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Psychological and relational functioning in Chilean women victims of domestic violence, with different levels of childhood relational adversity

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Domestic violence is a high prevalence women's health problem, regarding both, Chilean and international studies (Ellsberg, Jansen, Heise, Watts & García-Moreno, 2008; OMS, 2002; Universidad de Chile, 2001). It's social, economic, physical and mental health consequences are severe as they have been widely described in literature. (Humphreys, Thiara, 2003; WHO, 2002; Campbell, 2002).

It is a complex and multidimensional phenomenon embedded in cultural, social and family patterns, therefore, its prolonged permanence has to be studied considering these variables (Larraín, 1994; Velásquez, 2003).

From a clinical perspective, it has been reported its impact on women's mental health, and its associations with depression, anxiety and posttraumatic stress disorder (García-Moreno, Jansen, Ellsberg, Heise, & Watts; 2006; Campbell, 2002), but less have been studied on how systematic, cumulative and many times invisible traumatization process, experienced by victims, impacts on women's psychological functioning and specially, on their possibility of interrupting violence and revictimization, which is naturally the aim of clinical interventions with this population (Pico-Alfonso, Echeburúa & Martínez; 2008; Messman-Moore, Brown & Koelsch, 2005; Frankel, 2002; Montero, 2001).

This study attempts to tackle domestic violence victims on the very deep complexity of their psychodynamic dimensions, focusing on a traumatization perspective.

The *main objective* of this investigation is to characterize a sample of domestic violence Chilean victims by means of an operationalized psychodynamic diagnosis, exploring in a differentiated way their structural functions, dysfunctional interpersonal

patterns and intra-psychoic conflicts. Finally, the objective is to determine the associations among these characteristics and the relational trauma features: type, severity and extension of adult violence, childhood adverse relational experiences and self-vulnerabilities.

The *clinical relevance* of this study, lays on its opportunity to go into deep dimensions of the psychological functioning of this population, contributing to the enrichment of conceptual and clinical observations with empirical evidence, that may facilitate treatment planning and focusing on clinical issues that constitute obstacles and impasses to the interruption of violence cycles, such as relational dysfunctionality or structural vulnerability; which may be on the basis of re-victimization .

Another aspect which is tackled in this investigation and, that is part of the re-victimization phenomena, is *secondary victimization* risk; this refers to the suffering experienced by the victims, because of institutions or professionals attitudes in their process of help-seeking. Secondary victimization can be expressed by minimizing the problem, reproaching or blaming the woman for the violence she is suffering, intrusive interventions which do not respect the victim's rhythm and premature referral to other services (Pérez Contreras, 2011; Calle Fernández, 2004)

The method proposed for this study is based on the assessment and description of the dimensions mentioned above, by means of the OPD clinical interview, in a sample of domestic violence victims attending specialized centers in Santiago de Chile. The Operationalized Psychodynamic Diagnosis (OPD) is a multidimensional diagnosis system which enrich traditional diagnostics of mental disorders, with psychodynamic dimensions useful for therapeutic indication and psychotherapy process (OPD Task Force, 2008).

The specific qualities of violence and its length are assessed and scored by the “Domestic Violence Assessment Module”, which was developed by the author as an adaptation of OPD Axis I, for the aims of this study. The childhood adverse relational experiences, mental disorders, cultural and socio-demographic variables are evaluated with instruments which will be described below in this dissertation report.

This research has attained the approval of the Ethics Committee of the Psychology Department of Pontificia Universidad Católica de Chile.

The present document reports the main findings of the dissertation, presenting four scientific articles. The design of this investigation corresponds to a non-experimental, correlational and cross-sectional research. The method, including participants, measures, data collection and analysis are specified in each of the articles presented below. The hypotheses tested are presented, as well, in the mentioned articles. Finally, the general conclusions and a discussion of the findings is developed. The instruments used and the informed consent letter are attached at the end of the document.

1.- Domestic violence and violence against women

Several concepts have been used to refer to the abuses suffered by women in their family and couple relationships. It has been denominated domestic violence, intimate partner violence, gender violence, among others (Velásquez, 2003; OMS, 2000).

