace (1986) found from a sample of 2,338 male students that 17.9% sustained a mild or moderate injury as a result of being a victim of IPV. Follingstad, Wright, Lloyd and Sebastian (1991) found, from comparing the psychological effects of physical abuse on men and women, that following physical abuse approximately; 75% of the abused men reported experiencing anger, 40% reported being emotionally hurt, 35% reported experiencing sadness or depression, 30% reported seeking revenge, 23% reported feeling the need to protect themselves, 15% reported feeling shame or fear and 10% felt unloved or helpless. In addition, Stets and Straus (1990) found that abused men were significantly more likely to experience psychosomatic symptoms, stress, and depression than non-abused men.

Kasian and Painter (1992) found in a study of emotional abuse in 1,625 college-aged male participants that, 20% reported isolating and emotionally controlling behaviours by their partners, 15% reported the diminishment of their self-esteem by their partners, 20% reported experiencing jealousy behaviours from their partners, 10% reported experiencing verbal abuse from their partners and 10% reported experiencing withdrawal behaviours from their partners. Similarly, Simonelli and Ingram (1998) found that 90% of their male sample reported experiencing emotional abuse. Their study also found that experiencing emotional abuse

accounted for 14%-33% of the variance in depression and 15%-16% of the variance in psychological distress. Hines and Malley-Morrison (2001) found that male victims of IPV that experience severe forms of emotional abuse in their relationships, the higher their symptom counts for PTSD and alcoholism. Both of these relationships were statistically significant.

Existing Review

Preliminary searches for existing systematic reviews and meta-analyses were conducted in January 2008 via an electronic database in DARE, Cochrane Library, PsychINFO, ASSIA, Medline, ERIC, MEDLINE, Social Services Abstracts, National Criminal Justice Reference Abstracts, Web of Science and Health Sciences. This search identified one systematic review aiming to evaluate the effectiveness of any intervention aimed at preventing violence against women (MacMillan & Wathen with the Canadian Task Force on Preventive Health Care, 2001). The review looked at a number of factors, such as screening tools to detect violence, couples based therapy, screening for abused pregnant women and abused women. In regards to abused women the review found that there was insufficient evidence to recommend for or against any specific treatment (MacMillan et al., 2001). They stated that this might be due to unsuitable programs not being available in Canada. Looking more closely, the review only evaluated five studies on interventions with abused women. In addition, the review did not discuss treatment programs for women directed at reducing the impairment associated with exposure to violence (for example, treatment of depression or posttraumatic stress disorder). The review did not mention participants' ethnicity or consider ethnic differences. They review suggested the need for more research to be conducted on the effectiveness of treatment programmes on IPV (MacMillan et al., 2001).

The Current Review

Despite the frequent calls for efficacious therapies for victims of IPV, no empirically validated treatments have been clearly established (Enns, Campbell & Courtois, 1997; Mancoske, Standifer & Cauley, 1994; Miller, Veltkamp & Kraus, 1997; Paul, 2004). The literature still demonstrates a focus on the definition of and screening for IPV rather than empirical testing of therapeutic strategies (Follingstad, 2000; Gondolf, Heckert & Kimmel, 2002; Tjaden, 2004). Consequently, Fals-Stewart and Kennedy (2004) identified the need for more research into interventions with IPV due to the clinical and public safety importance and the small number of studies that have examined these issues. Therefore, it is imperative that more research is conducted to elucidate the critical features of any IPV intervention.

Taking into consideration the MacMillan et al. (2001) review and the above information it was found that there was a need to further explore what treatments are effective in reducing symptoms of IPV in a systematic approach. Despite having established within the thesis that both males and females can be victims of IPV, a majority of studies that look at IPV intervention still focus on female victims and male perpetrators (Fals-Stewart & Kennedy, 2004; Follingstad, 2000; Gondolf, Heckert & Kimmel, 2002). Consequently, there is a modest amount of literature looking at interventions for male victims to conduct a review. Therefore, this review will only focus on female victims of IPV.

Aims and Objectivities

Aim

The aim of this systematic review was to look at the effectiveness of treatment for BME victims of IPV, however, limited articles were found for both BME and male victims of IPV.

Consequently, this led to the broadening of the aim of the systematic review to any ethnic group and looking at just female victims. For this chapter, effective interventions for female victims of IPV are defined as the decline of psychological effects of IPV (e.g. PTSD, depression, anxiety) and re-abuse and increase in self-esteem and safety behaviours.

Objectives

The objectives of this systematic review are as follows:

1) To determine if IPV interventions for women reduce the effects of IPV from pre to post intervention. If yes:
    a. To determine which treatment is more effective.
    b. To determine what makes treatment effective.
2) To determine if IPV interventions for women reduce the risk of re-abuse.
3) To identify which ethnic groups were included within the studies.

Review Design and Method

Sources of Literature

A search was conducted on a number of electronic databases on the 20th May 2008, 3rd June 2008 and on the 18th June 2010 in conjunction with university deadlines. The databases searched were decided in consultation with a specialist person working at the NHS library in Stafford. These included; MEDLINE(R), PsychINFO 1806 to 2010, EMBASE 1980 to 2010, ASSIA: Applied Social Sciences Index and Abstracts 1987 to current, ERIC 1966 to current, Health Sciences 1982 to current and Web of Science 1900 to current. The two studies identified in the scoping exercise (MacMillan et al., 2001; Sullivan & Bybee, 1999) were hand searched and elicited further

references to studies that matched the inclusion criteria. Furthermore, three experts were contacted in order to gain more resources.

Search strategy

A search strategy for potential articles was completed to identify all primary outcome studies. All searches were completed with a specialist person working at the NHS library in Stafford. An initial scoping exercise assessed the quantity of potentially relevant studies. The search was mainly conducted through using electronic databases with the same search criteria being applied; however, some slight variations were applied for some databases (see Appendix 1.1). The most popular databases where searched first for existing systematic reviews and meta analysis. These included Cochrane library, Bandolier, DARE, NHS EED and HTA. Then MEDLINE(R), EMBASE and PsychInfo were searched looking for relevant studies, followed by Applied Social Sciences Index and Abstracts (ASSIA), ERIC, Health Sciences and Web of Science. This was in order to get sufficient articles and more thorough scope of the research.

In addition, papers that were not available in the English language and/or where editorials and comment papers, and/ or unpublished work were not included in the review. This can lead to some publication bias and exclude valuable information that may be informative when evaluating effective IPV interventions. However, in order to have quality findings the above papers were excluded and due to financial constraints this was a more practical method.

Search Terms

Due to the large amount of terms that are relevant to this subject and review, an initial search was conducted to identify and narrow down more relevant search terms. The search terms that were

chosen for this review, were the terms that were popular amongst the researchers and terms that had a broad definition, in order to identify the maximum amount of studies. The results may be affected by employing this type of strategy; however by using all relevant search terms for IPV may have resulted in a large amount of hits resulting in irrelevant papers and lack of quality findings. The terms identified (domestic violence or intimate partner violence or battered women AND treatment or group work or Cognitive therapy or Forgiveness therapy or Psychodynamic therapy or Psychotherapy) were entered into the search databases in order to find relevant articles (see Appendix 1.1). The aid of search techniques was also employed such as thesaurus searching and mapping. This was in order to ensure retrieval of relevant material, standardise terminology and spelling, and to allow terms to be searched with its more specific headings (or sub-categorised). Although mapping and thesaurus searching is a more efficient way to search for studies, keywords were utilised in order to minimise the amount of studies that might be lost due to incorrect coding. Whilst this greatly increased the number of hits and duplicates, it also allowed for consistency across electronic resources because some databases did not have the mapping option. Therefore, domestic violence, battered women and intimate partner violence were checked for their inclusion of physical abuse, sexual abuse and emotional abuse.

Study Selection

Initial scoping searches and a review of previous literature on the databases mentioned above led to the formation of inclusion/exclusion criteria (see Appendix 1.2);

Population: Females over the age of 18 years who have been victims of domestic violence/IPV and/or are identified to be at risk of domestic violence/IPV, including pregnant women.

Intervention: Exposure to treatment due to being victims/or at risk of IPV i.e., feminist based treatment, psychotherapy, cognitive behavioural therapy.

Comparator: No treatment.

Outcome: Re-victimisation, self report.

Study Type: Cohort, case control, RCT and before-and- after study.

Exclusion: Excluding females under the age of 18, narrative reviews, opinion papers, editorials or commentaries.

Language: No restrictions were imposed; however, foreign language articles must have been translated into English language.

The Inclusion/Exclusion Criteria criterion was applied by the author to all studies. Those abstracts which did not reveal enough information to apply the criteria were assessed using the full text article. All articles passing the criteria or those which the author was unsure about, and any of potential relevance were downloaded as full text. Those which were not available were ordered at a local library from which obtained them from British Library. The author was unable to retrieve two articles.

Quality Assessment

Studies that met the inclusion/exclusion criteria were assessed for their quality. A quality assessment checklist adapted from The Critical Appraisal Skills Programme (CASP; 2000), was developed prior to the review. Different quality assessment checklists were applied to different study designs in order to accurately assess the validity of each study (see Appendix 1.3). Each study was assessed in relation to, selection bias, performance and measurement bias, and attrition bias. Furthermore, other key variables assessed were, aims of the study, study design, sample

selection, selection bias, attrition rates, statistical analysis, clarity of outcome measure, identification and measurement of risk factor, and appraisal of limitations.

A scoring system was implemented to assess the quality of each research study. Two points were given when criteria was met, one point was given when criteria was partly met and zero point were given when criteria was not met. The total quality score was obtained by adding the scores of each item, giving a total score ranging from 0 to 44 for cohort studies, 0 to 60 for case-control studies, 0 to 60 for RCT and 0 to 40 for before and after studies.

According to Moher et al. (1998) the inclusion of poorer quality studies in a meta-analysis is associated with an increased estimate of benefit and therefore may alter the interpretation of the effect of an intervention. Therefore, in order to ensure a good quality review only those studies that scored a quality assessment of 60% were included in the review. Any studies that attained quality assessment scores below the cut-off point (60%) were not include in the review. To assure the variables were being assessed correctly and consistently, a second reviewer also assessed each study, and achieved an inter-rater reliability of 0.86. There were no major differences found between the author and 2nd reviewer quality assessment scores. Differences between the author and reviewer scores were resolved by consensus. For example, the largest difference found was 10%, when reviewing the Muelleman and Feighny (1999) study. The author had given the study a quality score of 65% and the reviewer had given the study a quality score of 75%. The difference was resolved by both the author and reviewer going through the study together and discussing how they had reached their scores. Subsequently, a new score that was agreed by both the author and reviewer were given for each criterion. This resulted in the study getting a quality score of 70%.

Data Extraction

A data extraction form was developed based on the assessment criteria. Data extraction was carried out, in order to extract relevant data from each study using the pre-defined form (see Appendix 1.4). The extraction form allowed for both general information and more specific details to be extracted, which will be required to make conclusions in this review. These included; study design, characteristics, sample information including number of participants in each group, specifics of type of exposure, measurement of exposure including validity if a tool was used, type of abuse, follow-up period if applicable, measurement of treatment, steps taken to improve validity of self-reporting and interviews, attrition rates, confounding factors (CF), clarity of study and limitations of study.

Information which was indecipherable from the studies was recorded as 'unknown.' This only occurred with one study (Reed & Enright, 2006), as the length of follow up was unclear. The limitation of recording information as 'unknown' is that the missing information may affect the findings of this review. In circumstances of more flexible time constraints, the authors of the study would be contacted in order to establish this information, however as this task was not feasible within the time frame of the initial review in 2008, the information remained unknown to the author.

Results

The total number of hits was 5995 identified from electronic databases, a further eight studies were identified from existing systematic reviews/ studies and one from an expert (see Figure 2.1). There were 5302 that were not relevant or duplicate references that were removed from the review and two unobtainable articles. Of the remaining 101 studies, 60 failed to meet the

inclusion criteria. The remaining 41 studies were quality assessed, in which 13 met the cut off of 60% or above. Four of these were longitudinal studies and subsequently nine studies were analysed. Figure 2.1 displays the process of study selection with detail regarding the number of studies excluded at each stage.

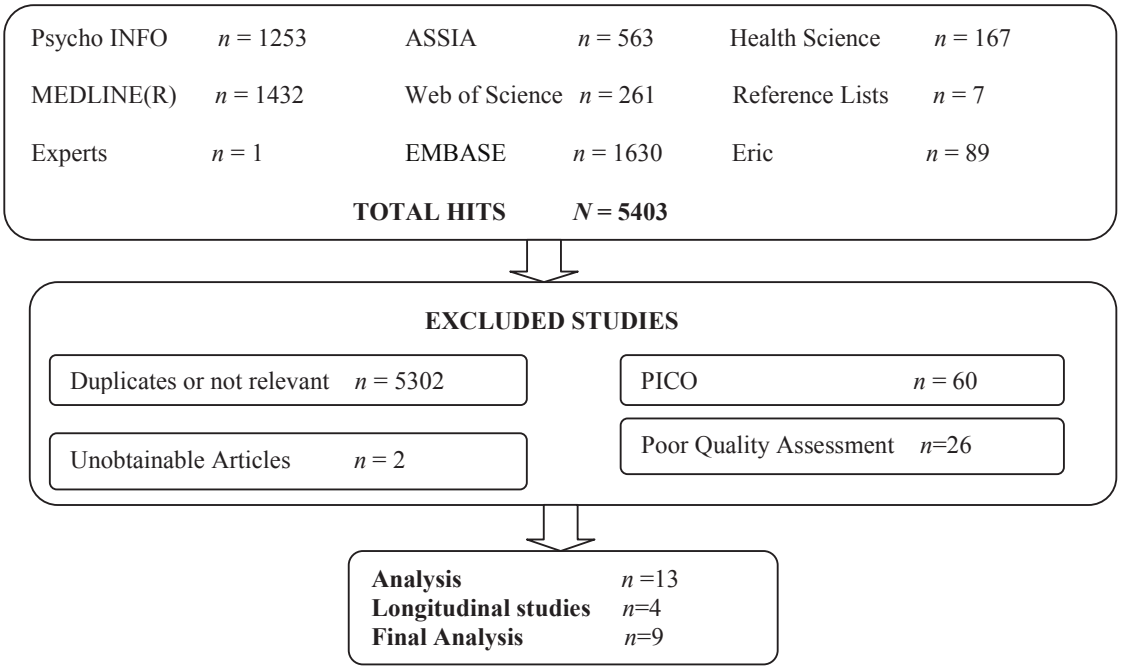

Figure 2.1: Papers identified and excluded.

Characteristics of Included Studies

The characteristics of the study were evaluated and the results are presented in Table 2.3.

Data Extraction Results

Data was extracted using the extraction form (see Appendix 1.4) and the results are presented in Table 2.4.

Table 2.3: *Characteristics of Included Study*.

Author, year, country of study, study type	Hypothesis/ Aim of study	Sample size	Intervention used and outcome measures	Comparison Group	Abuse type	Findings
Johnson & Zlotnick (2006) U.S.A Before and after study	Evaluate the initial feasibility and efficacy of an individual, cognitive-behavioural treatment for battered women with PTSD.	56	HOPE (helping to overcome PTSD) intervention: Beginning sessions focused on psychoeducation regarding interpersonal violence, PTSD, and safety planning. Earlier sessions also focused on teaching women information and skills that empower them to establish their independence and to make informed choices. Later sessions of HOPE incorporate established cognitive– behavioral skills to manage PTSD and its associated features (e.g., cognitive-restructuring, managing triggers) and optional modules that address some of the co-occurring problems frequently found in battered women (e.g., substance use and grief). Number of psychological questionnaires used to measure outcome including Conflict Tactics Scales (CTS-2; Straus, Hamby, McCoy, & Sugarman, 1996), Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I; First, Gibbon, Spitzer & Williams, 2002), Clinician Administered PTSD Scale (CAPS; Blake et al., 1990), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), Effectiveness in Obtaining Resources Scale (EOR; Sullivan & Bybee, 1999), Conservation of Resources- Evaluation (COR-E; Hobfoll & Lilly, 1993), Social Adjustment Scale-Self-Report (SAS-SR; Weissman, Prusoff, Thompson, Harding & Myers, 1978) and the Client Satisfaction Questionnaire (CSQ; Nguyen & Attkisson, 1983).	None	Any	Ethnicity sample: white (*n*=9), African American (*n*=7), Hispanic (*n*=2) and other (not specified) (*n*=2). No comparisons made. Intent to treat analyses indicates that participants experienced significant decreases in PTSD symptoms (baseline *M*= 60.17, *SD*= 27.18; six months post shelter *M*=24.00, *SD*= 23.11) and depressive symptoms (baseline *M*= 19.39, *SD*= 9.56; six months post shelter *M*=11.33, *SD*= 10.99); loss of resources and degree of social impairment (baseline *M*= 3.01, *SD*= 0.63; six months post shelter *M*=3.54, *SD*= 0.46); significant increases in their effective use of community resources (baseline *M*= 64.65, *SD*= 20.66; six months post shelter *M*=33.24, *SD*= 32.97) and overall adjustment (baseline *M*= 2.70, *SD*= 0.65; six months post shelter *M*=2.03, *SD*= 0.59). Effect sizes substantially strengthened were: PTSD=.66, depression=0.50, effective use of community resources=.50, resource loss=.49 and social adjustment=.51. Gains were maintained over time.
Kubany, Hill & Owens	To see if there is a reduction in PTSD and	37	CTT-BW-. The sessions covered trauma history	Delayed CTT-BW	Any	Participants' ethnic backgrounds were diverse, including White

(2003) Hawaii Cross-sectional	depression using the cognitive trauma therapy for battered women with posttraumatic stress disorder (CTT-BW) approach and to see if there is a difference between delayed CTT-BW and immediate CTT-BW conditions.		exploration, PTSD education, stress management, exposure to abuse and abuser reminders, self-monitoring of negative self-talk, cognitive therapy for guilt, modules on self-advocacy, assertiveness, and how to identify perpetrators. Psychological questionnaires used include; Traumatic Life Events Questionnaire (Kubany, Haynes, et al., 2000), The Distressing Event Questionnaire (Kubany, Leisen, Kaplan & Kelly, 2000), Beck Depression Inventory (Beck, Steer & Garbin, 1988),Trauma-Related Guilt Inventory (Kubany et al., 1996) , Sources of Trauma-Related Guilt Survey – Partner Abuse Version (Kubany, Owens & Leigh, 1998), Personal Feelings Questionnaire (Harder & Lewis, 1986), Client Satisfaction Questionnaire (Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves & Nyguen, 1979) and Clinician-Administered PTSD Scale (Blake et al., 1990).			(*n*=18), Asian (*n*=10; Japanese, Chinese, Filipino and Indonesian), Pacific Islander (*n*=6; Native Hawaiian and Samoan) and "other" ethnicities (*n*=3; Black and Puerto Rican). CTT-BW was efficacious across ethnic background. No difference in delayed or immediate group in initial assessment. No significant changes in scores among participants in the delayed CTT-BW between first and second pre-therapy score. Significant changes in scores among participants in the immediate CTT-BW between first and second pre-therapy score. Compared with pre-therapy assessments, there were also significant reductions in depression (*M* = 83%), trauma-related guilt (*M* = 83%), trauma-related guilt cognitions (*M* = 82%), and shame (*M* = 72%). Self-esteem scores increased by a mean 92%. All gains were maintained at 3-month follow-up assessments.
Kubany, Hill, Owens, Iannce-Spencer, McCraig, Tremayne & Williams (2004) Hawaii Cross-sectional	The purpose was to conduct a second treatment-outcome study of CTT-BW that was methodologically superior to the first study (Kubany, Hill & Owens, 2003) First, the sample size was considerably larger (*N* = 125 vs. *N* = 37). Second, the study used multiple therapists (seven) versus only one. Third, follow-up assessments were conducted at six months as well as at three months post therapy.	125	CTT-BW-. The sessions covered trauma history exploration; PTSD education; stress management; exposure to abuse and abuser reminders; self-monitoring of negative self-talk; cognitive therapy for guilt; and modules on self-advocacy, assertiveness, and how to identify perpetrators. Traumatic Life Events Questionnaire (Kubany, Haynes, et al., 2000), The Distressing Event Questionnaire (Kubany, Leisen, Kaplan & Kelly, 2000), Beck Depression Inventory (Beck, Steer & Garbin, 1988),Trauma-Related Guilt Inventory (Kubany et al., 1996) , Sources of Trauma-Related Guilt Survey – Partner Abuse Version (Kubany, Owens & Leigh, 1998),Personal Feelings Questionnaire (Harder & Lewis, 1986), Client	Delayed CTT-BW	Any	Findings support Kubany, Hill and Owens (2003). Backgrounds were diverse and included White (*n*=66), Native Hawaiian (*n*=11), Filipino (*n*=9), Japanese (*n*=8), Black (*n*=6), Samoan (*n*=6), American Indian (*n*=2) and other or mixed ethnicity (*n*=17). White and ethnic minority women benefited equally from CTT- BW. No difference in delayed or immediate group in initial assessment. No significant changes in scores among participants in the delayed CTT-BW between first and second pre therapy score. Significant changes in scores among participants in the immediate CTT-BW between first and second pre therapy score.

			Satisfaction Questionnaire (Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves & Nyguen, 1979), Clinician-Administered PTSD Scale (Blake et al., 1990) and Rosenberg Self-Esteem Scale (Rosenberg, 1965).			PTSD remitted in 87% of women who completed CTT-BW, with large reductions in depression and guilt and substantial increases in self esteem. Similar treatment outcomes were obtained by male and female therapists with different levels of education and training. Gains were maintained at three (75% immediate, 65% delayed) and six months follow up (59% immediate, 69% delayed)
McFlarlane, Groff, O'Brien & Watson (2006) U.S.A RCT	To assess the comparative safety behaviors, use of community resources and extent of violence following two levels of intervention. 1. Abused women who participate in case management intervention will report more adopted safety behaviors than abused women who receive abuse assessment and an information card only. 2. Abused women who participate in case management intervention will report greater use of community resources than abused women who receive abuse assessment and an information card only. 3. Abused women who participate in the case management intervention will report less violence as measured by number of threats of abuse, assaults, danger risks for homicide, and events of work harassment than abused women who receive abuse assessment and a referral card only.	360	Wallet sized referral card lists a safety plan and sources for IPV services (shelter, legal, counseling, and police). Contacted every six months by a project staff member and asked to make an appointment at the clinic for a one hour interview. No counseling, education, referrals, or other services were offered. 20 minute nurse case management protocol – 15-item safety plan brochure from the March of Dimes protocol, including supportive care Guided referrals and anticipatory guidance. Outcome measures were differences in the number of threats of abuse, assaults, danger risks for homicide, events of work harassment, safety behaviors adopted, and use of community resources between intervention groups over 24 month period.	Yes	Physical or sexual abuse	Card only: White non-Hispanic (n=24), Black non-Hispanic (n=52), Hispanic (n=82) and other (n=0). Case management: White non-Hispanic (n=14), Black non-Hispanic (n=37), Hispanic (n=108) and other (n=2). No comparisons of ethnicity made. Two years following treatment; both treatment groups of women reported significantly ($p < .001$) fewer threats of abuse (M = 14.5; 95% CI =12.6- 16.4), assaults (M = 15.5, 95% CI=13.5- 17.4), danger risks for homicide (M = 2.6; 95% CI=2.1- 3.0) and events of work harassment (M = 2.7; 95% CI=2.3-3.1). However, there were no significant differences between groups. Compared to baseline, both groups of women adopted significantly ($p < .001$) more safety behaviors by 24 months (M = 2.0; 95% CI=1.6-2.3); however, community resource use declined significantly ($p < .001$) for both groups (M = -0.2; 95% CI=-0.4- -j0.2). There were no significant differences between groups. Disclosure of abuse, such as what happens with abuse assessment, was associated with the same reduction in violence and increase in safety behaviors as a nurse case management intervention. Simple assessment for abuse and offering of referrals has the potential to interrupt and prevent recurrence of IPV and associated trauma.
Muelleman &	The aim was to see whether an Emergency	183	After a woman was identified as having acute injuries	None	Any	No ethnic breakdown of participants were given beside that more

Feighny (1999) U.S.A Before and after study	Department (ED) based advocacy program resulted in increased community resource utilisation by battered women.		as a result of domestic violence, she was asked if she wanted to meet with an advocate to discuss options for dealing with her situation. If she was interested, the advocate was paged. Advocate would discuss the incident, address safety issues, educate the women about the cycle of violence, and inform her of resources available in the community. Given educational information to take away. The meeting usually lasted 1 ½ hours. The baseline group (BRIDGE group) were women who were injured by their current or former boyfriend or husband during a six month period before the start of the BRIDGE program. During this period, identified women had been offered an information sheet with resource phone numbers on it. The after advocacy group consisted of women identified prospectively in the ED as injured by their current or former boyfriend or husband and who met with a BRIDGE advocate during the first 6 months of the program. Outcome measures: proportion of women with shelter use, shelter based counselling, police calls, full order of protection, and repeat ED visits for domestic violence after the index ED visit.			black women were in the BRIDGE group (75% versus 61%, *p*=.05). After the initiation of the program, shelter use increased from 11% to 28% (*p*=0.003) and shelter based counselling increased from 1% to 15% (*p*=.001). There was no significant change in repeat police calls (25% versus 35%, p=14), full orders of protection (9% versus 6%, *p*=.58), or repeat ED visits for domestic violence (11% versus 8%, *p*=.63). Increase in self esteem and decrease in PTSD. Conclusion: Brief intervention (advocacy in ED) alone would not be sufficient to tackle a problem as complex as domestic violence.
Reed & Enright (2006) U.S.A Cohort study	Study compares forgiveness therapy (FT) with an alternative treatment (AT; anger validation, assertiveness, interpersonal skill building). Study hypothesised that individuals who participated in FT would demonstrate less depression, anxiety, and posttraumatic stress symptoms and more self-esteem, environmental mastery, and finding meaning in suffering than those who engaged in the	20	FT treatment-manualised protocol for treatment:(a) defining forgiveness (what it is and is not) and the distinction between forgiveness and reconciliation, (b) examining psychological defenses, (c) understanding anger, (d) examining abuser-inculcated shame and self-blame, (e) understanding cognitive rehearsal, (f) making a commitment to the work of forgiving, (g) grieving the pain and losses from the abuse, (h) reframing the former abusive partner (his personal	The AT was designed and delivered (with a written protocol) to match as closely as possible the basic elements of the therapy approach (anger validation	Any	Ethnicity: European Americans (*n*=18, 90%), Hispanic American (*n*=1, 5%) and Native American (*n*=1, 5%). No ethnic comparisons made. Participants in FT experienced significantly greater improvement than AT participants in depression, trait anxiety, posttraumatic stress symptoms, self-esteem, forgiveness, environmental mastery, and finding meaning in suffering, with gains maintained at follow-up (*M*= 8.35 months, *SD:* 1.53).

	more standard therapeutic procedure (AT), which does not directly target the amelioration of this resentment.		history, fallibility, and culpability; the unfair, unequal power established by his abusive behavior; his inherent worth), (i) exploring empathy and compassion, (j) practicing goodwill (i.e., merciful restraint, or foregoing resentment or revenge; generosity and moral love), (j) finding meaning in unjust suffering, and (k) considering a new purpose in life of helping others. FT was criterion-based. Psychological Abuse Survey (an adaptation from Follingstad, 2000; Follingstad et al.,1990; Sackett and Saunders, 1999), The Enright Forgiveness Inventory (EFI; Subkoviak et al., 1995), Coopersmith Self-Esteem Inventory (CSEI; Coopersmith, 1989). State–Trait Anxiety Inventory (STAI; Spielberger, 1983), Beck Depression Inventory–II (BDI-II; Beck, Steer & Brown, 1996), Environmental Mastery Scale (Ryff & Singer, 1996), Finding PTSS checklist, Meaning in Suffering (Reed, 1998), and Story measure.	with mourning, assertiveness strategies, and interpersonal skills).		FT has implications for the long-term recovery of post-relationship emotionally abused women. Gains made by FT group compared with AT group suggesting that FT was more efficacious in reducing anxiety.
Rinfret- Raynor, Paquet-Deehy, Larouche et al. (1992) Canada Cohort study	1) The three kinds of treatment would see subjects improve on the variables studied between the beginning and the end of the intervention, and these improvements would be maintained over time. 2) The feminist intervention received by subjects in the experimental group/group intervention would produce results superior to those achieved by battered women receiving individual treatment along the same model. 3) The feminist intervention received by subjects in the experimental group/individual intervention would produce results superior to those achieved by battered women receiving	181	The feminist model progressively shifts from reducing tensions and providing support for the woman's decision, to reducing victim behaviours by helping her regain her self-esteem and her autonomy. The model can be applied in the form of individual intervention or of group intervention. Standardised psychological questionnaires. Three groups: feminist group intervention, individual feminist intervention, individual intervention using other approaches. Structured interviews involving a number of multiple choice questionnaires.	Yes- individual feminist intervention, & other intervention	Any	No breakdown of ethnic groups. All three groups had a reduction in anxiety, depression, and somatisation. Sixty-nine women who were living with their partner at the start of the intervention 39.1 % left. Violence had stopped for 21.7% of women in the sample (35/161) at the post-test, for 24% (30/124) at the first follow-up interview and for 11.4% (14/123) at the last interview Improvement in socio-economic change for 52% of participants at follow-up.

	individual treatment from practitioners in the comparison group.					The first hypothesis was largely confirmed by statistical tests conducted on measurements of dependent variables defining the intervention's effectiveness, while the second and third hypotheses must be rejected, Claiming the superiority of individual intervention of the feminist model over the other individual approaches studied was rejected by the research. The comparison group intervention contributed more to an increased use of reasoning by partners or ex-partners while individual intervention in the experimental group contributed slightly more to reducing physical aggression than interventions of the comparison group.
Sullivan (1991) U.S.A. RCT	Research designed to examine impact of providing sort term advocacy services to women leaving battered women shelters. Community advocates could be effective change agents in women that have been abused.	46	Experimental condition: received intensive one to one services with trained professionals for 10 weeks. The intervention consisted of helping women devise safety plans when needed and providing advocacy services. Safety plans were individualised on the basis of each woman's history, needs and circumstances. Consisted of five stages: assessment, implementation, monitoring, secondary implementation, and termination. Control group received no additional services. Outcome measure: Physical violence: incidence of abuse (MCTS), risk for being re-abused, social support, quality of life, and ability to obtain community resources. Psychological abuse: several psychological outcomes (all self-report). A modified version of the Conflict Tactics Scale (Straus, 1979), 33-item Index of Psychological Abuse (Sullivan, Parisian & Davidson, 1991), Quality of life (Withey, 1976), Depression Scale (Radloff, 1977), Social Support (Bogat, Chin, Sabbath & Schwartz, 1983) and Effectiveness in obtaining	Control Group	Any	Ethnicity: 48% White, 32% Black, 8% Hispanic, 1% Arab American, 11% other. No ethnic comparisons made. Women who had worked with advocates reported being more effective in reaching their goals than women in the control condition (t [41]= -2.58, p<.0; ω^2=.12). Standardised means for the two groups were -0.41 for the control condition and 0.19 for the experimental group. Abuse outcomes: unable to adequately compare due to very small number of women involved with assailant. However, at 10 week follow up six participants who went back to their partner reported no further abuse and five participants that did not return to their partner reported physical abuse by their ex-partner. Other outcomes: intervention group better able to obtain resources. No differences between groups for independence from assailants were reported.

			Resources and Difficulty Obtaining Resources.			
Sullivan & Davidson (1991) Longitudunal study, same sample used in Sullivan, (1991) study. U.S.A RCT	Looking at short term advocacy intervention Expanded on Sullivan (1991) Community advocates could be effective change agents in women that have been abused.					Abuse outcomes: unable to adequately compare due to very small number of women involved with assailant. Four women reported experiencing further abuse within 10 weeks off leaving shelter. Other outcomes: Intervention group better able to obtain resources. No differences between groups for independence from assailants were reported. Conclusion: Women need numerous resources when they leave shelters.
Sullivan, Tan, Basta, Rumptz & Davidson (1992) U.S.A RCT	Community advocates could be effective change agents in women that have been abused. Looking at a larger sample. Study based on Sullivan (1991) and Sullivan and Davidson (1991). 1.Battered women would be in need of numerous resources upon their shelter exit. 2.Working with advocates would increase women effectiveness in obtaining resources and social support. 3. Success in obtaining resources and their social support would increase women's level of life satisfaction and decrease of their risk of further abuse.	141	Upon leaving shelters women were interviewed and offered advocacy service and 10 weeks after they left shelter. The intervention consisted of helping women devise safety plans when needed and providing advocacy services. Safety plans were individualised based on each woman's history, needs and circumstances. Consisted of five stages: assessment, implementation, monitoring, secondary implementation, and termination. Physical violence: incidence of abuse (MCTS), risk for being re-abused, social support, quality of life, and ability to obtain community resources. Psychological abuse: several psychological outcomes (all self-report). A modified version of the Conflict Tactics Scale (Straus, 1979), 33-item Index of Psychological Abuse (Sullivan, Parisian & Davidson, 1991), Quality of life (Withey, 1976), Depression Scale (Radloff, 1977), Social Support (Bogat, Chin, Sabbath & Schwartz, 1983), Effectiveness in obtaining Resources and Difficulty Obtaining Resources.	Control group	Any	Ethnicity: 45% White, 43% Black, 8% Hispanic, 1% Asian American, remaining native American, Arab American or mixed heritage. No ethnic comparisons made. Abuse outcomes: No differences between groups. Lower levels of physical abuse, depression, fear, and anxiety. Other outcomes: intervention group reported more access to resources, better social support, and greater quality of life. Women need numerous resources when they leave shelters and advocate is effective in change.

Sullivan, Campbell, Angelique, Eby & Davidson (1994) Longitugnal study, same sample used in Sullivan et al. (1992) study. U.S.A RCT	To expand on Sullivan et al. (1992) and see if advocacy affects long term outcomes in women that have been abused.	131				No significant differences between groups. 68% were still involved with men that abused them compared to 88% at 10 week interview. Decrease in physical abuse from 10 week to six month follow up. However, 43% experienced further physical abuse at six month follow up. 95% experienced further psychological abuse. 23% received medical treatment and 32% felt they needed but did not get it. Improvement from 10 week to 6 month follow up. Significant improvement in intervention group who reported more access to resources and greater quality of life. Dependency on partner finances appeared to be a major factor in victim staying in relationship.
Tan , Basta, Sullivan & Davidson (1995) Longitugnal study, same sample used in Sullivan et al. (1992) and Sullivan et al. (1994) study. U.S.A RCT	Secondary analysis of data from Sullivan et al. (1994), to explore link between social support and abuse.	146				Abuse outcome: at post-intervention (10 weeks) interview, women in the control group who had experienced violence were less satisfied with their social support while women in the intervention group were satisfied whether they experienced further abuse or not. This did not persist at follow-up.
Sullivan & Bybee (1999) RCT	Longitudinal study based on Sullivan et al. (1992) and Sullivan et al. (1994) study. Larger sample. To see if community advocates could be effective change agents in	278	Upon leaving shelters women were interviewed and offered advocacy service an 10 weeks after they left shelter.	Control group	Any	45% African American 42% were European American, 7% Latina, 2% Asian American and the remainder were Native American, Arab American, or of mixed heritage.

U.S.A	women that have been abused.		The intervention consisted of helping women devise safety plans when needed and providing advocacy services. Safety plans were individualised on the basis of each woman's history, needs and circumstances. Consisted of five stages: assessment, implementation, monitoring, secondary implementation, and termination. Physical violence: incidence of abuse (MCTS), risk for being re-abused, social support, quality of life and ability to obtain community resources. Psychological abuse: several psychological outcomes (all self-report). Psychological abuse: several psychological outcomes (all self-report). A modified version of the Conflict Tactics Scale (Straus, 1979), 33-item Index of Psychological Abuse (Sullivan, Parisian & Davidson, 1991), Quality of life (Withey, 1976), Depression Scale (Radloff, 1977), Social Support (Bogat, Chin, Sabbath & Schwartz, 1983), Effectiveness in obtaining Resources and Difficulty Obtaining Resources.			Decrease in physical violence at post intervention and two year follow up. Intervention group reported significantly less violence than controls post intervention (group x time interaction $F42,60= 2.38$, $p<0.5$). At two years, 89% of controls reported re-abuse, vs. 76% of women in the intervention group. No overall main effect of condition across entire study. No significant differences between groups over time for psychological abuse. Overall significant decrease for both groups. Intervention group had lower risk for re-abuse at two year follow up. Intervention group reported less involvement with assailants across time and more effective in "ending relationship when they wanted" and "reaching their goals" Intervention group was better able to obtain resources and reported higher satisfaction with social support and improved quality of life across time. Decrease in depression and no significant differences in depression between groups.

Table 2.4: *Data from Included Studies.*

Author, year, country of study and study type.	Sample Methods	Domestic violence measure	Intervention: Inclusion criteria, setting, no. of sessions	Statistical Analysis	Attrition Rate	CF	Quality score (QS)/ Strength and weaknesses
Johnson & Zlotnick (2006) U.S.A Before and after study	Random sample recruited from 2 shelters.	Revised Conflict Tactic Scales (CTS-2; Straus, Hamby, McCoy & Sugarman, 1996).	1) Domestic violence in the month prior to admittance in the shelter. 2) Presence of PTSD or sub-thresholds PTSD symptoms from the abuse. 3) Excluded if lifetime diagnosis of bipolar disorder or psychosis or on psychotropic medication in the past month/ or significant ideation or risk Residents who did not report any exclusionary criteria in a phone screen were scheduled for baseline assessment. Participants were interviewed one week, three months and six months after they left shelter. One HOPE session twice per week (9-12 sessions in total), by qualified therapist.	MANOVA	10%	yes	70% √Higher effect sizes for all outcomes were found for those women who completed a minimum dose of treatment. ×Results should be interpreted with caution due to small sample and lack of control group.
Kubany, Hill & Owens (2003) Hawaii Cross -sectional	Referred by victim service agencies randomly assigned to immediate or delayed sample.	Self report and number of psychological questionnaire.	1) Telephone screening. 2) Consecutive pairs structured interview and questionnaire assessments. Traumatic Life Events Questionnaire (Kubany, Haynes, et al., 2000), The Distressing Event Questionnaire (Kubany, Leisen, Kaplan & Kelly, 2000), Beck Depression Inventory (Beck, Steer & Garbin, 1988), Trauma-Relted Guilt Inventory (Kubany, Hynes, et al., 1999) , Sources of Trauma-Related Guilt Survey – Partner Abuse Version (Kubany, Owens & Leigh, 1998), Personal Feelings Questionnaire (Harder & Lewis, 1986), Client Satisfaction Questionnaire (Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves & Nyguen, 1979) and Clinician-Administered PTSD Scale (Blake et al.,1990). 3) Randomly assigned to Immediate or delayed CTT-BW. 4) Two weeks after Immediate condition, participants received post therapy assessment. 5) Six weeks after initial assessment, delayed group received pre therapy assessment and CTT-BW group received their post therapy assessment. 6) Follow up assessment, 3 months after therapy.	ANOVAs/ Chi-square tests initial scores. Repeated measures multivariate analyses of variance (MANOVA; Group x Measurement Period x Measure)	14%	Yes	95% √There was no difference in pattern when comparing demographics, and measure of variables for therapy between completers and non completers. ×These facts may limit transportability of CTT-BW and its replicability by independent teams. ×This treatment has not been tested on women who are still in abusive relationships or considering reconciliation.

			Individual therapy= 8 to 11 sessions in total, two session per week. Each session lasting 1.5 hr each.				
Kubany, Hill, Owens, Iannce-Spencer, McCraig, Tremayne & Williams (2004) Hawaii Cross-sectional	Referred by victim service agencies randomly assigned to immediate or delayed sample.	Self report and number of psychological questionnaire.	1) Semi structured phone interviews for screening. 2) Initial assessment-(informed consent, structured PTSD interview, psychological questionnaire sane as Kubany et al., 2004). 3) Every two consecutive women randomly assigned to immediate or delayed CTT-BW condition. 4) Two weeks after Immediate condition, participants received post therapy assessment. 5) Six weeks after initial assessment, delayed group received pre therapy assessment and CTT-BW group received their post therapy assessment. 6) Follow up assessment, three months after therapy. Individual therapy= 8 to 11 sessions in total, two session per week. Each session lasting 1.5 hr each.	ANOVAs/ Chi-square tests initial scores. Repeated measures multivariate analyses of variance (MANOVA; Group x Measurement Period x Measure)	20%	Yes	95% √The mean period of time that participants had been out of an abusive relationship was 5.3 years. ×Although assessors were blind to participants' condition assignment, no interrater reliability checks on the CAPS.
McFlarlane, Groff, O'Brien & Watson (2006) U.S.A RCT	Repeated measures Shelter.	Abuse assessment criteria, The safety behaviour checklist (McFlarlane & Parker, 1994), The Severity of Violence Against Women Scale (Marshall, 1992) and The Danger Assessment Scale (Campbell 1995).	Assessed for IPV. A positive response to either physical or/and sexual abuse on the abuse assessment scale. Randomly assigned to either condition Initial interview, 6 month, 12 month and 18 month follow up.	Repeated measures analyses of variance (ANOVAS).	12% info card 11% (case managemen t group)	Yes	78% √Acceptable loss to follow-up and lack of placebo group. ×Inability to mask participants, recall bias, no blinding. The study procedures may have increased social desirability bias that decreased women's willingness to disclose continued abuse.
Muelleman & Feighny (1999) U.S.A Before and after study	Random sample. Present at emergency department through sustained injuries by domestic violence.	Presentation to emergency department/self reported.	Come through Emergency Department One session of 1½ hours of advocacy work. Six months- Advocacy group, number of sessions and content unclear.	t -test	Unclear	Yes	65% ×The experience or profession of the advocate was unclear. ×The number of sessions and content unclear of the sessions within the group. ×No comparison to any other treatment.
Reed & Enright (2006)	Matched pair sample/ emotionally abused	Psychological Abuse Survey (Follingstad, 2000; Follingstad et	A participant was excluded from the study if she demonstrated current involvement in an abusive relationship,	One tailed matched pairs t-tests.	0%	Yes	69%

U.S.A Cohort study	women who had been permanently separated for 2 or more years.	al., 1990; Sackett & Saunders, 1999), a posttraumatic stress symptom checklist (PTSS; from the *DSM–IV;* APA, 1994), and a psychological screening checklist.	described a history of childhood physical abuse, or demonstrated evidence of significant ongoing psychiatric illness, such as suicidal ideation or psychosis. One hr/weekly, the mean treatment time overall was 7.95 (*SD*= 2.61) with a minimum of five months and a max of 12 months. Psychological questionnaires measured pretest-post test and follow up. Follow up was conducted however, length of follow up not clear.				√No loss to follow up. ×No blinding and small sample size. ×Difficult to evaluate abuse outcomes due to very small cohort size.
Rinfret-Raynor et al. (1992) Canada Cohort study	Randomly assigned to three groups/ referred by social services.	Revised Conflict Tactic Scales (CTS-2; Straus et al., 1996).	Assessed for IPV and referred to study by Social services. Separated less the tw years from the partner. Baseline questionnaires measuring self esteem, social adjustment, Rathus Assertiveness Schedule and SCL 90. Interventions lasted between 5 and 10 months session and time unclear for all 3 interventions. First interview (pretest) beginning of the intervention, the second (post-test) one month after the end of the intervention and two follow-up interviews were then conducted at six month intervals.	ANOVA	32%	Yes	65% √Standardised psychological questionnaires and self report. ×Other approaches were not defined. ×No blinding.
Sullivan (1991) U.S.A. RCT Sullivan & Davidson (1991)	Random sample/ women leaving shelter after at least 1 night's stay.	Self report of any abuse.	Spent at least one night in the shelter and planned to stay in the vicinity for three months. 6-8 h/wk for 10 weeks post-shelter of one-on-one advocacy counseling. Interviews conducted at pre-intervention, at 5 weeks during intervention, at 10 weeks post-intervention, and at 20 weeks follow-up	MANOVA	4%	Yes	69% ×Small sample size. ×Disproportionately weighted to intervention group. ×No blinding. ×Impossible to evaluate abuse outcomes due to very small ×Difficult to evaluate abuse outcomes due to very small cohort size.

Sullivan Tan, Basta, Rumptz & Davidson (1992) U.S.A RCT Sullivan, Campbell, Angelique, Eby & Davidson (1994) Tan , Basta, Sullivan & Davidson (1995)	Random sample/ Women leaving shelter after at least one night's stay.	Self report of any abuse.	Spent at least one night in the shelter and planned to stay in the vicinity for three months. 4-6 h/wk for 10 weeks post-shelter of one-on-one advocacy counseling. Interviews conducted pre-intervention and at 10 weeks post-intervention. Interviews conducted at post-intervention at six months follow-up. Spent at least one night in the shelter and planned to stay in the vicinity for three months. 4-6 h/wk for 10 weeks post-shelter of one-on-one advocacy counseling Interviews conducted at pre-intervention, at 10 weeks post intervention, and at six months follow-up.	MANOVA	6%	Yes	75% ×Self-report outcomes. ×No blinding at 10 weeks √but interviewer blinded to group assignment until after initial interview. √Acceptable loss to follow-up (93% retention rate at 6 months). ×Self-report outcomes ×No blinding √Acceptable loss to follow-up (93% retention rate at six months). ×Self-report outcomes ×No blinding
Sullivan & Bybee (1999) U.S.A RCT	Random sample/ women leaving shelter at least one night's stay.	Self report of any abuse.	Spent at least one night in the shelter and planned to stay in the vicinity for three months. Interviews conducted at pre-intervention, shelter exit, at 10 weeks post intervention and at 6, 12, 18, 24 moths of follow up. 4-6 hours a week post shelter of one to one advocacy counselling.	MANOVA	3%	Yes	75% √Acceptable loss to follow up: 97% retention rate and no differences in attrition between groups. √Complete longitudinal data available for 87% of participants. ×Self report outcomes. ×No blinding.

√= strengths ×=weaknesses

Descriptive Data Synthesis

Egger, Schneider and Smith (1998) argue that meta-analyses of observational epidemiological studies can produce spuriously accurate and subsequently misleading summary statistics. Therefore, studies were examined in a qualitative manner in order to complete the quality assessment forms. This include a using a voting-counting exercise. Due to the nature of the statistical analyses used, the recommended task of calculating effect sizes (Breakwell, Hammond, Fife-Shaw & Smith, 2006) was not implemented.

Study Populations

All nine studies identified women over the age of 18 who had experienced some form of IPV and who had suffered physical, psychological and/or emotional abuse from an intimate partner. All the studies identified women from the community who volunteered to be part of the study and eight studies required that the woman were no longer in the abusive relationship. In addition, out of the nine studies only seven reported the ethnic origin of the participants.

Five of the studies identified women who had been abused by an intimate partner through their stay at shelters (Johnson & Zlotnick, 2006; McFlarlane et al., 2006; Sullivan, 1991; Sullivan et al., 1994; Sullivan & Bybee, 1999). One study identified battered women through the examination and consultation in an emergency department (Muelleman & Feighny, 1999). For one study, women who had been abused by an intimate partner were referred by social services (Rinfret-Raynor et al., 1992).

For two of the studies, women were referred through victim service agencies (Kubany, Hill & Owens, 2003; Kubany et al., 2004). Women qualified for participation if they had been out of an abusive relationship for at least thirty days, if they had not been physically or sexually abused or stalked by anyone for at least 30 days, met diagnostic criteria for partner-abuse-related PTSD and obtained a score on the Global Guilt Scale of the Trauma-Related Guilt Inventory reflecting at least moderate abuse-related guilt. They were excluded if they were currently abusing alcohol or drugs and/or had schizophrenia or bipolar disorder (Kubany, Hill & Owens, 2003; Kubany et al., 2004). The limitation with Kubany, Hill and Owens (2003) and Kubany et al. (2004) study is that they have excluded women that are in abusive relationships; consequently, this may affect the generalisability of their findings.

