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# Posttraumatic stress and depression symptoms as correlates of deliberate self-harm among community women experiencing intimate partner violence

Véronique Jaquier, Julianne C. Hellmuth, Tami P. Sullivan \*

Department of Psychiatry, School of Medicine, Yale University, New Haven, CT, USA

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## ABSTRACT

Deliberate self-harm (DSH) among women in the general population is correlated separately with posttraumatic stress, depression, and abuse during childhood and adulthood. The prevalence of these DSH correlates is particularly high among women exposed to intimate partner violence (IPV), yet few studies have examined DSH among this high-risk population and none have examined these correlates simultaneously. Two hundred and twelve IPV-victimized women in the community participated in a 2-h retrospective interview. One-third reported current or past DSH. Discriminant analysis was used to examine which posttraumatic stress and depression symptoms and types of current IPV and childhood abuse were uniquely associated with current DSH. Findings show that women who currently use DSH reported greater severity of posttraumatic stress numbing symptoms and more severe sexual IPV compared to women who used DSH only in the past. Examining factors that are associated with women's current DSH in this population is critical so that a focus on DSH can be integrated into the treatment plans of women who are receiving mental health care, but also so that women who are not receiving such care can be referred to adequate mental health services.

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## 1. Introduction

Deliberate self-harm (DSH), whereby an individual deliberately causes tissue damage without suicidal intent (Gratz, 2001), is consistently and strongly associated with sexual victimization in both childhood (Gladstone et al., 2004; Mina and Gallop, 1998; Noll et al., 2003) and adulthood (Campbell et al., 2007; Gratz, 2006) and with mental health problems such as posttraumatic stress (Cloitre et al., 2002; Harned et al., 2006, 2010b; Nada-Raja and Skegg, 2011) and depression (Boudewyn and Liem, 1995; Hawton et al., 1999). Despite the high prevalence of the aforementioned DSH correlates among women experiencing intimate partner violence (IPV; Caetano and Cunradi, 2003; Desai et al., 2002; Golding, 1999; Sullivan et al., 2009) few studies have examined DSH in this high-risk population (Boyle et al., 2006; Levesque et al., 2010; Noll et al., 2003; Sansone et al., 2007). DSH and IPV constitute critical health issues: according to recent data, 6% of women experience IPV annually (Black et al., 2011) and 4–8% of women in the general population use DSH (Brown et al., 2007). IPV-victimized women are up to three times more likely to present with DSH than non-victimized women (Boyle et al., 2006).

Past research has taken different approaches to simultaneously examining DSH and IPV. In one instance, both constructs were examined as common consequences of childhood sexual abuse (Noll et al., 2003). In other research, their associations were examined in women psychiatric inpatients (Sansone et al., 2007), emergency medicine patients (Boyle et al., 2006), and university students (Levesque et al., 2010). No study to date, however, has examined the prevalence of DSH among IPV-victimized women in the community. Past studies are further limited in that they did not assess separately past and current DSH. Further, while some studies distinguished IPV types (Levesque et al., 2010; Noll et al., 2003), no study simultaneously examined multiple types of IPV and types of childhood abuse. Failing to distinguish among psychological, physical, and sexual IPV or childhood emotional, physical, and sexual abuse as correlates of DSH is problematic since research indicates that types of abuse are differentially related to mental health outcomes (e.g., Clemmons et al., 2007; Dutton et al., 2006; Hedtke et al., 2008; Senn and Carey, 2010; Sullivan et al., 2006).

It is critical to examine factors that are associated with current use of DSH among IPV-victimized women so that (a) for women who already are receiving mental health care, a focus on DSH can be integrated into their treatment plans, and (b) for women who are not receiving such care but are in contact with other service providers, those providers can better identify the need for a referral to mental health services. Therefore, the purpose of this study is to determine the extent to which different posttraumatic

\* Correspondence to: Department of Psychiatry, School of Medicine, Yale University, The Consultation Center, 389 Whitney Avenue, New Haven, CT 06511, USA. Tel.: +1 203 789 7645; fax: +1 203 562 6355.