Even though violence against women occurs in different contexts; politics, social, institutional, this study tackles violence in the context of intimate partner relationship and it is going to be denominated domestic violence or intimate partner violence indistinctly.

The notion of *gender* is fundamental to the study of domestic violence. This recognizes cultural and subjective differences between genders based on social constructions about female and male identities, which have historically perpetuated and legitimated supremacy and dominance of men with respect to women in the culture. This leads to the notion of *relational abuse*, being gender inequality and power abuse a central issue in domestic violence comprehension (Velásquez, 2003; Ravazzola, 1996).

The World Health Organization has defined violence against women as any act of gender based violence which provokes or potentially provokes emotional, physical or sexual harm or pain, and this includes threatens, coercion and privation of liberty in public or private life (Organización de las Naciones Unidas, 1996).

Domestic violence refers to the abuse of power within intimate partner relationships which is manifested in a *coercive interpersonal pattern* in which the perpetrator violates the victim's liberties, submitting her to an unwanted position, which is justified by patriarchal arguments like discipline or protection (WHO, 2000; Velásquez, 2003; Ravazzola, 1996; Loketek, 1997).

Intimate partner violence tends to be repetitive and cyclical and it increases on severity along time (Walker, 1979). The following types of domestic violence have been described in literature (WHO, 2000):

Physical violence: a range of actions using physical force of varying severity, like slapping, punching, kicking, biting, burning, scalding, smothering, beating, throwing objects or using knives or guns.

Sexual violence: forced sexual contact, including marital rape, vaginal, oral or anal intercourse, or being exposed to unwanted sexual acts.

Psychological or emotional violence: manipulation, isolation from family or friends, intimidation, humiliation and denigration. Deprivations from economical maintain has been included in this kind of violence as well.

These three types of violence were included and assessed in this study.

1.1.- Prevalence of domestic violence

Domestic violence is present in all countries, cultures and social levels, with no exception, although some populations as lower class groups are in a higher risk (WHO, 2002). Prevalence rates vary among studies because of different conceptualizations and methods to measure it. International prevalence studies have found rates between 15% and 71% of physical, sexual or both, along women's life; and between 4% and 54% in the last twelve months. In almost all of the populations studied it was found a significant superposition of physical and sexual violence, being more prevalent in rural and traditional towns, than in industrialized cities. In the majority of samples, violence was severe and frequent (García-Moreno, Jansen, Ellsberg, Heise, Watts, 2006).

Psychological abuse has been studied less, although victims confer great importance to it, but this has been a more difficult variable to operationalize. Women who suffered psychological violence reported significantly more controlling behaviors from their partners than non-victims (García-Moreno, Jansen, Ellsberg, Heise, et al, 2006).

Based in the WHO (2000) definitions, physical, emotional and sexual violence were operationalized in the "Domestic Violence Assessment Module" (see Annex 3). With respect to the national prevalence, epidemiologic studies developed in different regions of Chile, showed that 36% to 50% of women have suffered intimate partner violence along her lives (DESUC, 2006; 2004; Universidad de Chile, 2001).

1.2.- Consequences of domestic violence in women's mental health

There are wide and long term consequences of domestic violence on quality of life, physical and mental women's health (Campbell, 2002). Studies have shown that victims of domestic violence are more likely to present undermined general health conditions, specific health problems, such as gynecological disorders, chronic pain, difficulties with daily activities and a more frequent use of health services, than other women (Ellsberg, Jansen, Heise, Watts & García-Moreno, 2008; Campbell, 2002; OMS, 2000).

In the general population study by Ellsberg et al (2006) it was found as well, that women who reported having suffered domestic violence at least once in their lives, presented significantly more emotional distress, suicidal ideas and attempts, than women who haven't suffered domestic violence.

A publication of the Center of Control and Prevention of Disease in United States reported the results of a national survey conducted in 2005. It was found that women who had experienced intimate partner violence (threatens or acts) were more likely to present health adverse conditions and risk behaviors than those who have not (Center for Disease Control and Prevention, 2008).