Methodological Evaluation

Seven of the studies included in the review were published after 1999, and the remaining studies were published between 1991 and 1999 (see Table 2.5). The mean sample size of the studies was 137 (range 20-360). Seven of the studies used a control or comparison group design and two used a single group design. All of the studies reported recruiting their participants through using a convenience sample. Six of the studies randomly assigned their participants to groups and one of the studies used a matched pair design (Reed & Enright, 2006). Only two studies reported in detail how they randomly assigned their participants to groups (Kubany, Hill & Owens, 2003; Kubany et al., 2004).

Table 2.5: *Summary of Methodological Evaluation.*

Population	Study	Study type	Sample Method	Sample Size	Age range	Comparison group
Shelter	Johnson & Zlotnick (2006)	Before and after study	Random sample	56	Range=* (*M*=32, *SD*=7)	None
	Sullivan & Davidson (1991)	RCT	Random sample	46	Range= 17-50 (*M*=26, *SD*=*)	Yes-Control group
	Sullivan et al. (1992)	RCT	Random sample	141	Range=17-61 (*M*=28.5, *SD*=*)	Yes- Control group
	Sullivan & Bybee (1999)	RCT	Random sample	278	Range=18-59 (*M*=29, *SD*=*)	Yes- Control group
Clinic	McFlarlane et al. (2006)	RCT	Repeated measures	360	Range=* (*M*=30.6, *SD*=7.2)	Yes-Comparison group
Community	Kubany et al. (2003)	Cross-sectional	Random sample	37	Range=22-62 (*M*=36.4, *SD*=9.1)	Yes-Comparison group
	Kubany et al. (2004)	Cross-sectional	Random sample	125	Range=18-70 (*M*=42.2, *SD*=10.1)	Yes-Comparison group
	Muelleman & Feighny (1999)	Before and after study	Random sample	183	Range=* (*M*=31, *SD*=*)	None
	Reed & Enright (2006)	Cohort study	Matched pair sample	20	Range=32-54 (*M*=44.95, *SD*=7.01)	Yes – Comparison group
	Rinfret-Raynor et al. (1992)	Cohort Study	Random sample	181	Range=19-60 (*M*=34, *SD*=*)	Yes-Comparison group

Note.*statistic not stated within study.

Follow up Participants

There was a wide range of follow up across the studies ranging from 3 to 24 months. The Sullivan and Bybee's (1999) longitudinal study had the longest follow up time of 24 months. They performed routine follow-ups, every six months, which may have contributed to one of the lowest attrition rates (3%) reported in the review. From their longitudinal study, Sullivan and Bybee's (1999) intervention group reported significantly less violence than controls post intervention

(group x time interaction $F42,60= 2.38$, $p<0.5$). At two years follow up, 89% of women in the control group reported re-abuse, vs. *76% of* women in the intervention group. The study conducted by Reed and Enright (2006) reported follow up results and an attrition rate of 0% however, the length of follow up was unclear. On follow-up, Reed and Enright (2006) found that gains were maintained by FT group compared with AT group, suggesting that FT was more efficacious in reducing anxiety.

Rinfret-Raynor et al. (1992) reported the highest attrition rate (32%). This could be due to the different length of times the interventions had taken to be conducted. In addition, five studies performed a six month follow up with all reporting maintaining gains over time (Johnson & Zlotnick, 2006; Kubany, Hill & Owens, 2003; Kubany et al., 2004; Reed & Enright, 2006; Sullivan et al., 1994). Rinfret-Raynor et al. (1992) conducted a 10 month follow up and McFlarlane et al. (2006) reported an eight month follow up. In McFlarlane et al. (2006) two year follow up, both treatment groups of women reported significantly ($p < .001$) fewer threats of abuse ($M = 14.5$; 95% *CI*=12.6 - 16.4), assaults ($M = 15.5$, 95% *CI*=13.5 - 17.4), danger risks for homicide ($M = 2.6$; 95% CI=2.1 - 3.0) and events of work harassment ($M = 2.7$; 95% *CI*=2.3 - 3.1).

No effects of age were found in the included studies. The highest mean age (M=45, SD=7.01) was reported in Reed and Enright (2006) study and the lowest mean age (M=26, range 17-50) was reported in Sullivan and Davidson (1991) study.

Domestic Violence Measures and Outcome Measures

Within the review, four studies assessed IPV through self report (Muelleman & Feighny, 1999; Sullivan, 1991; Sullivan & Bybee, 1999; Sullivan et al., 1994). Rinfret-Raynor et al., (1992) and Johnson and Zlotnick (2006) used the CTS-2 (Straus et al., 1996) to assess inclusion for treatment of IPV. Other measures used were; the Safety Behaviour Checklist (McFlarlane & Parker, 1994), The Severity of Violence Against Women Scale (Marshall, 1992) and the Danger Assessment Scale (Campbell, 1995) to assess inclusion criteria for their intervention. Reed and Enright (2006) used the Psychological Abuse Survey (adapted from Follingstad, 2000; Follingstad et al., 1990; Sackett & Saunders, 1999), a posttraumatic stress symptom checklist (American Psychiatric Association [APA], 1994), and a psychological screening checklist.

Kubany et al. (2003) and Kubany et al. (2004) used a number of standardised questionnaires to establish inclusion criteria for their studies. The same measures were used as outcome measures to establish if there had been an improvement at post intervention. The Client Satisfaction Questionnaire (Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves, & Nyguen, 1979) was also used as an outcome measure. Reed and Enright (2006) and Johnson and Zlotnick (2006) used a number of other psychological questionnaires to measure outcome.

To measure outcome of physical violence and psychological effects, a majority of the studies used self report, incidence of abuse (MCTS), risk for being re-abused, social support, quality of life, and ability to obtain community resources. One study measured outcome through, the proportion of women who used shelter based counselling, police calls, full order of protection, and repeat

accident and emergency visits for domestic violence after the initial index ED visit (Muelleman & Feighny, 1999).

Intervention

Advocacy Counselling

Focus of Intervention: Five of the studies used an advocacy approach and also had good quality scores (McFlarlane, et al., 2006 [*QS*=78%]; Muelleman & Feighny, 1999 [*QS*=65%]; Sullivan, 1991 [*QS*=69%]; Sullivan & Bybee, 1999 [*QS*=75%]; Sullivan et al., 1994 [*QS*=75%]). The advocacy approach consisted of helping women devise safety plans when needed, provide advice and help contact numbers. Safety plans were individualised based on each woman's history, needs and circumstances (Sullivan, 1991; Sullivan et al., 1994; Sullivan, 1999). In one study an advocate would discuss the incident, address safety issues, educate the women about the cycle of violence, and inform her of resources available in the community (Muelleman & Feighny, 1999).

Duration, Frequency and Period of Intervention: A majority of the interventions lasted for 6 to 14 hours a week for 10 consecutive weeks of one-on-one advocacy counselling (Sullivan, 1991; Sullivan et al., 1994; Sullivan, 1999). In one study the duration of the advocacy group was six months however, frequency of the advocacy group was unclear (Muelleman & Feighny, 1999).

Statistical Analysis: After the initiation of the program, shelter use increased for 11% to 28% ($p<.003$) and shelter based counselling increased from 1% to 15% ($p<.001$). There was no change in repeat police calls (25% versus 35%, $p>.14$), full orders of protection (9% versus 6%, $p>5.8$),

or repeat ED visits for domestic violence (11% versus 8%, $p>.63$; Muelleman & Feighny, 1999). In addition, Sullivan & Bybee (1999) found indviduals who were in the intervention group reported significantly less violence than controls post intervention (group x time interaction $F[42,60]= 2.38$, $p<.05$). At two year follow up, 89% of women in the control group reported re-abuse, versus 76% of women in the intervention group (Condition x Time interaction $F[l, 263]= 4.91$, $p<.05$). The intervention group was better able to obtain resources and reported higher satisfaction with social support and improved quality of life across time. These gains were maintained over a two year follow up period. Both the groups had similar results on participants' decrease of depression.

Psychoeduction and Cognitive Behavioural Skills

Focus of Intervention: Three studies with high quality scores of 70% (Johnson & Zlotnick, 2006) and 95% (Kubany et al., 2003; Kubany et al., 2004) looked at victims suffering from one of the most common effects of domestic violence, PTSD. One of the interventions they used included the CTT-BW intervention (the cognitive trauma therapy for battered women with posttraumatic stress disorder). This intervention includes; trauma history exploration, PTSD education, stress management, self-monitoring of negative self-talk, cognitive therapy for guilt, modules on self-advocacy, assertiveness, and how to identify perpetrators.

The HOPE intervention (helping to overcome PTSD; Johnson & Zlotnick, 2006) focuses on psychoeducation regarding interpersonal violence, PTSD, and safety planning. Earlier sessions also focus on teaching women information and skills that empower them to establish their independence

and to make informed choices. Later sessions of HOPE incorporate established cognitive–behavioral skills to manage PTSD and its associated features (e.g. cognitive-restructuring, managing triggers) and optional modules that address some of the co-occurring problems frequently found in abused women.

Duration, Frequency and Period of Intervention: Kubany et al. (2003) and Kubany et al., (2004) reported that the duration of the interventions was between eight to eleven sessions, which were conducted twice per week for 1.5 hr (Kubany et al., 2003; Kubany et al., 2004). The HOPE sessions were conducted twice per week (9-12 sessions in total; Johnson & Zlotnick, 2006). A qualified therapist conducted the sessions in all three papers (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004).

Statistical Analysis: In the first analysis, a significant interaction effect involving treatment group and measurement period was observed, $F(1, 70) = 127.85$, $p<.001$. This F ratio reflects a significant improvement between Assessment 1 and Assessment 2 for the immediate CTT-BW group, $F(1, 44) = 334.94$, $p<.0001$, but no change for the delayed group, $F(1, 26) = 3.35$, $p>.05$ (Kubany et al., 2003; Kubany et al., 2004).

Kubany et al. (2003) and Kubany et al. (2004) found a significant Treatment Group x Measurement Period interaction was also observed in the second MANOVA, $F(1, 70) = 70.72$, $p<.0001$. As before, this reflected significant improvement on the composite of dependent measures for the immediate treatment group, $F(1, 44) = 132.73$, $p<.0001$, without corresponding changes among

those in the delayed group, $F(1, 26) = 2.92$, *ns.* In the third MANOVA, a significant Group x Period interaction, $F(1, 70) = 89.33$, $p<.0001$, was again observed. In this instance, both groups showed some improvement and there was a greater degree of improvement for the immediate treatment group, $F(1, 44) = 244.68$, $p<.0001$, than the delayed treatment group, $F(1, 26) = 4.55$, $p<.05$. Compared with pre-therapy assessments, there were also significant reductions in depression ($M = 83\%$), trauma-related guilt ($M = 83\%$), trauma-related guilt cognitions ($M = 82\%$), and shame ($M = 72\%$). In addition, self-esteem scores increased by a mean of 92%.

Additionally, Johnson and Zlotnick's (2006) intent to treat analyses indicated that participants experienced significant decreases in PTSD symptoms, depressive symptoms, in their loss of resources and degree of social impairment. There were significant increases in their effective use of community resources. All three studies had a follow up of three months, and gains were maintained over time.

Forgiveness Intervention

Focus of Intervention: One study (*QS*=69%) looked at Forgiveness Therapy (FT) which has a manualised protocol for treatment (Reed & Enright, 2006). The treatment includes defining forgiveness (what it is and is not) with a noted distinction between forgiveness and reconciliation. It examined psychological defences, understanding anger, examining abuser-inculcated shame and self-blame. It also explores cognitive rehearsal, making a commitment to the work of forgiving, grieving the pain and losses from the abuse. In addition, the therapy also looks at reframing the former abusive partner (his personal history, fallibility, and culpability; the unfair, unequal power

established by his abusive behaviour; his inherent worth), and exploring empathy and compassion. The therapy helps the victim practices goodwill (i.e., merciful restraint, or foregoing resentment or revenge; generosity; and moral love), finding meaning in unjust suffering and considering a new purpose in life of helping others. The intervention can be delivered one to one, and in group interventions.

Duration, Frequency and Period of Intervention: The duration and frequency of the intervention was not clear, the interventions lasted for 11 months. What was reported in the study was that the researcher interviewed the participants at baseline, and then at 6, 8 and 12 months post intervention (Reed & Enright, 2006).

Statistical Analysis: Participants in FT experienced significantly greater improvement than the participants in AT treatment group. FT participants demonstrated a statistically significantly greater increase in forgiving the former abusive partner, $t(9) = 5.80$, $p<.001$; in self-esteem, $t(9) = 2.12$, $p<.05$; in environmental mastery (everyday decisions), $t(9) = 1.84$, $p<.05$; in finding meaning in suffering (moral decisions), $t(9) = 2.34$, $p<.05$; and in new stories (survivor status), $t(9) = 3.58$, $p<.01$. The experimental group demonstrated a statistically significantly greater reduction in trait anxiety, $t(9) = -2.43$, $p<.05$; in depression, $t(9) = -1.88$, $p<.05$; in posttraumatic stress symptoms, $t(9) = -2.54$, $p<.05$; and in old stories (victim status), $t(9) = -5.01$, $p<.001$. The gains were maintained at follow-up (M =8.35 months, SD 1.53). FT has implications for the long-term recovery of post-relationship emotionally abused women. Gains made by FT group

compared with AT group suggested that FT was more efficacious in reducing anxiety (Reed & Enright, 2006).

Feminist Model

Focus of Intervention: One study (*QS*=65%) focused on a therapy based on the feminist model (Rinfret-Raynor et al., 1992). The intervention progressively shifts from reducing tensions and providing support for the woman's decision, to reducing victim behaviour's by helping her regain her self-esteem and her autonomy. The model can be applied in the form of individual intervention or of group intervention (Rinfret-Raynor et al., 1992).

Duration, Frequency and Period of Intervention: The period of the intervention lasted between 5 and 10 months and was delivered b a qualified therapist. The session time and frequency of the intervention was unclear.

Statistical Analysis: Intervention had a reduction in anxiety, depression, and somatisation. Out of 69 women who were living with a partner at the start of the intervention, 39.1 % left. Violence had stopped for 21.7% of women in the sample (35/161) at the post-test, for 24% (30/124) at the first follow-up interview and for 11.4% (14/123) at the last interview. There was improvement in socio-economic change for 52% of participants at follow. The superiority of individual intervention of the feminist model over the other individual approaches studied was rejected by the research. The comparison group intervention contributed more to an increased use of reasoning by partners or ex-partners while individual intervention in the experimental group contributed slightly more to

reducing physical aggression (Reed & Enright, 2006). In addition, Table 2.6 gives a summary of the main findings from the result section.

Table 2.6: *Outcome of Studies by Sample Type.*

	Study	Outcome measure	Intervention type	Outcome	Quality score *(QS)*
Shelter	Johnson & Zlotnick (2006)	PTSD, depressive symptoms, loss of resources and degree of social impairment, use of community resources and overall adjustment.	Psycho-education, cognitive–behavioural skills to manage PTSD and optional modules (e.g., substance use and grief).	Decrease in PTSD depressive symptoms, loss of resources and degree of social impairment Increases in use of community resources and overall adjustment.	70%
	Sullivan & Davidson (1991)	Incidence of abuse (MCTS), risk for being re-abused, social support, quality of life, and ability to obtain community resources.	Advocacy services. Safety plans individualised on the basis of each woman's history, needs and circumstances.	10% of the sample was re-abused within the 1st 10 weeks and additional 10% within 10 weeks. Advocacy only helpful short term.	69%
	Sullivan et al. (1994)	Incidence of abuse (MCTS), risk for being re-abused, social support, quality of life, and ability to obtain community resources.	Advocacy services. Safety plans individualised on the basis of each woman's history, needs and circumstances.	Decrease in physical abuse. More access to resources and greater quality of life.	75%
	Sullivan & Bybee (1999)	Incidence of abuse (MCTS), risk for being re-abused, social support, quality of life and ability to obtain community resources.	Advocacy services. Safety plans individualised on the basis of each woman's history, needs and circumstances.	Decrease in physical intervention group was better able to obtain resources ad reported higher satisfaction with social support and improved quality of life across time. Decrease in depression.	75%
Clinic	McFlarlane et al. (2006)	Differences in the number of threats of abuse, assaults, danger risks for homicide, events of work harassment, safety behaviours adopted, and use of community resources between intervention groups.	20 minute nurse case management protocol. 15-item safety plan brochure from the March of Dimes protocol, including supportive care Guided referrals and anticipatory guidance.	Decrease in threats of abuse assaults, danger risks for homicide and events of work harassment. Increase in more safety behaviours.	65%
Community	Kubany et al. (2003)	PTSD, depression	CTT-BW and psycho-education	Reductions in depression, trauma-related guilt, trauma-related guilt cognitions and shame, Self-esteem scores increased.	95%
	Kubany et al. (2004)	PTSD, depression	CTT-BW and psycho-education.	PTSD remitted in 87% of women who completed Reductions in depression and guilt and substantial increase in self esteem.	95%
	Muellem an & Feighny (1999)	Proportion of women with shelter use, shelter based counselling, police calls, full order of protection, and repeat ED visits for domestic violence after the index ED visit.	Advocate would discuss the incident, address safety issues, educate the women about the cycle of violence, and inform her of resources available in the community. Given educational information to take away.	Shelter use increased, shelter based counselling increased, no significant change in repeat police calls or full orders of protection or repeat ED visits for domestic violence. Increase in self esteem and decrease in PTSD.	65%
	Reed & Enright (2006)	depression, anxiety, and posttraumatic stress symptoms and more self-esteem, environmental mastery, and finding meaning in suffering	FT treatment-manualised	Decrease in depression, trait anxiety, posttraumatic stress symptoms, self-esteem, forgiveness, environmental mastery, and increase in finding meaning in suffering.	69%
	Rinfret-Raynor et al. (1992)	Anxiety, depression, and somatisation.	The feminist model	Decrease in anxiety, depression and somatisation.	65%

Discussion

Main Findings of the Review

The systematic review aimed to look at the effectiveness of treatment for victims of IPV. The results of this review are discussed in terms of the four main objectives identified earlier on in the review.

1. *To Determine if IPV Women Interventions Reduce the Effects of IPV from pre-post intervention.*

All of the studies found a direct association between IPV and psychological effects that individuals were experiencing. Therefore, one of the main aims of the studies was to prevent re-abuse and/or psychological effects experienced by IPV victims. Some of the studies also looked at safety behaviours (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004; McFlarlane et al., 2006; Muelleman & Feighny, 1999; Sullivan & Davidson, 1991; Sullivan et al., 1994).

The studies found that there was a reduction in psychological symptoms, with most of the studies reporting these reductions were maintained over time. There was a decrease in PTSD (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004; Muelleman & Feighny, 1999; Reed & Enright, 2006; Sullivan & Davidson, 1991), depression (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004; Rinfret-Raynor et al., 1992; Reed & Enright, 2006; Sullivan, 1999), anxiety (McFlarlane et al., 2006; Rinfret-Raynor et al., 1992; Reed & Enright, 2006), somatisation (Rinfret-Raynor et al., 1992; Sullivan, 1999), trauma related guilt and trauma related cognitions (Kubany et al., 2003; Kubany et al., 2004; Rinfret-Raynor et al., 1992; Reed & Enright). There was

also an increase in self esteem (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004; Muelleman & Feighny, 1999, Reed & Enright), quality of life (Rinfret-Raynor et al., 1992; Sullivan et al., 1994; Sullivan, 1999) and safety behaviours (Johnson & Zlotnick, 2006; McFlarlane et al., 2006; Sullivan, 1999).

a. To Determine Which Treatment is More Effective.

The review failed to establish enough data to validate which treatment was more effective. Hence, the review explored what factors were the same across the treatment to make them more effective.

b. To Determine What Makes Treatment Effective.

Most of the studies looked at an advocacy based approach (Muelleman & Feighny, 1999; McFlarlane et al., 2006; Sullivan & Davidson, 1991; Sullivan, 1999). Three studies looked at a psycho education and cognitive behavioural skills approach (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004), one study looked at FT (Reed & Enright, 2006) and another study looked at a feminist based approach (Rinfret-Raynor et al., 1992). These interventions mainly targeted the behavioural repertoire and motivating factor units of Bell and Naugle (2008) model.

One-to-one long term interventions appeared to make treatment more effective, with sessions normally lasting one hour a week. For the majority of the studies, having a qualified or trained individual conducting the session seemed more effective and beneficial for participants (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kubany et al., 2004; McFlarlane et al., 2006; Muelleman & Feighny, 1999; Sullivan & Davidson, 1991; Sullivan, 1999).

2. To Determine if IPV Women Interventions Reduce the Risk of Re-abuse.

If considering clinical rather than statistical significance, the most significant change for advocacy intervention was reported by Sullivan et al. (1999). The intervention group reported significantly less violence than controls post intervention (group x time interaction $F[42, 60]= 2.38$, $p<0.5$). At two years, 89% of controls reported re-abuse, versus 76% of women in the intervention group. For the feminist model approach violence had stopped for 21.7% of women in the sample (35/161) at the post-test, for 24% (30/124) at the first follow-up interview and for 11.4% (14/123) at the last interview (Rinfret-Raynor et al., 1992). The problem in this review was that four studies recruited participants who were no longer in violent relationships; therefore, re-abuse was not a possible outcome (Johnson & Zlotnick, 2006; Kubany et al., 2003; Kuban et al., 2004; Reed & Enright, 2006).

3. To identify which ethnic groups were included within studies.

Out of the nine studies only two made comparisons across ethnicity and found that CTT-BW was efficacious across ethnic background (Kubany et al., 2003; Kubany et al., 2004). However, further exploration of their ethnic groups showed that the two studies were not as diverse as the majority of the participants were White.

Seven of the studies gave an ethnic breakdown but did not take this further and look at any associations between ethnicity and intervention (Johnson & Zlotnick, 2006; McFlarlane et al., 2006; Reed & Enright, 2006; Sullivan, 1991; Sullivan & Bybee, 1999; Sullivan et al., 1992). Of the studies seven included White, three African American, four Black, two European Americans,

four Hispanic and five included other ethnicity. Overall the largest ethnic groups in each study was White and then African American participants.

Two of the studies did not give an ethnic breakdown (Muelleman & Feighny, 1999; Rinfret-Raynor et al., 1992).

Strengths and Weaknesses of the Review

The current review includes different interventions for treating physical, sexual and psychological abuse amongst abused women. Whilst this may have led to false negatives in findings, this inclusion is likely to be a positive factor in this review. In MacMillan et al. (2001) systematic review, they may have introduced an element of bias by looking at two different interventions from five studies in treating abused women. By looking at all types of abuse and intervention as part of the inclusion criteria, it strengthened the relevance and applicability of the review findings to a larger and less specific population.

The sample size was a weakness in the review as some of the studies had small samples (e.g. Johnson & Zlotnick, 2006; Kubany et al., 2003; Reed & Enright, 2006), consequently making it hard to generalise the results. Due to the sensitivity of the subject it can be difficult to recruit large samples for the studies (Dutton & Painter, 1993). There were also large drop-out rates for victims of domestic violence interventions (MacMillan et al., 2001; Dutton & Painter, 1993). This could be due numerous reasons such as participants may go back to their abusive partner or financial

constraints. The sample within this review consisted of clinical, shelter and community samples which was realistic and therefore makes the review more applicable to the general population.

In the last two decades, there has been growing research to support the notion that males can also be victims of IPV, and that there are a growing number of women perpetrators of IPV (Archer, 2000). However, this review did not address interventions tailored to male victims or women perpetrators, therefore being a limitation of this review. This is because despite growing research most of the current treatments available in today's society which have been identified by this review still have a feminist based approach to treatment, that women are victims and men are perpetrators (MacMillan et al., 2001).

Methodological Considerations

To reduce bias in a review it is important to consider the methodology used, in order to assist future research in conducting methodologically sound research. Although existing reviews assisted the author, the inclusion/exclusion criteria utilised by MacMillan et al. (2001) differed greatly to the current review. MacMillan et al. (2001) looked at effectiveness of battered women interventions; however, this was just part of a number of issues they addressed. This therefore limited the references and statistical information provided.

In order to produce a large amount of methodologically valid studies this review used quality assessment forms to assess each study. The limitation of using quality assessments forms in this systematic review was that the author may have lost studies and valuable findings which may have

contributed towards the objectivities of this review. However, in order to have quality findings, such quality assessments forms are necessary. Furthermore, when conducting the search the author had a number of hits, which may have led to feasibility issues arising. However, the search strategies employed in this review were very thorough and inclusive. In addition, a problem with most systematic review is producing bias through the inclusion and exclusion process. Another issue that arose when trying to gain access to references was financial constraint. Financial constraints contributed to the exclusion of articles in languages other than English.

Interpretation of the Findings

One of the difficulties with studies of interventions for IPV is selecting appropriate outcome measures (MacMillian et al., 2001; Muelleman & Feighny, 1999). Consequently, most studies do not provide the results of physical or psychological examinations. Some studies, especially those describing interventions for women, do not provide abuse outcomes per se, and the main measures are such outcomes as the amount of social support the women have access to, their use of safety behaviors or safety planning, or their use of community resource.

The link between these types of outcomes and subsequent abuse has not been empirically established (MacMillan et al., 2000). Furthermore, studies that use re-abuse as an appropriate measure suffer from several flaws. For instance, a woman may not go back herself and may not have control over whether she is abused again as she may go back due to economic reasons. Therefore, some authors claim that the significant outcomes should be determined by the women

themselves (e.g. Sullivan, 1998). Therefore, an alternative outcome of incidence of abuse, generally self-reported, is often used.

As evidenced by this review, there are limited studies that have looked at ethnicity and IPV intervention. This could be due to a number of factors; firstly, obtaining a general sample of victims of IPV is difficult due to the nature and sensitivity of this topic. With BME communities there are additional factors of women coming forward and volunteering in studies such as; language barriers, lack of awareness of services and religious and cultural factors. In addition, there are practical problems with obtaining representative samples of cultures (and subcultures) where patriarchal values are part of the traditions of a closed community; this issue was discussed in the introduction.

Clinical Generalisability

Within this review, eight studies used standardised measures in order to measure outcome to obtain data that is more valid. The standardised measures use a number of variables in order to see whether the intervention was effective or not, this therefore, making the review more applicable to the population of interest.

It must be noted that even though the researchers tried to control confounding variables, many of the women in the samples were financially dependent on their husbands, isolated and mainly uneducated. The role that these factors may play on some of the effects that the women may be experiencing might not be all due to the domestic violence (Johnson & Zlotnick, 2006; Kubany et

al., 2003; Kubany et al., 2004; Muelleman & Feighny, 1999; Reed & Enright, 2006; Sullivan & Davidson, 1991). Another factor that was not studied was ethnic diversity. This may enhance some of the effects of IPV and add other variables preventing women from leaving the relationship.

Furthermore, the participants within all of the studies volunteered to be part of the research. This then puts into question why some women who are in abusive relationships or have been in abusive relationships do not include themselves in research studies. Due to the nature and sensitivity of the topic area it is not surprising why some women do not come forward. However, this may affect the clinical generalisabilty of the review findings, as those women who volunteer may represent a different sample to those women who do not volunteer. As such, this may have implications for treatment and treatment outcomes?

Recommendations for Practice

Findings from the current review support the need for more initiatives to be aimed at providing intervention programs for abused women. Although such interventions may be costly, the costs of implementing such interventions outweigh the effects and costs it has on individuals, children, families, and society. The review found that intervention does not have to be complex or expensive, even a simple advocacy based service can help reduce the damage that IPV can cause. However, in more complex cases short term intervention is not enough and more long-term intervention with a qualified therapist will help in elevating the effects of domestic violence in some women.

In addition, the measurement of the effect of interventions may need to incorporate the fact that women are in various stages of change. The process of moving towards freedom from violence will require targeting interventions to fit the woman's current stage and help her move forward to the next stage. In addition, treatment programmes need to move forward from their feminist based approach and be more evidence based, taking into account more up-to-date research.

Most of the treatment programmes reviewed did not consider cultural or ethnic differences as a factor. A number of studies did state that they were ethnically diverse. However, a closer look at the ethnic groups showed that the ethnic participants were not as diverse and there was evidence of ethnic lumping. The numbers of participants from ethnic minorities was small and mainly covered the Latino or Black population. This puts into question the reliability and validity of these treatments programme in regards to their cross-cultural applicability. Therefore, more research needs to be conducted with more diverse BME groups (e.g., South Asian population).

Recommendations for Future Research

This systematic review clearly identifies the need for additional research employing rigorous designs to test the effectiveness of IPV interventions on important clinical outcomes. The following issues need to be addressed, both to allow primary health care providers to respond appropriately to IPV and to inform a more proactive approach to prevention at the level of public policy. In addition, most of the studies did not consider ethnic diversity; therefore, more research needs to be conducted with more a more diverse BME populations e.g. South Asian population.

Conclusion

Findings from this review show that interventions are effective in reducing effects of IPV and increase quality of life. Interventions are more effective when there is a combination of advocacy service and therapy in particular a cognitive behavioural approach to look at psychological trauma by a qualified therapist. In addition, when interventions are tailored to the individual's stage of change it is likely to be more effective. However, due to the limited empirical studies that have been conducted within this area the strength of this link is still questionable. Therefore, further research needs to be conducted looking at what variables make treatment effective, on larger samples and/or more culturally diverse samples.

To get a more comprehensive examination of IPV treatment Chapter two goes on to explore IPV intervention through an individualised case study, ME. Chapter 2 examines how witnessing and experiencing a range of abuse including IPV affected a 48 year old BME African Caribbean woman who has a diagnosis of paranoid schizophrenia. It has been found that trauma experiences such as witnessing and experiencing abuse and IPV are increasingly being recognised as important in the onset and maintenance of psychosis and these findings support the finding of effects of IPV discussed earlier in this Chapter. The findings of Chapter 1 aided and contributed to the development of the treatment plan for the case study in Chapter 2, by applying CBT. It will be shown that CBT was also an effective treatment for distress of psychotic symptoms (discussed in Chapter 2).

CHAPTER 2:

Case study ME: Female inpatient with a diagnosis of paranoid schizophrenia and a history of witnessing parental violence, experiencing sexual abuse and intimate partner violence.

This chapter is not available in the digital version of this thesis.

CHAPTER 3:

Psychometric Test Critique: Critical Review of the Conflict Tactics Scales-2

Introduction

This review examines the Conflict Tactics Scales-2 (CTS-2; Straus, Hamby, Boney-McCoy & Sugarman, 1996) in terms of its scientific properties, focusing also on its cultural applicability in assessing intimate partner violence (IPV) within South Asian communities. Accordingly, the review will first give an overview of the CTS-2, its potential use and the content of the tool. After which the review will examine the reliability and validity of the CTS-2. It must be noted that there are two main versions of the CTS-2, the CTS-2 and the Child-Parent CTS (CPCTS; Straus, Hamby, Finkelhor, Moore & Runyan, 1998). For the purpose of this review only the CTS-2 will be discussed.

Overview of the Conflict Tactics Scales (CTS-2)

The CTS (original version) was created in 1979 by Murray A. Straus (Straus, 1979) and is based on conflict theory (Adams, 1965; Coser, 1967; Dahrendorf, 1959; Scazoni, 1972; Simmel, 1955; Straus, 1979). This theory assumes conflict is an inevitable part of all human associations, whereas violence as a tactic to deal with conflict is not.

The CTS (original version) measures behaviour and the extent to which both partners in a dating, cohabiting, or martial relationship engage in psychological and physical attacks on each other, and also their use of reasoning or negotiation to deal with conflicts (Straus, 1979). CT Scales are not intended to measure attitudes about conflict or violence nor the causes or consequences of using different tactics (Straus et al., 1996; see Table 2.1).

Table 4.1: *CTS-2 Scales: Definition and Number of Items.*

Scales	Definition	Number of Items
Negotiation	"Actions taken to settle a disagreement through discussion" (Straus et al., 1996; p. 289)	6 items (3 emotional & 3 cognitive items).
Psychological Aggression	Both verbal and non verbal aggressive acts	8 items (4 minor & 4 severe items).
Physical Assault	Physical assault by a partner e.g. kick, punch, slap	12 items (5 minor & 7 severe items).
Sexual Coercion	"Behaviour that is intended to compel the partner to engage in unwanted sexual activity" (Straus et al., 1996; p. 290)	7 items (3 minor & 4 severe items).
Physical Injury	"Measures partner inflicted physical injury, as indicted by bone or tissue damage, a need for medical attention, or pain continuing for a day or more" (Straus et al., 1996; p.290)	6 items (2 minor & 4 severe items).

The CTS-2 is the most widely used instrument for identifying IPV (Straus, 2001). The CTS (original version) or the CTS-2 have been used in over 70,000 empirical studies and about 400 peer reviewed scientific or scholarly papers (see Acierno, 2000), including longitudinal birth-cohort studies (i.e., Moffitt & Caspi, 1999). Additionally, at least ten books reporting results based on the CTS (original version) or CTS-2 have been published (e.g., Straus, 2001; Straus & Gelles, 1990; Straus, Gelles & Steinmetz, 1980).

As the CTS (original version) was widely used, it was examined and a number of suggested revisions were made (Straus et al., 1996). The revised CTS was known as the CTS-2. The theoretical basis and mode of operationalisation are fundamentally the same for the CTS (original version) and CTS-2. The main changes included, the addition of two scales (the injury scale and sexual coercion scale); improving items by changing them or clarifying the wording; adding new items; improving operationalisation of minor and severe for all categories; and a more simplified format/questionnaire (see Straus et al., 1996).

The CTS-2 includes 78 items; half referring to the respondent's behaviour and half to the partner's behaviour. The frequency of each item is rated on an eight-point sale; never, once, twice, 3-5 times, 6-10 time, 11-20 times, more than 20 times, or "not in the past year but did happen before". This produces "Self" and "Partner" scores for five dimensions of negotiation, psychological aggression, physical assault, injury scale and sexual coercion (see Table 1). In addition, items are categorised as either mild or severe; mild physical assaults include "restraining physically" to "threatening with a knife/weapon" while severe physical assaults include "beating up" and "choking/asphyxiating".

The CTS-2 is a versatile tool which can be used and administered in various settings (in-person interview, telephone interview, self administered questionnaire, and computer administered questionnaire). The CTS-2 is also available in a number of languages (English; Chinese; Dutch; Finish; Flemish; French; German; Hebrew; Italian; Korean; Portuguese; Russian; Sesotho; Spanish; Swedish; Zulu).

Reliability

Internal Consistency

Internal consistency is the extent to which tests assess the same characteristic, skill or quality. This type of reliability often helps researchers interpret data and predict the value of scores and the limits of the relationship among variables (Breakwell, Hammond, Fife-Shaw & Smith, 2006).

Straus et al. (1996) reported that adding additional scales and items to the CTS-2 increased its reliability. Alpha coefficients of reliability for the CTS-2 reported in 41 articles ranged from .34 to .94, with a mean of .77 (Straus, 2005). A study of the CTS-2 in 17 nations (student population) found similar results (Straus, 2004) making the tool more applicable cross-culturally.

However, Straus (2007) reported that the occasional low alpha coefficient occurred when the behaviour measured by some of the items (e.g., attacking a partner with a knife or gun) was absent or nearly absent in some samples (Straus, 2007). In addition, for India (a South Asian Country) the internal consistency reliability was high (Straus, 2004; see Table 3.2).

Table 4.2: *Alpha Coefficients of Reliability for India (Straus, 2004).*

	n.	**Physical Assault**	**Physical Injury**	**Sexual Coercion**	**Negotiation**	**Psychological Aggression**
India	74	.93	.92	.90	.89	.81
Male	18	.93	.97	.98	.92	.75
Female	57	.93	.91	.86	.88	.81

One of the main criticisms of the CTS-2 is that a majority of the studies assessing the reliability and validity of the CTS-2 have used a student and/or dating sample, therefore there is a question over its applicability in the general population (Hamel & Nicholls, 2007). In addition, Meyer,

Vivian and O'Leary (1998) reported that the CTS-2 had higher internal consistencies in a dating sample on the sexual aggression scale than found in a community sample. The sexual aggression scale was found to have a very low internal consistency in a community sample, whereas the psychological and physical aggression scales had strong internal consistencies (Meyer et al., 1998). Therefore, it was suggested by Hamel and Nicholls (2007) that scales such as the Koss Scale (Koss & Gidycz, 1985) and a variation of the Koss Scale used by Meyer and colleagues (1998) may be more suitable to assess sexual aggression in a community sample because they have higher internal consistencies and therefore the results are more reliable. However, Straus et al. (1996) argues that the factor structure of the student sample is very similar to that of clinical and national samples (see Straus, 1979, 1990).

Test-re-test Reliability

Test–retest reliability examines if a test yields the same score for a person on different occasions. If a test fails to yield the same score for a subject then this affects the reliability (Kline, 1986). The CTS-2 has very high test-retest reliability (Straus, 2004).

According to Straus (2007) there have been more studies reporting higher alpha coefficient (which only measure's internal consistency) for the CTS-2 than test-retest reliability studies. Therefore, there appeared to be no data for test–retest reliability for cross- cultural studies. Straus (2007) explains that this is because it requires testing the same subjects on two closely spaced occasions and obtaining this sample generally is difficult, and therefore more difficult when trying to obtain this sample cross culturally. The absence of test-retest reliability is typical of social and

psychological measures, including the CTS-2 (Straus, 2004), and the Trauma Inventory (Piedmont, 2007). Nonetheless, Straus (2007) identified two samples (student population) that conducted test-retest reliability. The coefficients for the various scales ranged from .49 to .90 with a mean of .72 (Straus, 2007) showing a high test re-test reliability.

Furthermore, Vega and O'Leary (2007) studied a sample of 82 men who were court-mandated to a batterer intervention programme. They found that the test-retest reports of physical assault (r = 0.76) and injury (r = 0.70) were over 0.70, showing high reliability. However, reliability was weaker for psychological aggression (r = 0.69), and negotiation (r = 0.60), but even weaker for sexual coercion (r = 0.30). Overall, the test re-test reliability for some of the scales on the CTS-2 have good reliability besides sexual coercion. However, due to the lack of evidence for test-retest reliability caution needs to be taken when analysing data, especially when applying the CTS-2 cross-culturally.

Validity

Face Validity

Face validity is related to content validity. Face validity is not validity in the technical sense; it refers not to what the test actually measures but to what it appears superficially to measure. Face validity pertains to whether the test looks valid to the examinees who take it, the administrative personnel who decide on its use, and other technically untrained observers (Kline, 1986). Straus et al (1996) and Vega and O'Leary (2007) reported that the CTS-2 measures the actual occurrence of violence and as a result has 'face' validity. However, the limitation in having high face validity,

which the CTS-2 does, is that the measure is transparent and therefore this may have an effect on how a participant may answer the questions. There is ample evidence in the psychology literature that suggests that respondents like to give the answers that they believe the interviewer wants to hear (Schwartz, 1999). To overcome face validity and to avoid bias, a number of measures can be put in place (e.g., asking for examples after questions, collecting data using more than one instrument and comparing the results across the methods and blind responding; Reenen, & Bloom 2009).

Criterion Validity

Criterion validity is a measure of agreement between the results obtained by the given survey instrument and more objective results for the same population (Breakwell, et al., 2006). The objective results are obtained either by a well established instrument or by direct measurement. The criterion validity may be quantified by the correlation coefficient between the two sets of measurements (Shuttleworth, 2009). Criterion validity can be split into two basic forms, predictive validity and concurrent validity. Predictive validity involves the measure being compared with some future event. However, there are no studies that have looked at the predictive validity of the CTS-2. Concurrent validity involves the measure being compared with a measure obtained at the same time (Shuttleworth, 2009). However, Straus and Gelles (1990) argued that it is difficult to measure the concurrent validity of the CTS (original version), as this association cannot be determined if the CTS (original version) is the only measure of the phenomenon or if (rightly or wrongly) other measures are thought to be inaccurate or invalid.

Therefore, one approach taken to investigate the concurrent validity of the CTS (original version) has been to examine the level of agreement between CTS (original version) scores as reported by more than one family member. The importance of viewing couple agreement as an indication of the validity of the CTS (original version) as a measure of spouse abuse is stressed by Edelson and Brygger (1986) and Szinovacz (1983). Browing and Dutton (1986) found that each partner tended to under report his or her own violence. The mean violence index was 9.3 as reported by the husband, but almost twice as high (17.3) as reported by their wives; the mean index score for violence by wives was 6.7 as reported by their husbands, but only 3.9 as reported by the wives. The correlation between spouses for husband's violence was .65, but only .26 for violence by the wife. In addition, Jouriles and O'Leary (1985) found coefficients for husband's violence were .43 for the therapy sample and .40 for the community sample, compared to .40 for wife violence therapy sample and .41 for the community sample.

For the CTS-2, the criterion validity was evidenced by eight of the CTS-2 scales and the Past Feelings and Acts of Violence Scale (PFAV; see Cervantes, Duenas, Valdez & Kaplan, 2006). In addition, there are now more than a hundred published studies using the CTS (original version) and CTS-2, but only five examined concurrent validity (Straus, 2004). All five found that the CTS-2 is correlated with other measures of approximately the same constructs (Straus, 2007). For instance, the concurrent validity of the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER) and Novaco Anger Scale was demonstrated by their high positive correlations with the CTS-2 scores (see Au et al., 2008). However, scales such as B-SAFER were based on the original CTS, and therefore may have contributed to the high positive correlations with the CTS-2 scores.

It must be noted that the CTS-2 is not a psychological/psychometric test, and the handbook does not include broad-based standard scores or information about diagnostic interpretation. Straus (2007) argues that to date there is no better instrument then the CTS-2 in measuring conflict between partners Therefore, from looking at the criterion validity of the CTS-2 it would be a good indicator of measuring conflict between partners, however other appropriate measures would also have to be used alongside the CTS-2 to measure attitudes, causes or consequences.

Content Validity

Content validity evidence involves the degree to which the content of the test matches a content domain associated with the construct (Breakwell et al., 2006). In order to improve content validity, the CTS (original version) items were revised and new items added. This was done on the basis of the experiences of the researchers of the CTS (original version), a review of critiques, additions, and related measures or modifications of the CTS (original version; such as Campbell, 1995; Dobash & Dobash, 1979; Grotevant & Carlson, 1989; Margolin, 1991; Marshall, 1992; Neidig, 1990; Saunders, 1992; Statistics Canada, 1993; Tolman, 1989). Additionally, in order to select items a statistical criterion was used which included, eliminating items with a bimodal distribution, examining internal consistency, and for the psychological aggression scale an additional statistical criterion chi-square was used. Then a conceptual criterion was used which included; eliminating similar items; examining the level of reading skill required to understand the item; and researchers judgment concerning the importance of each item as an indicator of the latent dimension measured by the scale (see Straus et al., 1996).

Like most tests the CTS-2 includes only a sample of possible violent acts. Although the behaviours in the CTS-2 may be valid, the methods used to select behaviours to include in the CTS-2 do not guarantee that they are an adequate sample of violent behaviours. Nonetheless, one indication that they are an adequate sample comes from a study by Dobash, Dobash, Cavanagh and Lewis (1994) who are among the most strident critics of the CTS (original version). They used qualitative methods to identify typical violent acts. However, their list of violent acts is almost identical to the items in the CTS-2 (Straus, 2007).

When revising the items in the CTS-2 the researchers had taken into account the necessity to balance the competing objectives of a scale that is short enough to be practical to use in typical research and clinical settings, with the objectives of a scale that is long enough to provide an adequate level of reliability (Straus et al., 1996). The brevity of the CTS-2 makes its use possible in situations which preclude a longer instrument. However, its brevity is also a limitation because it means that the subscales are limited to distinguishing minor and severe levels of each of the tactics. For example, with only eight items the psychological aggression scale cannot provide subscales for separate dimensions such as rejecting, isolation, terrorising, ignoring, and corrupting (Straus, 2007).

Construct Validity

To demonstrate construct validity a test must be correlated with other variables with which it should be theoretically associated (Campbell & Fiske, 1959). Research shows that the psychological aggression and physical assault scales should be more highly correlated with the

sexual coercion scale for men then for women (Straus et al., 1996). Straus et al. (1996) found significant correlations between, psychological aggression and sexual coercion (r = .66 for men and .25 for women, r = 4.53, p<.01); and physical assault and sexual coercion (r = .90 for men and .26 for women, r = 10.17, p<.01).

Furthermore, previous research shows that physical assaults by men result in serious injury more often than do assaults by women (Stets & Straus, 1990). High correlations were found between physical assault and injury for men than for women (r =.87 for men and .29 for women, r = 9.10; Straus et al., 1996), therefore adding to the construct validity of the physical assault and injury scale.

The conflict-escalation theory of couple violence argues that verbal aggression against a partner, rather than being cathartic and tension reducing, tends to increase the risk of physical assault (Berkowitz, 1993). Therefore, psychological aggression and physical assault should be highly correlated, which they were (r = .71 for men and .67 for women; Straus et al., 1996).

Moreover, Straus (2004) found evidence of construct validity cross culturally, from examining a number of different student samples from universities across the world. Correlations showed that universities with a high assault rate also tend to have a high injury rate (measured by the CTS-2); the larger the percentage of students at a university who experienced frequent corporal punishment as a child (measured by the CP-CTS), the higher the percentage of students who physically assaulted a dating partner (measured by the CTS-2); and university sites where one partner tends to

be dominant in dating relationships (measured by demographic characteristics questionnaire) tend to have higher rates of assault on dating partners (measured by the CTS-2).

It is important to note, that much of the evidence put forward for construct validity comes from Straus himself and there is not much independent examination. Consequently, one could argue that Straus' findings could be biased.

In addition, a principle of conflict theory (Coser, 1967; Dahrendorf, 1959) is that inequality increases the risk of violence because the dominant person or group may use violence to maintain their position or the subordinate person or group may use violence to make the balance of power more equal. Feminist theorists are major critics of the CTS (original version) and CTS-2 because the instrument finds that about the same percentage of women as men assault their partners. This contradicts the feminist theory that partner violence is almost exclusively committed by men as a means to dominate women (Straus, 2007).

Furthermore, Bhanot and Senn (2007) note that in South Asian countries such as India, women tend to be subordinate in the family. Consequently, it was not surprising that out of the 33 university sites across the world, India had the highest correlation for dominance and physical violence (over .70; where males tended to be more dominant in the dating relationships there were higher rates of physical assaults on their partners). Therefore, these correlations provide supplementary evidence for the construct validity of the CTS-2 physical assault scale in South Asian countries

Appropriate Norms

Due to the nature of the subject (partner violence) most studies were based on convenience samples. Consequently, most studies using the CTS (original version) and CTS-2 did not use control groups (Straus, 2005). Furthermore, a limitation of most studies using the CTS-2 is that the results refer to the behaviour of university students and may not apply to the general population and especially not to the low-income and low-education sectors of the population (Straus et al, 2006; Straus, 2004).

The issue with the majority of data collected within the IPV field and those that use the CTS-2, is that most of the data is collected in a one-dimensional way, participants are volunteers and the responses are mainly self report. Also, these samples initially came from women's shelters (mainly looking at female victims) and now often from student samples (mixed gender). Therefore, the studies are subjected to bias and have implications for the generalisability of these findings to clinical populations (e.g., psychiatric populations).

Nonetheless, the CTS (original version) manual provided percentile norms based on data obtained from the 1975 survey and 1985 national survey (Straus, 1995). Additionally, there is information for many clinical and general population samples in the more up to date CTS-2 Manual (Straus, Hamby & Warren 2003), in the core papers on the CTS (original version) and CTS-2 and in many publications by others (e.g., Hamel & Nicholls, 2007). These rates, mean scores and standard deviations can be used to evaluate specific cases or categories of cases. Despite having limited

cross-cultural normative data which are mainly based on student samples the validity and reliability found in South Asian countries is promising for the CTS-2.