E-mail address: [tami.sullivan@yale.edu](mailto:tami.sullivan@yale.edu) (T.P. Sullivan).

stress and depression symptoms, and types of IPV and childhood abuse, differentiate women who are currently using DSH from those who used it only in the past or not at all.

Research indicates that DSH, though maladaptive, is highly functional in the service of emotion regulation (Chapman et al., 2006; Gratz and Tull, 2010). Theories of emotion regulation suggest that DSH can be understood as a way (a) to express or control unbearable or intense negative emotions including pain, fear, and anger; (b) to cope with the effects of dissociation that result from the intensity of such negative emotions; or (c) to mitigate the effects of posttraumatic stress reexperiencing and emotional numbing symptoms (Briere and Gil, 1998; Brown et al., 2007; Dyer et al., 2009; Gratz, 2003). Compared to women who experience other types of traumatic life events, IPV-victimized women are at heightened risk for DSH since they often report experiencing an array of particularly intense negative emotions, including shame, guilt, and fear (Beck et al., 2011; Jaquier and Sullivan, *in press*) and are at high risk for both posttraumatic stress and depression symptoms (Caetano and Cunradi, 2003; Desai et al., 2002; Golding, 1999; Sullivan et al., 2009). These negative emotions and mental health problems, which are saliently related to DSH, tend to be more persistent and severe among individuals who experience interpersonal traumas such as IPV compared to impersonal traumas (Anders et al., 2011; Forbes et al., 2012). Further, IPV-victimized women endure a high probability of repeat victimization, continued negative effects of IPV victimization, and a minimal likelihood of recovery over time compared to women who experience other traumatic life events (Beeble et al., 2009; Blasco-Ros et al., 2010). IPV-victimized women are also at heightened risk for DSH because they are more likely than nonvictims to have experienced childhood sexual abuse (e.g., Golding, 1999; McGuigan and Middlemiss, 2005), which also is often related to poor emotion regulation skills (e.g., Cloitre et al., 2005).

Women with complex abuse histories often have similarly complex diagnostic profiles characterized by posttraumatic stress, depression, and DSH—which, in turn, are all characterized by emotion dysregulation (Chapman et al., 2006; Cloitre et al., 2005; Gratz and Tull, 2012). Women with such complex issues often have limited adaptive emotion regulation skills and incur many obstacles to gaining access to and receiving appropriate mental health care (Briere and Gil, 1998; Johnson and Zlotnick, 2006; Johnson et al., 2011). Few principles exist to guide clinical decision making for mental health care providers who treat these high-risk women (Forbes et al., 2007; Harned et al., 2010a). Therefore, the first step toward improving providers' clinical decision making among IPV-victimized women in various settings is to understand how current and past DSH are differentially related to women's abuse histories and co-occurring mental health problems. This exploratory study addresses this gap in the literature by examining the severity of women's posttraumatic stress and depression symptoms and the severity of their types of IPV and childhood abuse to identify correlates unique to current DSH (vs. past or no DSH) among IPV-victimized women in the community.

## 2. Method

### 2.1. Participants

Two hundred forty women were recruited from an urban community in New England. Recruitment flyers were posted throughout the community, including health clinics, churches, salons, grocery stores, and community agencies, inviting women to participate in the Women's Relationship Study, a larger study examining the daily relationships among IPV and various co-occurring problems. Eligibility was determined via phone screen. The primary inclusion criterion was that the woman had experienced at least one act of physical IPV by her current male partner during the prior 6 months as measured by selected screening questions from the Conflict Tactics Scales-2 (CTS-2; Straus et al., 2003). Additional

inclusion criteria were: (a) current involvement in a heterosexual intimate relationship of at least 6 months with contact at least twice per week; (b) continuous partner contact (i.e., no more than 2 weeks apart); and (c) monthly household income no greater than \$4200—determined a priori to methodologically control for differential resources associated with income (e.g., greater access to resources such as medical and mental health services). The final sample comprised of 212 women.

### 2.2. Procedures

A 2-h, semi-structured, computer-assisted interview was administered face-to-face by a trained master or doctoral-level research associate. After completion of the interview, all participants were debriefed, remunerated \$50, and provided with a list of community resources. All study procedures were approved by the Institutional Review Board of the primary investigator's institution.