In numerous studies it has been documented a high prevalence of domestic violence within psychiatric populations (Trevillion, Khalifeh, Woodall, Agnew-Davies & Feder, 2010). There is wide evidence of the associations between domestic violence and mental health problems; emotional stress, depression, anxiety, suicide attempts, PTSD, and trauma symptoms (Ludermir, Schraiber, D'Oliveira, Franca-Junior & Jansen, 2008; Fedovskiy, Higgins & Paranjape, 2008; Ceballo, Ramírez, Castillo, Caballero & Lozoff, 2004; Campbell, 2002).

In Chile, in the assessment of the National Primary Care Program for Depression Treatment it was found that 51,4% of the depressed women had suffered a violent episode in the two months previous to the evaluation. .It was also found a significant relationship between domestic violence and severity of depression (Universidad de Chile, 2002).

Concomitant psychopathology can be considered an effect of domestic violence in victims, but at the same time, it can constitute a personal obstacle of the victim to cope with her situation and leave the abusive relationship.

A Chilean study found that the treatment dropout rate of a depression program was 5 times higher in women with a domestic violence situation than in those who didn't present this problem (Universidad de Chile, 2002). This has a relation with some obstacles and impasses in intervention with victims that may have something to do with psychological functioning associated to relational traumatization. In this line, it has been stated that in trauma victims, treatments exclusively focused in symptoms are insufficient in victims of prolonged and repeated trauma (Schottenbauer, Glass, Arnkoff & Hafter Gray, 2008).

The antecedents mentioned above, are related to the aims of this doctoral investigation, as they refer to the complexity of the consequences in victim's functioning and behavior, and how at the same time, these effects could be considered as obstacles of change, and this is why it wouldn't be enough to treat mental symptoms without considering the abusive context.

There are few studies that evaluate in a differentiated way the effect of the types of violence in the development of mental disorders. Benice, Resick, Mechanic & Astin (2003) found that the severity of sexual violence explained a significant portion of the severity of PTSD, more than it was explained by physical violence. On the other hand,

it has been demonstrated that the more types of violence experienced by the victim, more PTSD symptoms she develops (Desai, Arias, Thomson & Basile, 2002).

In the present dissertation research, each type of violence and their severity are assessed. Their specific associations with different aspects of structural functioning in the victim are explored.

1.3.- Social and Cultural Factors Associated with Domestic Violence

There are socio-demographic and cultural factors associated with domestic violence. Poverty increases the risk of violence between couples and this has been explained considering that precarious economic situations raise the level of stress and conflict between the partners, especially concerning the relationship to money, jealousy and control issues. It has been observed that women who are empowered by their educational, economic and social levels are more protected from violence (Jewkes, 2002). The family income would be associated to the difficulties of the victim to leave a violent relationship, the lower family income is, the more difficult for a woman to leave (Lacey, 2010). In some studies education has been found to have a protective effect which would appear to begin at the level of higher studies, and which is independent of both income and age (OMS, 2005).

The presence of a traditional ideology that validates the rights of men to batter their partners is also associated with sexual violence (Benice, Resick, Mechanic & Astin, 2003). In Chilean studies, it was found that victims of domestic violence tend to have a hierarchical ideology of partner relationships, in which the man has the authority, and there is a greater acceptance of both physical and sexual violence. It was also found that physical and sexual violence is significantly greater within low and very low socio-economic levels, and among those who haven't finished high school.

With respect to the role of social networks, the less family and social support are, there is a greater prevalence of domestic violence (DESUC, 2004, 2006; Universidad de Chile, 2001).

This investigation incorporates social and cultural variables, because intimate-partner violence and family violence cannot be studied without considering elements of a broader context, which maintain abusive patterns in culture; and on the other hand, resources and obstacles that this context offers women.

2.- Interpersonal Traumatization and Revictimization. Childhood Relational Adversity in Victims of Domestic Violence

Regarding the relationship between a background of childhood trauma and domestic violence, several studies have shown that women who are victims of violence are more likely to have a physical or sexual abuse history than others. Abuse during childhood predisposes to a greater risk of later revictimization (Sahin, Timur, Ergin, Taspinar, Balkaya & Cubukcu, 2010; Lang, Aarons, Gearity, Laffaye, Satz, Dresselhaus, Murray & Stein, 2008; Vatnar & Bjorkly, 2008; Briere & Jordan, 2004). In the Chilean studies, women being sexually abused before the age of 15 and/or witnessing violence towards their mothers were both shown to be significant predictors of becoming victims of domestic violence as adults (DESUC, 2004, 2006; Universidad de Chile, 2001).