Conclusion

The review has examined the evidence for the reliability and validity of the CTS-2 (see Archer, 1999; Straus, 2005). There is evidence for high internal consistency and construct validity for the CTS-2. There is evidence that the internal consistency is stronger for some scales (i.e. psychological aggression) in a student sample than in a more general community sample.

The review has shown the research and evidence base for the CTS-2. In the case of the CTS (original version) and CTS-2 the most frequent criticisms reflect ideological differences rather than empirical evidence (Coleman & Straus, 1990; Straus, 1995). Specifically, many feminist scholars reject the CTS (original version) and CTS-2 because studies using this instrument find that about the same percentage of women as men assault their partners. This contradicts the feminist theory that partner violence is almost exclusively committed by men as a means to dominate women (DeKeseredy, 2002).

Furthermore, critics of the CTS (original version) and CTS-2 argue that the scales do not provide information about the context in which items occur and therefore may misrepresent the characteristics of violence between partners (DeKeseredy, 2002; Kimmel, 2002).Also, the CTS-2 fails to separate aggressive abuse from assaults used in self-defense. The designers of the CTS (original version) and CTS-2 agree that the context and other variables are important in studying

an phenomenon, but point out that the CTS (original version) and CTS-2 is a measure of behaviour and not intended to measure attitudes nor the causes or consequences of using different tactics (Straus et al., 1996). Hamel and Nicholls (2007) suggest that inquiries regarding motive, including those of power and control, are better pursued after the initial CTS-2 interview.

Most importantly it must be noted that the CTS-2 is the most valid and reliable tool measuring behaviours in IPV, and therefore it is the tool that it widely used and employed for this purpose. However, the widespread use of the CTS (original version) and CTS-2 has resulted in a proliferation of adapted forms (e.g., taking subscales or questions out of the CTS [original version] or CTS-2 for the purpose of the study), consequently leading to problems in comparing findings across studies (e.g., measuring internal consistency), and some confusion about its clinical and research application. Nonetheless, the more update manual of the CTS-2 clarifies this and informs readers on how best to apply the CTS-2 (Straus et al., 2003). It also brings the instrument up-to-date by correcting the psychometric shortcomings of the original CTS. The manual does this by compiling and organising, in a single source, the large body of information about the instrument (Straus et al., 2003).

In addition, different behaviours or tactics have different meanings and severity in different cultures. For example, spitting at a partner is seen as a severe insult in some parts of India, Pakistan and Bangladesh (Thiara, 2005). What the West may consider as sexual coercion may, in many cultures across South Asia, be understood as a husband's right and not be considered abuse (Thiara, 2005). Straus et al. (1996) noted it is impossible to include every behaviour and tactic that

may be considered as IPV and therefore the CTS-2 includes more general acts that are representative of the general population. Consequently, the CTS-2 does not include more specific cultural acts that may be considered as IPV. This was taken into account when designing the methodology of the empirical paper and measures were put in place to account for cultural differences (i.e., focus groups; Controlling Behaviours Scale Revised [CBSR], Graham-Kevan & Archer, 2003; Views on Relationship Aggression Scale [VRAS], Dixon, in preparation).

Furthermore, there is some support for internal consistency and construct validity for the CTS-2 when administering the instrument in a South Asian country (i.e., India). In order to increase the CTS-2 construct validity and re-test reliability, further research on the CTS-2 needs to directly investigate these tests cross-cultural in community samples, in particular South Asian communities.

The main limitations of the CTS-2 include being transparent, low internal consistency for sexual coercion scale within a community sample and lack of independent examination for construct validity. Nonetheless, every measuring instrument has limitations and problems, and the CTS-2 is no exception. These limitations need to be considered when interpreting results from the CTS-2 or when choosing an instrument to measure IPV (Dahlberg, Toal, & Behrens, 1998: Hamby & Finkelhor, 2001; Rathus & Feindler, 2004). Despite these limitations, from conducting this review, it has demonstrated that the CTS-2 would be a -quality and useful tool to use in the author's research examining IPV in the South Asian communities. Subsequently, Chapter 4 presents an empirical research investigating whether differences exist in rates of IPV in South Asian and non South Asian participants.

CHAPTER 4:

Empirical Research study: Intimate Partner Violence and Associations between South Asian and non South Asian Participants: A Community Sample.

Abstract

Aim: The aim of the research was to investigate whether differences exist in rates of IPV in South Asian and non South Asian participants.

Method: A sample of 191 participants were recruited through a poster that was placed in local community organisations in Greater Manchester asking them to attend a focus group or respond to an online survey. The survey included a demographic questionnaire, the Conflict Tactic Scale 2 (CTS2; Straus, Hamby, Boney-McCoy & Sugarman, 1996), Controlling Behaviours Scale Revised (CBSR; Graham-Kevan & Archer, 2003) and the Views on Relationship Aggression Scale (VRAS; Dixon, in preparation).

Results: No significant differences were found between the CTS-2 and CBS-R subscales and reciprocal violence within ethnicity. However, South Asian participants were more likely to report using severe psychological aggression, control tactics and were more likely to report experiencing severe injury compared to non South Asian participants. Differences were found between South Asian/ non South Asian and male/ female participants' responses on the VRAS. Finally, those that approved of physical aggression were more likely to be physically violent towards their intimate partner compared to those who disapproved.

Conclusion: The limitations of the research were discussed and recommendations for future research were also considered. Furthermore, the findings were seen as an extension to existing literature and highlight the need for future research into the links between the differences in IPV between South Asian and non South Asian communities within Britain.

Introduction

Findings from the systematic review showed that studies and research on IPV that had claimed to be ethnically diverse were not, there was evidence of ethnic clumping, not one of the studies looked at the South Asian population and only two out of the nine studies examined ethnic differences. To enhance evidence based literature within this area it was recommended that further research be conducted on IPV within the BME population. As the BME community is so diverse the researcher decided to focus on South Asian communities defined as Bangladeshi, Indian and Pakistani. This is primarily because South Asian countries have one of the highest rates of IPV (UNICEF, 2000) and there seems to be a lack of relevant literature surrounding issues of IPV on South Asian communities within the U.K. (South Asia Regional Initiative, 2009; Thiara, 2005). Moreover, a diversity of issues surrounds IPV within South Asian communities, as they appear to vary from community to community, country of upbringing and within some sub-groups between generations (Southall Black Sisters, 2004).

In order to gain a better understanding of the rationale for this research the introduction will examine the feminist view and more current research looking at the western view that IPV is reciprocal, examine IPV within South Asian countries and examine IPV within South Asian communities within the U.K.

Feminist Theory

Feminist theory views violence in intimate relationships as a reflection of the patriarchal organisation of society in which men play a dominant role (Dobash & Dobash, 1977; Lenton,

1995; Walker, 1984; Yllo, 1988). Violent behaviour operates as a means of achieving male dominance, power and control in the home (Mauircio & Gormley, 2001). Support for this view comes from cross cultural studies which suggest that violence towards women is more prevalent in cultures and sub-cultures where males dominate decision making and women are assigned rigid and subservient gender roles (Heise, 1998; Smith, 1990; Yllö, 1984).

Numerous sources have shown how extensively, yet subtly, culture has influenced individuals' perceptions, beliefs, and attitudes supportive of IPV (Chalmers et al., 1996; Jaffe, Sudermann, Reitzel & Killip, 1992; MacLachlin, Ager & Brown, 1996; Markowitz, 2001; Tontodonato & Crew, 1992). Barnett, Lee and Thelan (1997) found from their study that husbands who demonstrate patriarchal beliefs and attitudes tend to be more violent towards their wives and noted that in some cultures marital violence may be more acceptable than in others. Furthermore, it was reported by UNIFEM (2003) that in some cultures IPV may be condoned, but legislation is never made sufficiently concrete to combat this effectively. In addition, understanding of culture and its influence on individuals' beliefs are therefore crucial when addressing IPV.

Likewise, the South Asian community can operate as a very cohesive force which sanctions and reinforces the concepts of honour and shame (honour is integral to maintaining patriarchy). The existence of notions such as 'izzat' (honour) and 'sharam' (shame) both play a pivotal role in policing, controlling and containing women's behaviours and lifestyle, in particular their sexuality (Southall Black Sisters, 2004). Such concepts of 'sharam' and 'izzat' prevail amongst South Asian families regardless of religion, caste and class.

Feminist theorists (such as Dobash & Dobash, 1977; Lenton 1995; Leonard & Senchak, 1996; Walker, 1984) have been successful in associating patriarchal values with IPV with the notion that males are the perpetrators and females are the victims of IPV (Mauircio & Gormley, 2001). Nonetheless, feminist theories have been criticised for ignoring individual differences consequently failing to explain why most men who live in a patriarchal society are not violent towards their partners, as well as failing to explain the occurrence of IPV in lesbian relationships (Mauricio & Gormley, 2001), gay relationships and violence towards men by women.

The Western View: Reciprocal IPV

There is growing research evidence in the West that has found that IPV is reciprocal and therefore contradicts the feminist theory (Archer, 2000; Gary & Foshee, 1997; Johnson, 1995; Stith, Smith, Penn, Ward & Tritt, 2004; Straus, 2004). Whitaker, Haileyesus, Swahn and Saltzman (2007) found from their American sample of 11370 respondents on 18761 heterosexual relationships that almost 24% of all relationships had some violence and half (49.7%) of those were reciprocally violent. In nonreciprocal violent relationships, women were the perpetrators in more than 70% of the cases. Reciprocity was associated with more frequent violence among women but not men. Douglas and Straus (2003) did a cross cultural dating violence study with a sample of 6,900 university students from seventeen nations. The authors found that adolescent girls were 1.15 times more likely to assault their partners than adolescent boys, regardless of whether overall assault or severe assault rates were considered.

Numerous researchers, such as Dixon and Graham-Kevan (2010) agreed that after IPV assaults, women tended to suffer from more severe physical and psychological injury then men. Evidence for this comes from a number of studies. Archer's (2000) analysis found that women suffered 65% of IPV injuries and Straus' (2005) Canadian study showed that female victims of spousal violence were more than twice as likely to be injured as male victims. Whitaker et al. (2007) found that men were more likely to inflict injury than women and reciprocal IPV was associated with greater injury than was nonreciprocal IPV regardless of the gender of the perpetrator.

Some authors claim that women's violence occurs only in the context of male violence against them (Swan & Snow, 2006; Walker, 1989). However, research has shown that reciprocal partner violence does not appear to be only comprised of self-defensive acts of violence (Carney, Buttell & Dutton, 2007). Several studies have found that men and women initiate violence against an intimate partner at approximately the same rate (Carney et al., 2007; DeKeseredy & Schwartz, 1998; Follingstad, Wright, Lloyd & Sebastian, 1991; Gray & Foshee, 1997; Straus, 2004). Therefore, the data suggests that self-defence cannot fully explain the reciprocal violence phenomenon.

An explanation for such a phenomenon has been put forwarded by Archer (2000). Archer felt that the diminishing of patriarchal values within the western world and disapproval of men hitting women may play an important role in female perpetrated IPV. Archer (2000) highlighted that a number of studies have found both sexes view acts of physical aggression towards a partner more negatively when the aggressor is a man (such as Fiebert & Gonzalez, 1997; Miller & Simpson;

1991). Furthermore, Archer (2000) reported a study by Fiebert and Gonzalez (1997) of female college students who had initiated partner assaults, which found many of the women felt no fear of retaliation or said that men could easily defend themselves so the women's physical aggression did not matter. Therefore, attitudes, beliefs and norms within countries, societies and communities are important factors in IPV.

However, Renee et al. (2006) noted that caution needs to be applied when analysing such data. Results on female perpetration will vary depending on specific wording of survey questions, how the survey is conducted, the definition of abuse or IPV used and the willingness or unwillingness of victims or perpetrators to admit that they have been abused or abused others.

IPV in Asian Countries

In the South Asian region, the prevalence of IPV (violence by a male to his female partner) ranges from 50% in India to 80% in Pakistan and 50% in Bangladesh (UNIFEM, 2003). Even more disturbing are the culture-specific forms of violence in the South Asian region such as honour killings, acid attacks, face mutilations, torture and stove burning (UNIFEM, 2003).

Archer (2006) found from his community samples from 16 nations that women's victimisation relative to men's was higher in countries where women had less power (e.g., a high negative correlation, $r = -0.79$ was found for India). Furthermore, the proportion of men approving of a husband slapping his wife was strongly negatively correlated with GEM (United Nations, Gender

Empowerment Index) across 12 nations, indicating more approval in countries where women have less power.

Fikree, Razzak and Durocher (2005) conducted a study in Karachi, Pakistan on 176 men. Apart from using a modified version of the CTS-2, information on demographics, behaviours and attitudes to wife abuse (verbal and physical) were elicited. It was found that 49.4% men reported slapping, hitting and punching their wives, 55% of the men reported being victims of physical violence during childhood and 65% of the men had observed their mothers' being physically abused. Significant predictors for IPV in the logistic regression analysis included the belief that men have a right to hit their wives, low economic status, cultural issues and experience of abuse within childhood.

Furthermore, South Asia Regional Initiative (2009) and UNIFEM (2003) report that women's vulnerability and the low status of females generally, combined with poverty, illiteracy, limited employment, education and economic opportunities and traditional, social and cultural norms constrain choice severely together to create an environment conducive to abuse. There is also a lack of legal protection and enforcement of rights which contributes to the cycle of abuse (Fikree et al., 2005). The police often refuse to register cases unless there are obvious signs of injury and the woman is encouraged to reconcile with her husband not only by families but by society and the legal system (South Asia Regional Initiative, 2009). Even though the authorities in South Asia appear to recognise the scale of IPV, no country in South Asia has successfully legislated against

IPV because IPV has been perceived by lawmakers to be a private matter that must be left alone (UNIFEM, 2003).

IPV and South Asian Community within the U.K.

Shoaib (2009) found high rates of self reported perpetrated severe physical violence (63.6% respondent to partner [R to P] and 70.5% partner to respondent [P to R]) from a student sample of 44 participants. Also, 74% of the female participants reported experiencing severe physical violence compared to 64.7% of male participants ($\chi^2(1) = 4.48$, $p < .05$) and South Asian (85.6%) participants were more likely to use severe physical violence than non South Asian (43.5%) participants ($\chi^2(1) = 8.46$, $p < .05$).

Furthermore, Chew-Graham, Bashir, Chantler, Burman and Batsleer (2002) found that IPV, language problems, family and children's issues were among some of the factors that led to South Asian women in Manchester suffering distress, mental health problems and committing self-harm and suicide. They noted that these experiences were reinforced by an extremely efficient community grapevine and other factors such as, racism and stereotyping of Asian women, Asian communities and Islam, the concept of '*izzat'* (honour) in Asian family life and perceived barriers to services (e.g., language, lack of awareness, cultural sensitivity).

Greenwood, Feryad, Burns and Frances (2000) found that a number of women experienced distress due to experiencing violence or abuse and pressure around marriages and relationships. They found that individuals who were reporting distress had few outlets in which to express this

distress and people did not feel that they could look to their families for support. Similarly, Bowl (2007) reported that a number of South Asian women within the U.K. are forced into marriages and reported experiencing abuse.

In addition, Anand and Cochrane (2005) report found that between 1988 to 1992, 1,979 women of all races aged between 15 and 34 took their own lives. Of these, 85 were Asian (4.3%) which was nearly double their proportion of the population (Hussain & Cochrane, 2004). One of the main factors of suicide was related to family culture conflict, where the young woman was apparently in disagreement with her parents' or husband's traditional or religious expectations.

In a study in Bradford, Macey (1999) found that Muslim men used Islam to justify violence against women, whereas women used religion as a source for strength and a negotiating vehicle for the cultural and religious taboos imposed by their spouses. Thus, studies on South Asian communities within the UK have shown that attitudes, beliefs and norms play an important role in IPV.

Rationale for Study

There has been limited research completed looking at the prevalence rates of IPV within South Asian communities. Those research studies that have been completed on IPV within South Asian communities have mainly looked at service issues, barriers to coming forward (e.g., in the context of self harm and suicide; Bowl, 2007; Greenwood et al., 2000) or family maltreatment (Fikree et al., 2005). There appeared to be a lack of published studies that compared IPV between South

Asian male and female participants and non South Asian participants, within the U.K. Another issue with the literature in this area is that most of the published literature on IPV is focused from the perspective of the victim (e.g.,, Fikree et al., 2005; Martin, Tsuim Maitra & Marinshaw, 1999) within the U.K (e.g., Anand & Cochrane, 2005; Greenwood et al., 2000; Hussain & Cochrane, 2004). Despite the contribution of a few studies (e.g. Chew-Graham et al., 2002; Fikree et al., 2005; Greenwood et al., 2000; Macey, 1999) in understanding South Asian communities and IPV, all agree that more research needs to be conducted in this area.

Rationale for Using Greater Manchester

Profile of Greater Manchester

Greater Manchester is one of the most diverse multicultural societies within the U.K with a significant ethnic minority comprising 12.6% of the district population. The diversity of the ethnic minority community in Greater Manchester (see Table 5.1) has to be acknowledged; unfortunately, the available figures do not take into consideration the changes such as the recent influx of refugees and asylum seekers. Despite this, in the Greater Manchester region the population of Pakistanis is 6.1%, Indian 2.7% and Bangladeshi 1%. Importantly, 1 in 8 of all Pakistanis and 1 in 12 of all Bangladeshis in Britain reside in Greater Manchester. This cultural diversity of Greater Manchester is expected to increase over time, given existing trends (Office for National Statistics, 2009).

Table 5.1: *2007 Estimates of Ethnic Groups in Greater Manchester (Office for National Statistics, 2009).*

Ethnicity	Greater Manchester	North West	England
All Persons	**458100**	**6864300**	**51092000**
White	**75.8**	**92.1**	**88.2**
White: British	69.1	89.4	83.6
White: Irish	2.6	1	1.1
White: Other White	4	1.7	3.5
Mixed	**3.3**	**1.2**	**1.7**
Mixed: White and Black Caribbean	1.2	0.4	0.6
Mixed: White and Black African	0.6	0.2	0.2
Mixed: White and Asian	0.8	0.4	0.5
Mixed: Other Mixed	0.7	0.3	0.4
Asian or Asian British	**11.1**	**4.4**	**5.7**
Asian or Asian British: Indian	2.7	1.5	2.6
Asian or Asian British: Pakistani	6.1	2.1	1.8
Asian or Asian British: Bangladeshi	1	0.5	0.7
Asian or Asian British: Other Asian	1.3	0.4	0.7
Black or Black British	**5.5**	**1.1**	**2.8**
Black or Black British: Caribbean	1.9	0.4	1.2
Black or Black British: African	3.1	0.6	1.4
Black or Black British: Other Black	0.5	0.1	0.2
Chinese or Other Ethnic Group	**4.3**	**1.1**	**1.5**
Chinese or Other Ethnic Group: Chinese	2.7	0.7	0.8
Chinese or Other Ethnic Group: Other Ethnic Group	1.6	0.4	0.7

Domestic violence in Greater Manchester

During 1996-1997, Greater Manchester Police reported receiving 10,000 calls of IPV compared to 15,699 in 1999-2000. Table 5.2 shows the number of IPV incidents reported in Greater Manchester between 2002 and 2006 (Greater Manchester Police, 2007). Hence, revealing that IPV is on the increase. What must be noted though is that the increase of reports may be due to an increase in awareness of IPV. Moreover, the Living with Fear report (1999) found that IPV cost Greater Manchester £278 million per year.

Table 5.2: *Number of IPV Incidents Reported in Greater Manchester.*

Year	Number of IPV Incidents Reported
2002	45424
2003	57995
2004	56492
2005	43132
2006	63131

It has already been established within the thesis that research suggests that there is a serious number of under reported cases of IPV not only on part of the victims, which is common amongst ethnic minorities but also by official agencies (Greater Manchester Police, 2007). Furthermore many agencies do not keep specific or consistent records on ethnic breakdown of IPV.

Aim and Hypothesis

Research suggests that in the West, violence between intimate partners is reciprocal; however, research has also been put forward to suggest that societies which have more patriarchal beliefs (such as South Asian communities) will tend to have more nonreciprocal violence than reciprocal violence. Furthermore, individuals with more patriarchal beliefs will use more control tactics and violent methods within their relationship. Therefore, the aim of this research is to investigate whether differences exist in rates of IPV in South Asian and non South Asian participants. Specifically, the following hypotheses were considered:

Hypothesis 1: There will be a difference in a UK community sample in the extent of reciprocal violence and control tactics used between South Asian and non South Asian participants.

Hypothesis 2: South Asian participants will be more likely to use psychological aggression, physical assault and cause injury to their partner (measured by Conflict Tactic Scale 2) than non South Asian participants.

Hypothesis 3: South Asian participants will be more likely to report using more control tactics on the Controlling Behaviours Scale-Revised than non South Asian participants.

Hypothesis 4: It is hypothesised that there will be differences between South Asian and non South Asian participants and male and female participants on the Views on Relationship Scale questionnaire.

Hypothesis 5: There will be an association between those who approve of physical violence and rates of IPV, despite participants' ethnicity or gender.

Hypothesis 6: It is hypothesised that ethnicity (South Asian) and approval of violence on the VRAS subscales will be significant predictors of severe physical violence.

Methodology

Sample

A sample was obtained from male and female community members over the age of 18 living within Greater Manchester. Posters were put on notice boards within community organisations inviting participants to attend a focus group and/or to complete an online survey (see Appendix

3.1). With adverts posted on notice boards it is not possible to calculate a response rate, as it is not clear how many people read it and/or accessed the web link (see Figure 4.1).

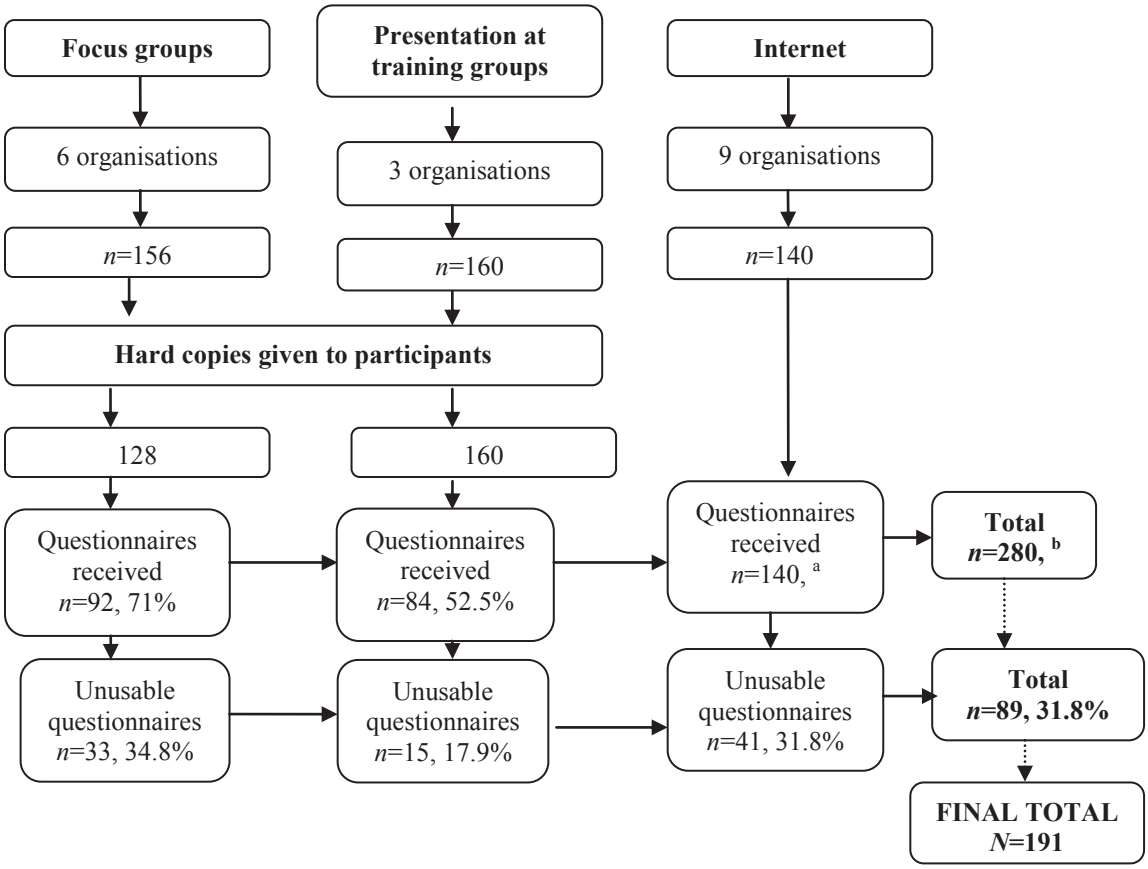

Figure 4.1: Questionnaires received back from venues.

[a]Not possible to calculate a response rate as it is not clear how many people accessed the web link.

[b]Not possible to calculate response rates as it is not clear how many people attended the focus and then choose to complete the questionnaire on line.

Thus, 156 participants attended the focus groups and 160 attended the presentation at the training event Also, 140 participants responded to the online survey and 176 hard copy questionnaires were received. Unfortunately, 89 (31%) of the participants did not tick the consent question or did not answer the questions; subsequently, their data was excluded from the study (see Figure 4.1).

Of the remaining 191 participants, 38.7% (*n*=74) were male and 61.3% were female (*n*=117). The age of the participants ranged from 18 to 51 (*M*=28.53, *SD*=6.42; see Table 5.3). The majority of participants reported being of British nationality (92.7%; *n*=177); however, 5.6% (*n*=11) of participants identified themselves as being of another nationality (such as Pakistani and Bangladeshi). Of the sample, 52.9% (*n*=101) participants considered themselves to be of South Asian origin compared to 47.1% (*n*=90) who did not. In addition, 65.6% (*n*=124) of participants considered themselves to live by western values compared to 34.4% (*n*=65) who did not. The term "live by western values" was defined in this study as whether an individual feels they live by western or South Asian values, customs and norms. This term "western" is used frequently within the South Asian community to describe those who have western values, customs and norms and also includes religious and cultural differences. For example, wearing western clothing (anything that may not be considered as traditional dress), drinking alcohol, going to social venues such as night clubs or pubs and having intimate relationships prior to marriage. Frequency data of participants' ethnicity, employment, current relationship status, average relationship status and current relationship status (sexual or non sexual) is recorded in Table 5.3.

Procedure

The researcher contacted 21 different community organisations in Manchester to assess whether they would give their consent. Fifteen organisations agreed in principle to use their venue and suggested appropriate ways of conducting the study. These suggestions were taken into account when developing the methodology. Once ethical approval was given, the organisations were contacted for formal consent to use their venue to access participants (see Appendix 3.2). Nine

Table 5.3: *Frequency Data for Characteristics of Participants Recoded (N=191).*

Characteristics of Participants Recoded	Total Sample Recoded	
	n	**%**
Sex of participants (*n*=191)		
Male	74	(38.7%)
Female	117	(61.3%)
Age category (*n*=191)		
16-20	8	(4.2%)
21-25	66	(34.6%)
26-30	52	(27.2%)
31-35	43	(22.5%)
36-40	12	(6.3%)
41-45	5	(2.6%)
46-50	3	(1.6%)
51+	2	(1%)
South Asian Origin (*n*=191)		
Yes	101	(52.9%)
No	90	(47.1%)
Employment (*n*=188)		
Employed	135	(71.8%)
Not employed	53	(28.2%)
Current relationship status (*n*=190)		
Single	36	(18.9%)
Dating relationship	36	(18.9%)
Stable relationship/Married	118	(62.1%)
Average relationship status (*n*=187)		
Dating relationship	76	(49.6%)
Stable relationship	111	(59.4%)
Current relationship status sexual or none sexual (*n*=190)		
Sexual	129	(67.5%)
None sexual	60	(31.6%)
Live by western values (*n*=189)		
Yes	124	(65.6%)
No	65	(34.4%)

venues agreed to take part in the study and posters (see Appendix 3.1) were placed on notice's boards within the venues to recruit participants. The posters gave a brief outline of the study, a web link to access information and the survey online, dates for focus groups and requirements for participation. Data was collected through the focus groups (see Appendix 3.3) and through the online survey (see Appendix 3.4).

Focus groups

In six organisations, 156 participants attended 11 focus groups (a range between 8 to 25 participants attended each group), which were held over four weeks. There was a schedule (see Appendix 3.3.1) and standardised instructions for the focus groups (see Appendix 3.3.2). The focus groups lasted from 45 minutes to 80 minutes and included a 10 minute standardised presentation and 50 minutes for participants to fill out the questionnaires. The focus group was started by giving a letter of invitation (Appendix 3.3.3), information sheet and Frequently Asked Questions Page (Appendices 3.3.4 & 3.3.5) and a consent form (Appendix 3.3.6). After gaining participants' consent, they were given the questionnaires to look through (Appendix 3.4). During this process a number of questions were raised by participants and this led to numerous discussions. The researcher gave the option for participants to complete the questionnaire at the venue, home or online. There were 128 participants who requested hard copies of questionnaire. Participants were asked to put their completed questionnaire in the envelope (provided by the researcher) and asked to post it in the secure locked box that was placed at the reception venue. The researcher allowed time for those participants wishing to complete questionnaire at the venue. The researcher then debriefed the participants (Appendix 3.3.2). After two months the researcher returned to the venues and collected 92 (71%) completed hard copy questionnaires.

Presentation at Training Group

In the remaining three organisations, the researcher presented the 10 minute research presentation (see Appendix 3.3.2) prior to the commencement of five training events. Altogether, 160 hardcopy questionnaires were handed out and participants were asked complete these at home or online.

Those that completed the hard copy questionnaires were asked to put the questionnaire in the envelope provided, seal it and post it in the secure locked box at the reception venue. There were 84 (52.5%) completed hard copy questionnaires collected from the venue. Overall, 288 hard copies were given out and 176 (61.11%) questionnaires were returned. It is possible that some of the participants chose to do the online version. Furthermore, out of the 176 questionnaires collected from the nine difference venues, 48 (27%) questionnaires could not be used because participants had not signed the consent form.

Online questionnaire

The participants were given the option of completing the questionnaire online (see Appendix 3.5) via a website link. This option was given on the posters, in the focus group and within the training events. There were 140 participants who responded to the online survey, of which 41 (39%) participant's online questionnaire data could not be used as they had not signed the consent (7; 6%) form or answered any of the questions (34; 32%).

The first screen participants viewed when they accessed the web link was a brief information page (see Appendix 3.5.1). The information was limited so it did not distress participants but detailed enough to allow them to understand the nature of the study and if they felt they were suitable for it. Participants would then go on to view three separate windows, each of which provided more detailed information about the study (see Appendix 3.5.2, 3.5.3 & 3.5.4). Information that was likely to cause more distress (details of aggressive acts that were going to be listed in the study) was presented in the second of these windows, so that participants would have plenty of time to

opt out of the study before viewing this information. The second window outlined various agencies that participants could contact for further help/advice about issues of aggression in relationships. At the end of each window, participants were asked to confirm that they understood the nature of the study and were happy to continue. If they did not want to continue they have the option to opt out of the survey and were instructed how to do this. Participants were then asked to complete the consent form (see Appendix 3.5.6) followed by the questionnaires (see Appendix 3.4). Once participants completed the questionnaire, there was a section debriefing the participants and a list of a number of various agencies that participants could contact for further help and/or advice (refer to Appendix 3.5.7).

Ethical consideration

The steps outlined above were taken to ensure ethical considerations were highlighted in both the focus group and online questionnaire and that participants were fully aware of their rights. Participants were not placed under any pressure to take part; participants were informed they did not have to participate and that they could withdraw from the study at any point. It was also made clear that participants did not have to answer all questions and a 'no response' option was given.

Furthermore, as the questionnaires were anonymous, participants were asked to provide a code name and were given the researcher's and supervisor's contact details so they could remove data associated with the code name, if participants change their mind for any reason. Contact information for Niteline, NHS Direct, National Domestic Violence helpline and the Samaritans were also provided to ensure that if the questionnaire or letter distressed participants than

appropriate help could be sought. The participants were also made aware that only the researcher and her supervisor would analyse anonymous participant data.

Measures

Three measures were used in this study, the Conflict Tactic Scale 2 (CTS2; Straus, et al., 1996), the Controlling Behaviours Scale revised (CBSR; Graham-Kevan & Archer, 2003), and the Views on Relationship Aggression Scale (VRAS; Dixon, in preparation; see Appendix 3.4). Apart from these measures, the beginning of the questionnaire asked participants a variety of demographic questions and questions about participants current and past relationships (see Appendix 3.4.1).

Conflict Tactics Scale 2 (CTS2; Straus et al., 1996)

The CTS-2 has been used for over one decade to evaluate aggression within families and intimate relationships (see Chapter 3). The CTS-2 includes 78 items, half referring to the participant's behaviour (Respondent [R]) and half to the partner's behaviour (Partner [P]). Using an 8-point scale the participant simply indicates how often each behavioural act has occurred. This produces "Self" and "Partner" scores for five dimensions of negotiation, psychological aggression, physical assault, injury level and sexual coercion. Due to ethical considerations the CTS-2 was modified (see Appendix 3.4.2) and subsequently the 14 questions referring to sexual coercion were removed; participants were not required to comment on their sexual experience throughout the study. The questions were removed due to the request and advice given from some of the venue managers who felt that some individuals from the South Asian community may get offended or disregard the study because of the sexual coercion section.

Controlling Behaviours Scale revised (CBS-R; Graham-Kevan & Archer, 2003)

This CBS-R (see Appendix 3.4.3) was developed using literature from the Domestic Abuse Intervention Project (DAIP; Pence & Paymar, 1993). The DAIP literature cites examples of controlling behaviours consistently reported (by both victims and perpetrators) as being used by violent men against their partners. It has been shown to have good discriminative ability (Graham-Kevan & Archer, 2003).

On the CBS-R, the respondents used a 5-point response format to indicate how often during the past year with their partners, they had used each behaviour, the anchors ranged from 0 never to 4 always. All the items on the CBS-R are behavioural acts and can be scored to derive a mean overall controlling behaviours total, or five sub scores, each of which is a particular type of control tactic. The subscales are 'Using Economic Abuse' (items 1-4), 'Using Coercion and Threats' (items 5-8), 'Using Intimidation' (items 9-13), 'Using Emotional Abuse' (items 14-18), 'Using Isolation' (items 19-24). Crohbach's alpha for partner (P) and self (S) reports satisfactory reliability (0.70 or above) for coercion and threats (P: $\alpha = .72$, S: $\alpha = .70$), emotional abuse (P: $\alpha = .81$, Ss $\alpha = .75$), isolation, (P: $\alpha = .88$, S: $\alpha = .84$) and intimidation (P: $\alpha = .74$, S: $\alpha = .62$; Field, 2005). However, the economic scale reliability was not as good (P: $\alpha = .58$, S: $\alpha = .45$) and subsequently caution needs to be applied when interpreting this scale.

All the items are appropriate for male and female victims. The questionnaire does not rely on respondents cohabiting or having children. The drawback with the CBS-R subscale is that the

items are derived from accounts of female victims and so may not fully encompass the types of behaviours more usually used by women perpetrators (Borjesson, Aaron & Dunn, 2003).

Views on Relationship Aggression Scale (VRAS; Dixon, in preparation)

The VRAS has 28 scenarios (see Appendix 3.4.4). Three factors are manipulated to create change in each scenario, namely: 1. sex (male/female); 2. level of provocation (none /minor infidelity/major infidelity/minor physical violence/severe physical violence/disobedience); and 3. severity of physical aggression (minor/severe). Participants are asked six questions about each scenario and their responses to these dependent variables are then measured,to what extent do they approve of the aggressors actions, to what extent do they approve of the victim retaliating to the physical assault, how much physical harm could the assault bring to the victim,how much emotional harm could the assault bring to the victim how far do they think the victim can defend themselves from the aggressor and to,what legal sanction do they deem suitable for the aggressor?

Treatment of Data

After individuals completed the hard copy and online questionnaires, the data was added to an Excel spreadsheet. Each participant was designated a number as well as their code name in order to protect anonymity. After the data was added to SPSS (Version 17) frequency analysis was conducted, after which some demographic variables were recoded for analysis that is more meaningful. Then the CTS-2 and CBS-R where recoded into yes or no and the CTS-2, CBS-R and VRAS were computed to give subscales scores.

Demographic data, CTS-2 and CBS-2 data were compared with gender and ethnicity variables using chi square analysis in order to find out if groups differed significantly in these factors. The difference in age between the groups was investigated using an independent t-test. The data was then analysed to answer the first three hypotheses. Due to the number of chi-squares computed the alpha value required for significance was lowered, using Bonferroni's correction which corrects for the number of chi-square tests and the d.f. involved in each test. In addition, to measure the strength of the relationship between the two variables, Odd-Ratio (*ODs*) was used instead of Cramer's V to calculate the effect size. Odds-Ratio is noted to the best method to use when analysing binary data (Field, 2005).

Using the linear data in the VRAS, first one way ANOVAs were used to help investigate hypothesis four. Levene's test was applied to test for homogeneity of variance and if this assumption was not met then Welch's *F* was reported instead (Field, 2005). Pearson's correlations coefficient *r* were used to calculate the effect size (Field, 2005). Secondly, independent t-tests were used to investigate hypothesis five. Levene's test was applied to test for homogeneity of variance and if this assumption was not met then "equal variances not assumed" was reported instead. Cohen's *d* was used to calculate the effect size for two independent groups as suggested by Rosenthal and Rosnow (1991) and Field (2005). Logistic regression was used to investigate hypothesis six and identify predictive variables for physical violence perpetration.

Results

Frequency data and Characteristics of Participants Data

For the purpose of this analysis employment was re-coded into employed (*n*=135, 71.8%) or unemployed (*n*=53, 28.2%). Most frequent/average relationship style was re-coded into stable (defined as stable, married or cohabiting; *n*=111, 59.4%) or dating (*n*=76, 49.6%) type relationships. Current relationships were re-coded into whether participants were single (*n*=36, 18.9%), in dating (*n*=36, 18.9%) or stable relationship/married (*n*=118, 62.1%; see Table 5.4). In terms of demographics, Table 5.4 shows that South Asians were significantly more likely to be in a stable relationship than non South Asians ($\chi^2(2) = 10.17$, $p<.01$) but the effect size was small $r=.23$. Based on the odds ratio (*ORs*) female participants were 1.96 times more likely to be in a stable relationship than male participants ($\chi^2(1) = 5.01$, $p<.05$). Male participants were 2.25 (*ORs*) times more likely to be in a current sexual relationship than female participants (χ^2 (1) =5.75, $p<.05$). South Asian participants were 14 (*ORs*) times more likely not to live by western values than non South Asian participants (χ^2 (1) =32.59, $p<.01$).

Table 5.4: *Characteristics of Participants Recoded and Associations Between Male/Female and South Asian/Non South Asian Participants (N=191).*

Characteristics of Participants Recoded	**South Asian (*n*=101) n %**	**Non South Asian (*n*=90) n %**	***df Chi square***	**Male (*n*=74) n %**	**Female (*n*=117) n %**	***df Chi square***
Sex of participants (*N*=191)			1 .31			
Male	41 (40.6%)	33 (36.7%)		--	--	--
Female	60 (59.4%)	57 (63.3%)				
Ethnicity (*N*=191)						1 .31
South Asian	--	--	-- --	41 (55.4%)	60 (51.3%)	
Non South Asian				33 (44.6%)	57 (48.7%)	
Age category (*N*=191)						
16-20	7 (6.9%)	1 (1.1%)	-- --	3 (4.1%)	5 (4.3%)	
21-25	30 (29.7%)	36 (40%)		16 (21.6%)	50 (42.7%)	
26-30	27 (26.7%)	25 (27.8%)		19 (25.7%)	33 (28.2%)	
31-35	23 (22.8%)	20 (22.2%)		26 (35.1%)	17 (14.5%)	
36-40	7 (6.9%)	5 (5.6%)		8 (10.8%)	4 (3.4%)	
41-45	3 (3%)	2 (2.2%)		2 (2.7%)	3 (2.6%)	
46-50	2 (2%)	1 (1.1%)		0 (0%)	3 (2.6%)	
51+	2 (2%)	0 (0%)		0 (0%)	2 (1.7%)	
	M=29.06 *SD*=6.98	*M*=27.94 *SD*=5.72		*M*=29.97 *SD*=6.7	*M*=29.97 *SD*=5.6	
Employment (*n*=188)			1 .59			1 .08
Employed	74 (74%)	61 (69.3%)		54 (73%)	81 (71.1%)	
Not employed	26 (26%)	27 (30.7%)		20 (27%)	33 (28.9%)	
Current relationship status (*n*=190)			2 10.17*			2 2.10
Single	24 (24%)	12 (13.3%)		11 (14.9%)	25 (21.6%)	
Dating relationship	11 (11%)	25 (27.8%)		17 (23%)	19 (16.4%)	
Stable relationship/ Married	65 (65%)	53 (58.9%)		46 (62.2%)	72 (62.1%)	
Average relationship status (*n*=187)			1 .30			1 5.01**
Dating relationship	41 (41.4%)	35 (39.8%)		37 (50.7%)	39 (34.2%)	
Stable relationship/Married	58 (58.6%)	53 (60.2%)		36 (49.3%)	75 (65.8%)	
Current relationship status (sexual or none sexual, *n*=189)			1 .30			1 5.75**
Sexual	70 (70%)	30 (33.7%)		58 (78.4%)	71 (61.7%)	
None sexual	30 (30%)	59 (66.3%)		16 (21.6%)	44 (38.3%)	
Live by western values (*n*=189)			1 32.59*			1 .21
Yes	47 (47%)	77 (86.5%)		50 (67.6%)	74 (64.3%)	
No	53 (53%)	12 (13.5%)		24 (32.4%)	41 (35.7%)	

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

Frequency Data for CTS-2 and CBS-R

Surprisingly, the rates of conflict reported on a number of the subscales were high. For example, 67% (*n*=128) of the participants reported using severe psychological aggression and 69.6% (*n*=133) reported experiencing severe psychological aggression, 45.5% (*n*=87) of the participants reported using severe physical violence and 55.5% (*n*=106) reported experiencing severe physical violence. Furthermore, 31.4% (*n*=60) of the participants reported causing severe injury and 44.5% (*n*=85) reported experiencing severe injury (see Table 5.5).

Table 5.5: *Frequency Data for Subscales on the CTS-2 (N=191).*

CTS-2 Subscales		**Total Sample (*N*=191)**					
		Yes		**No**		**Unknown**	
		n	**%**	***n***	**%**	***n***	**%**
Negotiation	R[a] to P[b]	160	(83.8%)	3	(1.6%)	28	(14.7%)
	P to R	156	(81.7%)	2	(1%)	33	(17.3%)
Minor Psychological Aggression	R to P	164	(85.9%)	14	(7.3%)	13	(6.8%)
	P to R	154	(80.6%)	12	(6.3%)	25	(13.1%)
Severe Psychological Aggression	R to P	128	(67%)	47	(24.6%)	16	(8.4%)
	P to R	133	(69.6%)	43	(22.5%)	15	(7.9%)
Minor Physical Violence	R to P	103	(53.9%)	73	(38.2%)	15	(7.9%)
	P to R	138	(72.3%)	35	(18.3%)	18	(9.4%)
Severe Physical Violence	R to P	87	(45.5%)	89	(46.6%)	15	(7.9%)
	P to R	106	(55.5%)	62	(32.5%)	23	(12%)
Minor Injury	R to P	55	(28.8%)	117	(61.3%)	19	(9.9%)
	P to R	71	(37.2%)	104	(54.5%)	16	(8.4%)
Severe Injury	R to P	60	(31.4%)	108	(56.5%)	23	(12%)
	P to R	85	(44.5%)	95	(49.7%)	11	(5.8%)

Note. [a]R= Respondent, [b]P = Partner.

Interestingly, on the CBS-R participants reported using high rates of control tactics within their relationships. The frequency data showed that 73.8% (*n*=141) of the participants reported using coercion and threats and 63.9% (*n*=122) reported experiencing coercion and threats. Data also showed that 72.8% (*n*=139) of the participants reported using emotional abuse and 76.4% (*n*=146) of the participants reported experiencing emotional abuse. Additionally, 73.8% (*n*=141)

of the participants reported using isolation and 74.9% (*n*=143) of the participants reported experiencing isolation (see Table 5.6).

Table 5.6: *Frequency Data for Subscales on the CBS-R (N=191).*

CBS-R		**Total Sample (*N*=191)**					
		Yes		**No**		**Unknown**	
		n	**%**	***n***	**%**	***n***	**%**
Economic Abuse	R[a] to P[b]	102	(53.4%)	78	(40.8%)	11	(5.8%)
	P to R	132	(69.1%)	49	(25.7%)	10	(5.2%)
Coercion and Threats	R to P	141	(73.8%)	39	(20.4%)	11	(5.8%)
	P to R	122	(63.9%)	58	(30.4%)	11	(5.8%)
Intimidation	R to P	117	(61.3%)	61	(31.9%)	13	(6.8%)
	P to R	107	(56%)	55	(28.8%)	29	(15.2%)
Emotional Abuse	R to P	139	(72.8%)	41	(21.5%)	11	(5.8%)
	P to R	146	(76.4%)	31	(16.2%)	14	(7.3%)
Isolation	R to P	141	(73.8%)	40	(20.9%)	10	(5.2%)
	P to R	143	(74.9%)	38	(19.9%)	10	(5.2%)

Note. [a]R= Respondent, [b]P = Partner.

Surprisingly, high rates of conflict were reported on both the minor and severe subscales. Therefore, further analysis will only be carried out for the severe subscales on the CTS-2 for more meaningful analysis.

Hypothesis 1: There will be a difference in a UK community sample in the extent of reciprocal violence and control tactics used between South Asian and non South Asian participants.

In order to answer this hypothesis, data from the CTS-2 (negotiation, severe psychological aggression, severe physical violence and severe injury) and CBS-R (economic abuse, coercion and threats, intimidation, emotional abuse, isolation) subscales were re-coded into nonreciprocal and reciprocal. No significant results were found between CTS-2 (nonreciprocal and reciprocal) subscales and ethnicity. However, in terms of gender, male participants were 6.92 times more

likely to report reciprocal injury within their relationship than female participants ($\chi^2(1) = 10.02$, $p < .01$); see Table 5.7).

Table 5.7: *Significant Association Between CTS-2 (Reciprocal and Nonreciprocal) and Gender (N=191).*

CTS-2 Subscales	Male (*n*=74)				Female (*n*=117)				*df*	*Chi Square*
	Nonreciprocal		Reciprocal		Nonreciprocal		Reciprocal			
	n	%	*n*	%	*n*	%	*n*	%		
Severe Injury (*n*=83)	3	(10.7%)	25	(89.3%)	25	(45.5%)	30	(54.5%)	1	10.02*

Note. *$p < .01$.

Further analysis was conducted to see if there were any associations between South Asian male and female participants and non South Asian male and female participants. Only one significant association was found. All of the South Asian male participants (100%, *n*=15) reported reciprocal severe injury compared to only 44.7% (*n*=17) of South Asian female participants ($\chi^2(1) = 13.73$, $p < .01$; *ORs* 18.75; see Figure 4.2).