The average age of women in this sample was 36.6 years (S.D.=10.5). Overall, 78.7% of women had children. Most women were either unemployed (34.4%) or unable to work (30.7%), with a mean level of education of 12 years (S.D.=1.6) and a mean annual household income of \$13,304 (S.D.=\$9600). One hundred and forty-four women were African American, 43 were White, nine were Latina, six were American Indian or Alaska Native, and 10 identified themselves as multi-racial or did not specify their race. Over half of the couples were living together (59.4%) and the length of their relationship ranged from 6 months to 33 years ( $M=6.5$  years,  $S.D.=6.4$ ).

### 2.3. Measures

#### 2.3.1. Deliberate self-harm

The Deliberate Self-harm Inventory (DSHI; Gratz, 2001) is a 17-item self-report measure designed to examine non-suicidal DSH. The DSHI documents the frequency, age of onset, duration, severity, and most recent occurrence of DSH. To reduce participant burden, we combined questions that were similar and dropped questions with a low frequency of responses in Gratz's (2001) study. Women were asked whether they had engaged in (1) cutting, (2) burning, (3) carving, (4) scratching, (5) sticking sharp objects into their skin, (6) preventing their wounds from healing, or (7) anything else to hurt themselves. Internal consistency for this revised measure was good,  $\alpha=0.71$ . The referent time period for assessment of DSH was the duration of women's current intimate relationships. Women were classified into three mutually exclusive groups: (a) women who self-harmed in their current relationship, (b) women who self-harmed only in the past, and (c) women who never self-harmed.

#### 2.3.2. Posttraumatic stress

The severity of posttraumatic stress was measured using the 49-item Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995). Posttraumatic stress symptom severity was assessed in relation to IPV by the current partner for the duration of the relationship. Diagnostic criteria (B) re-experiencing, (C) avoidance and emotional numbing, and (D) arousal symptoms were assessed over the previous 6 months. Building on previous research supporting the utility of a four-cluster structure for posttraumatic stress symptoms (Krause et al., 2007; Yufik and Simms, 2010), we separated the DSM-IV (American Psychiatric Association, 1994) avoidance and numbing symptoms. Four-cluster symptom severity scores were created by summing women's responses: 0 (*not at all, or only one time*), 1 (*once a week or less, or once in a while*), 2 (*2 to 4 times a week, or half the time*), and 3 (*5 or more times a week, or almost always*). Reliability for these subscales was good:  $\alpha=0.87$  for the five re-experiencing symptoms,  $\alpha=0.78$  for the five numbing symptoms, and  $\alpha=0.79$  for the five arousal symptoms (cluster D); the inter-item correlation for the two avoidance symptoms was 0.46. Seventy-one women (33.5%) met the criteria for posttraumatic stress disorder in this sample.

#### 2.3.3. Depression

The Center for Epidemiological Studies–Depression Scale (Radloff, 1977) was used to assess depressive symptoms over the previous 6 months. This scale contains 20 items. Response categories ranged from 0 (*rarely or none of the time*) to 3 (*most or all of the time [5–7 days a week]*). Responses were summed to create the total score, with strong internal consistency,  $\alpha=0.91$ . One-hundred and sixty-one women (75.9%) scored above the CES-D severity threshold of  $\geq 16$  which indicates a positive screener for depression.

#### 2.3.4. Intimate partner violence

Physical IPV severity was measured with the Conflict Tactics Scales-2 (CTS-2; Straus et al., 2003). For the present analyses, a reference period of 6 months was chosen. Physical IPV response categories that comprised a range of values were recoded (Straus et al., 2003; i.e., *twice, 3–5 times* [recoded to 4], *6–10 times* [recoded to 8], *11–20 times* [recoded to 15], and *more than 20 times* [recoded to 25]). The physical IPV score was the sum of the 12 CTS-2 items of the assault subscale (e.g., pushed, kicked, choked),  $\alpha=0.89$ . To gain comprehensive information about sexual and psychological IPV, these constructs also were measured by

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