Studies on interpersonal trauma highlight the high risk of revictimization in victims (Herman, 2002). It has been proposed that the impact of revictimization can be cumulative and/or interactive, i.e., the consequences of the trauma can increase if there are new incidents, or the effects of the current trauma can be increased by the effects of the earlier traumas (Briere & Jordan, 2004).

Interpersonal trauma has characteristics and consequences that distinguish it from other types of trauma (Briere y Spinazzola, 2005; Van der Hart, Nijenhuis y Steele, 2005; Herman, 1992). Herman (1992) proposes the existence of a complex form of PTSD in survivors of prolonged and repeated trauma. This situation occurs in the context of a coercive relationship with a subordinating perpetrator, from whom the victim cannot escape. The psychological impact produced has common traits whether the trauma occurs in the public or political sphere, or in the intimacy of family or sexual relationships, as in the case of child abuse and domestic violence.

Sluzki (1994) proposes that the devastating effect of domestic violence, as well as other forms of social violence, stem from the combination of two factors: the person supposed to protect the victim is the one who attacks her, and the transformation of the protective character into a violent one occurs in a context and reasoning that denies or justifies this transformation. In this way, the victim is left without the possibility of naming the behavior of her aggressor as “violent,” and she loses her ability to consent or dissent.

The devastating and traumatic experience is given a redefinition of the violence: “I did it for your own good;” “You made me do it;” “This is what you like;” “I do it because you deserve it.” The effect is to distort and misconstrue the victim’s perception, breaking her defenses, and plunging her into despair and defenselessness (Velásquez, 2003; Sluzki, 1994).

Domestic violence situations tend to be systematic and chronic processes of victimization in which the abuse alternates cyclically with promises of change, repentance and reward, which provoke confusion, indecision and alienation to the victim (Walker 1979). The traumatization produces a psychic destitution due to long suffering and the victim’s lack of control. As a survival strategy and to regain some

control over the experience, the victim becomes attached to her aggressor, follows his desires, identifies with him and justifies him (Velásquez, 2003; Frankel, 2002; Montero, 2001).

The violent act is traumatic for its ability to incapacitate the victim's adequate response, and for the confusion that occurs in the psychic organization of the victim. Moreover, there would be some conditions for the traumatic experience remaining inscribed in the psyche: psychological conditions, the possibility of integrating the experience and activating the psychic defenses that would allow the victim to bear it. That is to say, the traumatic experience is a real fact whose impact also depends on internal conditions, resources and the psychic weaknesses of the victim (Tutte, 2004; Velásquez, 2003). Some of these internal conditions (structural vulnerabilities) and their associations with objective aspects of violence (type and severity) are tackled in the present investigation.

One of the first theoretical developments on domestic violence was the "battered woman syndrome". Based on gender perspective, this proposed that the symptoms observed in battered women were consequences of the systematic violence suffered by the woman, transferring the focus from the intrapsychic characteristics of the women to the violence itself (Walker, 1979).

Many years later, Humphreys and Thiara (2003) proposed a causal relation between the violence and emotional disorders, in such a way that the latter were understood as "symptoms" of the abuse. The authors pointed out that the lack of consideration of the role of domestic violence trauma, had been converted into a problem in treating these issues as part of the mental health of the women. There was a tendency to stigmatize the victims with a diagnosis of personality disorders and

attribute them to “mental health problems.” The fact that they continued living with the aggressor, for these authors, was really the cause of their mental health problems.