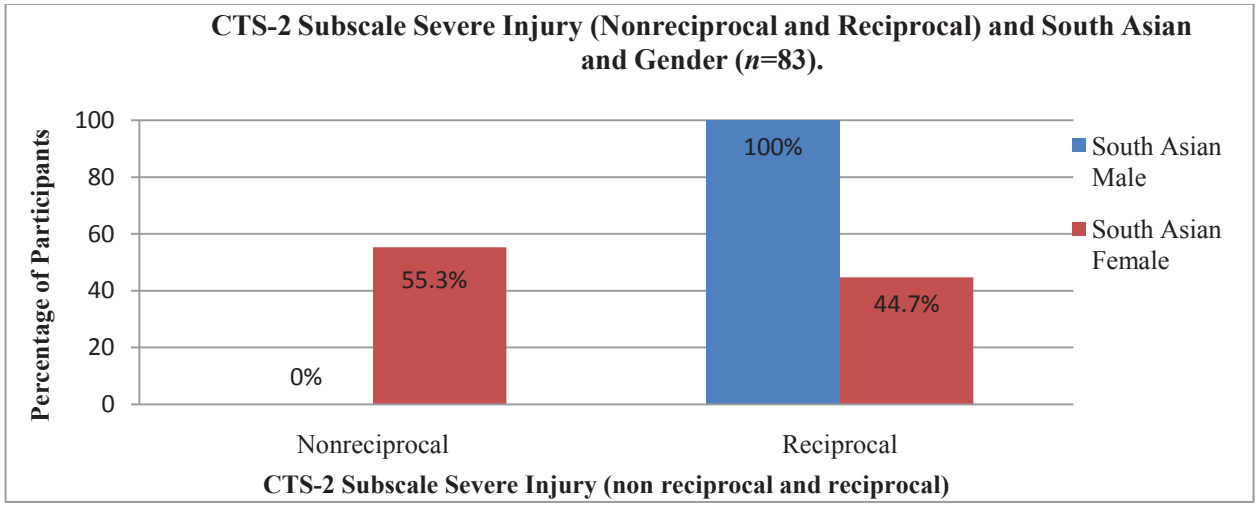

Figure 4.2: Association between CTS-2 subscale severe injury (nonreciprocal and reciprocal) and South Asian male and female participants ($\chi^2(1) = 13.73$, $p < .01$; *ORs* 18.75).

No significant associations were found between CBS-R subscales (nonreciprocal and reciprocal) and ethnicity. However in terms of gender, male participants were 11.44 times more likely to report reciprocal emotional abuse ($\chi^2(1) = 8.23$, $p<.01$) and 7.65 times more likely to report reciprocal isolation ($\chi^2(1) = 5.04$, $p<.03$) than female participants (see Table 5.8).

Table 5.8: *Significant Associations Between CBS-R (Reciprocal and Nonreciprocal) and Gender (N=191).*

CBS-R Subscales	**Male (*n*=74)**				**Female (*n*=117)**				***df***	***Chi square***
	Nonreciprocal		**Reciprocal**		**Nonreciprocal**		**Reciprocal**			
	n	**%**	***n***	**%**	***n***	**%**	***n***	**%**		
Emotional Abuse (*n*=150)	1	(1.7%)	58	(98.3%)	15	(16.5%)	76	(83.5%)	1	8.23*
Isolation (*n*=149)	1	(2%)	50	(98%)	13	(13.3%)	85	(86.7%)	1	5.04**

Note. *$p<.01$, **$p<.03$.

Further analysis showed more reciprocal coercion and threats for non South Asian male participants (91.3%,n=21) compared to non South Asian female participants (62.6%,n=23;$\chi^2(1)=6.48$, $p<.02$; *ORs* 3.71) and more reciprocal economic abuse for South Asian female participants (82.6%,n=38) compared to South Asian male participants (56.3%,n=18; $\chi^2(1)=6.16$, $p<.02$; see Figure 4.3).

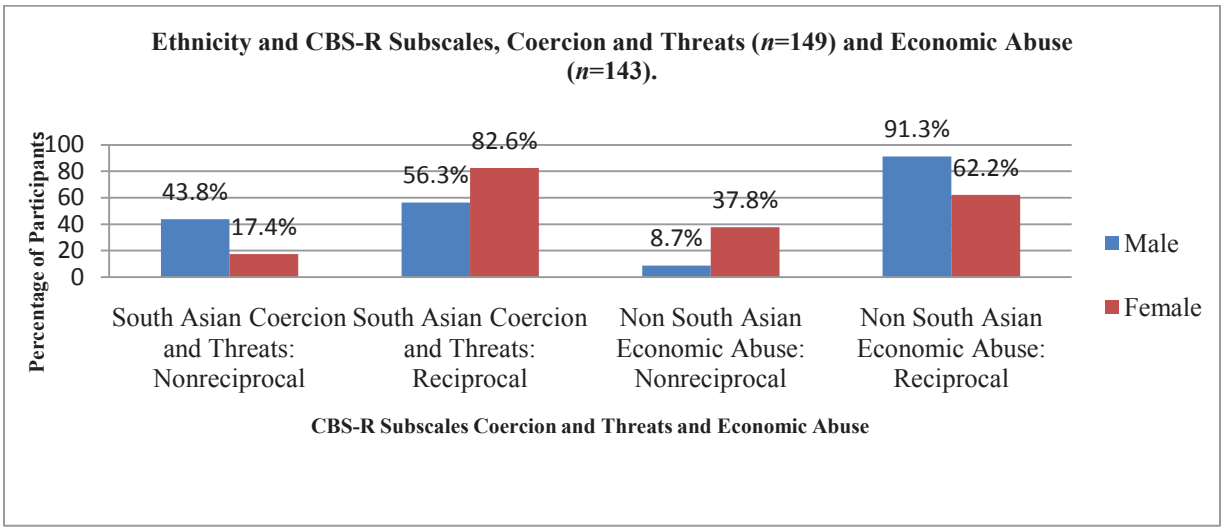

Figure 4.3: Significant associations between CBS-R subscales coercion and threats (nonreciprocal and reciprocal) and South Asian males and females*, and economic abuse (nonreciprocal and reciprocal) and non South Asian males and females**.

*Significant ($\chi^2(1)=6.48$, $p<.02$) **Significant ($\chi^2(1)=6.16$, $p<.02$)

Hypothesis 2: South Asian participants will be more likely to use psychological aggression, physical assault and cause injury to their partner (measured by Conflict Tactic Scale 2) than non South Asian participants.

Analysis showed that South Asian participants used more severe psychological aggression ($\chi^2(1)=11$, $p<.01$; *ORs* 3.23) and experienced more severe injury than non South Asian participants ($\chi^2(1)=5.83$, $p<.03$; *ORs* 2.08; see Table 5.9). Further analysis was conducted to see if there were any differences in terms of gender. It was found that 84.8% (n=56) of male participants experienced severe psychological aggression compared to 70% (n=77) of female participants ($\chi^2(1)=4.93$, $p<.03$; *ORs* 2.40; see Figure 4.4) and 74.6% (n=44) South Asian female participants experienced physical violence compared to 48.3% (n=14) of South Asian male participants ($\chi^2(1)=5.99$, $p<.02$; *ORs* 3.15; see Figure 4.5).

Table 5.9: *Significant Associations Between South Asian and Non South Asian Participants for CTS-2 (N=191).*

CTS-2 Subscales	South Asian (*n*=101)		Non South Asian (*n*=90)		*df*	*Chi square*
	Yes n %	No n %	Yes n %	No n %		
Severe Psychological Aggression R [a]to P[b] (*n*=175)	77 (83.7%)	15 (16.3%)	51 (61.4%)	32 (38.6%)	1	11*
Severe Injury P to R (*n*=180)	52 (55.9%)	4 (44.1%)	33 (37.9%)	54 (62.1%)	1	5.83**

Note. [a]R= Respondent, [b]P = Partner, *p<.01, **p<.03.

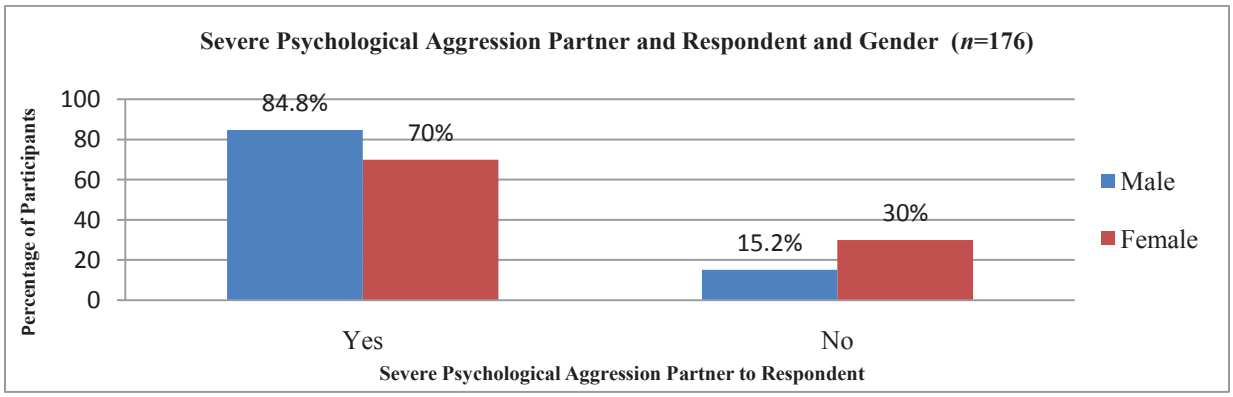

Figure 4.4: Significant association between severe psychological aggression and gender ($\chi^2(1) = 4.93$, $p<.03$; *ORs* 2.40).

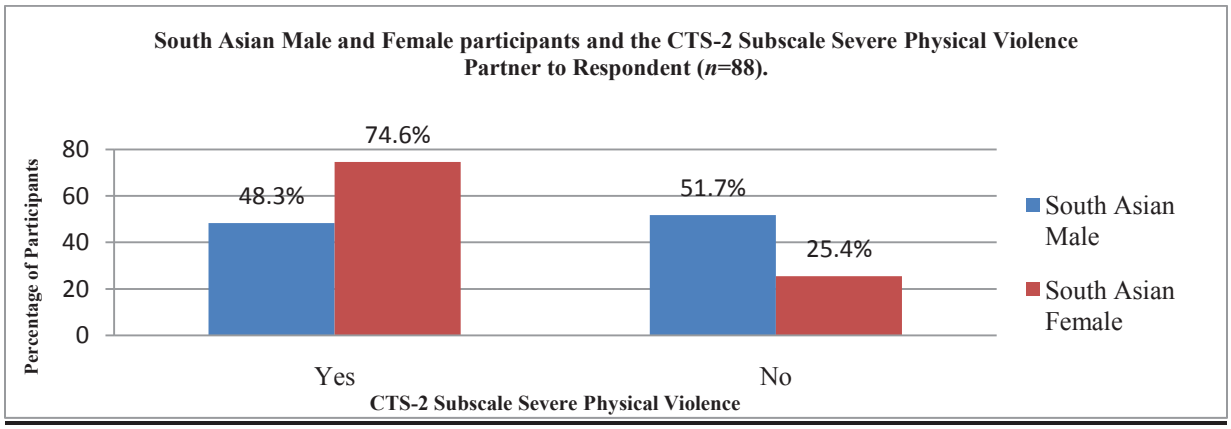

Figure 4.5: Significant association between CTS-2 subscale severe physical violence and South Asian male and female participants ($\chi^2(1) = 5.99$, $p<.02$; *ORs* 3.15).

Hypothesis 3: South Asian participants will be more likely to report using more control tactics on the Controlling Behaviours Scale-Revised than non South Asian participants.

Hypothesis 1 showed no differences on the CBS-R in terms of ethnicity and reciprocity. Despite this, further analysis showed that South Asian participants were 3.83 times more likely to experience economic abuse than non South Asian participants ($\chi^2(1) = 14.70$, $p<.01$; see Table 5.10).

Table 5.10: *Significant Associations Between South Asian and Non South Asian Participants for Subscales on the CBS-R (N=191).*

CBS-R	**South Asian (*n*=101)**		**Non South Asian (*n*=90)**		***df***	***Chi square***
	Yes	**No**	**Yes**	**No**		
	n **%**	***n*** **%**	***n*** **%**	***n*** **%**		
Economic Abuse P [a] to R[b] (*n*=181)	80 (85.1%)	14 (14.9%)	52 (59.8%)	35 (40.2%)	1	14.70*

Note. [a]R= Respondent, [b]P = Partner, *$p<.01$.

Further analysis was conducted to see if there were any differences in terms of gender. Compared to female participants, male participants were 2.14 more likely to report using economic abuse ($\chi^2(1) = 5.63$, $p<.01$), 6.85 times more likely to use coercion and threats ($\chi^2(1) = 14.95$, $p<.01$), 3.49 times more likely to use intimidation ($\chi^2(1) = 12.05$, $p<.01$) and 2.96 times more likely to use emotional abuse ($\chi^2(1) = 6.73$, $p<.01$; see Table 5.11).

Table 5.11: *Significant Associations Between Male and Female Participants for Subscales on the CBS-R (N=191).*

CBS-R	**Male (*n*=74)**		**Female (*n*=117)**		***df***	***Chi square***
	Yes	**No**	**Yes**	**No**		
	n **%**	***n*** **%**	**n** **%**	***n*** **%**		
Economic Abuse R[a] to P[b] (*n*=180)	45 (68.2%)	21 (31.8%)	57 (50%)	57 (50%)	1	5.63*
Coercion and Threats R to P (*n*=180)	62 (93.9%)	4 (6.1%)	79 (69.3%)	35 (30.7%)	1	14.95*
Intimidation R to P (*n*=178)	54 (81.8%)	12 (18.2%)	63 (56.3%)	49 (43.7%)	1	12.05*
Emotional Abuse R to P (*n*=180)	58 (87.9%)	8 (12.1%)	81 (71.1%)	33 (28.9%)	1	6.73*

Note. [a]R= Respondent, [b]P = Partner, *$p<.01$.

In addition, further analysis showed that South Asian male participants were 6.48 times more likely to use coercion and threats than South Asian female participants ($\chi^2(1) = 6.98$, $p < .01$) and South Asian female participants were 2.43 more likely to experience coercion and threats than South Asian male participants ($\chi^2(1) = 4.02$, $p < .01$). In comparison, non South Asian male participants were 7.28 times more likely to use coercion and threats than non South Asian female participants($\chi^2(1) = 8.01$, $p < .01$). However, non South Asian male participants were 3.46 more likely than non South Asian female participants to report experiencing coercion and threats ($\chi^2(1) = 5.16$, $p < .01$; see Table 5.12).

Furthermore, 63.2% (n=36) of South Asian females reported experiencing intimidation compared to 76.5% (n=26) of South Asian males ($\chi^2(1) = 8.22$, $p < .01$; *ORs* 5.68) and 87.5% (n=28) of non South Asian males reported using intimidation compared to 49.1% (n=27) of non South Asian females ($\chi^2(1) = 12.84$ $p > .01$; *ORs* 7.29). In addition, non South Asian male participants were 16.93 more likely to use emotional abuse ($\chi^2(1) = 14.14$, $p < .01$) and 15.05 times more likely to experience emotional abuse than non South Asian female participants ($\chi^2(1) = 12.83$, $p < .01$; see Table 5.12).

Table 5.12: *Associations Between South Asian Male and Female Participants and Non South Asian Male and Female Participants for CBS-R (N=191).*

CBS-R Subscales		**Coercion and Threats**		**Intimidation**		**Emotional Abuse**	
		R [a] to P[b]	**P to R**	**R to P**	**P to R**	**R to P**	**P to R**
South Asian (*n*=101)		***n*=93** **n %**	***n*=94** **n %**	***n*=76** **n %**	***n*=76** **n %**	***n*=93** **n %**	***n*=91** **n %**
Male (*n*=41)	Yes	32 (94.1%)	18 (52.9%)	26 (76.5%)	18 (52.9%)	26 (76.5%)	27 (79.4 %)
	No	2 (5.9%)	16 (47.1%)	8 (23.5%)	16 (47.1%)	8 (23.5%)	7 (20.6%)
Female (*n*=60)	Yes	42 (71.2%)	44 (73.3%)	36 (63.2%)	25 (83.3%)	45 (76.3%)	51 (89.5%)
	No	17 (28.8%)	16 (26.7%)	21 (36.8%)	7 (16.7%)	14 (23.7%)	6 (10.5%)
Df		1	1	1	1	1	1
Chi square		6.98*	4.02**	1.74	8.22*	.00	1.76
Non South Asian (*n*=90)		***n*=87** **n %**	***n*=86** **n %**	***n*=87** **n %**	***n*=86** **n %**	***n*=87** **n %**	***n*=86** **n %**
Male (*n*=33)	Yes	30 (93.8%)	27 (84.4%)	28 (87.5%)	20 (62.5%)	31 (100%)	31 (100%)
	No	2 (6.2%)	5 (15.6%)	4 (12.5%)	12 (37.5%)	0 (0%)	0 (0%)
Female (*n*=57)	Yes	37 (67.3%)	33 (61.1%)	27 (49.1%)	34 (63%)	36 (65.5%)	37 (67.3%)
	No	18 (32.7%)	21 (38.9%)	28 (50.9%)	20 (37%)	19 (34.5%)	18 (32.7%)
Df		1	1	1	1	1	1
Chi square		8.01*	5.16**	12.84*	.00	14.14*	12.83*

Note. [a]R= Respondent, [b]P = Partner, *p<.01, **p<.02.

Hypothesis 4: It is hypothesised that there will be differences between South Asian and non South Asian participants, and male and female participants on the Views on Relationship Scale questionnaire.

Table 5.13 and 5.14 shows the number of significant and non-significant linear trends between participants' ethnicity and their responses on the VRAS subscales. One way ANOVAs graphs showed the direction of the mean rate on the VRAS subscales with ethnicity (Appendix 3.6 Figure 1). The effect size was calculated using the ANOVA contrast tests *t*-statistic (see Appendix 3.6 Table A) as suggested by Field (2005), in order to show an objective and standardised measure of the magnitude of the observed effect. In summary, compared to non South Asian participants, South Asian participants were significantly more likely to approve of male aggressors using severe violence, female aggressors using minor violence and severe violence, and irrespective of

Table 5.13: *One-Way ANOVAs, Significant Differences and Effect Sizes[a] Between South Asian and Non South Asian Participants' Views on the VRAS Subscales, About Male Physical Aggression to a Female Partner (N=191).*

VRAS Subscales: Male Aggressor	Ethnicity of Participant						Effect Size
	Non South Asian (*n*=90)		South Asian (*n*=101)				
	Mean	*SD*	*Mean*	*SD*	*df*	*F*	$r_{contrast}$[b]
Minor Violence							
Approval of violence	1.421	0.402	1.519	0.823	1	1.062	--
Approval of retaliation	1.834	0.542	2.488	1.216	1	22.629*	0.90
Victim injury	2.479	0.727	2.965	0.917	1	15.806*	0.96
Emotional distress	3.433	0.808	3.618	0.698	1	2.754	--
Victim self defence	2.414	0.531	2.280	0.836	1	1.677	--
Punishment aggressor	1.098	0.809	1.255	0.824	1	.667	--
Severe Violence							
Approval	1.352	0.472	1.440	0.710	1	.980	--
Approval of retaliation	1.893	0.700	2.848	0.645	1	31.793*	0.89
Victim injury	3.417	0.965	3.683	1.023	1	3.328	--
Emotional distress	3.702	0.906	3.971	0.905	1	3.998**	0.95
Victim self defence	2.453	0.643	2.237	0.904	1	3.481	--
Punishment aggressor	1.921	1.183	2.104	0.990	1	1.281	--

Note. [a] The effect sizes have been calculated for the contrast tests (see Appendix 4.6, Table A) for more meaningful analysis (Field, 2005). [b] Effect size: 0.20=small, 0.50=medium and 0.80=large. *p<.01,**p<.05.

Table 5.14: *One-Way ANOVAs, Significant Differences and Effect Sizes[a] Between South Asian and Non South Asian Participants' Views on the VRAS Subscales, About Female Physical Aggression to a Male Partner (N=191).*

VRAS Subscales: Female Aggressor	Ethnicity of Participant						Effect Size
	Non South Asian (*n*=90)		South Asian (*n*=101)				
	Mean	*SD*	*Mean*	*SD*	*df*	*F*	$r_{contrast}$[b]
Minor Violence							
Approval of violence	1.617	0.713	1.891	0.955	1	4.851*	0.85
Approval of retaliation	1.545	0.524	1.822	1.822	1	10.011*	0.91
Victim injury	2.377	0.783	1.948	0.646	1	16.126*	0.95
Emotional distress	3.280	0.601	2.603	1.082	1	27.680*	0.92
Victim self defence	3.137	0.912	3.577	0.971	1	.890*	0.94
Punishment aggressor	1.059	0.899	0.784	0.791	1	4.804*	0.60
Severe Violence							
Approval of violence	1.287	0.396	1.771	0.970	1	19.941*	0.88
Approval of retaliation	1.676	0.556	1.958	0.849	1	7.079*	0.92
Victim injury	3.234	0.649	2.823	0.713	1	16.436*	0.94
Emotional distress	3.745	0.837	3.142	0.990	1	19.770*	0.95
Victim self defence	2.967	0.835	3.507	1.002	1	15.792*	0.96
Punishment aggressor	1.860	0.982	1.475	1.043	1	6.614**	0.73

Note. [a] The effect sizes have been calculated for the contrast tests (see Appendix 4.6, Table A) for more meaningful analysis (Field, 2005). [b] Effect size: 0.20=small, 0.50=medium and 0.80=large. *p<.01, **p<.05.

gender of aggressor or severity of violence, they were more likely to approve of retaliation by the victim.

Table 5.15 and 5.16 shows the number of significant and non significant linear trends between participants' gender. One way ANOVAs graphs showed the direction of the mean rate on the VRAS subscales with gender (Appendix 3.6 figure 2). The effect size was calculated using the ANOVA contrast tests *t*-statistic (see Appendix 3.6 Table B) as suggested by Field (2005), in order to show an objective and standardised measure of the magnitude of the observed effect. In summary in terms of gender, compared to female participants', male participants were significantly more likely to approve of male aggressor using minor violence, female aggressor using minor and severe violence, and irrespective of severity, they were more likely to approve of female victim retaliating (see Table 5.15 and 5.16).

Table 5.15: *One-Way ANOVAs, Significant Differences and Effect Sizes[a] Between Male and Female Participants' Views on the VRAS Subscales, About Male Physical Aggression to a Female Partner (N=191).*

VRAS Subscales: Male Aggressor	**Gender of Participant**						**Effect Size** $r_{contrast}$[b]
	Female (*n*=74)		**Male (*n*=117)**				
	Mean	***SD***	***Mean***	***SD***	***df***	***F***	
Minor Violence							
Approval of violence	1.245	0.404	1.865	0.809	1	34.49*	0.92
Approval of retaliation	2.152	1.165	2.208	0.620	1	.181	-
Victim injury	2.757	0.990	2.681	0.580	1	.433	-
Emotional distress	3.747	0.738	3.156	0.634	1	30.496*	0.91
Victim self defence	2.241	0.779	2.527	0.511	1	8.871*	0.56
Punishment aggressor	1.182	0.888	1.177	0.690	1	.002	-
Severe Violence							
Approval of violence	1.173	0.353	1.789	0.743	1	40.06*	0.97
Approval of retaliation	2.455	1.412	2.261	0.900	1	1.276	-
Victim injury	3.748	1.054	3.221	0.808	1	14.721*	0.74
Emotional distress	4.127	0.892	3.341	0.717	1	42.08*	0.96
Victim self defence	2.199	0.835	2.590	0.649	1	12.275*	0.69
Punishment aggressor	2.158	1.165	1.775	0.901	1	61.97*	0.98

Note. [a]The effect sizes have been calculated for the contrast tests (see Appendix 4.6 Table B) for more meaningful analysis (Field, 2005).[b]Effect size: 0.20=small, 0.50=medium and 0.80=large. *p<.01.

Table 5.16: *One-Way ANOVAs, Significant Differences and Effect Sizes[a] Between Male and Female Participants' Views on the VRAS Subscales, About Female Physical Aggression to a Male Partner (N=191).*

VRAS Subscales: Female Aggressor	Gender of Participant						Effect Size $r_{contrast}$[b]
	Female (*n*=74)		Male (*n*=117)				
	Mean	*SD*	*Mean*	*SD*	*df*	*F*	
Minor Violence							
Approval of violence	1.732	0.952	1.804	0.663	1	.293	-
Approval of retaliation	1.517	0.411	1.988	0.758	1	21.82*	0.92
Victim injury	1.924	0.730	2.561	0.584	1	41.50*	0.96
Emotional distress	2.832	1.057	3.105	0.675	1	4.509**	0.32
Victim self defence	3.624	1.032	2.908	0.621	1	34.154*	0.93
Punishment aggressor	0.782	0.866	1.143	0.786	1	2.106*	0.15
Severe Violence							
Approval of violence	1.399	0.821	1.782	0.657	1	10.596*	0.25
Approval of retaliation	1.557	0.470	2.286	0.874	1	39.38*	0.97
Victim injury	2.985	0.759	3.086	0.618	1	.845	-
Emotional distress	3.498	1.042	3.320	0.807	1	1.435	-
Victim self defence	3.439	1.029	2.915	0.726	1	34.154*	0.93
Punishment aggressor	1.577	1.096	1.799	0.895	1	2.219*	-

Note. [a]The effect sizes have been calculated for the contrast tests (see Appendix 4.6 Table B) for more meaningful analysis (Field, 2005). [b]Effect size: 0.20=small, 0.50=medium and 0.80=large. *p<.01,**p<.05.

Hypothesis 5: There will be an association between those who approve of physical violence and rates of IPV, despite participants' ethnicity or gender.

On average, those participants that reported using minor physical violence respondent to partner where more likely to approve of male aggressors using severe violence ($t(85)= 2.221$, $p<.05$, $r=0.48$), female aggressors using minor violence ($t(105)= 3.760$, $p<.01$, $r=.73$) and irrespective of gender of the aggressor or severity of violence, they were more likely to approve of retaliation by the victim ($t(108)=4.235$, $p<.01$, $r=0.82$;see Table 5.17).

Table 5.17: *Significant and Non Significant Independent T-Test Results and Effect Sizes. Between Minor Physical Violence Respondent to Partner (R to P) and VRAS Subscales Minor Approval and Minor Approval Retaliation (N=191).*

VRAS Subscales	Minor Physical Violence R[a] to P[b]						Effect Size*
	Yes (*n*=103)		No (*n*=73)				
	Mean	*SD*	*Mean*	*SD*	*df*	*t*	
Male aggressor							
Approval of minor violence	1.630	0.935	1.376	0.336	85	2.221**	0.48
Approval of minor violence for retaliation	2.579	1.211	1.906	0.726	108	4.235*	0.82
Female Aggressor							
Approval of minor violence	2.062	1.062	1.544	0.601	105	3.760*	0.73

Note. [a] R = Respondent, P= Partner. [b]Effect size: 0.20=small, 0.50=medium and 0.80=large. *p<.05,**p<.01.

Additionally, table 5.18 shows no significant difference between approval of male aggressor using severe violence and using severe physical violence. Nonetheless, those participants that reported perpetrating severe physical violence on their partners' were more likely to approve of a male victim retaliating in severe violence scenarios (M=2.786, SD=1.441) than those who did not report using severe physical violence (M=1.994, SD=0.910; $t(148)$=4.328, p<.01; r=0.71).

Table 5.18: *Significant and Non Significant Independent T-Test Results and Effect Sizes. Between Severe Physical Violence Respondent to Partner and VRAS Subscales Severe Approval and Minor Approval Retaliation (N=191).*

VRAS Subscales	Severe Physical R[a] to P[b]						Effect Size*
	Yes (*n*=87)		No (*n*=89)				
	Mean	*SD*	*Mean*	*SD*	*df*	*t*	
Male Aggressor							
Approval of severe violence	1.391	0.402	1.399	0.765	132	.096	0.02
Approval of severe violence for retaliation*	2.786	1.441	1.994	0.910	148	4.328*	0.71
Female aggressor							
Approval of severe violence	1.633	1.633	1.454	0.737	174	1.50	0.23
Approval of severe violence for retaliation	1.854	0.580	1.785	0.873	153	0.625	0.10

Note. [a] R = Respondent, P= Partner. [b]Effect size: 0.20=small, 0.50=medium and 0.80=large. *p<.01.

Hypothesis 6: It is hypothesised that ethnicity (South Asian) and approval of violence on the VRAS subscales will be significant predictors of severe physical violence.

A logistic regression was performed to see what variables predicted severe physical violence. Only those variables that were significant were used and these included; ethnicity (South Asian or non South Asian), gender (male or female), using severe physical violence, approval of male aggressor using minor violence, approval of female aggressor using minor violence , approval of male victim retaliating in minor violence scenarios , approval of male victim retaliating in severe violence scenarios, current relationship status recoded, living by western values, using and experiencing severe psychological aggression , causing and experiencing severe injury, using and experiencing economic abuse, using and experiencing coercion and threats, using and experiencing intimidation, using and experiencing emotional abuse and using and experiencing isolation.

From these variables only six variables were found to be significant predictors of severe physical violence. A full model with these six variables was significant (χ^2 (6) =111.64, p<.001) and correctly predicted severe physical violence in 93.5% of cases (see Table 5.19). Interestingly, from the six variables, experiencing severe injury appears to be the strongest predictor of participants using severe physical violence (Exp b=52.39, p<.001). Therefore, the odds of a participant who has experienced severe injury using severe physical violence are 52 times higher than those of a participant who has not experienced severe injury. Table 5.19 shows that the second largest predictor for the use of severe physical violence within this model is the use of

severe psychological aggression (Exp *b*=26.8, p<.001), followed by the experience of severe physical violence (Exp *b*=8.53, p<.02).

Table 5.19: *Predicting Severe Physical Violence (R to P) Using Logistic Regression Analysis.*

Variables	***B***	**Wald**	***p* value**	**Exp *b***	**95% CI for exp *b***	
					Lower	**Upper**
Constant	3.27	8.02	.005*	26.3		
South Asian	-1.60	4.54	.03**	.20[c]	.05	.88
Severe physical P[a] to R[b]	-2.14	5.67	.02**	8.53[d]	1.46	49.81
Female aggressor minor approval retaliation	-1.74	11.77	.001*	.18[c]	.07	.47
Severe psychological aggression R to P	3.29	12.03	.001*	26.8[d]	4.18	171.91
Using coercion and threats P to R	-1.70	4.85	.028**	.18[c]	.04	.83
Severe injury P to R	3.96	7.02	.008*	52.39[d]	2.80	980.14

Note. [a] P= Partner, [b]R= Respondent. [C] As the predictor increases the odds of the outcome occurring decreases.
[d]As the predicator increases the odds of the outcome occurring increases. R^2=.07 (Hosmer & Lemeshow), .59 (Cox & Snell), .80 (Negelkerke). Model χ^2 (6) =111.64, p<.001). *p<.01 **P<.05.

Furthermore, Table 5.19 showed that as three predictors increased the likelihood of the use of severe physical violence decreased. The predictors included experience of coercion and threats (Exp *b*=26.8, p<.001), approval of female aggressor retaliating in minor violence scenarios (Exp *b*=26.8, p<.001) and being South Asian (Exp *b*=26.8, p<.001). Therefore, the predictive variables found in this study which increased the likelihood of the outcome variable (perpetration of severe physical violence) included experience of severe injury, use of severe psychological aggression and experience of severe physical violence. The predictive variables found in this study which decreased the likelihood of the outcome variable (perpetration of severe physical violence) included being South Asian, approval of female aggressors use of retaliation in minor violence scenarios and experience of coercion and threats.

Themes that Emerged from the Focus Groups.

In the methodology, it was noted that during the course of the 11 focus groups a number of discussions were raised by participants and themes emerged from these discussions. It must be noted that nine of the groups were mixed gender and ethnicity (non South Asian and South Asian participants), two groups only had South Asian female participants and one group only had South Asian male participants. It was felt by the author that these themes would contribute to the aim of this research (see Appendix 3.7 for more detailed qualitative analysis):

1. In general participants felt that women were open to abuse no matter what their ethnic background. However, South Asian men and women felt there were additional causal factors to consider for South Asian victims of IPV (e.g., what the victim classifies as abuse, added factors of extended family and in-laws, different cultural upbringing from partner and forced marriages).
2. Both South Asian and non South Asian participants felt that the effects of IPV were the same for all victims of IPV. However, South Asian male and female participants reported that South Asian victims may express these effects differently (e.g., psycho somatic symptoms, and the effects may be prolonged due to pressure from family, community and services).
3. Participants felt that women used similar coping strategies no matter what their ethnic background (e.g., self harm or suicide, medication, playing the obedient partner, turning to religion and faith, keeping busy and taking anger out on their children).
4. South Asian men and women felt that there were extra barriers for South Asian victims of IPV. For instance, limited knowledge on services, stigma of divorce, being ostracised and

rejected from their own family and or community, racism from society, confidentiality, trust and being differentiated from non South Asian communities.

5. The all South Asian male group felt that victims of IPV should turn to extended family for support in an attempt to resolve conflict rather than outside intervention due to concepts of honour and shame. However, in the mixed groups, South Asian female participants felt that if necessary victims of IPV should access support services at the same time acknowledging that due to internal and external pressures this tended to happen as a last resort. Non South Asian participants felt as a first resort victims of IPV should turn to a friend and/or support services.
6. Both non South Asian and South Asian participants indicated that one of the main solutions around reducing IPV was prevention and breaking down barriers. Additional prevention strategies were suggested by participants for South Asian victims of IPV. For example, raising awareness within South Asian communities and talking more openly about all forms of abuse including sexual abuse.
7. The majority of the discussion within the focus groups revolved around issues of power and control. A majority of South Asian female participants felt that power and control was omnipotent in South Asian communities compared to non South Asian communities and was used to oppress women, keeping them within the IPV setting using tools to justify ones actions. What was more surprising was that some South Asian female and male participants believed that minor forms of violence (e.g. slapping) was part of marriage and was acceptable.
8. Another theme that emerged that differentiated South Asian and non South Asian participants' responses were societal oppressions. This included racism, religion, gender and

family oppression. Also, South Asian participants tended to talk about the impact of various perpetrators compared to non South Asian participants. All the participants felt the attitudes and beliefs of the victims were important factors of whether victims came forward and accessed services.

9. South Asian participants reported differences between British and non British born South Asian women. It was felt that non British born South Asian women compared to British born South Asian women tended to express the language of abuse differently, may not recognise some forms of abuse, lack awareness and education and may stay in IPV relationships due to immigration issues prolonging the effects of IPV.

Discussion

Frequency data for the CTS-2 and CBS-R showed that participants reported higher rates of severe psychological aggression, severe physical violence, severe injury, coercion and threats, emotional abuse, and isolation compared to a number of previous studies (Archer, 2000; Gary & Foshee, 1997; Johnson, 1995; Stith et al., 2004; Straus, 2004, Whitaker et al., 2007). Despite this, the rates were similar to that found by Fikree et al. (2005) and Shoaib (2009). The reason for such high rates could be explained by the increase of legislation and awareness of IPV within the West which has helped more victims of IPV come forward. This could be seen through the focus groups where participants were open and willing to discuss such sensitive issues and talk about personal experiences.

Overall, the findings from this study did not support hypothesis one, as no significant associations were found between the CTS-2 and CBS-R subscales and nonreciprocal and reciprocal violence within ethnicity. There was some support for hypothesis two, as South Asian participants were more likely to use severe psychological aggression and report experiencing severe injury than non South Asian participants. Furthermore, South Asian female participants were more likely to experience physical violence than South Asian male participants. Significant evidence was found to support hypothesis three, as South Asian participants were more likely to report using more control tactics on the CBS-R than non South Asian participants. Significant evidence was found for hypothesis four and differences were found between South Asian and non South Asian participants' responses, and male and female participants' responses on the VRAS. Four significant differences were found to support hypothesis five as those that approved of physical aggression were more likely to be physically violent towards their intimate partner compared to those who disapproved. There was evidence to support hypothesis six, as six variables were found to be significant predictors of severe physical violence.

The discussion will go on to explore these hypotheses in more detail and examine them in comparison to current literature within this area.

Hypothesis 1

The findings from this study did not support this hypothesis, as no significant associations were found between the CTS-2 and CBS-R subscales and nonreciprocal and reciprocal violence within ethnicity. In contrast to the findings from studies that have found that women were more likely to

be in reciprocal IPV relationships compared to men (e.g., Swan & Snow, 2006; Walker, 1989; Whitaker et al., 2007), this study found that male participants were more likely to report reciprocal injury, emotional abuse and isolation within their relationships than female participants.

In addition, this study found that South Asian male participants were more likely to report reciprocal severe injury, economic abuse and coercion and threats within their relationship than South Asian female participants. These findings support community studies such as DeKeserdy and Schwartz (1998) and Follingstad et al. (1991) who found that women's self-defence cannot fully explain the reciprocal phenomenon and Whitaker et al. (2007) study which found that reciprocal IPV is associated with greater injury than nonreciprocal IPV.

Hypothesis 2

In support of this hypothesis two significant associations were found between CTS-2 subscales and ethnicity. South Asian participants were more likely to use severe psychological aggression (83.7% compared to 61.4% of non South Asian) and report experiencing severe injury (55.9% compared to 37.9% of non South Asian) compared to non South Asian participants. In addition, further analysis showed one significant association between gender and ethnicity; asSouth Asian female (74.6%) participants were more likely to experience physical violence compared to South Asian male (48.3%) participants. However, in terms of gender male (84.8%) participants were more likely to report experiencing severe psychological aggression compared to female (70%) participants as suggested by Douglas and Straus (2003). In contrast to previous studies such as

Straus (2004), Straus et al. (1998), Straus et al. (2004) no other significant associations where found between gender and the CTS-2.

Hypothesis 3

This study found evidence to partially support hypothesis three as only one significant association was found between the CBS-R and ethnicity. It was found that South Asian participants were more likely to experience economic abuse than non South Asian participants.

In terms of gender, four significant associations were found with the CBS-R. Male participants were overall more likely to report using; economic abuse, coercion and threats, intimidation and emotional abuse compared to female participants. These results were in contrast to the findings of Shoaib (2009) who found that female participants used more intimidation compared to male participants. This contrast in findings could partly be explained by the type of sample used, as Shoaib (2009) used a student sample and the current study used a community sample.

Furthermore, in terms of gender and ethnicity South Asian male participants were more likely to use coercion and threats than South Asian female participants. Similarly, non South Asian male participants were more likely to use coercion and threats than non South Asian female participants. Additionally, South Asian female participants were more likely to experience coercion and threats than South Asian male participants, which corresponded with the findings from Shoaib (2009). However, this study also found that non South Asian male participants were more likely than non South Asian female participants to report experiencing coercion and threats.

Furthermore, similarly to Shoaib (2009) study South Asian female participants reported experiencing more intimidation than South Asian male participants. In comparison, this study also found that non South Asian male participants were more likely to use intimidation as well as emotional abuse and experiencing emotional abuse compared to non South Asian female participants.

Hypothesis 4

The analysis found significant results to support hypothesis four. In terms of ethnicity, South Asian participants were more likely to approve of the male aggressors use of minor physical violence and use of retaliation in minor and severe violence scenarios compared to non South Asian participants. In addition, South Asian participants felt that the male victim was more likely to get injured in the minor scenarios and suffer from severe emotional distress, compared to non South Asian participants. These results support the findings of studies such as Fikree et al. (2005).

Previous studies such as Fikree et al. (2005) did not explore participants' perceptions on female aggressors; therefore, no comparisons with the VRAS female aggressors subscales could be made with previous research. . Subsequently, this study added to existing literature by finding that South Asian participants were more likely to approve of female aggressors use of severe physical violence and retaliation in minor and severe violence scenarios, compared to non South Asian participants.. South Asian participants were more likely to feel that the female victim could defend herself in both the minor and severe violence scenarios compared to non South Asian participants.

Further analysis found some interesting findings between the VRAS subscales and gender. Male participants were more likely to approve of male aggressors use of minor and severe violence compared to female participants. As well as, male participants being more likely to approve of female aggressors use of retaliation in the minor and severe violence scenarios. These findings are in contrast with the findings of Fiebert and Gonzalez (1997) and Miller and Simpson (1991) studies, who found both sexes view acts of physical aggression towards a partner more negatively when the aggressor is a man.

In contrast to the findings of Fiebert and Gonzalez (1997), male participants felt that male victims could defend themselves in minor and severe violence scenarios and female participants felt that female victims could defend themselves in minor and severe scenarios. In contrast to the findings of Miller and Simpson (1991) study, the results from this study found that for severe punishment, male participants felt that in minor violence scenarios female perpetrators should be punished and female participants felt that in severe violence scenarios male perpetrators should be punished.

Hypothesis 5

Four significant differences were found to support hypothesis five and all had large effect sizes. Those participants that reported using minor physical violence on the CTS-2 were more likely to approve of minor violence by the male aggressor, minor violence by the female aggressor and retaliation by male aggressor in the minor violence scenarios. Those participants that reported using severe physical violence on the CTS-2 were more likely to approve of a male aggressor retaliating in the severe scenarios compared to those participants who did not report using severe

physical violence. These findings support the literature that there is an association between those who approve of physical violence and perpetrate violence (Archer, 2000; Fikree et al., 2005; Miller & Simpson, 1991). The case study also supports these findings, as ME approved of violence within her relationships and subsequently perpetrated violence.

Hypothesis 6

Six variables were found to be significant predictors of severe physical violence which contribute to the significant predictors found by Fikree et al. (2005). The predictive variables found in this study which increased the likelihood of the outcome variable (perpetration of severe physical violence) included experience of severe injury, use of severe psychological aggression and experience of severe physical violence. The predictive variables found in this study which decreased the likelihood of the outcome variable (perpetration of severe physical violence) included being South Asian, approval of female aggressors use of retaliation in minor violence scenarios and experience of coercion and threats.

These predictors (besides being South Asian, approval of female aggressors use of retaliation in minor violence scenarios and use of coercion and threats),and those found in Fikree et al. (2005) support the verbal rule, antecedents, and discriminative stimuli units of the Bell and Naugle (2008) model of predicting physical violence perpetration.

Themes that Emerged from the Focus Groups

From the focus groups a number of themes emerged, which highlighted similarities and differences between South Asian and non South Asian communities and British born and none British born South Asians. Participants felt that women were open to abuse no matter what their ethnic background and that the effects and coping strategies were the same for all victims of IPV. However, South Asian participants in particular felt that there were extra barriers for South Asian women coming forward and seeking help due to internal and external pressures which they felt would prolong the effects of IPV.

What was interesting was that the all South Asian male group felt that victims of IPV should turn to extended family for support in an attempt to resolve conflict; this view also appeared to be supported by non British born females (born in South Asia). Both non South Asian and South Asian participants indicated that one of the main solutions around reducing IPV was prevention and breaking down barriers through talking more openly about abuse. Another interesting point about the groups was that participants, in respect of gender or ethnicity, had a tendency to discuss IPV in terms of female victims and male perpetrators. In addition, some of the themes coincided with those found by Chew-Graham et al. (2002), Greenwood et al. (2000) and Hussain and Cochrane (2004). For instance, limited knowledge on services, stigma of divorce, being ostracised and rejected from their own family and or community, racism from society and concepts such as '*izzat*' (honour).

Limitations of the Study

There are several factors in relation to this study that may have influenced the results. The current study was limited by a large number of questionnaires that could not be used and the overall small sample size. Overall, of the 298 questionnaires received 31% could not be used. Subsequently, the data from 191 participants was not sufficient to make effective conclusions, and a larger sample may change the results significantly. Analysis showed no demographic differences between the participants who did not sign the consent form or complete the questionnaire compared to those who did sign the consent forms. In appears from feedback through email that some participants noted that the questionnaire was too long and subsequently this might have contributed to the high rate of participants that did not answer any of the questions online.

A number of measures were put in place (e.g., the use of focus groups, a variety of venues [mosques, community centres, voluntary organisations] and Urdu speaker facilitator, the author) to ensure a wide variety of participants were reached to increase the generalisability of the findings. However, the lengthy questionnaire may have deterred parts of the community from coming forward. For example, participants who had learning difficulties, participants that struggle to read and/or understand English, participants who are reluctant to come forward and volunteer for research projects. This therefore affects the generalisability of the findings of this study to these populations.

Another limitation with this study is ethnic lumping which does not allow for meaningful data and comparison across ethnic groups (Yang, 2007). Even though there are similarities between the

three different cultural groups (Indian, Pakistani and Bangladeshi), these cultural groups have sub cultural groups and therefore may differ in terms of e.g. beliefs, traditions and attitudes.

The term 'lives by western values' is open to interpretation and therefore could have impacted on the findings of this study. If the question 'western values' was more specific and broken down into examples of cultural and religious differences, then participants may have responded differently to the question. These findings may have contributed to hypothesis six and in understanding the differences between South Asian and non South Asian participants. Therefore, future studies may want to ask participants for an example next to the question and/ or when conducting focus groups to ask participants to define 'lives by western values' to develop examples to put in questionnaire.

The research was not designed to look at qualitative data and therefore no standardised measures were used during the discussions of the focus groups or accurate measures put in place to collect qualitative data. Subsequently, the qualitative data may not be a true representation of IPV within non South Asian and South Asian communities as it may be a biased representation by the researcher. However, despite this the themes raised a number of vital issues within this research area and could help direct future research.

Reflection of the Study

IPV is a sensitive topic and sensitive area to research, where many ethical issues need to be considered. For instance, being aware of the effects the study may have on participants that have

been affected by IPV and putting measures in place to ensure the least distress to the participants. Specifically relevant to this study is not offending people from different cultural, religious and social backgrounds. On reflection, through the process of implementing this study the author has learnt a number of crucial lessons. One of these lessons is discussed in detail below.

When the author initially considered conducting the research, she thought that there would be noticeable differences between South Asian and non South Asian participants with regards to IPV. This was mainly due to the author being South Asian and her personal understanding of the South Asian community. However, through the course of researching, designing and implementing the study the author learnt to appreciate the complexity of IPV in general and more specifically within the South Asian community. For example, when conducting the focus groups the author found other factors that played a part in IPV within South Asian communities. These factors included the ethnicity of their partner, the individual values and beliefs about IPV, educational status, parents and family values and beliefs, which part of Bangladesh, India or Pakistan they were from (e.g., rural or urban areas), where they had been brought up in the UK (close knit Asian community or in more mixed communities), and if they were married to a family member (e.g., first cousin).

The author enjoyed conducting the focus groups and felt this was a more useful exercise than employing the questionnaires because it gave her a real insight into the complexity of IPV in general and more specifically within the South Asian community. Consequently, on completion of the study the author found that she had made a number of stereotypical judgments and made

assumptions about the South Asian community prior to starting the study; a common fault also made by many services, leading to inadequate services provided to this community (Thiara, 2005). Therefore, this shows two important things, firstly, just because you are from the same ethnic background does not stop you from making stereotypical judgements and assumptions or make you more component to work with that community, and secondly the importance of evidence based literature.

Directions for Future Research

The research highlighted areas in which future research is needed. Future studies need to consider larger community samples across more than one area in the U.K. (this study only looked at samples within the Greater Manchester region) which may be more representative and relative to looking at differences in IPV between ethnic groups. As identified by the literature the term South Asian covers a variety of countries and ethnic communities and despite overlaps between cultures and traditions they do vary significantly (Southall Black Sisters, 2004; Yang, 2007). Therefore, future research needs to avoid ethnic lumping. Subsequently, it is recommended that more specific ethnic groups for instance Pakistani, Indian, and Bangladeshi communities should be looked at separately for more meaningful and relative data. It would also be interesting to look at whether the ethnicity of the partner has any effect on IPV perpetration.

It would be valuable to explore some of the themes further that emerged from the focus groups using a more robust qualitative design. For instance, differences were found between British and non British born South Asian women (e.g., in expressing the language of abuse differently, not

recognising some forms of abuse, lack of education, immigration issues and individual's geographical background). Focus groups or individual qualitative interviews could be conducted throughout the U.K. in various venues (e.g., schools, shelters, community organisations, voluntary organisations) employing standardised procedures (to ensure consistency across groups or individuals interviews and retrieval of information) and asking participants open ended questions. If would be beneficial if focus groups were mixed in terms of ethnicity, gender, literacy etc in order to increase generalisability of the findings. The benefit of doing focus groups or individual open ended qualitative interviews is that the participant does not necessary need to know how to speak English, read or write in English or Urdu and the interviewer can explore issues in more depth.

In addition, it would interesting to ask South Asian participants about common tactics and violence used within South Asian communities and comparing this to the subscales on CTS-2 and CBS-R.

The CBS-R found high rates of control tactics being used between intimate parents. Conflict theory assumes that conflict is an inevitable part of all human associations, whereas violence as a tactic to deal with conflict is not (Straus, et al., 1996), so this could contribute to why the rates on the CBS-R were so high. Additionally, the reason for such high rates could be explained by the increase of legislation and awareness of IPV within the West which has helped more victims of IPV come forward. This could be seen through the focus groups where participants were open and willing to discuss such sensitive issues and talk about personal experiences. Nonetheless, a better

understanding of why these rates were so high is needed. Therefore, future studies may benefit from looking at the frequency of conflict used, using the CBS-R and then employing a qualitative design to examine the underlying cause of the conflict in order to get a more accurate and true representation of the data.

Practice and Clinical Implications

In regards to practice, high rates of violence were found in this study compared to the rates put forward by Greater Manchester Police (2007), which shows the lack of victims reporting incidents of IPV despite ethnicity. Services and the police need to work alongside local communities regardless of ethnic background in raising awareness of IPV, educating women about abuse and services available, and breaking down barriers through talking more openly about abuse. Additionally, services and the police need to be mindful of cultural differences and need to be aware of culture barriers that prevent South Asian women coming forward and prolonging the effects of IPV and this needs to be effectively addressed when raising awareness and educating these communities

The predictive variables found in this study and those found by Fikree et al. (2005) support the verbal rule, antecedents, and discriminative stimuli units of the Bell and Naugle (2008) model in predicting physical violence perpetration. From a clinical perspective, this model shows promising results in the relevance of this model in helping to identify risk factors and treatment targets for both victims and perpetrators of IPV. However, caution needs to be applied (particularly with psychiatric populations) as the results are still preliminary.

Conclusion

The aim of the research was to investigate whether differences exist in rates of IPV in South Asian and non South Asian participants. There were no differences in IPV rates and reciprocal IPV in terms of ethnicity, which supports the findings of earlier studies such as Straus (2004). However, this study contributed to the literature by finding that South Asian male participants were more likely to use severe psychological aggression, severe injury and control tactics than non South Asian and South Asian female participants. Also, there was further support for current literature as a strong association between approval of IPV and physical perpetration was found (e.g. Archer 2000). In addition, the predictive variables found in this study besides being South Asian and those found by Fikree et al. (2005) support the verbal rule, antecedents, and discriminative stimuli units of the Bell and Naugle (2008) model in predicting physical violence perpetration.

CHAPTER 5:

Discussion

Discussion

Thiara (2005) stated that the development of research on ethnicity and IPV have generally been problematic, couched in stereotypical assumptions rather than being explored in detail or given centrality. Therefore, more evidence based research was needed in order to provide a better and more accurate understanding of IPV within BME communities, and more effective and appropriate services. Therefore, the aim of this thesis was to look at establishing some insight and research evidence base into IPV within BME communities in particular South Asian communities'. It must be noted that due to the findings from the systematic review and case study it was identified that further research was needed to look at prevalence and risk factors for IPV within BME communities.

In order to meet this aim, the discussion will look at how the content of this thesis has contributed to the understanding of IPV within BME communities in terms of terminology, prevalence, risk factors for physical violence perpetration, effects of IPV and treatment for IPV.

Terminology

The conceptual review found that there was an overall universal problem with defining violence between intimate partners and found that there was no agreed national or international definition (Dixon & Graham-Kevan, 2010; Graham-Kevan & Wigman, 2009). Despite this, most definitions made some reference to psychological, physical, sexual and economic abuse. In terms of ethnicity, Southall Sisters (2004) suggested that more culture specific forms of IPV should be included within the IPV definition stated by the Home Office (Walby & Allen, 2004). The problem with

defining violence was seen to be one of the limitations when examining prevalence rates of IPV. Therefore, the review highlighted the need for agreed terminologies and definitions on violence within families and between intimate partners to help better generalise and compare findings, especially cross culturally.

Prevalence

Firstly, for reliable prevalence rates cross culturally one must have a reliable and valid tool which can measure IPV prevalence cross-culturally. Subsequently, Chapter 3 found evidence for high internal consistency and construct validity for the CTS-2 when administering the instrument in a South Asian country (e.g., India). Therefore, it can be seen as a reliable and valid measure to use to identify prevalence of IPV within South Asian communises.

Furthermore, when reviewing prevalence rates within developing countries in South Asia and Africa it was found that males perpetrated more violence than females compared to Europe and Latin American countries were females perpetrated more violence than males. Therefore, one would expect higher rates of male to female violence within South Asian and African communities within the U.K. However, the 2001 BCS pointed to little difference in the prevalence of IPV by ethnicity (Walby & Allen, 2004) and this was supported by the findings from Chapter 4 study, which found no differences in IPV rates and reciprocal IPV in terms of ethnicity.

Despite ethnicity, compared to the 2001 BCS, Greater Manchester police (2007) and a number of previous studies (such as Archer, 2000; Gary & Foshee, 1997; Johnson, 1995; Stith et al., 2004;

Straus, 2004, Whitaker et al., 2007) high rates of violence were found amongst the participants as well as high rates of severe psychological aggression, severe injury, use of coercion and threats, emotional abuse, and isolation. This gives further support to the fact that there is serious under-reporting of IPV incidents (Walby & Allen, 2004; Thiara, 2005).

Nonetheless, the rates found from the current study were similar to that found in Fikree et al.'s (2005) community sample and Shoaib's (2009) student sample; therefore, showing that the increase of legislation, awareness of IPV and subsequent change in belief system within the West has helped more victims of IPV come forward to talk more openly about their relationships. This could be seen through the focus groups in Chapter 4, where participants were open and willing to discuss such sensitive issues and talk about personal experiences.

Risk factors for Physical Violence Perpetration

This thesis provided evidence for the risk factors put forward by Bell and Naugle (2008) and identified that this model appears suitable to help predict physical violence perpetration in BME communities. For instance, from the case study a number of risk factors were found within the assessment stage indicating the likelihood of ME becoming a victim and perpetrator of IPV including child abuse, attachment style, interpersonal conflict, drug and alcohol use and beliefs about violence. These risk factors were found in the motivating factor, antecedent and verbal units of Bell and Naugle (2008) model, and are highlighted in figure 5.1.

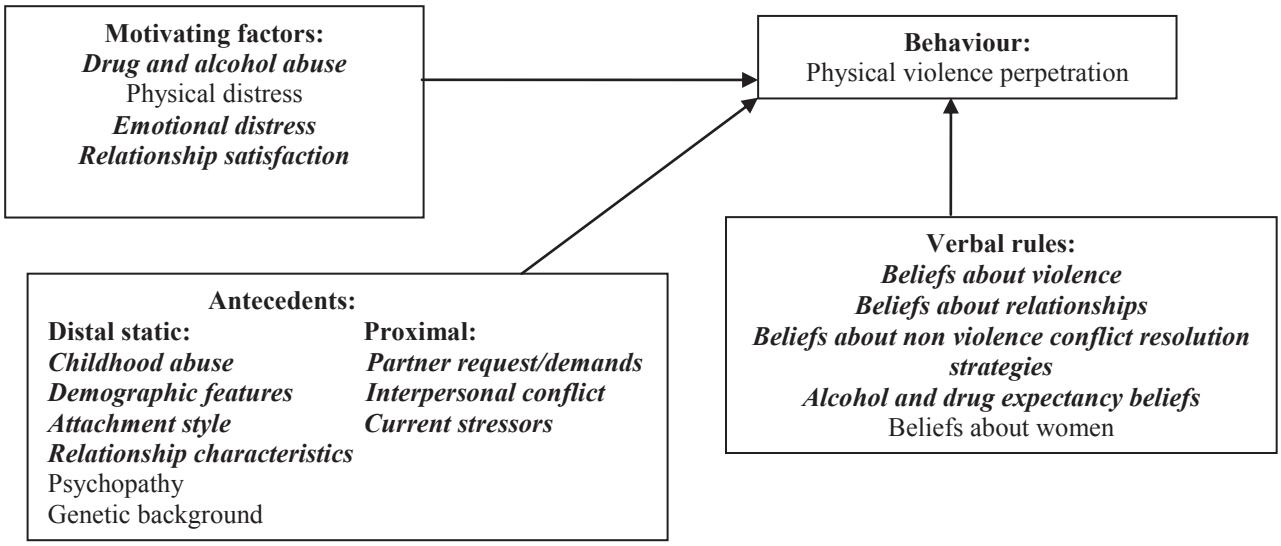

Figure 5.1: Risk factors from the Bell and Naugle (2008) model that are supported by the thesis are italicised.

From Chapter 4, six variables were found to be significant predictors of the perpetration of severe physical violence. The predictive variables found in this study which increased the likelihood of the outcome variable (perpetration of severe physical violence) included experience of severe injury, use of severe psychological aggression and experience of severe physical violence. The predictive variables found in this study which decreased the likelihood of the outcome variable (perpetration of severe physical violence) included being South Asian, approval of female aggressors use of retaliation in minor violence scenarios and experience of coercion and threats .

These findings contribute to the significant predictors found by Fikree et al. (2005; belief that they had the right to hit their wives, low economic status, cultural issues and experience of abuse within childhood). These risk factors were found in the verbal rule, antecedents, and

discriminative stimuli units of the Bell and Naugle (2008) model of predicting physical violence perpetration.

From a clinical perspective, Bell and Naugle (2008) model shows promising results in helping to identify risk factors and treatment targets for both victims and perpetrators of IPV within the community. This model also shows promising preliminary findings in its relevance within the psychiatric populations (e.g., identifying risk factors and treatment targets for patients). The thesis has also put forward support for the applicability of this model within BME communities and BME psychiatric populations.

Effects of IPV

The review found that the effects of IPV include PTSD, low self esteem, substance abuse, depression, anxiety, psychiatric disorders, physical injury, self harm, reproductive health problems, irritable bowel syndrome and chronic pain (Campbell, 2002; Golding, 1999; O'Leary, 1996; Plichta, 2004; Stark & Flitcraft, 1988; Sugarman et al., 1996; Testa & Leonard, 2001). Additionally, the case study supported the effects of and risk factors for victims of, IPV as identified by Carbone-Lopez et al. (2006) in terms of poor physical health, drug use and deterioration of mental health.

The systematic review, case study and research found that regardless of ethnicity or gender, the effects of IPV were similar and detrimental for all victims of IPV. Nonetheless, from the focus groups in Chapter 4, South Asian male and female participants reported that South Asian victims

may express their effects differently (e.g., psycho somatic symptoms) and the effects may be prolonged due to internal and external pressures from their family, community and services.

Treatment for IPV

Overall findings from the systematic review indicate that women's intervention were effective in reducing the effects of IPV in particular re-abuse, PTSD, trauma-related guilt cognitions and shame, anxiety, depression and somatisation. Treatment was effective when there was a combination of long term advocacy service and CBT. It was also found that interventions where likely to be effective when they were tailored to the individual's circumstances and stage of change. These findings were supported by the case study which demonstrates the importance of individualised assessment and formulation in order to identify the clients' treatment needs and stage of intervention.

The systematic review found a lack of valid and reliable data to show whether current treatment for IPV was effective for BME communities. Out of the nine studies, only two made comparisons across ethnicity but the studies were not diverse as the majority of the participants were White (Kubany et al., 2003; Kubany et al., 2004). In addition, seven of the studies gave an ethnic breakdown; however, they did not look at any associations between ethnicity and intervention (Johnson & Zlotnick, 2006; McFlarlane et al., 2006; Reed & Enright, 2006; Sullivan & Bybee, 1999). This supports Thiara's (2005) view about the problems with current research and puts in to question the reliability and validity of these IPV intervention programmes with regards to their cross-cultural applicability. Subsequently, more research is needed within this area.

Strengths and Limitations of Thesis

As demonstrated within this thesis, the field of IPV has undergone many changes over the last few decades. There has been a growing evidence base with the help of more structured and empirically based tools (e.g., the CTS-2), which have changed the way IPV is viewed. Unfortunately, little research had been completed on IPV within BME communities, due to difficulties in obtaining relevant samples and the assumption that the feminist theory has examined and dealt with the issue of diversity and ethnicity within IPV (Archer, 2002; Thiara, 2005). Subsequently, the thesis has contributed to this area by putting forward evidence based literature in terms of terminology, prevalence, risk factors for physical violence perpetration, effects of IPV and treatment for IPV.

Moreover, in the introduction it was illustrated that there was a lack of empirical evidence to support Bell and Naugle (2008) contextual model. This thesis has put forward evidence to support this model and its applicability within the BME community in terms of identifying risk factors for physical violence perpetration and treatment targets for IPV.

However, the weakness of this thesis is that one could argue that there is evidence of ethnic lumping as the BME group is so diverse (e.g. looking at the South Asian community; Indian, Pakistani and Bangladeshi) and by looking at just one sub group may have changed the findings within this thesis. However, this thesis can serve as a foundation for future research when looking at ethnicity and IPV.

Future Research

This thesis was constructed because of the lack of literature on IPV within BME communities. Subsequently, the findings within this research are provisional and therefore further research is needed in order to provide a stronger evidence base. Subsequently, the following recommendations for research are made:

- It would be beneficial to provide further evidence for Bell and Naugle (2008) contextual model by conducting research exploring some of the units separately and how effective they are in predicting physical violence perpetration taking into account ethnicity.
- The systematic review identified the need for additional research employing rigorous designs to test the effectiveness of IPV interventions taking into account larger samples as well as exploring ethnic differences.
- The research would benefit from being repeated on larger community samples across more than one area in the U.K. which may be more representative and relevant to looking at differences in IPV between ethnic groups. In addition, future studies might benefit from looking at sub groups (e.g., Pakistani community) and avoid ethnic lumping.
- Furthermore, when conducting research within South Asian communities within the UK it would be interesting to look at the frequency of violence and conflict using the CTS-2 and CBS-R in order to get a more accurate and true representation of the data.
- It would be beneficial to explore the themes found in the focus groups from a more rigorous qualitative design.

Practice and Clinical Implications

This thesis has covered a number of issues and has contributed to literature within the field of IPV within BME communities. Subsequently, from the findings of this thesis there are a number of practical implications. Firstly, from the systematic review it was found that treatment for IPV victims mainly targeted the behavioural repertoire, verbal rules and motivating factor units of Bell and Naugle (2008) model. However, from identifying risk factors for physical violence perpetration within the case study and empirical research it would be beneficial if treatment for IPV victims and perpetrators targets the antecedents unit of the model as well. Secondly, treatment for IPV needs to be tailored to the individual and their stage of change.

The findings also have implications for risk assessments within clinical populations. Most risk assessments such as the Historical, Clinical and Risk-20 (HCR-20) are used in psychiatric populations to identify a person's probability of violence and incorporate questions to identify relationship instability and abuse. However, this is only one of the many factors that the assessment addresses. Therefore, once a clinician has identified that a person has been a perpetrator or victim of IPV, it would be beneficial to explore the variables within the units in the Bell and Naugle (2008) model suggested above to obtain more information. Subsequently, consideration of such factors can aid in reporting the type and extent of risk presented by a person and in selecting intervention strategies intended to reduce the probability that an individual will demonstrate violence.

Furthermore, as identified by the research, high rates of violence were found in this study compared to the rates put forward by Greater Manchester Police (2007), which shows the lack of victims reporting incidents of IPV despite ethnicity. The introduction of the thesis acknowledged that by raising awareness of IPV might help victims come forward. Subsequently, services and the police need to work alongside local communities regardless of ethnic background in raising awareness of IPV, educating women about abuse and services available, and breaking down barriers through talking more openly about abuse. Additionally, services and the police need to be aware of and effectively address culture barriers that prevent BME women, in particular South Asian women reporting IPV incidents and leaving IPV relationships.

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Appendices

Appendix 1:

Literature Review Following a Systematic Approach:

Looking at the Effectiveness of Treatment for Victims of Intimate Partner Violence

Appendix 1.1: Search Strategy

Database	Search Strategy	Period	Number of Hits	Date
EMBASE	1. Battered Woman/ or Domestic Violence/ 2. Intimate partner violence.mp. 3. Treatment.mp. 4. Psychotherapy/ or group work.mp. 5. Cognitive Therapy/ 6. Cognitive Therapy/ or Cognitive Trauma Therapy.mp 7. forgiveness therapy/ 8. 1 or 2 9. 4 or 5 or 6 or 7 or 8 10. 8 and 9	1630	1980 to 2008 Week 22	20th May 2008
MEDLINE(R)	1. Battered Woman/ or Domestic Violence/ 2. Intimate partner violence.mp. 3. Treatment.mp. 4. Psychotherapy/ or group work.mp. 5. Cognitive Therapy/ 6. Cognitive Therapy/ or Cognitive Trauma Therapy.mp 7. forgiveness therapy/ 8. 1 or 2 9. 4 or 5 or 6 or 7 or 9 10. 8 and 9	1432	1950 to May Week 3 2008	20th May 2008
PsychInfo	1. Battered Woman/ or Domestic Violence/ 2. Intimate partner violence.mp. 3. Treatment.mp. 4. Psychotherapy/ or group work.mp. 5. Cognitive Therapy/ 6. Cognitive Therapy/ or Cognitive Trauma Therapy.mp 7. forgiveness therapy/ 8. 1 or 2 9. 4 or 5 or 6 or 7 or 8 10. 8 and 9 11. 2 or 3 12. 10 and 9	1253	1806 to June Week 1 2008	20th May 2008
ASSIA: Applied Social Sciences Index and Abstracts	Domestic violence or battered women or intimate partner violence and treatment or psychotherapy or group work or cognitive therapy or forgiveness therapy or exposure therapy	563	1987 to current	3rd June 2008
ERIC	Domestic violence or battered women or intimate partner violence and treatment or psychotherapy or group work or cognitive therapy or forgiveness therapy or exposure therapy	89	1966 to current	3rd June 2008
Health	Domestic violence or battered women	167	1982 to current	3rd June 2008

Sciences	or intimate partner violence and treatment or psychotherapy or group work or cognitive therapy or forgiveness therapy or exposure therapy			
Web of Science	Domestic violence or battered women or intimate partner violence and treatment or psychotherapy or group work or cognitive therapy or forgiveness therapy or exposure therapy	261	1900 to current	3rd June 2008

Appendix 1.2: Inclusion/ Exclusion Criteria

Title of study:
Author: **Date:** **Country:**

	Inclusion	Exclusion	Criterion met?	Comment
Population	Does the population consist of females over the age of 18, identified to be at-risk of domestic violence including pregnant women.	Adolescents	Yes Unclear No	
Intervention	Exposure to treatment due to being victims of domestic violence	N/A	Yes Unclear No	
Comparator	Other treatment programmes.		Yes Unclear No	
Outcomes	Re-victimisation, self report.	N/A	Yes Unclear No	
Study Type	Cohort, case control, RCT and before- and-after study.	Narrative reviews, cross-sectional, opinion papers, editorials or commentaries	Yes Unclear No	
Language	No restrictions however foreign articles have to be translated into English language.		Yes Unclear No	

If all questions answered yes, include in study.

Appendix 1.3: Quality Assessment Forms

a) Case control studies

QUESTION	Yes (2)	Partially (1)	No (0)	Unsure	COMMENT
INITIAL SCREENING					
Has the study addressed a clearly focused issue?					
Is the study addressing treatment in battered women?					
STUDY DESIGN					
Is a case control study an appropriate way of answering the question under the circumstances?					
Has the study addressed the question being asked?					
SELECTION BIAS					
Were the cases representative of the defined population?					
Has the classification of cases been reliably assessed and validated?					
Was there a sufficient number of cases selected?					
Were the controls representative of the defined population?					
Were the controls selected in a manner reducing bias?					
Was there a sufficient number of controls selected?					
Are the cases and controls comparable with respect to demographic/potential confounding factors?					
Were potential confounding variables controlled for (by matching or through stats)?					
PERFORMANCE AND DETECTION BIAS					
Were the participants blind to the measure of exposure?					
Were the assessor(s) blind to participants' outcome?					
Has violence experienced been clearly defined?					
Has treatment been clearly defined and measured?					
Was blinding incorporated where feasible?					
ATTRITION BIAS					
Were dropout rates and reasons for drop-out similar across					
OUTCOME BIAS					
Was outcome measured in a correct way?					
Were the measures valid and reliable for the defined					
CONFOUNDING FACTORS					

Were confounding variables considered?					
STATISTICS					
Was the statistical analysis used correct?					
ARE THE RESULTS BELIEVABLE?					
Are results unbiased?					
Are the results significant?					
Is the size of effect reasonable?					
Are methods and design reliable?					
Have limitations been discussed?					
APPLICABILITY OF FINDINGS					
Are the participants representative of UK women?					
Can results be applied to women regardless of culture and size?					
Can the results be applied to the UK population?					

b) Cohort studies

QUESTION	Yes (2)	Partially (1)	No (0)	Unsure	COMMENT
INITIAL SCREENING					
Has the study addressed a clearly focused issue?					
Is the study addressing treatment in battered women?					
STUDY DESIGN					
Is a cohort study an appropriate way of answering the question under the circumstances?					
Has the study addressed the question being asked?					
SELECTION BIAS					
Was the cohort representative of the defined population?					
Was a sufficient sample size used?					
Were the groups (where the victims of domestic violence similar at base line such as demographics and background factors (age, ethnicity, etc.)?					
Were the groups comparable in all important confounding variables (e.g. parental substance abuse)?					

Were any potential confounding variables controlled for?					
MEASUREMENT AND DETECTION BIAS					
Has violence experienced been clearly defined?					
Has treatment been clearly defined and measured?					
Were the measurements for outcome objective?					
Was the outcome measure validated?					
Were the assessment instrument(s) for outcome (psychometrics/questionnaire) standardised?					
Was the outcome assessed in the same way across groups?					
Were the participants blind to the research?					
Were the assessor(s) blind to the exposure?					
ATTRITION BIAS					
Were dropout rates and reasons for drop-out similar across groups?					
OUTCOME BIAS					
Was outcome measured in a correct way?					
Were the measures valid and reliable for the defined population?					
STATISTICS					
Was the statistical analysis used correct?					
ARE THE RESULTS BELIEVABLE?					
Are results unbiased?					

c) Before- and-After study

QUESTION	**Yes (2)**	**Partially (1)**	**No (0)**	**Unsure**	**COMMENT**
INITIAL SCREENING					
Has the study addressed a clearly focused issue?					
Is the study addressing treatment in battered women?					
STUDY DESIGN					
Is a Before- and-After study an appropriate way of answering the question under the circumstances?					
Has the study addressed the question being asked?					
SELECTION BIAS					
Was the cohort representative of the defined population?					
Was a sufficient sample size used?					

Were any potential confounding variables controlled for?					
MEASUREMENT AND DETECTION BIAS					
Has violence experienced been clearly defined?					
Has treatment been clearly defined and measured?					
Were the measurements for outcome objective?					
Was the outcome measure validated?					
Were the assessment instrument(s) for outcome (psychometrics/questionnaire) standardised?					
Were the participants blind to the research?					
Were the assessor(s) blind to the exposure?					
ATTRITION BIAS					
Was follow up long enough for the outcome to occur?					
Were drop out rates and reason for drop outs clearly defined?					
OUTCOME BIAS					
Was outcome measured in a correct way?					
Were the measures valid and reliable for the defined population?					
STATISTICS					
Was the statistical analysis used correct?					
ARE THE RESULTS BELIEVABLE?					
Are results unbiased?					

Adapted from Critical Appraisal Skills Programme (CASP, 2000)

Appendix 1.4: Data Extraction Form

General information:

Date of data extraction:

Title, authors, journal, publication details,
or any other identifying features of the study:

Identification of the reviewer:

Notes:

Re-verification of study eligibility:

Population:	Females over aged 18	Y	N	?
	Domestic violence victims	Y	N	?
Exposure:	Physical Abuse	Y	N	?
	Sexual Abuse	Y	N	?
	Other Abuse	Y	N	?
Comparator:	other treatment group	Y	N	?
Outcome:	Self report	Y	N	?
Re victimisation		Y	N	?

Study Design Cohort Case Control Before- and –after study

Continue? **Yes** **NO**

Specific Information

Population Characteristics

1. Target population (describe)
2. Inclusion criteria
3. Exclusion criteria
4. Recruitement procedures used (participation rates if avaliable)
5. Characteristics of participants

No. of participants enrolled :

No. of participants completed :

Age :

Ethnicity :

Gender :

Other information :

Type of abuse /Exposure **Additional Notes**

a) Physical Abuse ( )

b) Sexual Abuse ( )

c) Other abuse ( )

d) Treatment group ( )

Outcome

1) What was masured at baseline? (also, was abuse unsubstatiated or substantiated?)

   a.

   b.

   c.

2) What was measured after the intervention (or at follow-up?)

   a.

   b.

   c.

3) Type of abuse?

4) Who carried out the mesaurement? Was the assessor blinded?

5) How was outcome measured?

6) If a tool was used, was it validated? If so, how?

7) How was the validity of the self reported behaviour maximised?

8) What were the follow-up intervals? (where applicable)

9) Drop out rates (plus proportion of thise who did not agree to participate if stated) and reason for drop out:

10) Limitations:

11) Notes:

Analysis

1. Stats technique used
2. Were confounding variables assessed?
3. Attrition rate (overall rates)
4. Was attrition (missing data) adequately dealt with?
5. Number (or %) followed up from each condition

    a) Condition A
    b) Condition B

6. Overall study quality good reasonable poor
7. Number of 'unclear' or unanswered assessment items:
8. Notes:

Appendix 2:

Case study ME: Female inpatient with a diagnosis of paranoid schizophrenia and a history of witnessing parental violence, experiencing sexual abuse and intimate partner violence.

This chapter is not available in the digital version of this thesis.

Appendix 3:

Empirical Research study: Intimate Partner Violence and Associations between South Asian and non South Asian Participants: A Community Sample.

Appendix 3.1: Poster Inviting Participants to take Part in the Research

To *(head of organisation's name)*

I am currently in my third year undertaking a Doctorate in Forensic Psychology Practice at the University of Birmingham. As part of the course I have gained ethical approval from the University of Birmingham to conduct research exploring how people solve conflict in intimate relationships (e.g. by reasoning, discussion, verbal or physical violence) and to gain their views about various hypothetical relationship scenarios that contain different levels of aggressive acts. The research has three main objectives: to see how people solve conflict in intimate relationships, to see if there is a difference in attitudes and solving conflicts in intimate relationships between South Asian and Caucasian communities, and to examine predictors for the risk of physical abuse.

The reason I am conducting this study is that national studies in the U.K. estimate that 45% of women and 26% men are affected by domestic violence annually. However, it is widely believed that there is a serious number of under reported cases of domestic violence. Research has also shown the devastating effects domestic violence can have on individuals and families. In spite of sustained evidence to raise public awareness in a desperate attempt to prevent further escalation, domestic violence is still on the increase, especially within South Asian communities. Therefore, the current research will contribute knowledge in this under researched area. The study will also benefit individuals working with perpetrators and victims of domestic violence within South Asian communities. It will help them have a better understanding of the attitudes and beliefs men and women hold from South Asian communities.

I am contacting you to gain consent to approach people who attend your venue. Your cooperation in this research will be greatly appreciated and as this is an under researched area you will be contributing to knowledge in this field.

Once consent is given by the organisations, I would like to organise focus groups at the venue to recruit participants. The focus group will take between 45 minutes to 1 hour to complete, this will also include time for participants to complete the questionnaire. This would allow participants to gain a better understanding of the study and give opportunities for potential participants to ask questions. Posters will be put up in the venue giving a brief outline of the study, dates for the

focus group and requirements of participation. In order for people to participate in the study, they must be at least 18 years old. Participation in the study is voluntary and their response will be anonymous.

The participants would be given a questionnaire at the end of the focus group or presentation and asked to complete it within the session or alternatively they can complete it at home and post it in a secure locked box that I would leave at the reception venue. This box would be collected by me at a later date. The participants will also have an option of completing the questionnaire online. There are four sections to this questionnaire, the first section asks for general demographic information about you. The second section asks you to consider ways in which you have solved conflict in your relationship currently and in the past. The third questionnaire asks you to consider how many times you and your partner did each of these things e.g. made it difficult to work or study, controlled the others money, kept own money matters secret. The fourth section asks you to consider hypothetical relationship scenarios that happen between intimate partners. Completion of the questionnaire will take approximately 35 minutes. Please see the attached copies of the questionnaires.

Due to the nature of the subject and the content in questionnaire, I understand that there is potential for this to cause some discomfort to some participants. Various steps have been put in place in order to reduce this potential as much as possible, e.g., the nature of the questions are emphasised to participants before they begin to look at the questionnaire. In addition, helpline numbers such as The Samaritans, National Domestic Violence Helpline and NHS direct will be provided.

If you have any further questions or need further information about the study, please do not hesitate to contact me or Dr Catherine Hamilton-Giachritsis, at the University of Birmingham, Edgbaston, Birmingham, B15 2TT. Alternatively, you can contact via email on ...; and Dr Catherine Hamilton-Giachritsis my supervisor on.....

If you give your consent please email me on ... or .... with your name and organisation name, as well as where I can put a poster, details of convenient dates for the focus groups, and which groups I can deliver my presentation to. Alternatively, please call me on the mobile number listed above and I can forward a consent letter for you to sign.

Thank you for your time,

Kind regards,

Sohbia Shoaib & Dr Catherine Hamilton-Giachritsis

Appendix 3.3: Focus Groups

Appendix 3.3.1: Schedule of Focus Group and Presentation

1. Introduce myself.
2. Give letter of invitation to participants and read the letter to them.
3. Answer questions from the participants.
4. Give participants' research information sheet and frequently asked questions page (read out to participants).
5. Answer questions from the participants.
6. Give participants' consent form and explain its purpose.
7. Answer questions from the participants.
8. Give questionnaire in envelope to participants.
9. Allow time for those participants wishing to complete questionnaire at venue (Participants will also be informed of the option of completing online or at home. Ask participants to put their questionnaire in the envelope and seal. Post the questionnaire in the locked box which will be placed in reception.

Appendix 3.3.2: Standardised Instructions for Groups

Systematic instructions were used by the researcher during the focus groups. The presentation script was the same for both the focus group and when presenting at the various training events.

1. The researcher read thorough the following script.

> "My name is Sohbia Shoaib I am currently in my third year undertaking a Doctorate in Forensic Psychology Practice at the University of Birmingham. As part of the course I have gained ethical approval from the University of Birmingham to conduct research exploring how people solve conflict in intimate relationships (e.g. by reasoning, discussion, verbal or physical violence) and to gain their views about various hypothetical relationship scenarios that contain different levels of aggressive acts.
>
> "The reason I am conducting this study is that national studies in the U. K. estimate that, 45% of women and 26% men are affected by domestic violence annually. However, it is widely believed that there is a serious number of under reported cases of domestic violence. Research has also shown the devastating effects domestic violence can have on individuals and families. In spite of continued evidence to raise public awareness in a desperate attempt to prevent further escalation, domestic violence is still on the increase, especially within South Asian communities. Therefore, the current research will contribute knowledge in this under researched area. The study will also benefit individuals working with perpetrators and victims of domestic violence within South Asian communities. It will help them have a better understanding of the attitudes and beliefs men and women hold from South Asian communities."
>
> "Before you decide if you want to take part I would like you to read this brief information sheet so I can introduce the nature of the study and what will be required of you".

2. Participants were given a letter of invitation (see Appendix 3.3.3). The letter of invitation was read out by the researcher

This step was in place to ensure potential participants were fully aware of the nature of the study and examples of its content to minimise distress. It briefly detailed the purpose of the research and provided contact information for help lines and agencies dealing with partner violence that they may access free of charge if they chose to do so. Importantly participants were not placed under any pressure to take part; participants were clearly informed that they did not have to participate at this stage.

3. The researcher stayed with participants for the length of time it took them to view the brief information sheet and waited for their response or further questions. The following statement was read to those participants who refused to take part any further:

   "That's absolutely fine. Thank you for your time anyway. I will leave you with a copy of the brief information sheet just in case you would like to view any of the agency details listed on it".

4. For the remaining participants the researcher handed participants a more detailed information sheet and frequently asked questions page. These were read out to participants (see Appendix 3.3.4 & 3.3.5).

5. Participants were than given a consent form (Appendix 3.3.6) and the blank questionnaire concealed in an envelope (addressed to S. Shoaib).

6.

a. Within the training event participants were instructed by the researchers to:

   "First read the detailed information sheet again and consider the study further, if you still want to take part please complete the consent form. You may open the envelope which contains the questionnaire. By completing the consent form and filling in the questionnaire you are agreeing to take part able in the study. We will not ask you to sign anything as this study is nameless to the researchers. Therefore, at no point should you write your name on the questionnaire or show your questionnaire to the researcher or any other person. The only thing we ask you to do is to write a code name on the questionnaire so that if you

should decide to take out from the study at any point you can simply contact us namelessly and tell us that you want the data that matches to your code name to be deleted. Because of this we encourage you to keep the information sheet somewhere safe or write down the Principle Investigators contact details along with your code name in case you want to remove your data at a later stage. The questionnaire should take approximately 35 minutes. You may leave any questions that you don't want to answer blank. Once you have completed the questionnaire please put it back in the envelope, seal it and return it to the researcher by placing it in the large sealed box situated at….. (they were told where this was). If you prefer to post the questionnaire then a stamp and a sticky label with address on it is provided on the desk at the front of the room. If you decide you don't want to complete the questionnaire or only want to complete part of it that is fine, but please return it anyway so we can determine a response rate. There is also an option of completing the questionnaire online (details of online study were given to participants)".

b. Within the focus group participants were instructed by the researchers to:

"First read the detailed information sheet again and consider the study further, if you still want to take part please complete the consent form. You may open the envelope which contains the questionnaire. By completing the consent form and filling in the questionnaire you are agreeing to take part able in the study. We will not ask you to sign anything as this study is nameless to the researchers. Therefore, at no point should you write your name on the questionnaire or show your questionnaire to the researcher or any other person. The only thing we ask you to do is to write a code name on the questionnaire so that if you should decide to take out from the study at any point you can simply contact us namelessly and tell us that you want the data that matches to your code name to be deleted. Because of this we encourage you to keep the information sheet somewhere safe or write down the Principle Investigators contact details along with your code name in case you want to remove your data at a later stage. The questionnaire should take approximately 35 minutes. However, you have 50 minutes to complete the questionnaire as some people may require more time to complete the questionnaire. You may leave any questions that you don't want to answer blank. Once you have completed the questionnaire please put it back in the

envelope, seal it and return it to the researcher by placing it in the large sealed box situated at….. (they were told where this was). If you prefer to post the questionnaire then a stamp and a sticky label with address on it is provided on the desk at the front of the room. If you decide you don't want to complete the questionnaire or only want to complete part of it that is fine, but please return it anyway so we can determine a response rate. There is also an option of completing the questionnaire at home or online (details of online study were given to participants)".

7. The researcher than debriefed the participants.

"Thank you for participating in this research study.

Previous research has shown a high prevalence of Intimate Partner Violence within South Asian communities. Furthermore, there is very limited research on Intimate Partner violence in South Asian communities. The study aimed to investigate factors that arise within South Asian relationships where violence occurs and to see whether these factors are different to non South Asian couples.

May I take this opportunity to remind you that you can withdraw your data at any point after completing this questionnaire up until the publication of results. Do not give your name in correspondence or use any identifiable information. If you wish to withdraw your data, please write to Sohbia Shoaib or Dr Catherine Hamilton-Giachritsis, University of Birmingham, Edgbaston, Birmingham, B15 2TT, indicating your withdrawal from the study along with your code name. Do not give your real name.

If you are/have been a victim or perpetrator of relationship violence, or indeed if you find the contents of this questionnaire upsetting for some other reason and wish to discuss issues around aggression in relationships with someone, there are many avenues of free support, such as, The Samaritans helpline on 08457 90 90 90 (all), Women's Aid 0808 2000 247 (women and children), Manchester Women's Domestic Violence Helpline (0161

636 7525) or the National Centre for Domestic Violence 08709 220704 (all). If you are upset and require further help or advice around any of the issues presented in this questionnaire please do take advantage of the available support."

Appendix 3.3.3: Letter to Invite Participants to Complete Questionnaire

Dear reader

I am a postgraduate psychology student and I am looking for people to take part in a research study that I am carrying out for my thesis. I would be grateful if you would take a few minutes to read this sheet so you can decide whether you would like to take part.

The study looks at how people solve disagreements (i.e., reasoning, discussion, verbal or physical violence) in intimate relationships (i.e. married/dating/co-habiting). Your help in this research will be greatly appreciated and as this is an under researched area you will be contributing to knowledge in this field.

In order to participate in this study:

- You must be at least 18 years old.
- If you have to have been in a dating/married/ intimate relationship that has lasted for at least one month in your adolescent/ adult life
    - Then we would ask that you attempt to complete all sections of the questionnaire.
    - Completion of the questionnaire will take approximately 35 minutes.
- If you have not been in a relationship then you are only required to complete section 1 and 4.
    - Completion of the questionnaire will take approximately 20 minutes.

There are four sections to this questionnaire:

- The first section asks for general information about you.
- The second section asks you to consider ways in which you have solved disagreements in

your relationship currently and in the past.

- The third questionnaire asks you to consider how many times you and your partner did each of these things e.g. made it difficult to work or study, controlled the others money, kept own money matters secret.
- The fourth section asks you to consider hypothetical relationship scenarios that happen between intimate partners.

Your contribution in the study is voluntary and your response will be confidential. If you do not wish to take part, it will not affect the service that you receive from the organisation. If you do NOT wish to take part, place your empty/or part completed questionnaire in the envelope provided, seal it and post it in the locked box provided at the reception area. If you DO WANT to take part in this study please complete the questionnaire at the end of the presentation or alternatively you can complete it at home. On completion of the questionnaire, seal it in the envelope provided and post it in the locked box that is provided at the reception venue. If you wish to post your questionnaire then a stamp and address can be provided by the researcher. This box would be collected by me at a later date. Alternatively you can complete the questionnaire online. To access the link please email me on ... and I will send you an email with the link. Or you can type in the following web address below: **sohbiasurvey.com**

If you change your mind and no longer want your answers to be part of the study after you have completed and posted your questionnaire (which you can do up to the date of publication), please write to Sohbia Shoaib or Dr Catherine Hamilton-Giachritsis, University of Birmingham, Edgbaston, Birmingham, B15 2TT, indicating your withdrawal of your data from the study along with your code name (do not include your real name). If you require further information about this study at a later date, please telephone Dr Catherine Hamilton-Giachritsis or me (....).

Please note that some of these questions ask about violent acts. Therefore, if you choose to take part, it is important that you understand you may potentially experience some anxiety/distress due to the content of some of the questions. For example, one question will ask if you have ever punched/ kicked your partner or been punched/ kicked by a partner.

If you find the content of this questionnaire upsetting and wish to discuss the issues with someone, there are many avenues of support, such as The Samaritans (Tel: 08457 90 90 90), National Domestic Violence Helpline (0808 2000 247), NHS direct (Tel: 08457 46 47), Manchester Women's Domestic Violence Helpline (0161 636 7525) or Niteline (Tel: 0800 274750). If you are upset in any way by the questionnaire or indeed this letter, please do take advantage of the available support.

Kind regards,

Sohbia Shoaib

Appendix 3.3.4: Research Information Sheet

Studying examining how people solve conflict in dating/ intimate relationships and their views about aggression intimate partners.

This survey was designed to develop our understanding of how people solve conflict in relationships.

In order to participate in the study:

- **You must be at least 18,**
- **Have been in a dating/married or intimate relationship that has lasted for at least 1 month at some point in your life.**
- **If you have not been in a relationship then you are only required to complete sections 1 and 4 of the questionnaire.**

Completion of the questionnaire will take approximately 35 minutes.

Your participation is voluntary and you may refuse to participate or choose to withdraw from the study at any time- you are under no responsibility from the Organisation to participate. If you do not wish to answer some questions asked, simply tick the 'No response' answer to the relevant question/s.

There are four sections to this questionnaire:

- The first section asks for general information about you.
- The second section asks you to consider ways in which you have solved conflict in your relationship currently and in the past.
- The third questionnaire asks you to consider how many times you and your partner did each of these things e.g. made it difficult to work or study, controlled the others money, kept own money matters secret.
- The fourth section asks you to consider imaginary relationship situations that happen between intimate partners.

Please note that some of these questions ask about violent acts. Therefore, if you choose to take part, it is important that you understand you may potentially experience some anxiety or distress due to the content of some of the questions. For example, one question will ask if you have ever punched/ kicked your partner or been punched/ kicked by a partner.

If you find the content of this questionnaire upsetting and wish to discuss the issues with someone, there are many avenues of support, such as The Samaritans (Tel: 08457 90 90 90), National Domestic Violence Helpline (0808 2000 247), NHS direct (Tel: 08457 46 47) or the Manchester Women's Domestic Violence Helpline (0161 636 7525). If you are upset in any way by the questionnaire or indeed this letter, please do take advantage of the available support.

Your participation in this project is confidential and you will be among several hundred people. Your confidential responses will only be accessed by the researcher Sohbia Shoaib and the principal investigator of this project Dr Catherine Hamilton-Giachritsis. They will not know your name. The results of this study will be presented in a postgraduate research project and may be published in scientific journals, presented at professional conferences or used to develop violence prevention programs.

By completing the questionnaire, you agree to take part in the study. Therefore, you understand that your input in this survey is voluntary and you are free to refuse to answer any questions or completely pull out from the study at any time. You can pull out without giving a reason and without any consequences for you.

The first question asks you to give a code word of your choice, please make sure you fill this in. If you change your mind later and no longer want your answers to be part of the research, please write to Sohbia Shoaib or Dr Catherine Hamilton-Giachritsis, University of Birmingham, Edgbaston, Birmingham, B15 2TT, indicating your withdrawal from the study along with your code word. If you require further information about this study, please telephone myself on .....
It is important that any information received is accurate. **You are therefore asked to complete this in private and consider the questions carefully and honestly.** Your co-operation in this research will be greatly appreciated and, as this is under researched area, you will be contributing to knowledge in this field.
Thank you

Appendix 3.3.5: Frequently Asked Questions
Please read this information sheet and think about whether you would like to take part in this study further. After you have read this, if you still want to take part, you may open the envelope which contains the questionnaire.

Who can take part?
In order to take part in the study, you must be at least 18.

How long will it take?
Completion of the questionnaire will take approximately 35 minutes however within the venue you will be given 50 minutes to complete the questionnaire.

What is the study about?

This study explores how people manage disagreements and view the use of aggression between intimate or dating partners. If you choose to take part, you will be asked questions about how you have solved disagreements and whether you have experienced aggression in your past and current relationships and it will require you to read short situations that detail aggressive acts between partners.

There are four sections to the questionnaire:

- The first asks for general information.
- The second asks you to consider many ways in which you may have solved disagreements in your relationships. For example, questions will ask if you have ever done any of the following to a partner or if a partner has done this to you: showed them care; showed respect; punched or kicked; used a knife or gun.
- The third questionnaire asks you to consider how many times you and your partner did each of these things e.g. made it difficult to work or study, controlled the others money, kept own money matters secret.
- The fourth asks you to consider and comment on a series of imaginary situations where aggression arises within a couple. Aggressive acts are briefly described in section four; for example, it may say 'Nina punched him repeatedly in the face'.

Do I have to take to part?

No. Your input is voluntary and you may refuse to take part or choose to pull out from the study at any time –either during or after completing the questionnaire (up until publication of results). You are under no responsibility from the Organisation to take part. If you do choose to take part and you decide you do not want to answer certain questions you may leave them blank.

Will taking part in the study affect me negatively in any way?

If you choose to participate, it is important that you understand you may potentially experience some distress due to the content of some of the questions. Equally, you may not. If you are/have

been a victim of or the person responsible for relationship violence, or indeed if you find the contents of this questionnaire upsetting for some other reason and wish to discuss issues around aggression in relationships with someone, there are many avenues of free support, such as The Samaritans (Tel: 08457 90 90 90), National Domestic Violence Helpline (0808 2000 247), NHS direct (Tel: 08457 46 47) or Manchester Women's Domestic Violence Helpline (0161 636 7525). If you are upset and require further help or advice around any of the issues presented in this questionnaire please do take advantage of the available support

Will my responses be confidential?

Your contribution in this project is anonymous to the researchers and you will be among several hundred other people. Your responses will be anonymous and only anonymous information about groups of people will be used in any publication of the results at no point will your individual answers be published.

How can I pull out my data if I change my mind about taking part?

- The first question asks you to give a code name of your choice, please make sure you fill this in and make a note of it for yourself.
- This code name allows you, and only you, to recognise your responses.
- At no point will the researchers be able to recognise who you are. You can use this code name to take out your responses by contacting the Principle Investigator namelessly.
- If you decide to contact us via telephone or email do not give your name or use an identifiable e-mail account. If you wish to take out your data you can also write to Sohbia Shoaib or Dr Catherine Hamilton-Giachritsis, University of Birmingham, Edgbaston, Birmingham, B15 2TT, indicating your withdrawal from the study along with your code name. If you require further information about this study at a later date, please telephone Dr Catherine Hamilton-Giachritsis or myself on ... If you do this, your responses will be located in the data base via your codename and deleted – the researcher will not look at your responses before deleting them.

We encourage you to keep this information sheet somewhere safe or write down the Principle Investigator's contact details somewhere safe along with your code name in case you want to take out your data at a later stage.

How do I provide my permission to take part?

We are not going to ask you provide signed permission as your responses need to be anonymous, instead we simply ask you to check a box at the top of the questionnaire saying that you have read and understood the information sheets and give permission to take part in this study. Importantly, by giving permission to take part you are showing that you understand your involvement in the survey is voluntary and you are free to refuse to answer any question or completely pull out from the study at any time. You can pull out without giving a reason and without any cost to you during or after taking part.

Who will view my responses?

Your anonymous responses will only by accessed by the principal investigator and research students of this project. The combined results from this study will be presented in student theses and may be published in scientific journals, presented at professional conferences or used to develop violence prevention programs. If you require further information about this study, please email, Sohbia Shoaib at ...

Is this research important?

Yes. This is an under researched area and your co-operation in this research will be greatly appreciated. Hopefully, this research in combination with other projects will inform policy and treatment in the area of relationship conflict and aggression. Therefore, it is important that any information received is accurate. You are therefore asked to complete this in private and consider the questions carefully and honestly.

If I choose to take part - what do I do once I have completed the questionnaire?

Once you have completed the questionnaire please put it back in the envelope, seal it and return it to the researcher by placing it in the large locked box situated 'at X' (to be filled in) in

'organisation name' (to be filled in). If you decide you don't want to complete the questionnaire or only want to complete part of it that is fine, but please return it anyway so we can determine a response rate. If you prefer to post the questionnaire then a stamp and an address will be provided by the researcher.

Thank you

Are you happy to proceed?
YES ☐ NO ☐

Appendix 3.3.6: Consent Form

Please select Yes or No to the following questions.

	Yes	No
I confirm that I have read and understand the information sheet for the above study.		
I have had the opportunity to consider the information and have asked questions of the principle investigator and/or researcher (if I wanted to) and had these answered satisfactory.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.		
I understand that data collected during the study may be looked at by the two individuals from the University of Birmingham listed on the information sheet. I give permission for these individuals to have access to my anonymous answers.		
I am aware that the study may involve disclosing sensitive information.		
I am aware of the support available in case I become distressed during or after participation in the study.		
I am over 18 years old.		
I understand that there are no disguised questions or procedures in this study.		
I understand that I am free to choose not to answer a question without having to explain why.		
I understand that my responses in the questionnaire will be used in reports of this research.		
I understand that I am free to withdraw my results up until the publication of the results.		
I agree to take part in the above study.		

If you have replied 'No' to any of the above responses please do not continue with the questionnaire.

If you need further clarification on the study or questionnaire please contact me or Dr Catherine Hamilton-Giachritsis prior to completing the questionnaire.

If you have replied 'Yes' to all the above questions please continue to complete the questionnaires.

Appendix 3.4: Questionnaires

Appendix 3.4.1: Demographics questionnaire

Questionnaire – Please complete

Please provide a code name 4-8 characters in length (for use if wish to withdraw your questionnaire at any time)*:*_____

PLEASE NOTE, IF YOU CHOOSE NOT TO PROVIDE A RESPONSE TO ANY QUESTION BELOW PLEASE CIRCLE THE 'NO RESPONSE – (NR)' OPTION.

Please provide the following information

1	Your sex	Male	Female	NR
2	Your age			NR
3	What country were you born in?			NR
4	What is your nationality?			NR
5	Do you consider yourself to be of South Asian Origin?	Yes	No	NR
6	What is your country of permanent residence			NR
7	How many years have you lived in your country of permanent residence?			NR
8	Would you consider yourself to live by Western cultural values	Yes	No	NR
9	Your sexual orientation	Heterosexual		NR
		Gay		
		Lesbian		
		Bi-sexual		
10	Your current relationship status	Single		NR

		Dating (but not living together)		
		Stable relationship (but not living together)		
		Cohabiting		
		Divorced		
		Married (spouse present)		
		Married (separated)		
		Widow/er		
11	Your employment level	Not employed	Self employed	NR
		Housewife/ househusband	Student	
		Employed in part time work (0-16 hours)	Employed 16 hours or more	
		Please specify occupation:		N/R

13. Please choose from the list below which best describes your ethnic origin or racial/cultural background

A	White		NR
B	Black – Caribbean		
C	Black – African		
D	Black – other		
E	Asian – Indian		
F	Asian – Pakistan		
G	Asian – Chinese		
H	Asian – Other		
I	Asian – Bangladeshi		
J	White/Black Caribbean		
K	White/Black African		
L	Other mixed		
M	Other		
N	Not known		

Thinking about your relationship(s) in the past 12 months				
14	Are you currently in a dating or intimate relationship that has lasted at	Yes	No	NR

	least 1 month?			
15	How long has this relationship currently lasted?		Not applicable	NR
16	What is the sex of your partner?	Male	Female	NR
17	Which category best describes the relationship with that partner?	Dating but no sex Dating and sex Stable romantic partner but no sex Stable romantic partner and sex Engaged but no sex Engaged and sex Married	Not applicable	NR
18	Excluding any current relationship, have you been in a dating or intimate relationship that has lasted at least 1 month, at some point in the past 12 months?	Yes	No	NR
19	How long did the most significant past relationship in the last 12 months last?		Not applicable	NR
20	What was the sex of your partner?	Male Female	Not applicable	NR
21	Which category best describes the relationship with that partner?	Dating but no sex Dating and sex Stable romantic partner but no sex Stable romantic partner and sex Engaged but no sex Engaged and sex Married	Not applicable	NR
Thinking about your relationship(s) prior to the last 12 months				
22	Prior to the last 12 months (and excluding any long term current relationship), have you ever been in a dating or intimate relationship that has lasted more than 1 month?	Yes	No	NR
23	What was the length of time the most significant past relationship lasted.		Not applicable	NR
24	What was the sex of that partner	Male Female	Not applicable	NR

25	Which category best describes the relationship with that partner?	Dating but no sex Dating and sex Stable romantic partner but no sex Stable romantic partner and sex Engaged but no sex Engaged and sex Married	Not applicable	NR
26	Prior to the last 12 months, approximately how many intimate relationships have you been involved in, that have lasted longer than 1 month?		Not applicable	NR
27	Most commonly, how long did a typical relationships last?		Not applicable	NR
28	Which best describes the most frequent type of relationship/s you had?	Dating but no sex Dating and sex Stable romantic partner but no sex Stable romantic partner and sex Engaged but no sex Engaged and sex Married	Not applicable	NR

Note: if you have not been in a relationship then please go to section 4 of the questionnaire.

Appendix 3.4.2: Modified Conflict Tactics Scale 2 (CTS2; Straus et al, 1996)

No matter how well a couple get along, there are times when they disagree, get annoyed, want different things or just have spats or fights with each other. Couples have many different ways of trying to settle their differences. Here is a list of things you and your partner might have done during your relationship.

Consider how many times you and your partner did each of these things in the past 12 months AND

Consider life before the last 12 months - if any of these things have ever happened at some point in the past answer 'yes' or 'no' in the 'Ever' column.

Use the codes below to indicate how many times this happened.

0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = very frequently

Ever = it has happened at some point before the past 12 months (yes or no).

PLEASE NOTE, IF YOU CHOOSE NOT TO PROVIDE A RESPONSE TO ANY QUESTION BELOW PLEASE CIRCLE THE 'NO RESPONSE – (NR)' OPTION.

		In the past 12 months	Ever	
1	I showed my partner I cared even though we disagreed	0 1 2 3 4	Yes No	NR
2	My partner showed care for me even though we disagreed	0 1 2 3 4	Yes No	NR
3	I explained my side of a disagreement to my partner	0 1 2 3 4	Yes No	NR
4	My partner explained his or her side of a disagreement to me	0 1 2 3 4	Yes No	NR
5	I insulted or swore at my partner	0 1 2 3 4	Yes No	NR
6	My partner did this to me	0 1 2 3 4	Yes No	NR
7	I threw something at my partner that could hurt	0 1 2 3 4	Yes No	NR
8	My partner did this to me	0 1 2 3 4	Yes No	NR
9	I twisted my partners arm or hair	0 1 2 3 4	Yes No	NR
10	My partner did this to me	0 1 2 3 4	Yes No	NR
11	I had a sprain, bruise, or small cut because of a fight with my partner	0 1 2 3 4	Yes No	NR
12	My partner had a sprain, bruise or small cut because of a fight with me	0 1 2 3 4	Yes No	NR
13	I showed respect for my partners feelings about an issue	0 1 2 3 4	Yes No	NR
14	My partner showed respect for my feelings about an issue	0 1 2 3 4	Yes No	NR

15	I pushed or shoved my partner	0 1 2 3 4	Yes No	NR
16	My partner did this to me	0 1 2 3 4	Yes No	NR
17	I used a knife or gun on my partner	0 1 2 3 4	Yes No	NR
18	My partner did this to me	0 1 2 3 4	Yes No	NR
19	I passed out from being hit on the head by my partner in a fight	0 1 2 3 4	Yes No	NR
20	My partner passed out from being hit on the head in a fight with me	0 1 2 3 4	Yes No	NR
21	I called my partner fat or ugly	0 1 2 3 4	Yes No	NR
22	My partner called me fat or ugly	0 1 2 3 4	Yes No	NR
23	I punched or hit my partner with something that could hurt	0 1 2 3 4	Yes No	NR
24	My partner did this to me	0 1 2 3 4	Yes No	NR
25	I destroyed something belonging to my partner	0 1 2 3 4	Yes No	NR
26	My partner did this to me	0 1 2 3 4	Yes No	NR
27	I went to the doctor because of a fight with my partner	0 1 2 3 4	Yes No	NR
28	My partner went to the doctor because of fight with me	0 1 2 3 4	Yes No	NR
29	I chocked my partner	0 1 2 3 4	Yes No	NR
30	My partner did this to me	0 1 2 3 4	Yes No	NR
31	I shouted or yelled at my partner	0 1 2 3 4	Yes No	NR
32	My partner did this to me	0 1 2 3 4	Yes No	NR
33	I slammed my partner against a wall	0 1 2 3 4	Yes No	NR
34	My partner did this to me	0 1 2 3 4	Yes No	NR
35	I said I was sure we could work out a problem	0 1 2 3 4	Yes No	NR
36	My partner was sure we could work out a problem	0 1 2 3 4	Yes No	NR
37	I needed to see a doctor because of a fight with my partner but did not	0 1 2 3 4	Yes No	NR
38	My partner needed to see a doctor because of a fight with me but did not	0 1 2 3 4	Yes No	NR
39	I beat up my partner	0 1 2 3 4	Yes No	NR
40	My partner did this to me	0 1 2 3 4	Yes No	NR
41	I grabbed my partner	0 1 2 3 4	Yes No	NR
42	My partner did this to me	0 1 2 3 4	Yes No	NR
43	I stomped out of the room, or house, or yard during a disagreement	0 1 2 3 4	Yes No	NR
44	My partner did this to me	0 1 2 3 4	Yes No	NR
45	I slapped my partner	0 1 2 3 4	Yes No	NR
46	My partner did this to me	0 1 2 3 4	Yes No	NR
47	I had a broken bone from a fight with my partner	0 1 2 3 4	Yes No	NR
48	My partner had a broken bone from a fight with me	0 1 2 3 4	Yes No	NR
49	I suggested a compromise to a disagreement	0 1 2 3 4	Yes No	NR
50	My partner did this to me	0 1 2 3 4	Yes No	NR
51	I burned or scalded my partner on purpose	0 1 2 3 4	Yes No	NR

52	My partner did this to me	0 1 2 3 4	Yes No	NR
53	I accused my partner of being a lousy lover	0 1 2 3 4	Yes No	NR
54	My partner accused me of this	0 1 2 3 4	Yes No	NR
55	I did something to spite my partner	0 1 2 3 4	Yes No	NR
56	My partner did this to me	0 1 2 3 4	Yes No	NR
57	I threatened to hit or throw something at my partner	0 1 2 3 4	Yes No	NR
58	My partner did this to me	0 1 2 3 4	Yes No	NR
59	I felt physical pain that still hurt the next day because of a fight with my partner	0 1 2 3 4	Yes No	NR
60	My partner still felt pain the next day because of a fight we had	0 1 2 3 4	Yes No	NR
61	I kicked my partner	0 1 2 3 4	Yes No	NR
62	My partner did this to me	0 1 2 3 4	Yes No	NR
63	I agreed to try a solution to a disagreement which my partner suggested	0 1 2 3 4	Yes No	NR
64	My partner agreed to try a solution to a disagreement I had suggested	0 1 2 3 4	Yes No	NR

Appendix 3.4.3: Controlling Behaviours Scale Revised (CBSR; Graham-Kevan & Archer, 2003)

Here is a list of things you and your partner might have done during your relationship.

Consider how many times you and your partner did each of these things in the past 12 months AND

Consider life before the last 12 months - if any of these things have ever happened at some point in the past answer 'yes' or 'no' in the 'Ever' column.

Use the codes below to indicate how many times this happened.

0 = never, 1 = rarely, 2 = sometimes, 3 = often, 4 = very frequently

Ever = it has happened at some point before the past 12 months (yes or no).

PLEASE NOTE, IF YOU CHOOSE NOT TO PROVIDE A RESPONSE TO ANY QUESTION BELOW PLEASE CIRCLE THE 'NO RESPONSE – (NR)' OPTION.

		I did this to my partner			My partner did this to me			
		In the last 12 months	Ever		In the last 12 months	Ever		
1	Made it difficult to work or study	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
2	Controlled the others money	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
3	Kept own money matters secret	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
4	Refused to pay money/pay fair share	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
5	Threatened to harm the other one	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
6	Threatened to leave the relationship	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
7	Threatened to harm self	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
8	Threatened to disclose damaging or embarrassing information	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
9	Tried to make the other do things they didn't want to	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
10	Used nasty looks or gestures to make the other feel bad or silly	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
11	Smashed the other's property when annoyed/angry	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
12	Was nasty or rude to the other's friends and family	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
13	Vented anger on pets	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
14	Tried to put the other down when getting 'too big for their boots'	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
15	Showed the other up in public	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
16	Told the other they were going mad	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
17	Told the other they were lying or confused	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
18	Called the other unpleasant names	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
19	Tried to restrict time the other spent with family or friends	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
20	Wanted to know where the other went and who they spoke to when not together	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
21	Tried to limit the amount of activities outside the relationship the other is involved with	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
22	Acted suspicious or jealous of the other	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR
23	Checked up on the others movements	0 1 2 3 4	Yes	No	0 1 2 3 4	Yes	No	NR

24	Tried to make the other feel jealous	0 1 2 3 4	Yes No	0 1 2 3 4	Yes No	NR

Appendix 3.4.4: Views on Relationship Aggression Scale (VRAS; Dixon, in *preparation*)

Please read the following scenarios and immediately answer the questions that follow each. Please do not spend a long time thinking about your answers. Nina and Jay have been in a monogamous intimate relationship for over 12 months. Nina is an average sized woman and Jay an average sized man. Please imagine the following situations in their relationship and answer the questions associated with each.

IF YOU CHOOSE NOT TO PROVIDE A RESPONSE TO ANY QUESTION BELOW PLEASE CHECK THE 'NO RESPONSE – (NR)' OPTION.

1. Nina discovered that Jay had been flirting with a female work colleague. She came home one evening after work, where Jay was sat on the sofa watching television. She accused him of flirting with another woman and slapped him across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None____ ____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

2. Jay and Nina were having a heated discussion one evening. Nina slapped Jay across the face and he retaliated by slapping her across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of	1	2	3	4	5	N/R

□a□'s actions?						
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None___ _ ____ Up to 12 years in prison__	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

3. Nina came home drunk one evening after a stressful day at work. She approached Jay, who was sat on the sofa watching television and punched him repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None___ _ ____ Up to 12 years in prison__	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

4. Jay came home drunk one evening after a stressful day at work. He approached Nina, who was sat on the sofa watching television and slapped her across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R

c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None___ _ ____ Up to 12 years in prison__	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

5. Nina and Jay were having a heated discussion one evening. Jay slapped Nina across the face and she retaliated by slapping him across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None___ _ ____ Up to 12 years in prison__	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

6. Jay discovered that Nina had been flirting with a male work colleague. He came home one evening after work, where Nina was sat on the sofa watching television. He accused her of flirting with another man and punched her repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R

d)	**How likely is that Nina will be greatly emotionally distressed?**	1	2	3	4	5	N/R
e)	**How likely it is that Nina can defend herself against Jay?**	1	2	3	4	5	N/R
f)	**Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?**	None_____ Up to 12 years in prison__	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

7.	**Nina and Jay were having a heated discussion one evening. Jay shouted and yelled at Nina and said things to spite her, called her names and threatened to hit her. Nina slapped him across the face.**						
		Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a)	**To what extent do you approve of Nina's actions?**	1	2	3	4	5	N/R
b)	**To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?**	1	2	3	4	5	N/R
c)	**How likely is it that Jay will be physically injured, requiring medical treatment?**	1	2	3	4	5	N/R
d)	**How likely is that Jay will be greatly emotionally distressed?**	1	2	3	4	5	N/R
e)	**How likely it is that Jay can defend himself against Nina?**	1	2	3	4	5	N/R
f)	**Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?**	None_____ Up to 12 years in prison_	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

8.	**Jay came home from work to find that Nina had not done the housework that he expected her to do. He slapped her across the face.**						
		Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a)	**To what extent do you approve of □a□'s actions?**	1	2	3	4	5	N/R
b)	**To what extent would you approve if Nina retaliated with further physical aggression to Jay?**	1	2	3	4	5	N/R
c)	**How likely is it that Nina will be physically injured, requiring medical treatment?**	1	2	3	4	5	N/R
d)	**How likely is that Nina will be greatly emotionally distressed?**	1	2	3	4	5	N/R
e)	**How likely it is that Nina can defend herself against Jay?**	1	2	3	4	5	N/R

f)	**Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?**	None___ _ ____ Up to 12 years in prison__	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

9. Nina discovered that Jay had been flirting with a female work colleague. She came home one evening after work, where Jay was sat on the sofa watching television. She accused him of flirting with another woman and punched him repeatedly in the face and body.							
		Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a)	**To what extent do you approve of Nina's actions?**	1	2	3	4	5	N/R
b)	**To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?**	1	2	3	4	5	N/R
c)	**How likely is it that Jay will be physically injured, requiring medical treatment?**	1	2	3	4	5	N/R
d)	**How likely is that Jay will be greatly emotionally distressed?**	1	2	3	4	5	N/R
e)	**How likely it is that Jay can defend himself against Nina?**	1	2	3	4	5	N/R
f)	**Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?**	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

10. Jay and Nina were having a heated discussion one evening. Nina slapped Jay across the face and he retaliated by punching her repeatedly in the face and body.							
		Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a)	**To what extent do you approve of □a□'s actions?**	1	2	3	4	5	N/R
b)	**To what extent would you approve if Nina retaliated with further physical aggression to Jay?**	1	2	3	4	5	N/R
c)	**How likely is it that Nina will be physically injured, requiring medical treatment?**	1	2	3	4	5	N/R
d)	**How likely is that Nina will be greatly emotionally distressed?**	1	2	3	4	5	N/R
e)	**How likely it is that Nina can defend herself against Jay?**	1	2	3	4	5	N/R
f)	**Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?**	None___ _ ____	Police caution	Community service	Up to 6 months in	Up to three years in prison	N/R

	Up to 12 years in prison__ __	Up to 25 years in prison_		prison		

11. Nina came home drunk one evening after a stressful day at work. She approached Jay, who was sat on the sofa watching television and slapped him across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

12. Jay discovered that Nina had had sex with a male work colleague. He came home one evening after work, where Nina was sat on the sofa watching television. He accused her of having sex with another man and punched her repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

13. Nina and Jay were having a heated discussion one evening. Jay slapped Nina across the face and she retaliated by punching him repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

14. Jay came home from work to find that Nina had not done the chores in the house that he expected her to do. He punched her repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

15. Nina and Jay were having a heated discussion one evening. Jay punched Nina in the face and she retaliated by punching him repeatedly in the face and body.						
	Not at	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**

	all					
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

16. Jay discovered that Nina had been flirting with a male work colleague. He came home one evening after work, where Nina was sat on the sofa watching television. He accused her of flirting with another man and slapped her across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

17. Nina came home from work to find that Jay had not done the housework that she expected him to do. She slapped him across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**

a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R

18. Jay and Nina were having a heated discussion one evening. Nina shouted and yelled at Jay and said things to spite him, called him names and threatened to hit him. Jay slapped her across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None___ _ ____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None___ _ ____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

19. Nina discovered that Jay had had sex with a female work colleague. She came home one evening after work, where Jay was sat on the sofa watching television. She accused him of having sex with another woman and slapped him across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

20. Jay and Nina were having a heated discussion one evening. Nina shouted and yelled at Jay and said things to spite him, called him names and threatened to hit him. Jay punched her repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

21. Nina discovered that Jay had had sex with a female work colleague. She came home one evening after work, where Jay was sat on the sofa watching television. She accused him of having sex with another woman and punched him repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

22. Jay came home drunk one evening after a stressful day at work. He approached Nina, who was sat on the sofa watching television and punched her repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_ ___	Community service	Up to 6 months in prison	Up to three years in prison	N/R

23. Nina and Jay were having a heated discussion one evening. Jay punched Nina in the face and she retaliated by slapping him in the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

24. Jay discovered that Nina had had sex with a male work colleague. He came home one evening after work, where Nina was sat on the sofa watching television. He accused her of having sex with another man and slapped her across the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

25. Nina came home from work to find that Jay had not done the housework she expected him to do. She punched him repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

26. Jay and Nina were having a heated discussion one evening. Nina punched Jay in the face and he retaliated by slapping her in the face.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None_____ Up to 12 years in prison____	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

27. Nina and Jay were having a heated discussion one evening. Jay shouted and yelled at Nina and said things to spite her, called her names and threatened to hit her. Nina punched him repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of Nina's actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Jay retaliated with physical aggression to Nina's actions?	1	2	3	4	5	N/R
c) How likely is it that Jay will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Jay will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Jay can defend himself against Nina?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Nina in this instance?	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

28. Jay and Nina were having a heated discussion one evening. Nina punched Jay in the face and he retaliated by punching her repeatedly in the face and body.						
	Not at all	**A little**	**Somewhat**	**Mostly**	**Definitely**	**N/R**
a) To what extent do you approve of □a□'s actions?	1	2	3	4	5	N/R
b) To what extent would you approve if Nina retaliated with further physical aggression to Jay?	1	2	3	4	5	N/R
c) How likely is it that Nina will be physically injured, requiring medical treatment?	1	2	3	4	5	N/R
d) How likely is that Nina will be greatly emotionally distressed?	1	2	3	4	5	N/R
e) How likely it is that Nina can defend herself against Jay?	1	2	3	4	5	N/R
f) Which of the following legal sanctions do you deem suitable punishment for Jay in this instance?	None___ _ ____ Up to 12 years in prison__ __	Police caution Up to 25 years in prison_	Community service	Up to 6 months in prison	Up to three years in prison	N/R

Appendix 3.5: Online Survey

Appendix 3.5.1: Initial Advertisement that Participants will View Online.

ONLINE SURVEY asking about your experience & perceptions of aggression in intimate relationships.

This study investigates how people manage conflict and view the use of aggression between intimate or dating partners. If you choose to take part in this study it will ask you questions about how you solve conflict and whether you have experienced aggression or control in your past and current relationships. In addition, it will ask you about how you have felt in the last 12 months and require you to read short scenarios which describe partners aggressing against each other and comment on which behaviours you think are acceptable.

This study is an online survey administered by the system.

You must be at least 18 years old.

Appendix 3.5.2: Brief introductory text that participants will see prior to deciding to go any further with the online study.

This study consists of an online survey and investigates how people manage conflict and view aggression between intimate partners. If you choose to participate, it is important that you understand you may experience some discomfort due to the content of some questions. It will ask you about how you solve conflict and whether you have experienced aggression or control in your past and/or current relationships. In addition, it will ask you about how you have felt in the last 12 months and require you to read short scenarios which describe partners aggressing against each other and comment on which behaviours you think are acceptable.

In order to participate in the study, you must be at least 18.

Completion of the questionnaire will take approximately 35 minutes. While you are participating, your responses will be stored in a temporary holding area as you move through the sections, but they will not be permanently saved until you complete all sections and you are given a chance to review your responses.

If you choose to continue with this study, you will view two further windows next which contain more descriptive information about this study. You can therefore find out more detailed information before agreeing to participate. You will be informed when the questionnaire begins, so please follow the instructions and withdraw before this stage if you do not want to take part.

It is important that any information received is accurate. You are therefore asked to complete this in private and consider the questions carefully and honestly. Your co-operation in this research will be greatly appreciated and as this is an under researched area you will be contributing to knowledge in this field.

Appendix 3.5.3: More detailed study information that participants will read in the next window prior to deciding to go ahead with the study and provide their consent to take part.
Study Information - please read before going any further.

This study will ask you about how you solve conflict and whether you have experienced aggression or control in your past and/or current relationships.

Your participation is voluntary and you may refuse to participate or choose to withdraw from the study at any time, either during or after completing the questionnaire, until results are published. You are under no obligation to participate. If you do not want to answer some, or all of the questions asked, simply choose the option which states that you do not wish to provide a response ('No Response').

Your participation in this project is anonymous, and you will be among several hundred other participating participants. To clarify, the online system will store your responses anonymously in

an electronic file that can only be accessed by the researchers. Furthermore, results will only be presented or published in aggregate form; at no point will your individual responses be published. Aggregate results may be disseminated in a student research thesis, scientific journal and/or conference presentation.

Your participation in the study is voluntary and your response will be anonymous. If you wish not to take part it would not affect the service that you receive from the organisation. If you wish to withdraw your data, please write to Sohbia Shoaib or Dr Catherine Hamilton-Giachritsis, University of Birmingham, Edgbaston, Birmingham, B15 2TT, indicating your withdrawal from the study along with your code name. If you require further information about this study at a later date, please telephone Dr Catherine Hamilton-Giachritsis or myself on ...

Please confirm that you have read this information and understand the nature of the study by checking one of the options below:

If you want to continue with the study check 'Yes' if you do not want to continue check 'No' and then choose to withdraw by checking the 'withdraw' option at the top of this web page.

Appendix 3.5.4: Further detailed study information that participants will read in the next window prior to deciding to go ahead with the study and provide their consent to take part.

Study Information Continued - Please read before going any further.

After this information window, there are four questionnaire sections. The first asks for general demographic information. The second asks you to consider many ways in which you may have solved conflict in your relationships. For example, questions will ask if you have ever done any of the following to a partner or if a partner has done this to you: showed them care; showed respect; punched or kicked; used a knife or gun. The third questionnaire asks you to consider how many times you and your partner did each of these things e.g. made it difficult to work or study, controlled the others money, kept own money matters secret. The fourth asks you to consider and

comment on a series of hypothetical scenarios where aggression arises within a couple. Aggressive acts are briefly described in section four; for example, it may say 'Nina punched him repeatedly in the face'.

Please note that some of these questions ask about violent acts. Therefore, if you choose to participate, it is important that you understand you may potentially experience some discomfort due to the content of some of the questions. For example, one question will ask if you have ever punched/ kicked your partner or been punched/ kicked by a partner.

If you find the content of this questionnaire disturbing and wish to discuss the issues with someone, there are many avenues of support, such as The Samaritans (Tel: 08457 90 90 90), National Domestic Violence Helpline (0808 2000 247), NHS direct (Tel: 08457 46 47) or Manchester Women's Domestic Violence Helpline (0161 636 7525). If you are upset in any way by the questionnaire or indeed this letter, please do take advantage of the available support.

If you would like to take part in this study, it is important you understand that your participation in this survey is voluntary and you are free to withdraw from the study at any time. You can withdraw without giving a reason and without any cost to you.

Please confirm that you have read and understood this information, and that you consent to participate in this study by checking one of the options below:

I confirm that I have read and understood this information and that I consent to participate in this study (if you consent check 'Yes' if you do not consent check 'no' and then choose to withdraw by checking the 'withdraw' option at the top of this web page).

Appendix 3.5.6: Consent Form

Please select Yes or No to the following questions.

	Yes	No
I confirm that I have read and understand the information sheet for the above study.		
I have had the opportunity to consider the information and have asked questions of the principle investigator and/or researcher (if I wanted to) and had these answered satisfactory.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.		
I understand that data collected during the study may be looked at by the two individuals from the University of Birmingham listed on the information sheet. I give permission for these individuals to have access to my anonymous answers.		
I am aware that the study may involve disclosing sensitive information.		
I am aware of the support available in case I become distressed during or after participation in the study.		
I am over 18 years old.		
I understand that there are no disguised questions or procedures in this study.		
I understand that I am free to choose not to answer a question without having to explain why.		
I understand that my responses in the questionnaire will be used in reports of this research.		
I understand that I am free to withdraw my results up until the publication of the results.		
I agree to take part in the above study.		

If you have replied 'No' to any of the above responses please do not continue with the questionnaire.

If you need further clarification on the study or questionnaire please contact S.Shoaib or Dr Catherine Hamilton-Giachritsis prior to completing the questionnaire.

If you have replied 'Yes' to all the above questions please continue to complete the questionnaires.

Appendix 3.5.7: Debrief

Thank you for participating in this research study.

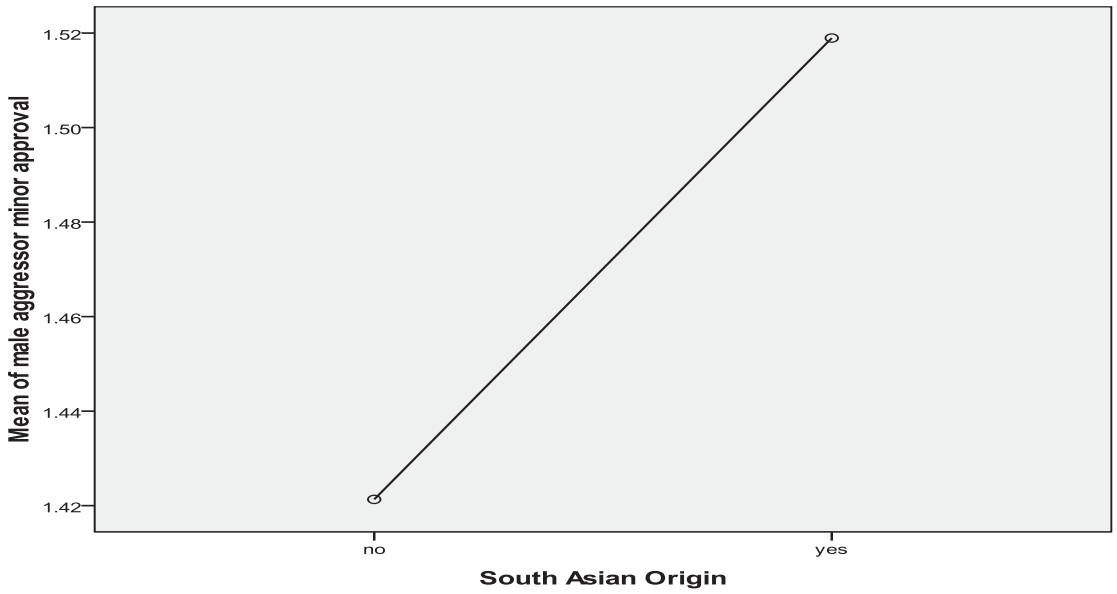
Previous research has shown a high prevalence of Intimate Partner Violence within South Asian communities. Furthermore, there is very limited research on Intimate Partner violence in South Asian communities. The study aimed to investigate factors that arise within South Asian relationships where violence occurs and to see whether these factors are different to non South Asian couples.

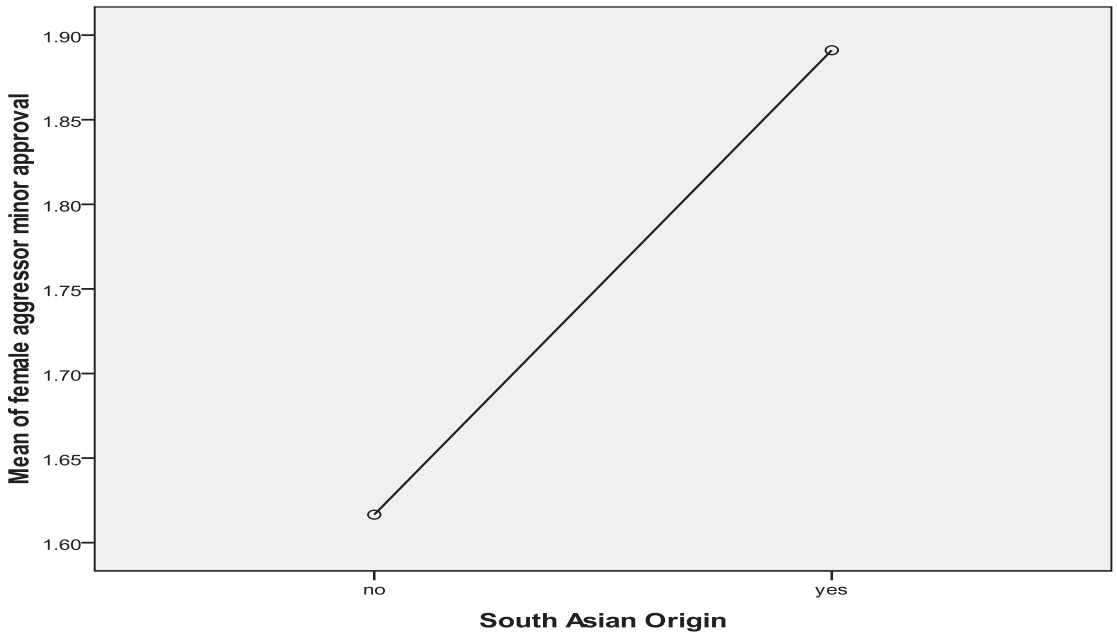
May I take this opportunity to remind you that you can withdraw your data at any point after completing this questionnaire up until the publication of the results. Do not give your name in correspondence or use any identifiable information. If you wish to withdraw your data, please write to Sohbia Shoaib or Dr Catherine Hamilton-Giachritsis, University of Birmingham, Edgbaston, Birmingham, B15 2TT, indicating your withdrawal from the study along with your code name. Do not give your real name.

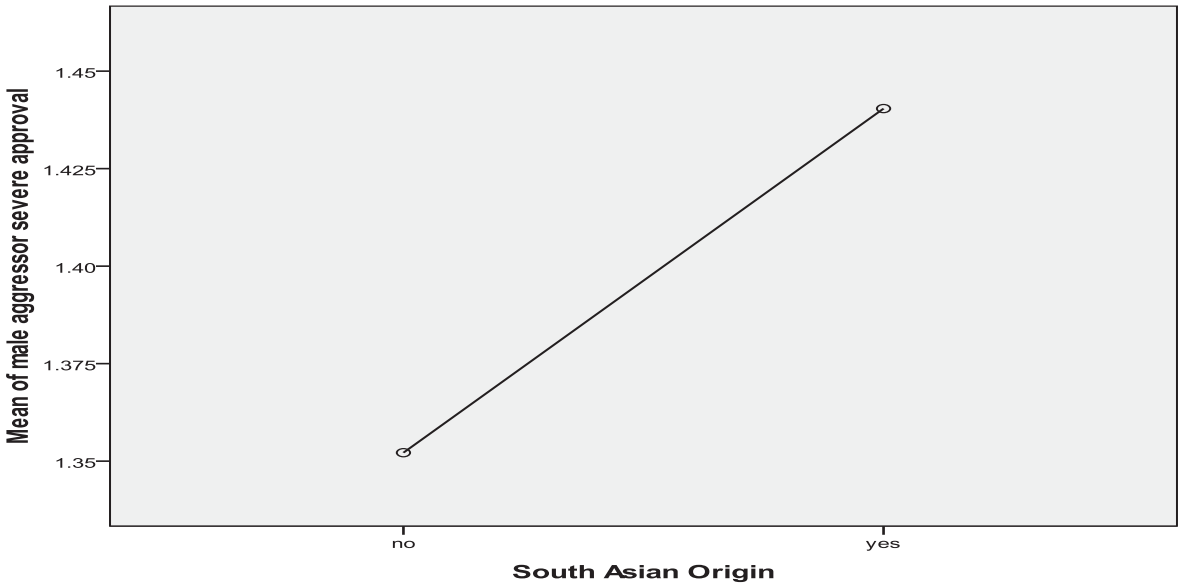
If you are/have been a victim or perpetrator of relationship violence, or indeed if you find the contents of this questionnaire upsetting for some other reason and wish to discuss issues around aggression in relationships with someone, there are many avenues of free support, such as, The Samaritans helpline on 08457 90 90 90 (all), Women's Aid 0808 2000 247 (women and children), Manchester Women's Domestic Violence Helpline (0161 636 7525) or the National Centre for Domestic Violence 08709 220704 (all). If you are upset and require further help or advice around any of the issues presented in this questionnaire please do take advantage of the available support."

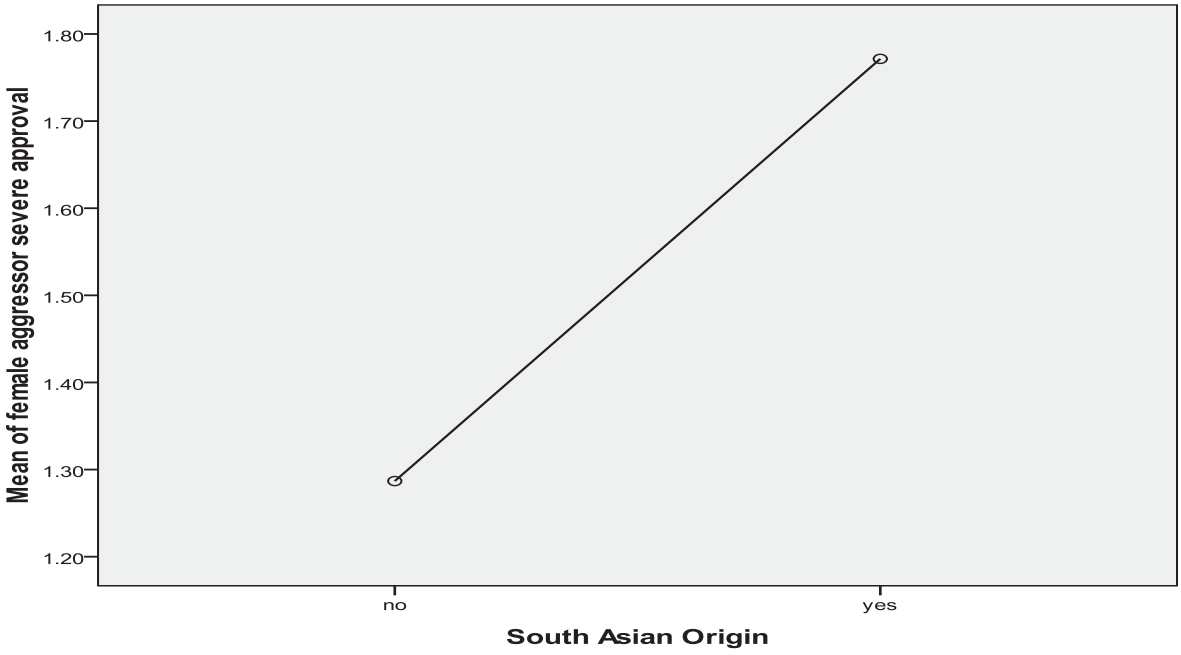
Appendix 3.6: Hypothesis 4 Tables and Graphs

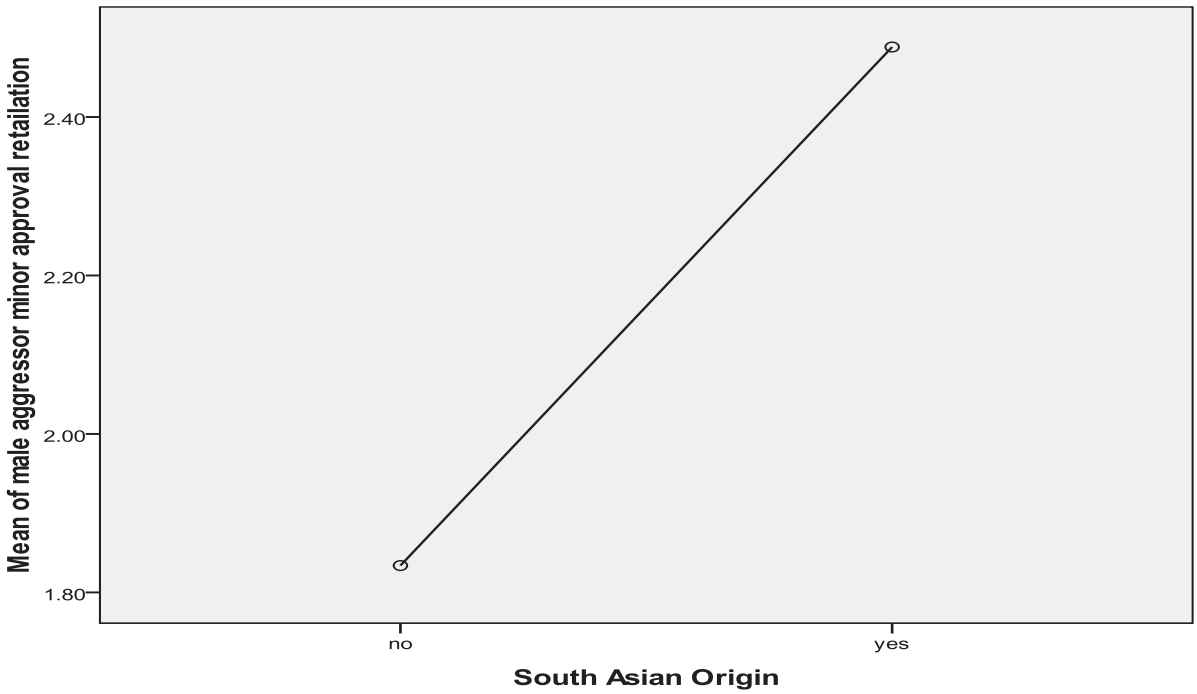
Figure 1: One way ANOVAs graphs showing the direction of the mean rate on the VRAS subscales with ethnicity.

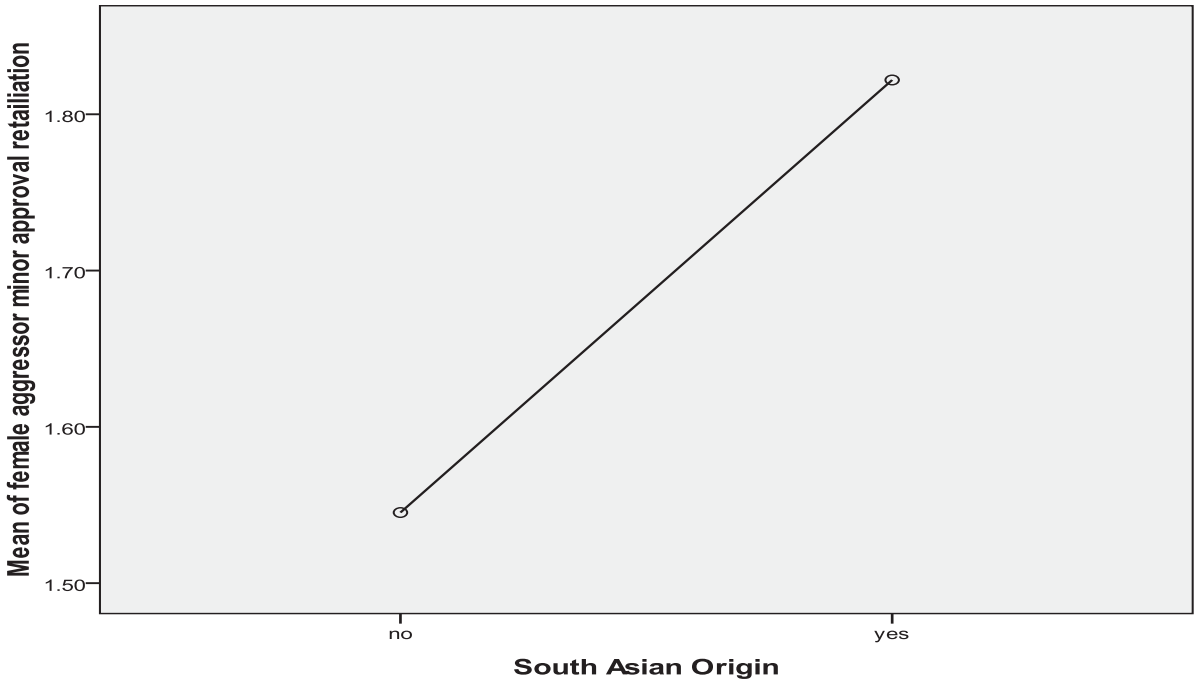


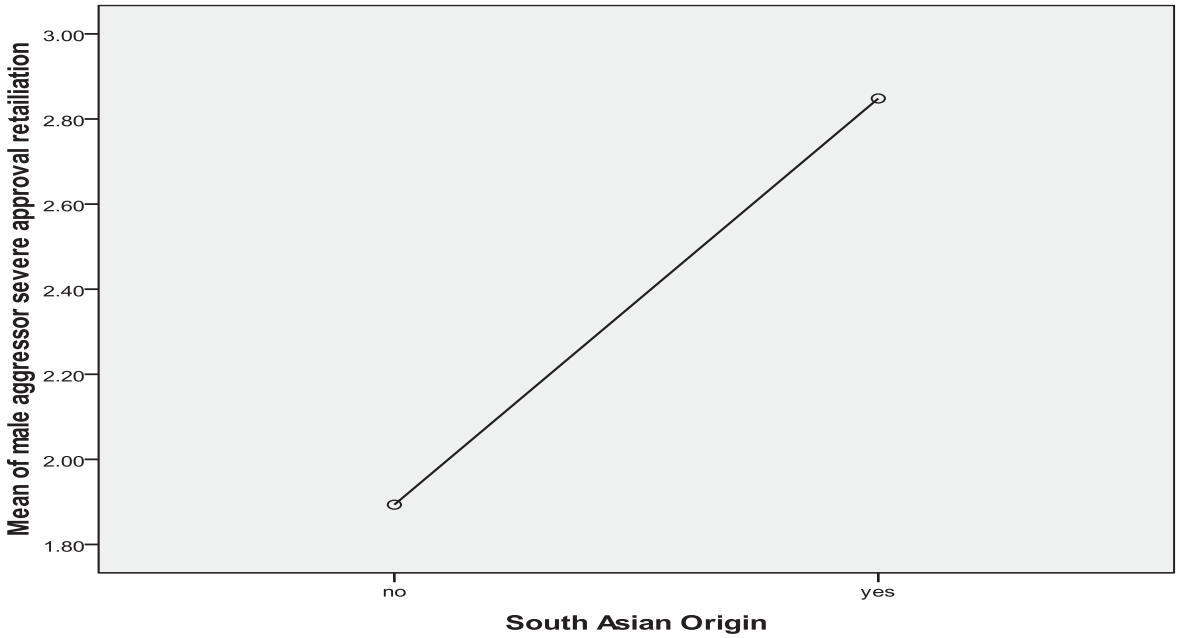


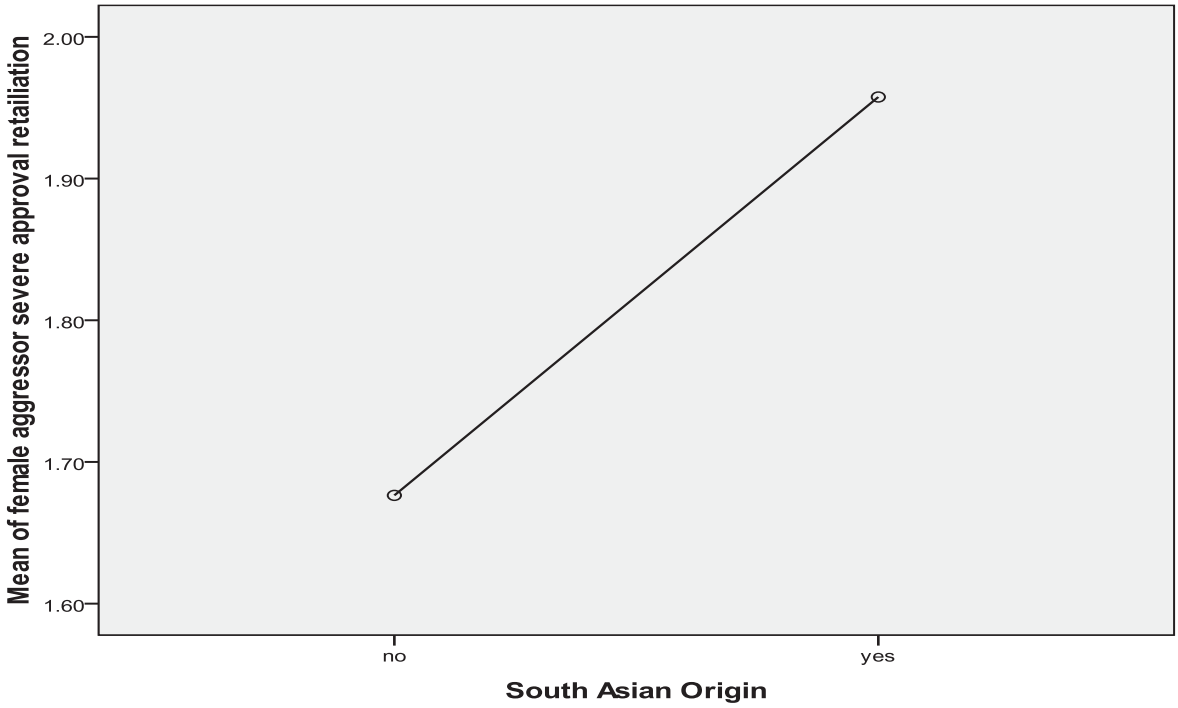

Mean of male aggressor severe approval
1.45
1.425
1.40
1.375
1.35
no
yes
South Asian Origin

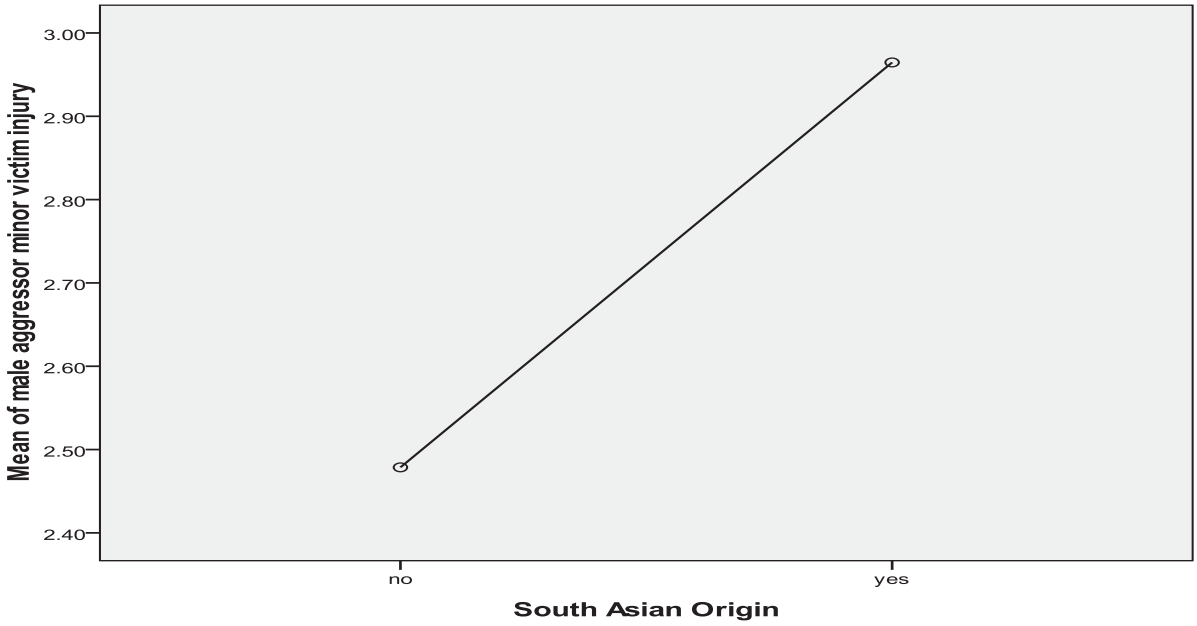

Mean of female aggressor severe approval
1.80
1.70
1.60
1.50
1.40
1.30
1.20
no
yes
South Asian Origin


Mean of male aggressor minor approval retaliation
2.40
2.20
2.00
1.80
no
yes
South Asian Origin


Mean of female aggressor minor approval retailiation
1.80
1.70
1.60
1.50
no
yes
South Asian Origin


Mean of male aggressor severe approval retailiation
3.00
2.80
2.60
2.40
2.20
2.00
1.80
no
yes
South Asian Origin


Mean of female aggressor severe approval retailiation
2.00
1.90
1.80
1.70
1.60
no
yes
South Asian Origin


Mean of male aggressor minor victim injury
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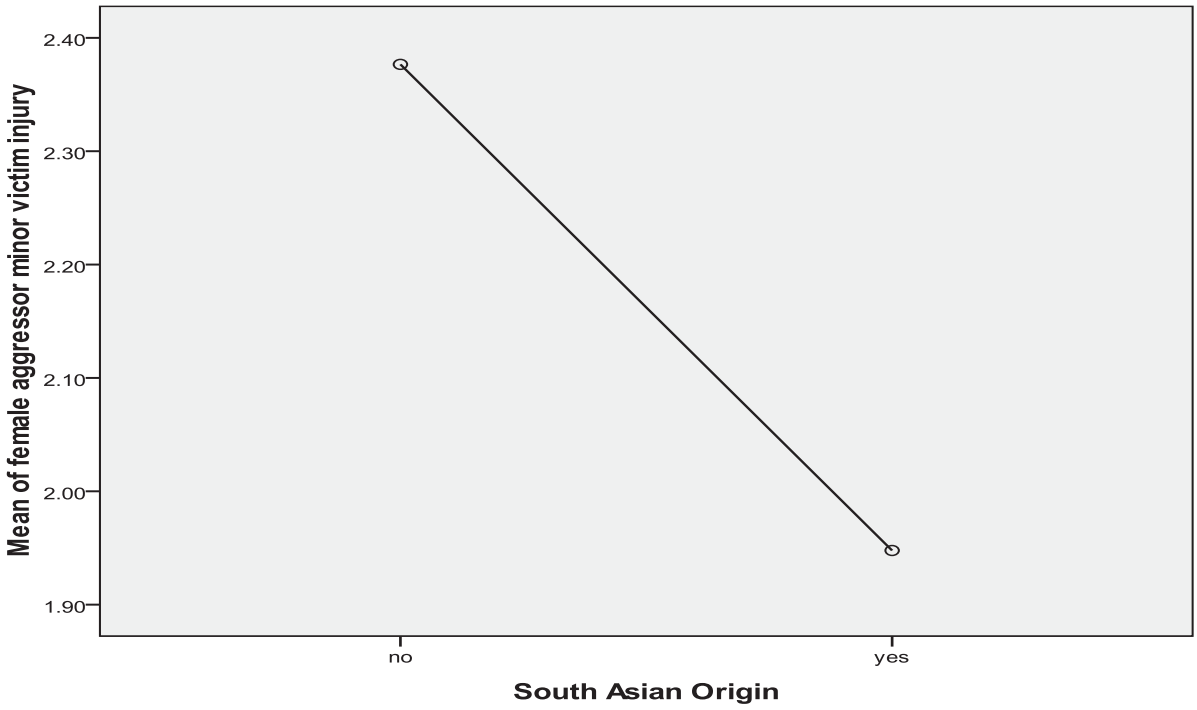
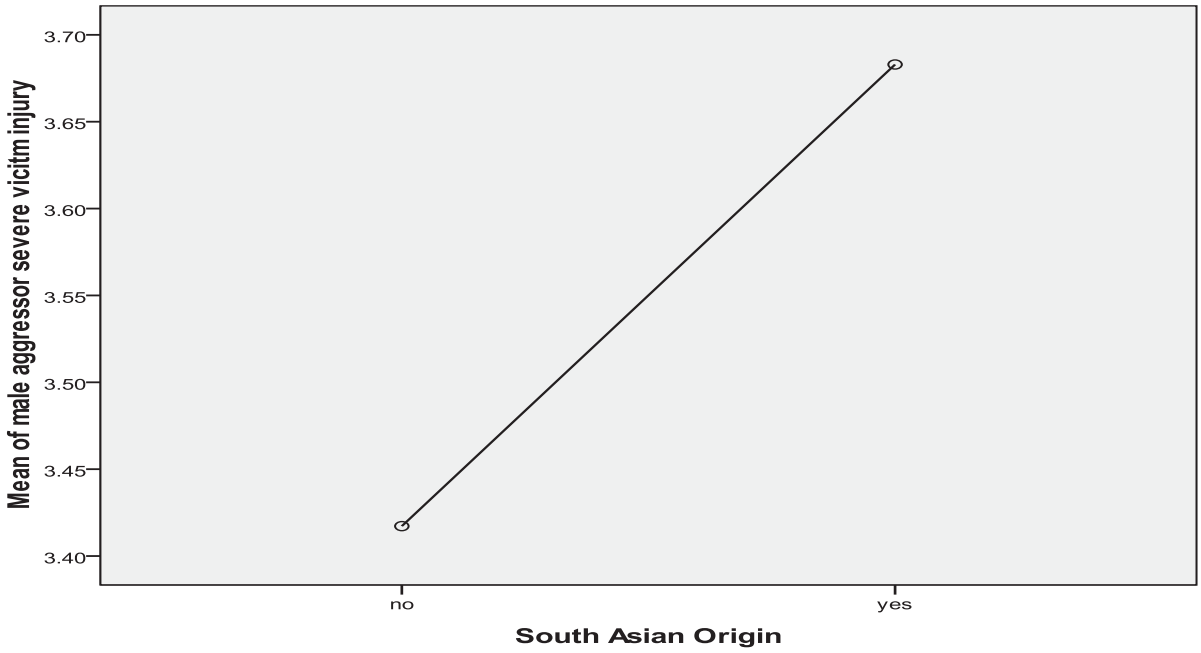
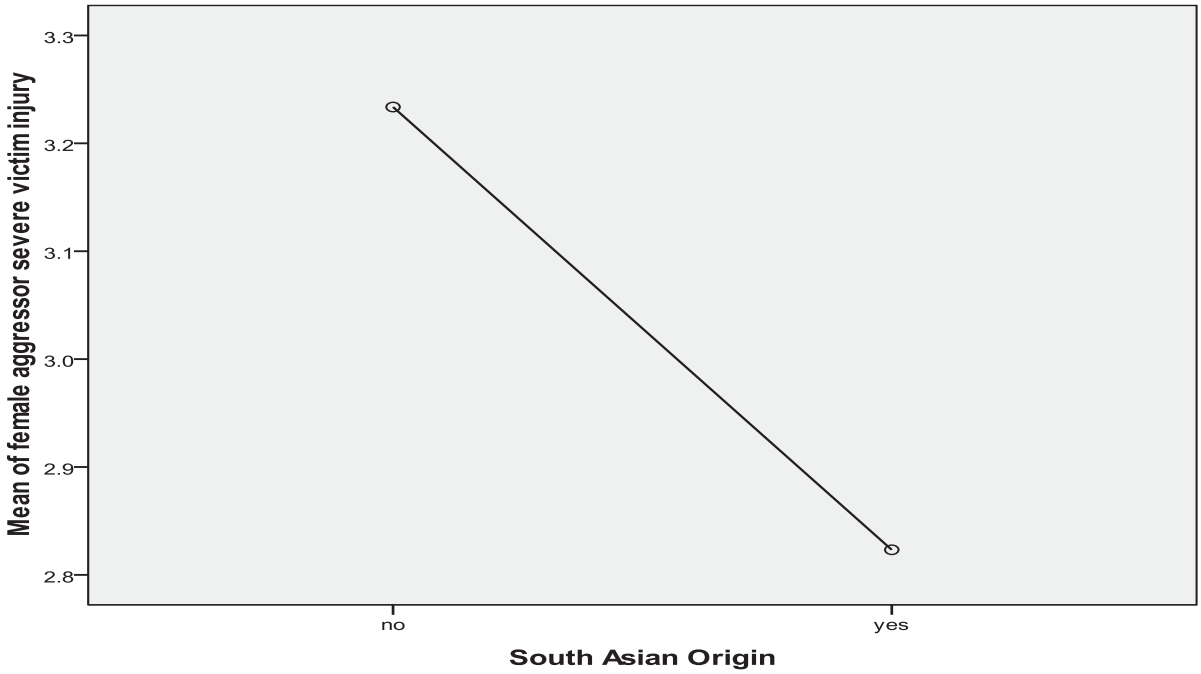
2.90
2.80
2.70
2.60
2.50
2.40
no
yes
South Asian Origin


Mean of female aggressor minor victim injury
2.40
2.30
2.20
2.10
2.00
1.90
no
yes
South Asian Origin


Mean of male aggressor severe vicitm injury
3.70
3.65
3.60
3.55
3.50
3.45
3.40
no
yes
South Asian Origin


Mean of female aggressor severe victim injury
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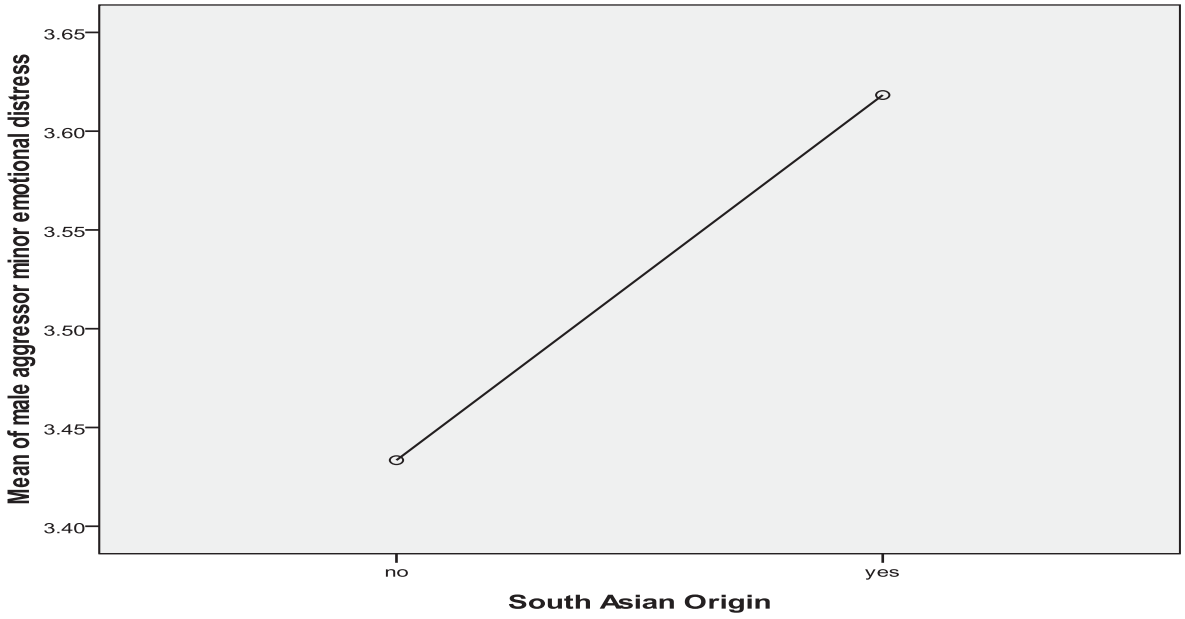
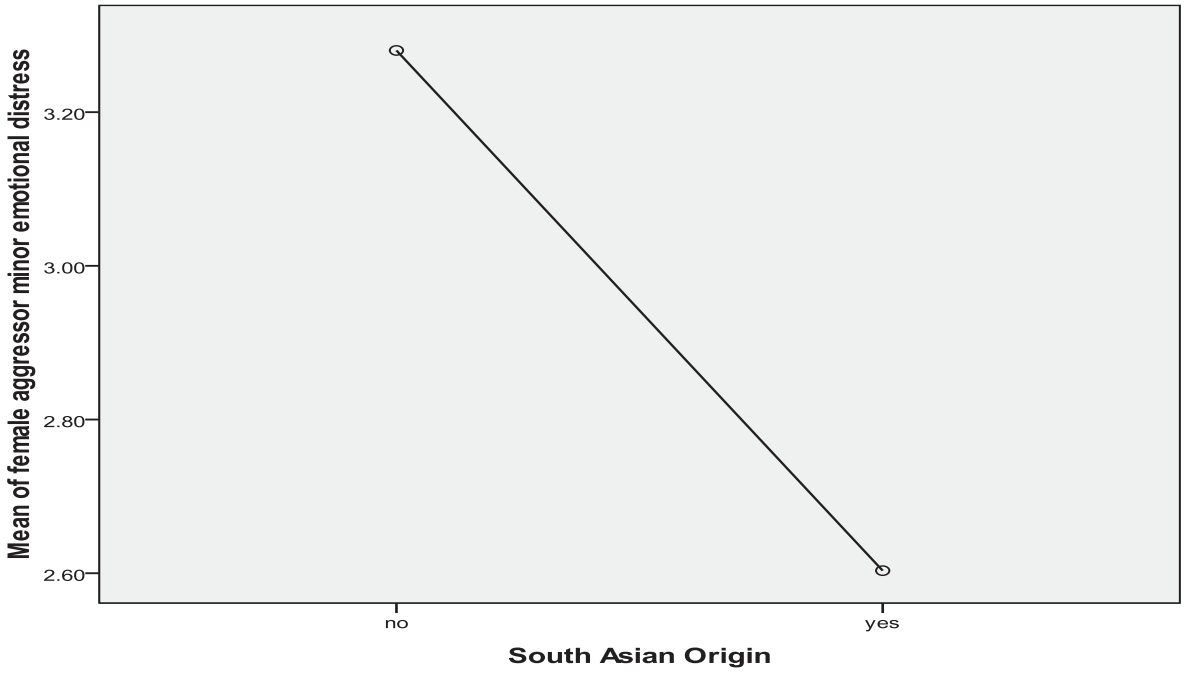
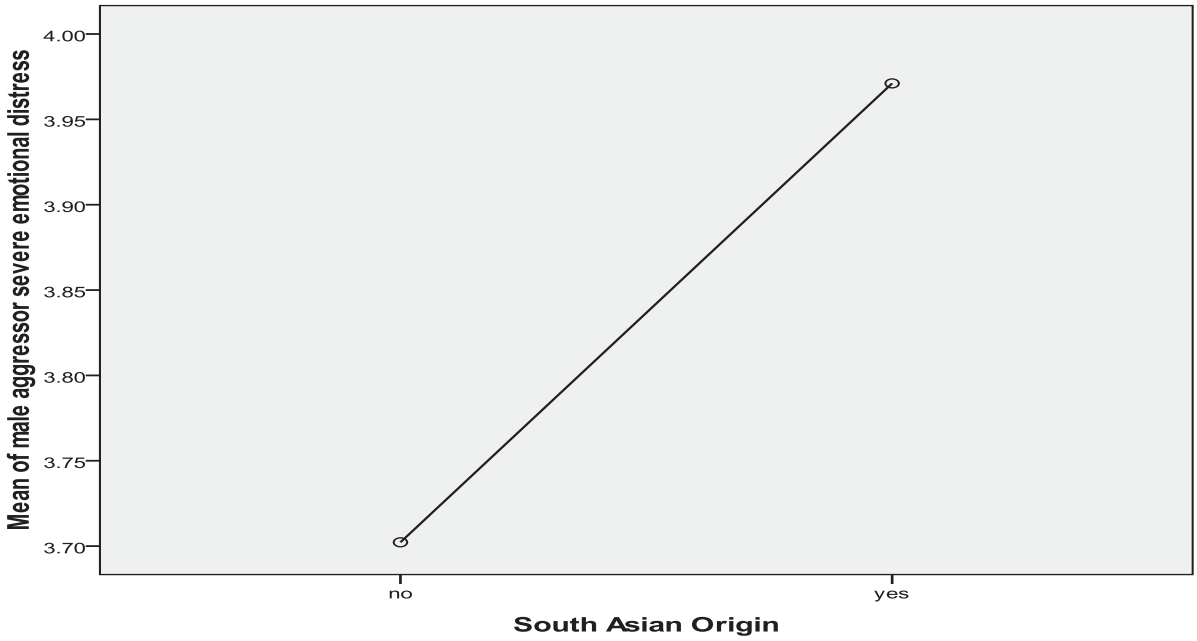
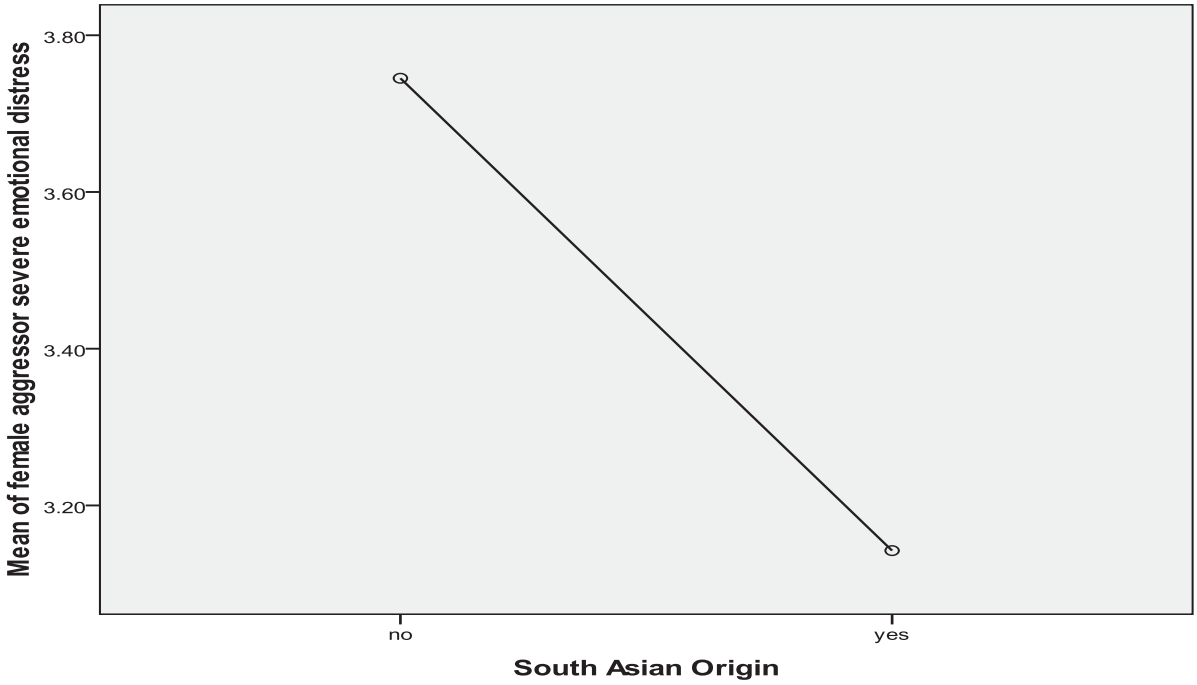
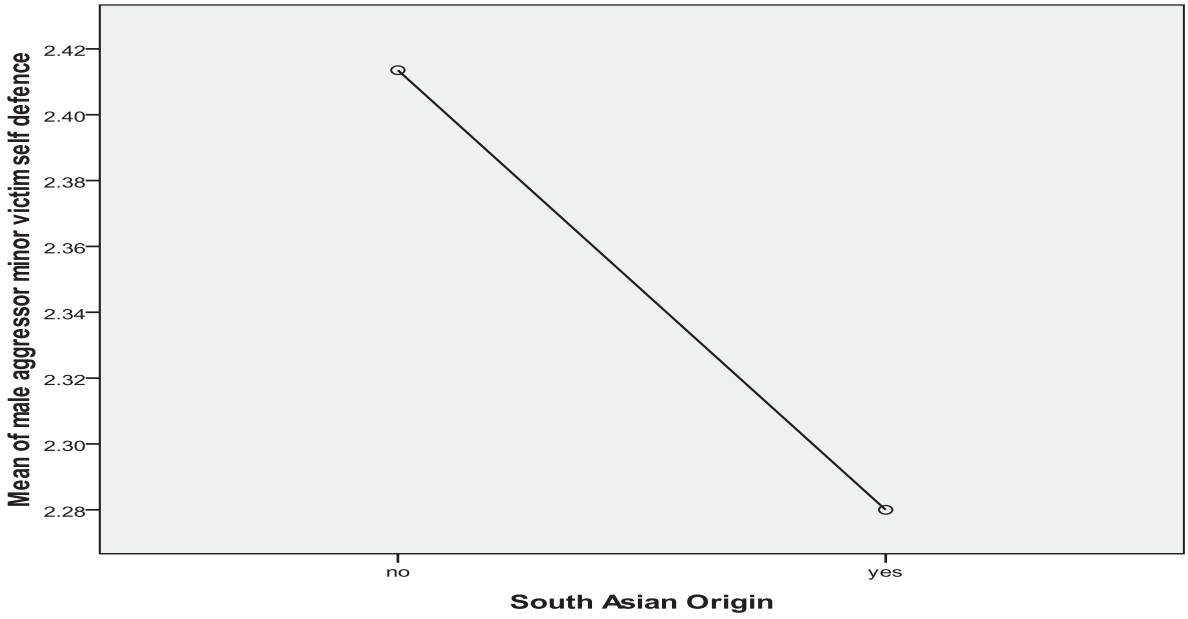
3.2
3.1
3.0
2.9
2.8
no
yes
South Asian Origin

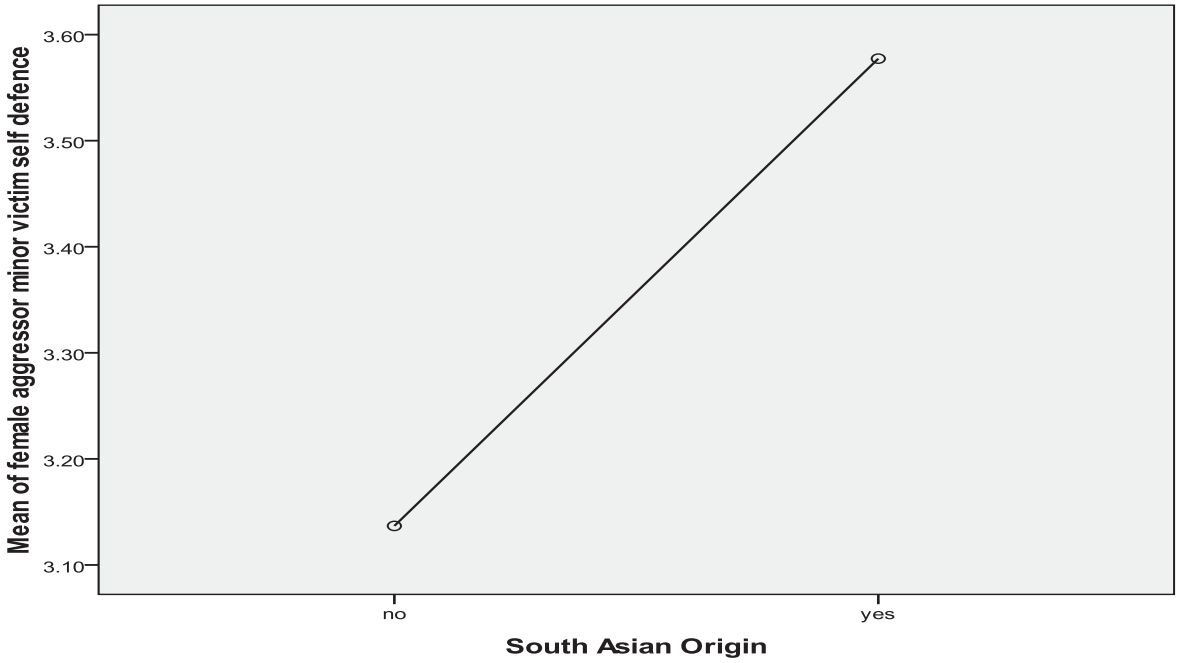

Mean of male aggressor minor emotional distress
3.65
3.60
3.55
3.50
3.45
3.40
no
yes
South Asian Origin

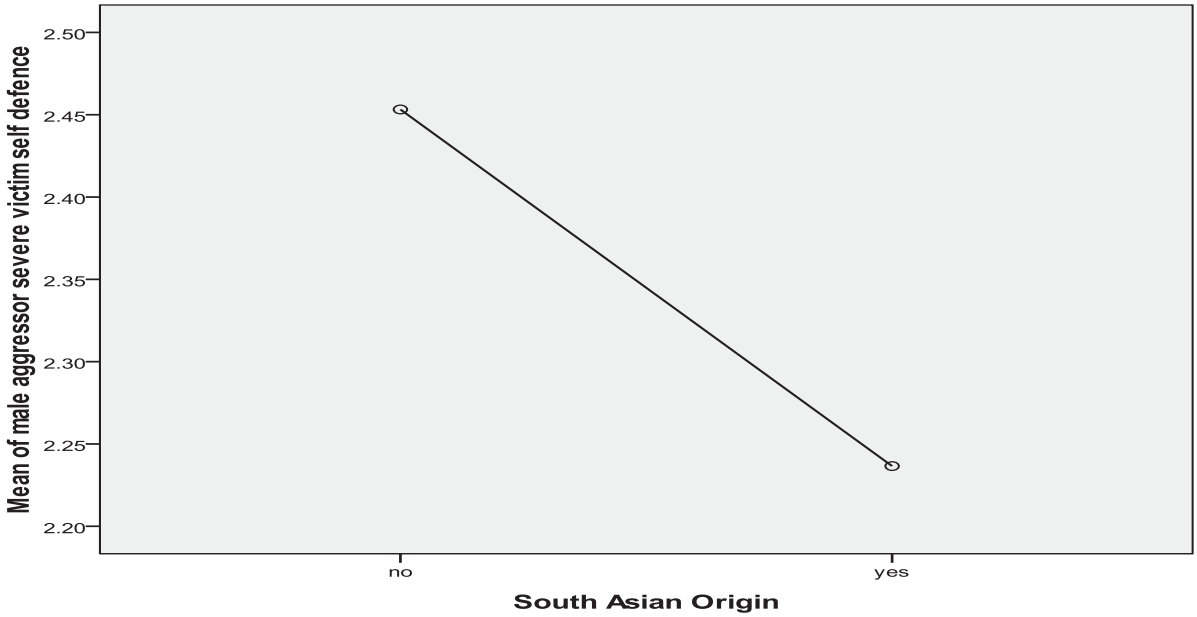

Mean of female aggressor minor emotional distress
3.20
3.00
2.80
2.60
no
yes
South Asian Origin

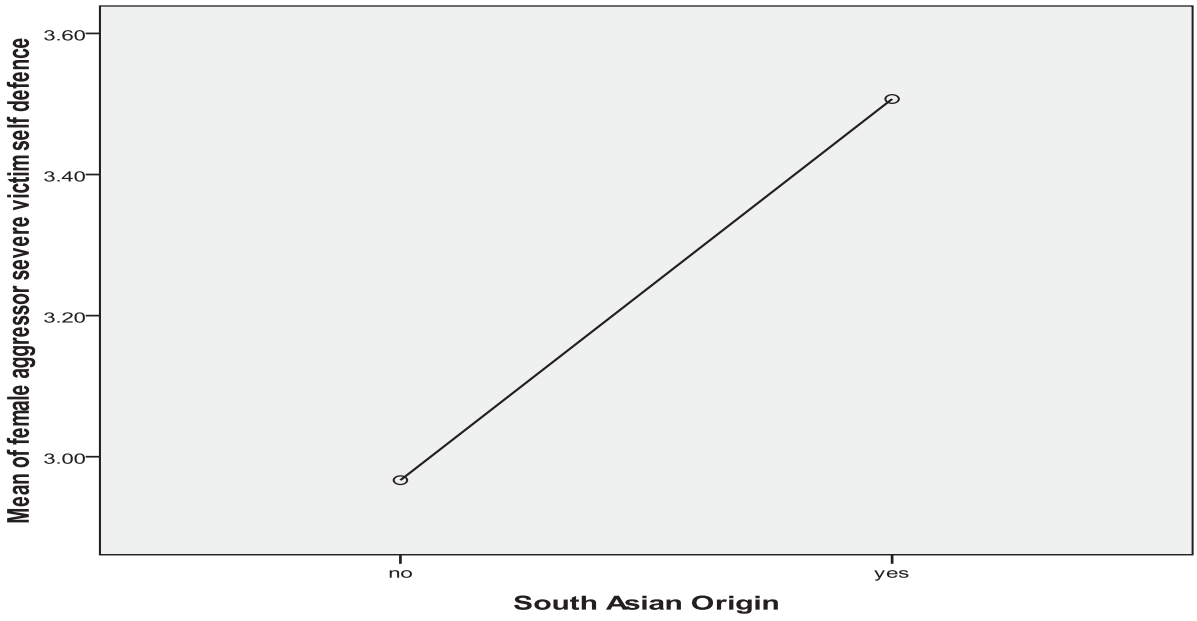

Mean of male aggressor severe emotional distress
4.00
3.95
3.90
3.85
3.80
3.75
3.70
no
yes
South Asian Origin

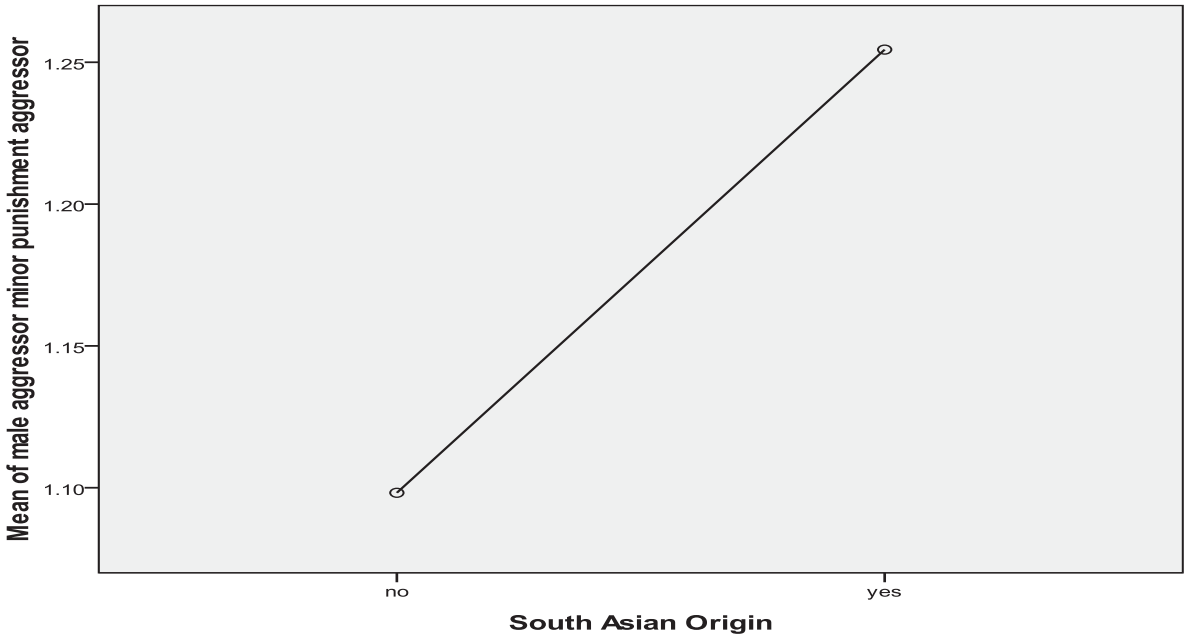

Mean of female aggressor severe emotional distress
3.80
3.60
3.40
3.20
no
yes
South Asian Origin

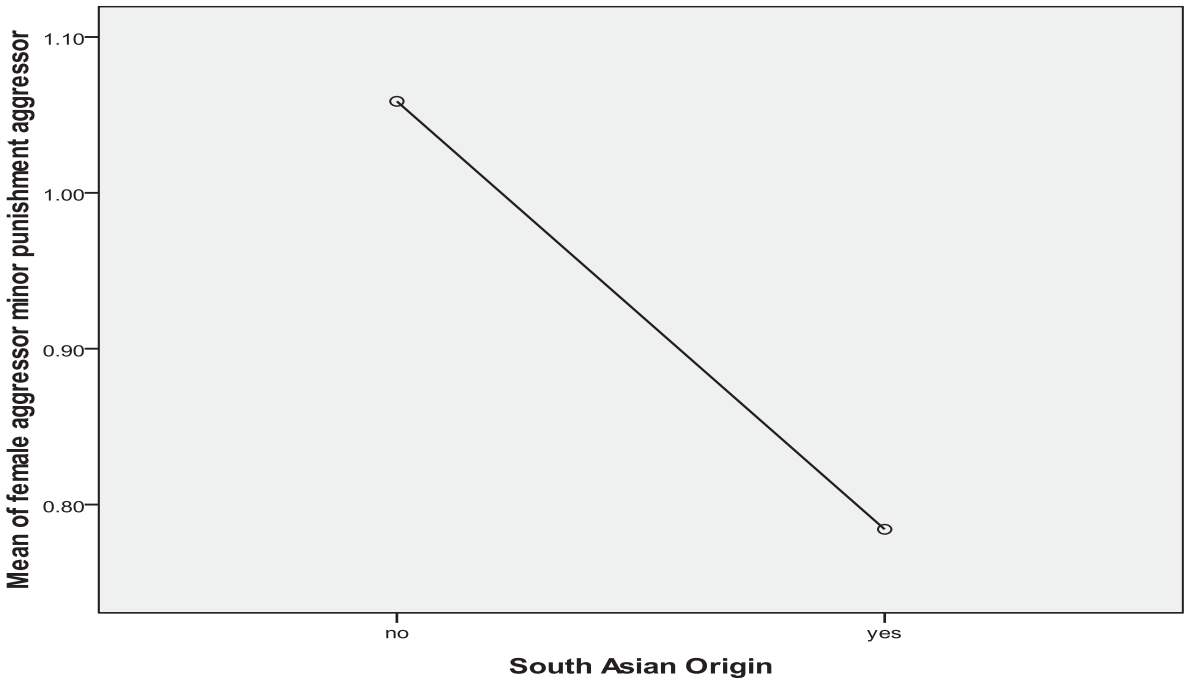

Mean of male aggressor minor victim self defence
2.42
2.40
2.38
2.36
2.34
2.32
2.30
2.28
no
yes
South Asian Origin

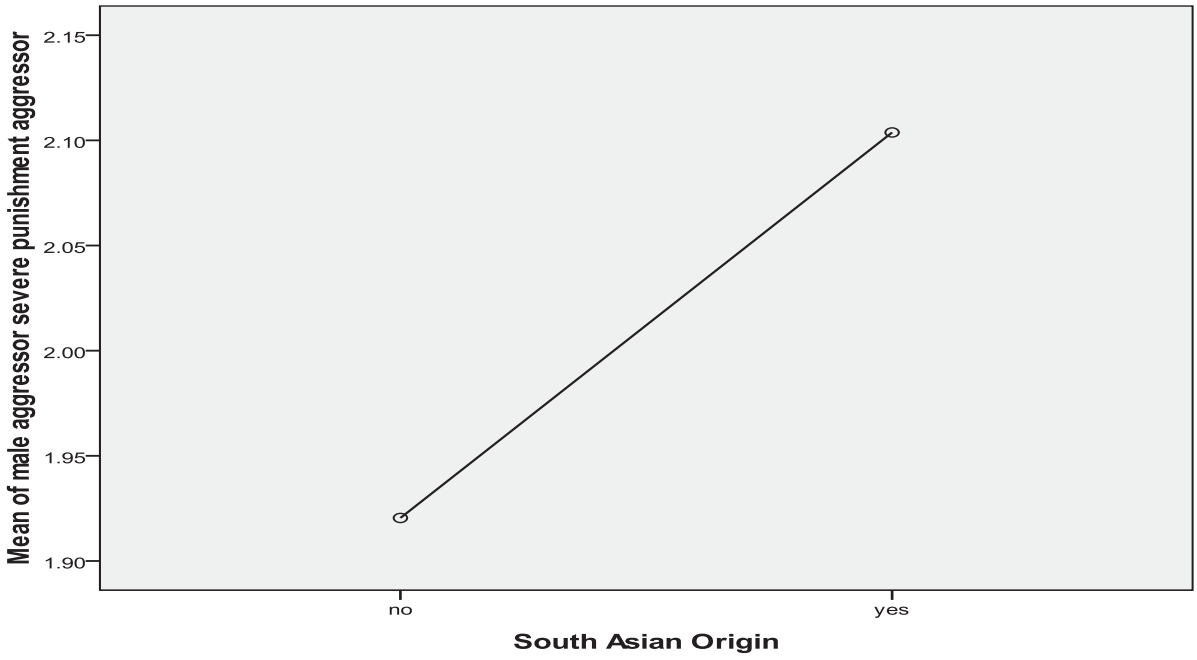

Mean of female aggressor minor victim self defence
3.60
3.50
3.40
3.30
3.20
3.10
no
yes
South Asian Origin


Mean of male aggressor severe victim self defence
2.50
2.45
2.40
2.35
2.30
2.25
2.20
no
yes
South Asian Origin


Mean of female aggressor severe victim self defence
3.60
3.40
3.20
3.00
no
yes
South Asian Origin


Mean of male aggressor minor punishment aggressor
1.25
1.20
1.15
1.10
no
yes
South Asian Origin


Mean of female aggressor minor punishment aggressor
1.10
1.00
0.90
0.80
no
yes
South Asian Origin


Mean of male aggressor severe punishment aggressor
2.15
2.10
2.05
2.00
1.95
1.90
no
yes
South Asian Origin

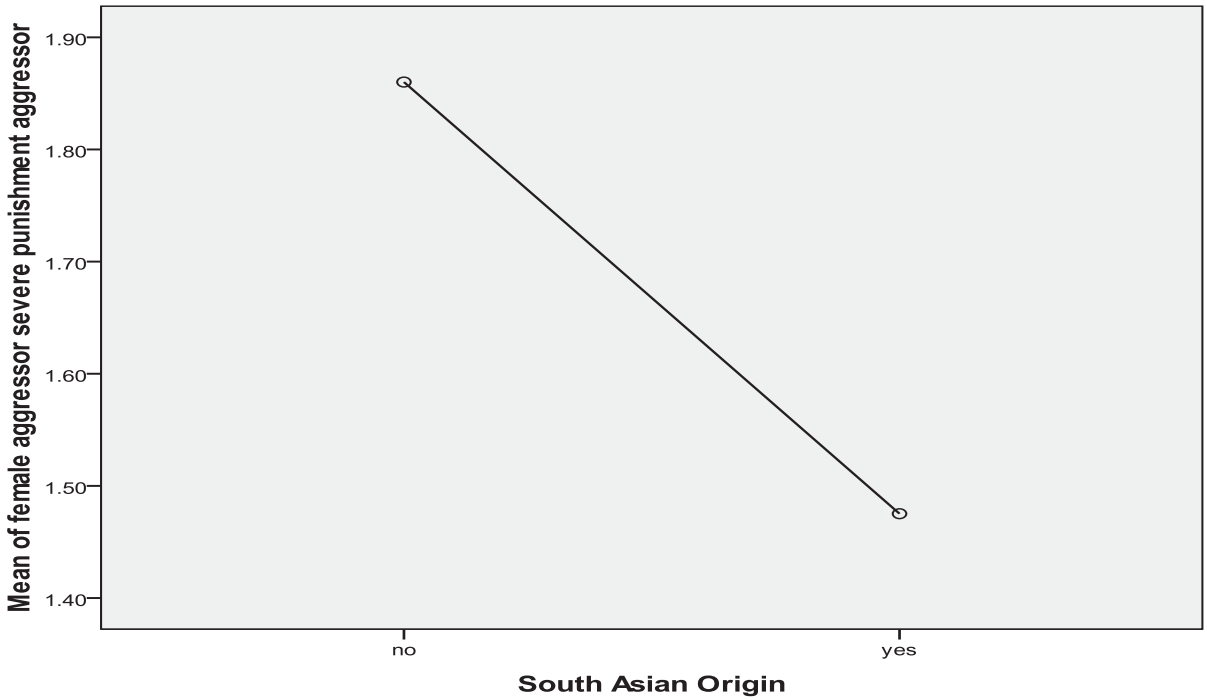

Mean of female aggressor severe punishment aggressor
1.90
1.80
1.70
1.60
1.50
1.40
no
yes
South Asian Origin

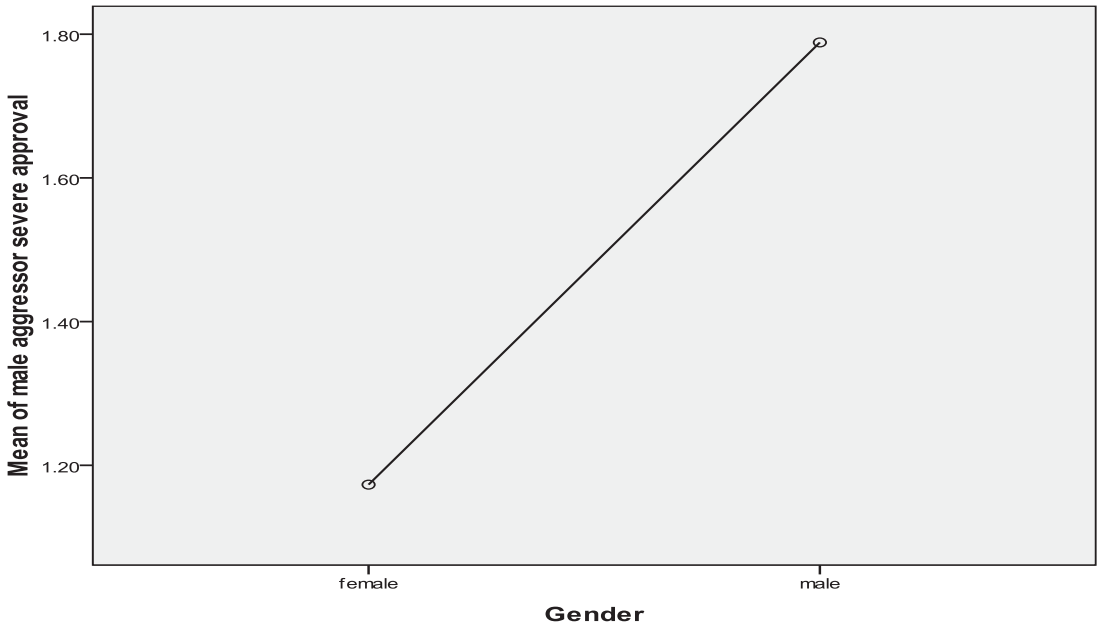
Table A: Contrast tests for ethnicity and VRAS subscales.

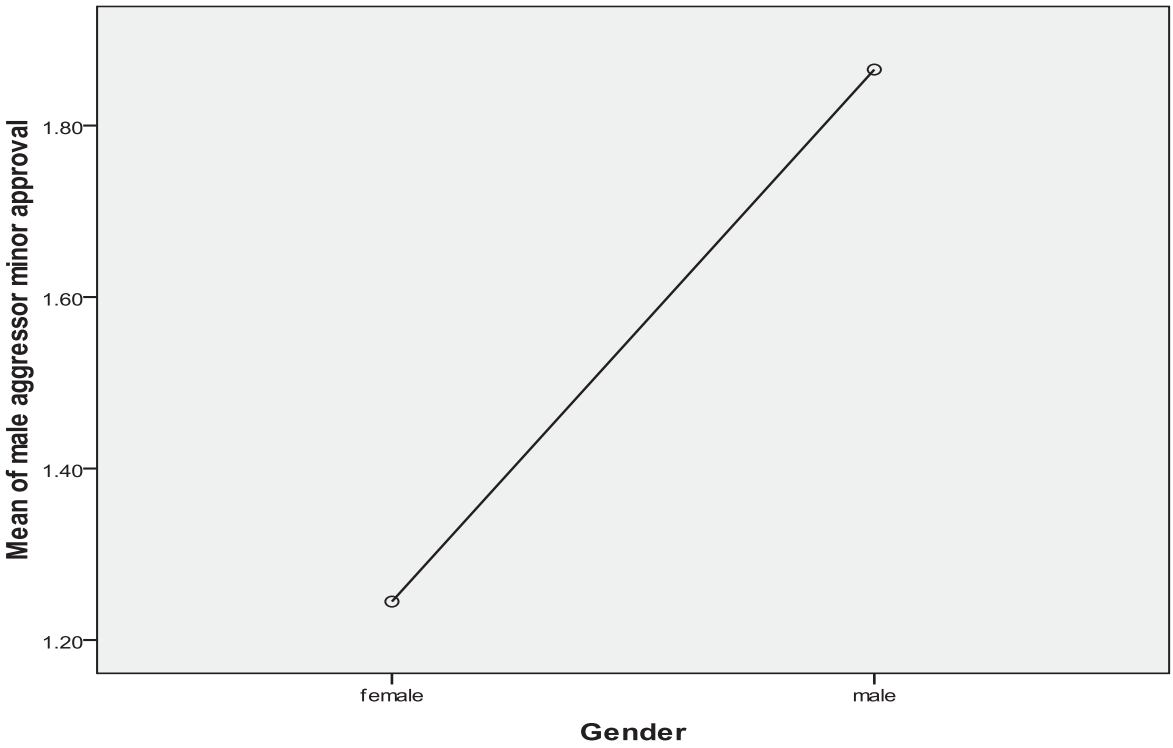
		Contrast	Value of Contrast	Std. Error	t	df	Sig. (2-tailed)
male aggressor minor approval	Assume equal variances	1	1.5189[a]	.06727	22.579	181	.000
	Does not assume equal variances	1	1.5189[a]	.08448	17.980	94.000	.000
female aggressor minor approval	Assume equal variances	1	1.8911[a]	.08750	21.613	180	.000
	Does not assume equal variances	1	1.8911[a]	.09878	19.144	93.000	.000
male aggressor severe approval	Assume equal variances	1	1.4404[a]	.06281	22.933	179	.000
	Does not assume equal variances	1	1.4404[a]	.07358	19.576	92.000	.000
female aggressor severe approval	Assume equal variances	1	1.7714[a]	.07727	22.924	180	.000
	Does not assume equal variances	1	1.7714[a]	.10000	17.714	93.000	.000
male aggressor minor approval retaliation	Assume equal variances	1	2.4883[a]	.09780	25.443	180	.000
	Does not assume equal variances	1	2.4883[a]	.12486	19.929	93.000	.000
female aggressor minor approval retaliation	Assume equal variances	1	1.8219[a]	.06082	29.955	180	.000
	Does not assume equal variances	1	1.8219[a]	.06652	27.390	93.000	.000
male aggressor severe approval retaliation	Assume equal variances	1	2.8482[a]	.12015	23.705	179	.000
	Does not assume equal variances	1	2.8482[a]	.15201	18.737	92.000	.000
female aggressor severe approval retaliation	Assume equal variances	1	1.9575[a]	.07446	26.291	180	.000
	Does not assume equal variances	1	1.9575[a]	.08752	22.368	93.000	.000
male aggressor minor victim injury	Assume equal variances	1	2.9646[a]	.08564	34.617	180	.000
	Does not assume equal variances	1	2.9646[a]	.09454	31.359	93.000	.000
female aggressor minor victim injury	Assume equal variances	1	1.9478[a]	.07379	26.396	180	.000
	Does not assume equal variances	1	1.9478[a]	.06660	29.246	93.000	.000
male aggressor severe victim injury	Assume equal variances	1	3.6829[a]	.10268	35.869	180	.000
	Does not assume equal variances	1	3.6829[a]	.10554	34.895	93.000	.000
female aggressor severe victim injury	Assume equal variances	1	2.823[a]	.0704	40.108	180	.000
	Does not assume equal variances	1	2.823[a]	.0735	38.405	93.000	.000

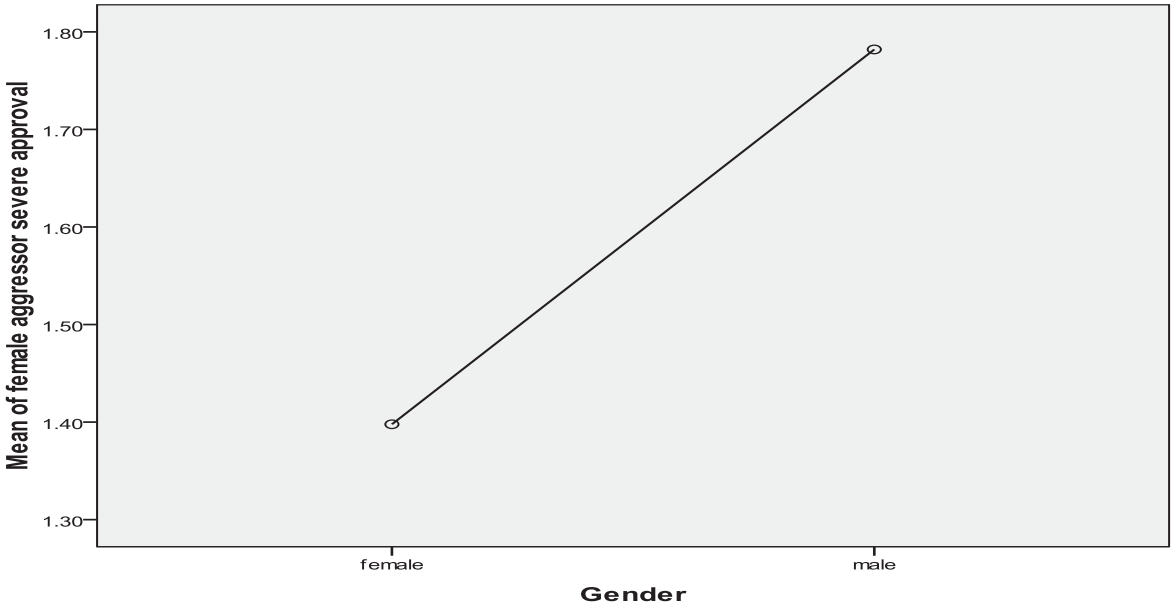
male aggressor minor emotional distress	Assume equal variances	1	3.6183[a]	.07725	46.842	181	.000
	Does not assume equal variances	1	3.6183[a]	.07166	50.495	94.000	.000
female aggressor minor emotional distress	Assume equal variances	1	2.6033[a]	.09105	28.592	180	.000
	Does not assume equal variances	1	2.6033[a]	.11160	23.328	93.000	.000
male aggressor severe emotional distress	Assume equal variances	1	3.9711[a]	.09387	42.302	179	.000
	Does not assume equal variances	1	3.9711[a]	.09382	42.326	92.000	.000
female aggressor severe emotional distress	Assume equal variances	1	3.1424[a]	.09479	33.151	180	.000
	Does not assume equal variances	1	3.1424[a]	.10207	30.786	93.000	.000
male aggressor minor victim self defence	Assume equal variances	1	2.2800[a]	.07272	31.353	180	.000
	Does not assume equal variances	1	2.2800[a]	.08622	26.444	93.000	.000
female aggressor minor victim self defence	Assume equal variances	1	3.5774[a]	.09728	36.772	180	.000
	Does not assume equal variances	1	3.5774[a]	.10019	35.706	93.000	.000
male aggressor severe victim self defence	Assume equal variances	1	2.2366[a]	.08170	27.376	179	.000
	Does not assume equal variances	1	2.2366[a]	.09369	23.871	92.000	.000
female aggressor severe victim self defence	Assume equal variances	1	3.5070[a]	.09494	36.939	181	.000
	Does not assume equal variances	1	3.5070[a]	.10282	34.107	94.000	.000
male aggressor minor punishment aggressor	Assume equal variances	1	1.2545[a]	.08336	15.049	182	.000
	Does not assume equal variances	1	1.2545[a]	.08410	14.917	95.000	.000
female aggressor minor punishment aggressor	Assume equal variances	1	.7841[a]	.08615	9.101	182	.000
	Does not assume equal variances	1	.7841[a]	.08070	9.716	95.000	.000
male aggressor severe punishment aggressor	Assume equal variances	1	2.1038[a]	.11156	18.858	181	.000
	Does not assume equal variances	1	2.1038[a]	.10162	20.703	94.000	.000
female aggressor severe punishment aggressor	Assume equal variances	1	1.4752[a]	.10351	14.252	182	.000
	Does not assume equal variances	1	1.4752[a]	.10640	13.865	95.000	.000

a. The sum of the contrast coefficients is not zero.

Figure 2: One way ANOVAs graphs showing the direction of the mean rate on the VRAS subscales with gender.




Mean of male aggressor minor approval
1.80
1.60
1.40
1.20
female
male
Gender

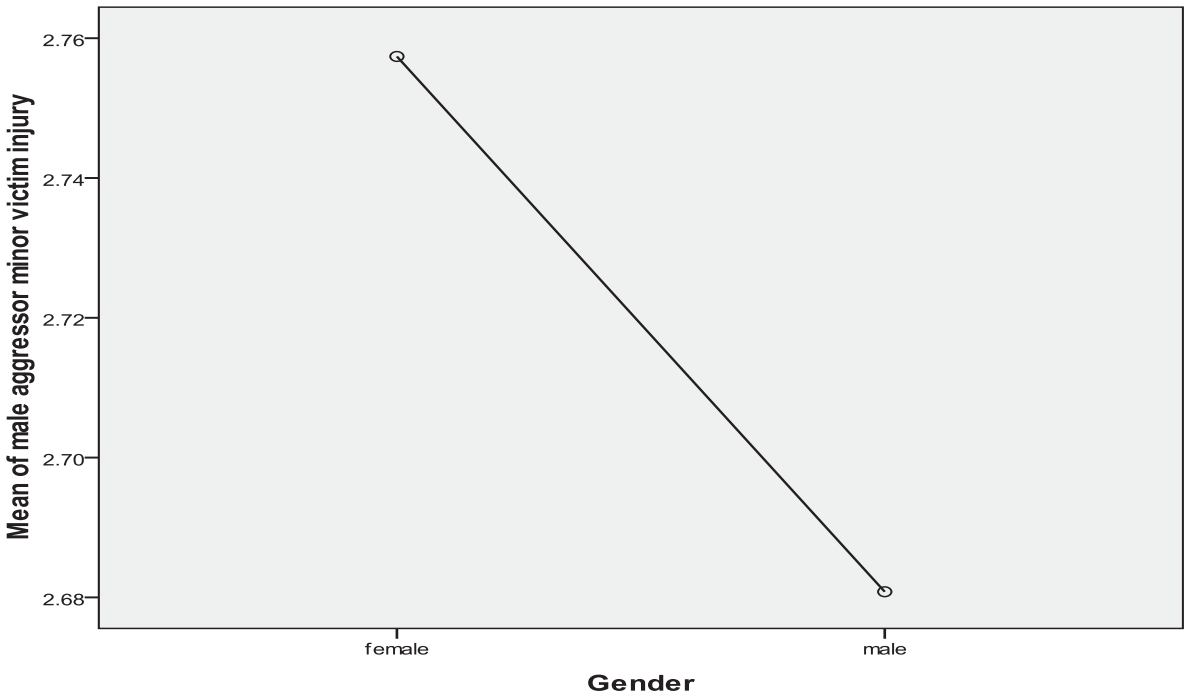

Mean of female aggressor severe approval
1.80
1.70
1.60
1.50
1.40
1.30
female
male
Gender

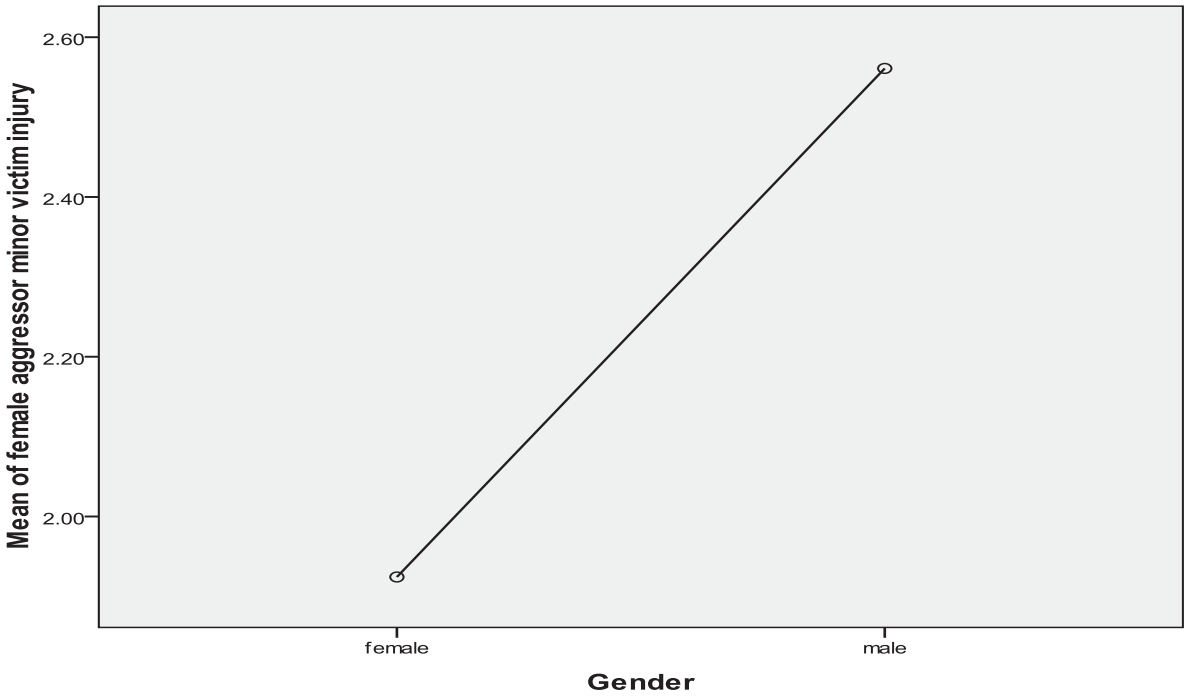

Mean of male aggressor minor approval retailation
2.21
2.20
2.19
2.18
2.17
2.16
2.15
female
male
Gender

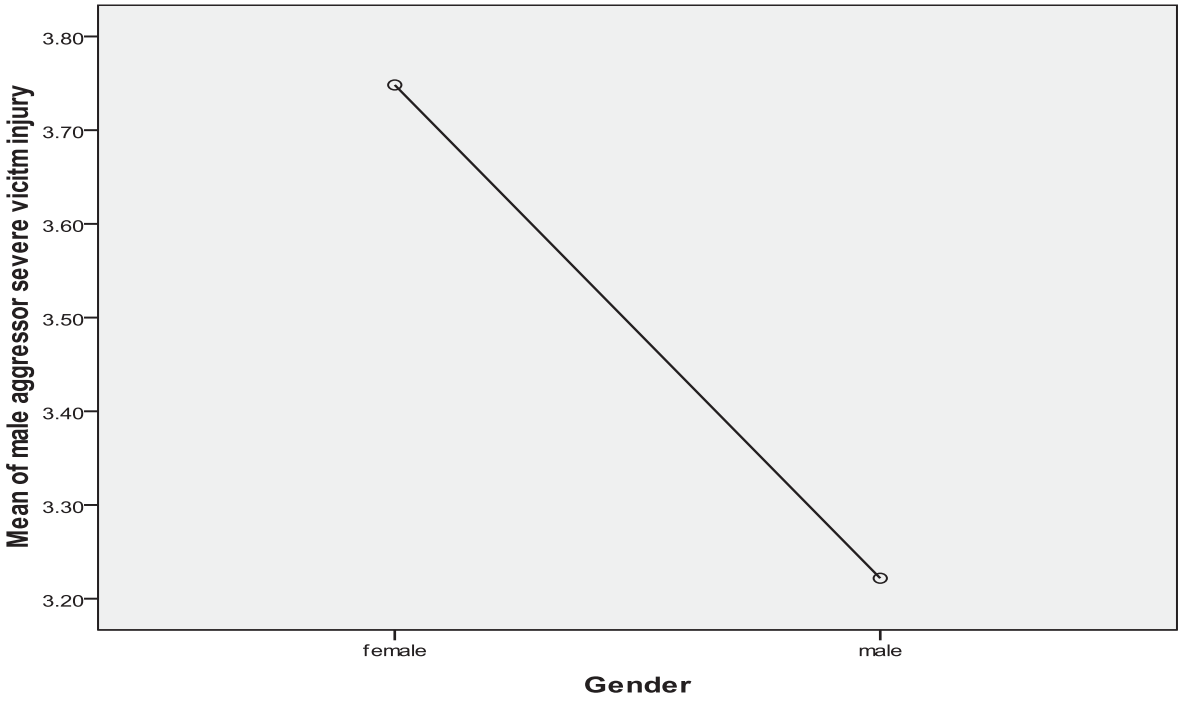

Mean of female aggressor minor approval retailiation
2.00
1.90
1.80
1.70
1.60
1.50
female
male
Gender

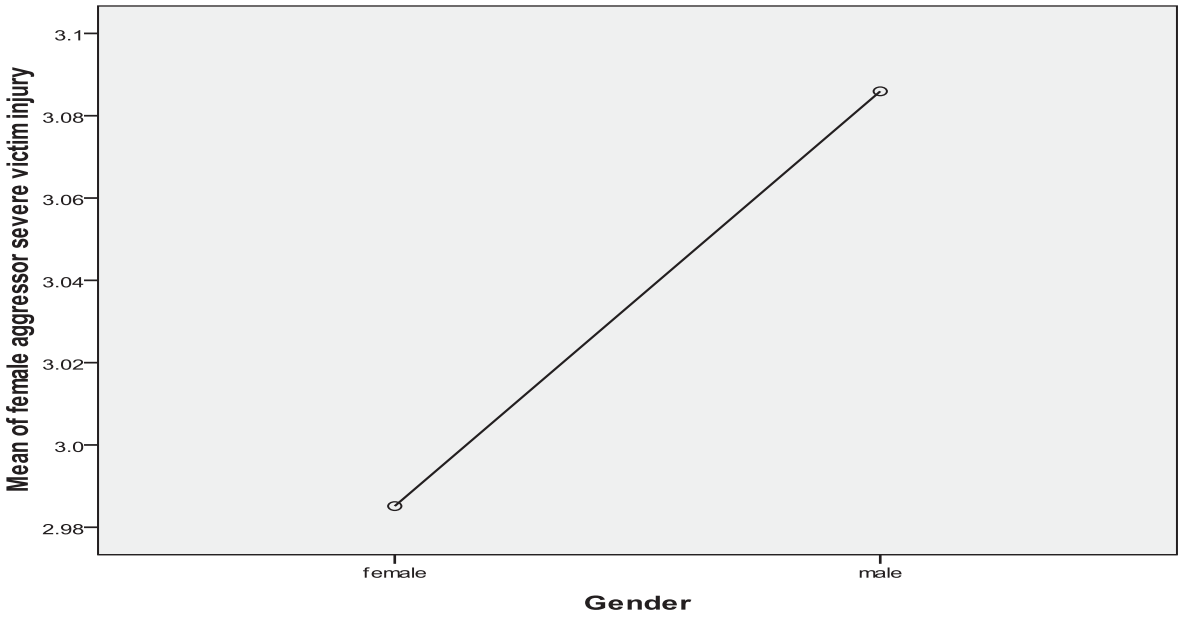

Mean of male aggressor severe approval retaliation
2.50
2.45
2.40
2.35
2.30
2.25
female
male
Gender


Mean of female aggressor severe approval retaliation
2.40
2.20
2.00
1.80
1.60
1.40
female
male
Gender

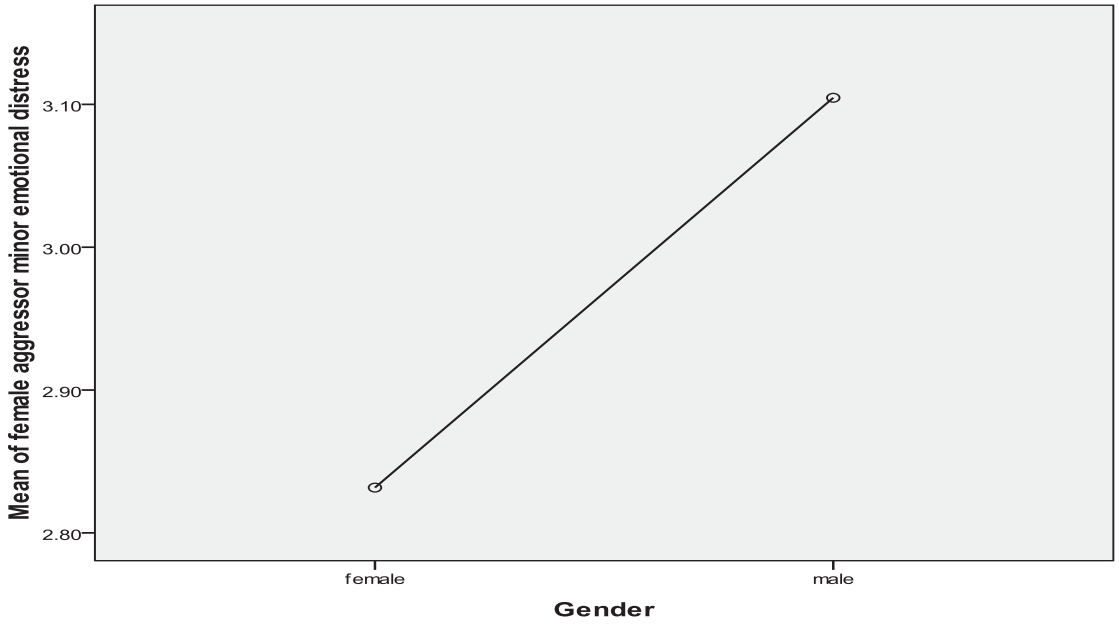

Mean of male aggressor minor victim injury
2.76
2.74
2.72
2.70
2.68
female
male
Gender


Mean of female aggressor minor victim injury
2.60
2.40
2.20
2.00
female
male
Gender


Mean of male aggressor severe vicitm injury
3.80
3.70
3.60
3.50
3.40
3.30
3.20
female
male
Gender


Mean of female aggressor severe victim injury
3.1
3.08
3.06
3.04
3.02
3.0
2.98
female
male
Gender


Mean of male aggressor minor emotional distress
3.80
3.60
3.40
3.20
female
male
Gender

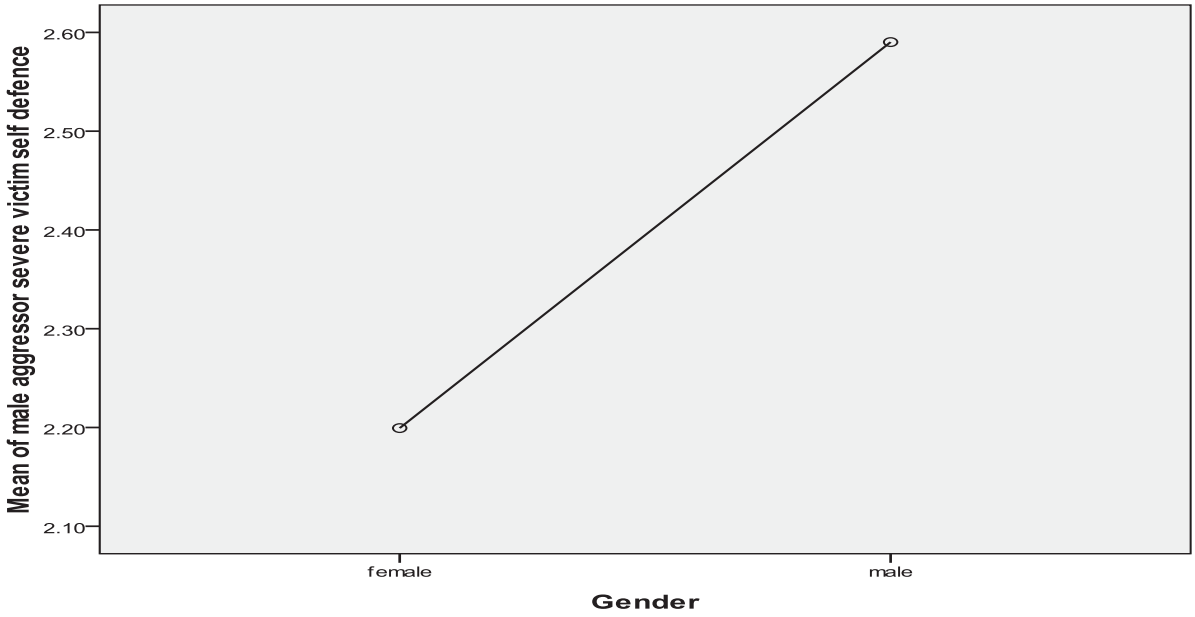

Mean of female aggressor minor emotional distress
3.10
3.00
2.90
2.80
female
male
Gender

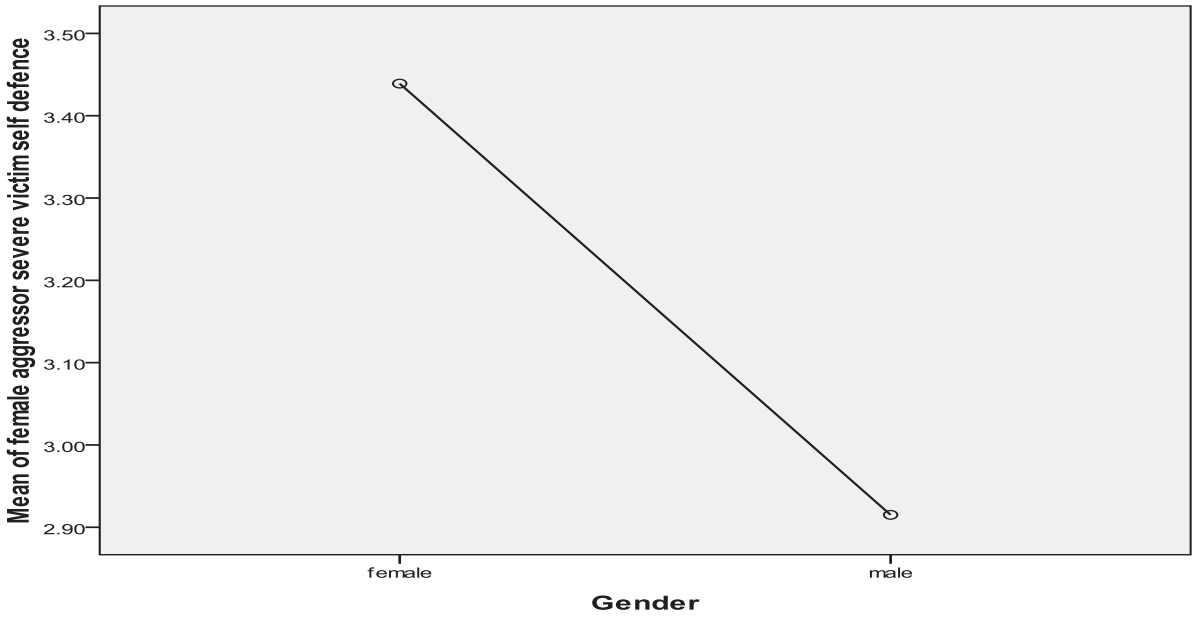

Mean of male aggressor severe emotional distress
4.20
4.00
3.80
3.60
3.40
3.20
female
male
Gender

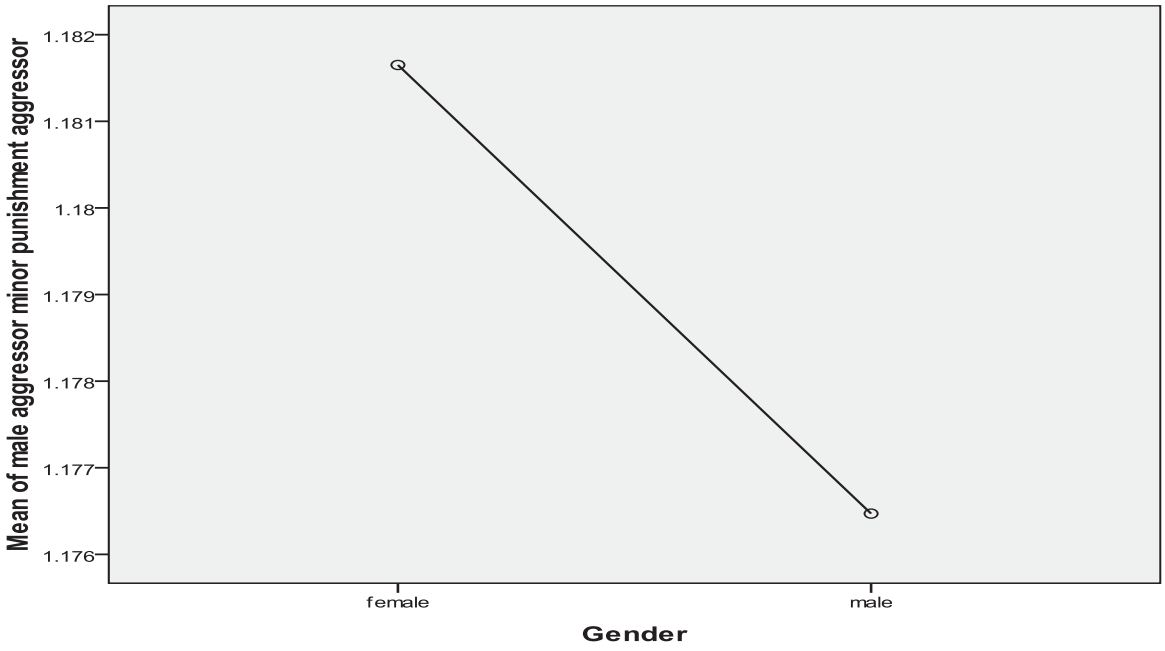

Mean of female aggressor severe emotional distress
3.50
3.45
3.40
3.35
3.30
female
male
Gender

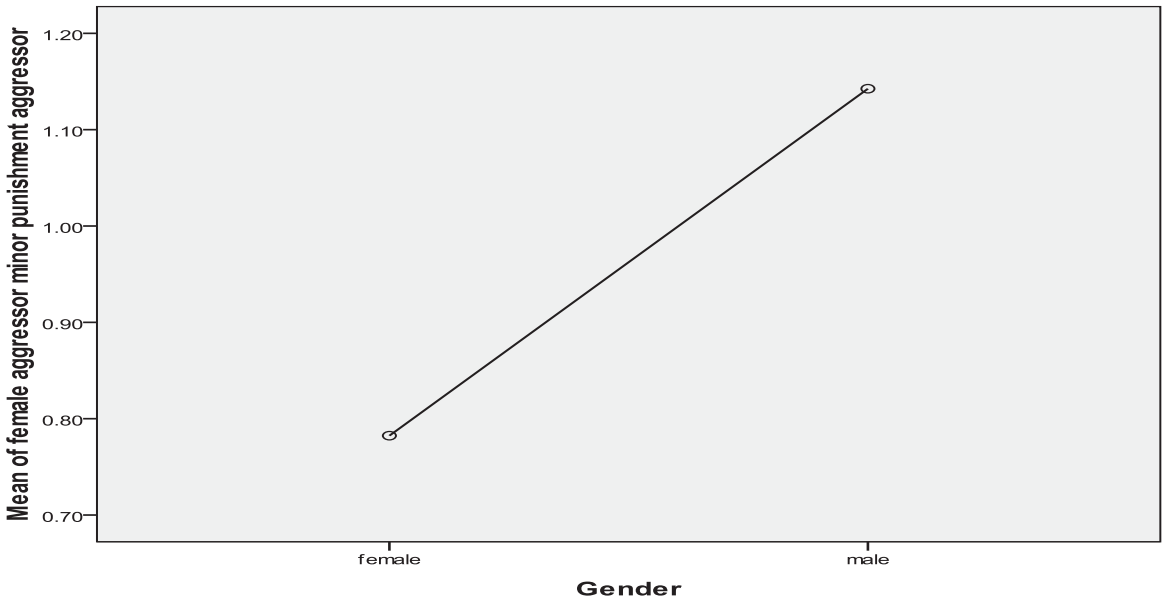

Mean of male aggressor minor victim self defence
2.60
2.50
2.40
2.30
2.20
female
male
Gender


Mean of female aggressor minor victim self defence
3.80
3.60
3.40
3.20
3.00
2.80
female
male
Gender


Mean of male aggressor severe victim self defence
2.60
2.50
2.40
2.30
2.20
2.10
female
male
Gender


Mean of female aggressor severe victim self defence
3.50
3.40
3.30
3.20
3.10
3.00
2.90
female
male
Gender


Mean of male aggressor minor punishment aggressor
1.182
1.181
1.18
1.179
1.178
1.177
1.176
female
male
Gender


Mean of female aggressor minor punishment aggressor
1.20
1.10
1.00
0.90
0.80
0.70
female
male
Gender


Mean of male aggressor severe punishment aggressor
2.20
2.10
2.00
1.90
1.80
1.70
female
male
Gender

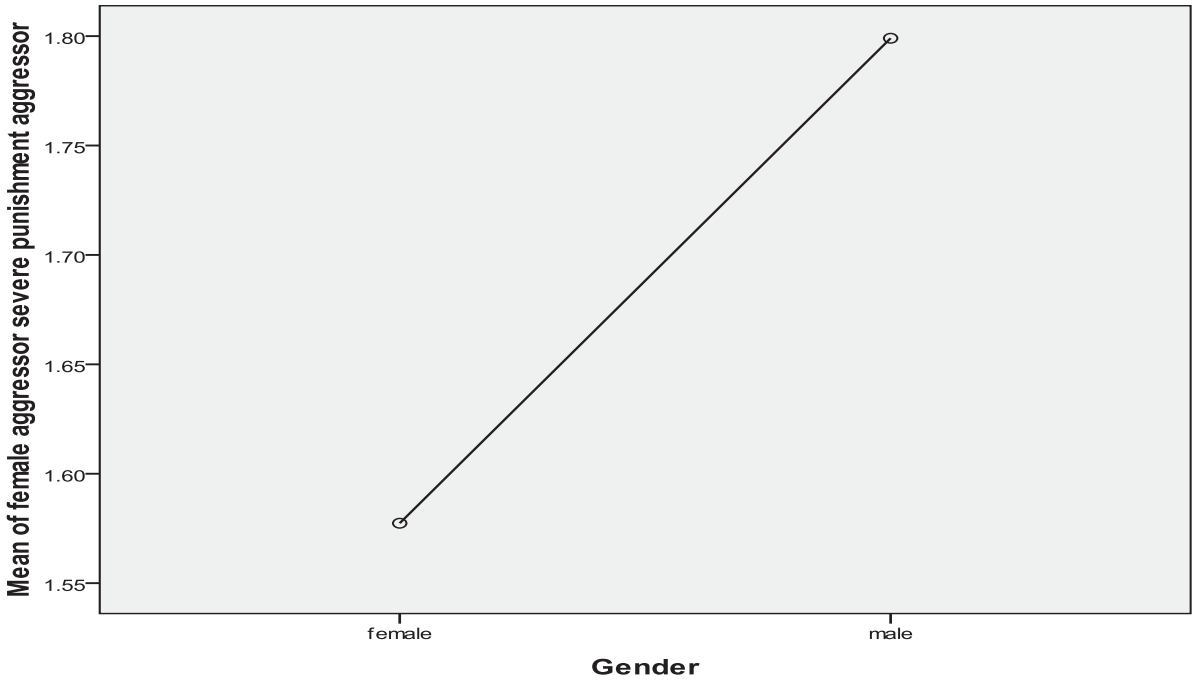

Mean of female aggressor severe punishment aggressor
1.80
1.75
1.70
1.65
1.60
1.55
female
male
Gender

Table B: Contrast tests for gender and VRAS subscales.

		Contrast	Value of Contrast	Std. Error	t	df	Sig. (2-tailed)
male aggressor minor approval	Assume equal variances	1	1.8653[a]	.07145	26.108	181	.000
	Does not assume equal variances	1	1.8653[a]	.09877	18.885	66.000	.000
male aggressor severe approval	Assume equal variances	1	1.7885[a]	.06515	27.454	179	.000
	Does not assume equal variances	1	1.7885[a]	.09149	19.549	65.000	.000
female aggressor minor approval	Assume equal variances	1	1.8040[a]	.10571	17.067	180	.000
	Does not assume equal variances	1	1.8040[a]	.08161	22.105	65.000	.000
female aggressor severe approval	Assume equal variances	1	1.7820[a]	.09424	18.910	180	.000
	Does not assume equal variances	1	1.7820[a]	.08089	22.030	65.000	.000
male aggressor minor approval retaliation	Assume equal variances	1	2.2078[a]	.12349	17.878	180	.000
	Does not assume equal variances	1	2.2078[a]	.07635	28.918	65.000	.000
male aggressor severe approval retaliation	Assume equal variances	1	2.2605[a]	.15394	14.684	179	.000
	Does not assume equal variances	1	2.2605[a]	.11083	20.396	65.000	.000
female aggressor minor approval retaliation	Assume equal variances	1	1.9881[a]	.06912	28.763	180	.000
	Does not assume equal variances	1	1.9881[a]	.09325	21.320	65.000	.000
female aggressor severe approval retaliation	Assume equal variances	1	2.2859[a]	.07949	28.757	180	.000
	Does not assume equal variances	1	2.2859[a]	.10757	21.251	65.000	.000
male aggressor minor victim injury	Assume equal variances	1	2.6808[a]	.10644	25.187	180	.000
	Does not assume equal variances	1	2.6808[a]	.07137	37.563	65.000	.000
male aggressor severe victim injury	Assume equal variances	1	3.2218[a]	.11868	27.148	180	.000
	Does not assume equal variances	1	3.2218[a]	.09875	32.627	66.000	.000
female aggressor minor victim injury	Assume equal variances	1	2.5609[a]	.08381	30.557	180	.000
	Does not assume equal variances	1	2.5609[a]	.07194	35.599	65.000	.000
female aggressor	Assume equal variances	1	3.086[a]	.0876	35.247	180	.000

severe victim injury	Does not assume equal variances	1	3.086[a]	.0760	40.592	65.000	.000
male aggressor minor emotional distress	Assume equal variances	1	3.1525[a]	.08574	36.769	181	.000
	Does not assume equal variances	1	3.1525[a]	.07750	40.676	66.000	.000
male aggressor severe emotional distress	Assume equal variances	1	3.3407[a]	.10246	32.604	179	.000
	Does not assume equal variances	1	3.3407[a]	.08822	37.866	65.000	.000
female aggressor minor emotional distress	Assume equal variances	1	3.1046[a]	.11531	26.923	180	.000
	Does not assume equal variances	1	3.1046[a]	.08303	37.392	65.000	.000
female aggressor severe emotional distress	Assume equal variances	1	3.3203[a]	.11864	27.988	180	.000
	Does not assume equal variances	1	3.3203[a]	.09931	33.433	65.000	.000
male aggressor minor victim self defence	Assume equal variances	1	2.5266[a]	.08551	29.549	180	.000
	Does not assume equal variances	1	2.5266[a]	.06293	40.148	65.000	.000
male aggressor severe victim self defence	Assume equal variances	1	2.5902[a]	.09509	27.238	179	.000
	Does not assume equal variances	1	2.5902[a]	.07988	32.424	65.000	.000
female aggressor minor victim self defence	Assume equal variances	1	2.9080[a]	.11139	26.107	180	.000
	Does not assume equal variances	1	2.9080[a]	.07640	38.064	65.000	.000
female aggressor severe victim self defence	Assume equal variances	1	2.9151[a]	.11366	25.647	181	.000
	Does not assume equal variances	1	2.9151[a]	.08874	32.851	66.000	.000
male aggressor minor punishment aggressor	Assume equal variances	1	1.1765[a]	.09950	11.824	182	.000
	Does not assume equal variances	1	1.1765[a]	.08360	14.073	67.000	.000
male aggressor severe punishment aggressor	Assume equal variances	1	1.7745[a]	.13039	13.610	181	.000
	Does not assume equal variances	1	1.7745[a]	.10928	16.238	67.000	.000
female aggressor minor punishment aggressor	Assume equal variances	1	1.1425[a]	.10154	11.252	182	.000
	Does not assume equal variances	1	1.1425[a]	.09528	11.990	67.000	.000
female aggressor severe punishment aggressor	Assume equal variances	1	1.7990[a]	.12452	14.448	182	.000
	Does not assume equal variances	1	1.7990[a]	.10854	16.574	67.000	.000

a. The sum of the contrast coefficients is not zero.

Appendix 3.7: Themes from Focus Groups

Themes that emerged from the focus groups on South Asian and non South Asian IPV victims included:

1. Additional causal factors for South Asian victims of IPV.

   South Asian and non South Asian participants felt that women were open to abuse no matter what their ethnic background however four additional causal factors for South Asian participants were identified through the groups. 1) What they classify as abuse e.g. South Asian female participants were more likely to define IPV as physical abuse compared to non South Asian participants. 2) South Asians had added factors of extended family and in-laws that appeared to play a crucial role within South Asian relationships and marriages. 3) Different expectations of gender roles especially when partner has a different cultural upbringing e.g. been born in South Asia and 4) forced marriages.

   Example of quote from South Asian male participant:

   "In laws can either be supportive to the victim or they can be authoritarian and/or interfering"

2. Similarities and differences in the effects of IPV.

   Both South Asian and non South Asian participants agreed that the effects for all victims of IPV were the same in terms of physical, behavioural, psychological and emotional effects. However, South Asian male and female participants talked about South Asian victims of IPV not being able to adequately express emotional problems, in western society this may be confused with psycho somatic symptoms or vice versa; majority of times they tend to exhibit a range of somatic symptoms. Hence, go to the GP seeing it as a medical condition. There seemed to be a consensus within the South Asian female participants that the effects of IPV would be worse for South Asian women compared to non South Asian participants because of added internal pressures from the family and community on making it work, and external pressures of services; therefore, prolonging the effects of IPV.

Example of quote from South Asian female participant:

"Because individuals cannot express intellectually express emotional problems; therefore, psychological distress sometimes manifests itself in physical symptoms (somatisation)"

An example of an expression of distress was given by a South Asian female participant:

"Dil ni vich khot perna (in my heart I feel a tightening)"

Furthermore, South Asian participants noted that there were extra barriers for those who have come from aboard, as they may not know the protocols to follow if they were a victim of IPV and therefore as a result may suffer more long term effects.

Example of quote from South Asian female participant:

"When women coming over from Pakistan, India and Bangladesh they have a lot of pressure to be the good wife and not to talk back and not to answer and not to be demanding... they are supposed to sort of do whatever the husband and family wants them...there's a pressure that if things go wrong, they can be sent back to their own country, it's a question of izzat (honour) *and sharam* (shame)*...because of this trauma many South Asian women feel trapped and therefore attempt or commit suicide and self harm"*

3. Similarities in coping strategies for victims of IPV.

   A theme emerged of how victims of IPV coped. This discussion was raised in a number of the groups and South Asian and non South Asian participants reported similar coping strategies. Some of the themes included; self harming or suicide, psychotic drugs and tranquilliser and anti depressants, playing the obedient partner hoping that this would prevent IPV and would eventually stop, hoping things would get better, turning to religion and faith, keeping busy with their children or with other activities and taking anger out on their children.

4. Service issues and extra barriers for South Asian victims of IPV.

   Another theme that merged was that there were extra barriers for South Asian women in terms of service issues. A number of barriers were put forward by South Asian participants that prevent South Asian women and men who are victims of IPV coming forward compared to non South Asian participants. For instance, South Asians have limited knowledge on services, stigma of divorce, being ostracised and rejected from their own family and or community, racism from society, confidentiality, trust and being differentiated from the Caucasian communities. A majority of South Asian female participants agreed it was worse for women.

   Examples of quote from South Asian female participants:

   "They will not turn to the police, GPs, statutory services, domestic violent departments/ organisation because of confidentiality, also the police and statutory services do not get involved because of cultural sensitivity therefore differentiating between white community".

   "Barriers placed by services, communication and language, stereotypes, issue of confidentiality can all prevent a South Asian victim coming forward".

   "It is very difficult for women to achieve a clean break when children are involved some women feel that have a male representative in the household is important".

5. Differences in accessing support.

   South Asian male participants felt that victims of IPV should turn to extended family for support in an attempt to resolve conflict rather than outside intervention due to concepts of honour and shame. However, South Asian female participants felt that if necessary victims of IPV should access support services at the same time acknowledging that this tended to happen as a last resort. Whereas, non South Asian participants felt that victims of IPV should turn to a friend or a support service.

South Asian participants noted that in some communities marriages are arranged through and in the extended family and community. Therefore, they may have siblings that are married into opposite families i.e. sister marries into one family and their sister marries her brother, this is known as '*Dvarti' or 'vata sata'*. If the marriage breaks down then more than one marriage is affected. Due to the close knit of the community if there are marital problems it is more than likely that this may become community knowledge, increase tension causing family feuds and it's the women's that's at fault.

Example of quote from South Asian male participant:

"*Conflict of is it the right thing to do...whether it would create more friction in a family and whether it would be disrespectful or shame brought on the family"*.

6. Additional prevention strategies suggested by participants for South Asian victims of IPV.
Both non South Asian and South Asian participants indicated that one of the main solutions around reducing IPV was prevention and breaking down barriers. Majority of them stated that where ever South Asian women have point of contact this should be used as an arena for information to raise awareness on IPV.

Example of quote from none South Asian female participant:

"Cinema advertisement, ads in local shops, leaflets in local GPs, through the Media,…Mothers and toddlers groups,…schools"

For the abuse to end all the participants discussed that's it was necessary for communities to begin to talk openly about all forms of abuse including sexual abuse. They felt that by me taking the sexual coercion section out of the CTS-2 was an example of *"cultural sensitivity gone wrong"* (quote by South Asian female participant) within the South Asian community. What they stated was that it was not good enough to show women how to escape, what they suggested was that men, women and children needed to be educated that IPV can come in any form and is and will always be wrong.

Examples of quotes from South Asian female participants:

"Raising awareness at early levels across the board in communities and at statutory levels"

"Changing attitudes of community leaders and the community who need to support their victims"

7. Similarities and differences in tools of power and control.

Majority of the discussion within the focus groups revolved around issues of power and control. The different forms of abuse identified included sexual, emotional, intimidation, physical, isolation, threats, using male privilege, economic, using immigration status, and using children. A majority of South Asian female participants felt that power and control was omnipotent in South Asian communities compared to non South Asian communities and was used to oppress women, keeping them within the IPV setting using tools to justify ones actions. What was more surprising was that some South Asian female and male participants believed that minor forms of violence e.g. slapping was part of marriage and was acceptable.

Example of quotes from south Asian female participants:

"Slap... nothing wrong with that"

"She may stay for the sake of the children as it could affect the upbringing and if she does leave she may not have any way of looking after her children financially and she can't live without them"

"*If their wives were from abroad as there is no social security benefits in South Asian countries they don't know any better. Husband won't tell her what she is entitled to and may expect her and the children to live on £5 week"*

8. Additional societal oppressions for South Asian participants.

   Another theme that emerged that differentiated South Asian and non South Asian participants' responses were societal oppressions. This included racism, religion, gender and family oppression.

   Examples of quotes from South Asian female participants:

   "Women are forced to stay or conform in relationships because of restrictions or cultural, religion or societal pressures...concepts such as honour and shame are more powerful than religion"

   "The societal oppression are all used for justification of behaviour by perpetrators and for services not to get involved"

South Asian participants tended to talk about the impact of various perpetrators compared to non South Asian participants.

Examples of quotes from South Asian female participant:

"The way in laws can have control over the victim, for example a mother in law, sister in law…"

"It seems the role of the mother in law in South Asian households can be a contradictory one. As she can give advice as well as police her daughter in law...in a way for the mother in laws it's a way for them to control their daughter in laws through their sons so they allow it to happen" .

All the participants felt the attitudes and beliefs of the victims were important factors of whether they came forward and accessed services, whether they felt the abuse was wrong or whether it was a part of the package of marriage. In addition, majority of the South Asian participants stated that issues of power and control are imposed under cultural locks which are disguised in the form of Izzat (honour), sharam (shame) and loyalties of whether it's the right

thing to do might influence a South Asian woman not to come forward, and or access services. There were also other mitigating aspects.

Examples of quotes from South Asian participants:

"It could affect the marriage prospects of other siblings"

"*Immigration status, if she comes from abroad for marriage. You're going to go home shamed and you are going to go home divorced"*

"Cultural issues, izzat and sharam will come up time and time again"

9. Differences found between British and non British born South Asian women.

Another theme that emerged from the data was similarities and differences found between British and non British born South Asian women in terms of IPV.

Example of quotes from none South Asian female participant:

"It doesn't matter where you're from or where you been brought up the causes, issue of power and control, feeling isolated, stigmatisation to be ostracised, self blame, the way you cope is similar"

However, the differences that emerged between British and non British born South Asian women in terms of IPV included:

- Language of expressing the abuse may be different.
- Non British born South Asian women may not recognise some forms of abuse.

  "South Asian have a narrow interpretation of domestic violence, more aware of the different forms of domestic violence in the west" (South Asian female participant).
- South Asian women in England might be more aware of the services that are available and could probably approach the appropriate services.

"British born are more aware of issues and services through education systems and may have alternative support networks i.e. family, friends, colleagues...women who come from abroad have limited or no awareness of services" (South Asian male participant).

- Lack of education in South Asian countries.
- Immigration issues for non British born South Asian.

  "*A women is trapped because of immigration rulings*, *society gives the partner more power and hence colludes with the abuse. He will not tell her what she is entitled to, he may isolate her from society and manipulate the situation for his benefit, she is at his mercy"* (South Asian male participant).
- Individual's geographical background i.e. come from urban or rural parts of South Asia.

  "Rural background, you get on with it there is no services, there's no public language"

  "Whereas urban areas are more advancement there is improvements in services, and women are more independent and knowledgeable, they won't put up with abuse" (South Asian female participant).