The concept of complex trauma and complex PTSD have helped to understand both the behavior and the difficulties of the victims of domestic violence. The characteristics that were originally described by Herman (1992) and supported by conceptual developments and empirical studies are the following:

1. A multiplicity of symptoms, within which are found several forms of somatization, disassociation and affective symptoms that combine and become more powerful.
2. The development of permanent changes in the personality as far as identity and interpersonal relationships go. In the relationship with herself, submission produces profound alterations in her identity. The image of herself, her bodily image, the internalized images of others, even her own values that would give her a sense of coherence are invaded and broken. In the relationship with the other, the perpetrator becomes the most powerful person for the victim. She develops a pathological attachment or a traumatic bond of extreme emotional dependence on the person who abuses her who becomes a source of comfort and degradation simultaneously (Frankel, 2002; Montero, 2001).

This description is similar to the idea of identification with the aggressor described by Ferenczi (1949) as an adaptive mechanism to survive the abusive relationship. The victim anticipates the desires and hopes of the aggressor and makes them her own, annulling herself and dissociating from her own feelings and needs, as a way of adapting and controlling the threat. Thus, in order to protect herself, the victim renounces her own sense of self to fit the image in the mind of her aggressor (Frankel, 2002).

3. A high risk of revictimization. Herman (1992) suggests that in the case of a complex trauma, the survivors have the risk of repeating the victimization, not only in re-experiencing the trauma, but also as a systematic and stable way of relating to themselves and others. Van der Kolk (1989) has pointed out that the behavior of revictimization, which would be a form of repeating the trauma, tend to diminish or disappear, when its meaning is understood by the victim in the context of the traumatization history. More severe and complex post traumatic consequences are frequently associated with a history of multiple interpersonal victimization that often began with abuse or neglect in childhood (Ford & Kidd, 1998; Zlotnick, Zakriski, Shea, Costello, Begin & Pearlstein, 1996). The background of childhood victimization in women who suffer domestic violence can result in a more intense and less appropriate response to the new victimization (Briere & Jordan, 2004).

In the same line, it has been pointed out that the symptoms attributed to personality disorders and that reflect structural deficits, especially self-destructive or interpersonal ones, would probably be reenactments of the childhood trauma (Trippany, Helm & Simpson, 2006).

There are very few studies tackling the relationship between domestic violence and personality disorders. Pico-Alfonso, Echeburúa and Martínez (2008) studied the associations among symptoms of personality disorders and intimate partner violence. They compared three groups: women who were victims of physical and psychological violence; women who were victims of psychological violence; and a control group (not victims of violence). They found that the women with both types of violence and those with only psychological violence had significantly more personality disorders symptoms

than the control group, and that these differences were independent of the effects of childhood abuse.

Briere & Jordan (2004) found that the alterations in self-capacities were associated to interpersonal trauma more than to other types of traumatic events, and that childhood trauma presents a greater correlation with these impairments when comparing them to adult victimization.

Nevertheless, another study found that a history of adult sexual victimization was associated with greater alterations of the self and that a deficient functioning of the personality predicted victimization even in the absence of previous trauma. Sexual victimization whether as a child or an adult was associated directly to new sexual victimizations (Messman-Moore, Brown & Koelsch, 2005).

A question arises from these findings whether the victim establishes and stays in a violent relationship due to her personality impairments, consequence of the harm due to childhood trauma, or does the domestic violence have devastating effects in itself that annul or limit the possibilities of these women getting out of the situation.

The assumption that orients this investigation is that there probably exists a recursive or reciprocal relationship between the psychic and relational functioning, violence and revictimization; in the sense that these variables interact in such a way that the history of previous victimizations predisposes to re-victimizations and that both are associated to vulnerabilities in the personality. These, in turn, would constitute obstacles in leaving the violent situation.

A form of revictimization that former victims of domestic violence often suffer is secondary victimization, negative responses of the environment, characterized by criticism, rejection, blaming and stigmatizing on the part of those who should help the victims (Calle Fernández, 2004)

This phenomenon, rooted in cultural sexist beliefs that tend to blame and devalue victims of domestic violence, involves a lack of understanding about their suffering and their psychological needs. This has prejudicial effects on resolving the situation as it increases the defenselessness and despair of the victims (Kreuter, 2006; García- Pablos, 1993; Campbell, 2005). The present study, through the relational diagnosis, searches to shed light on the re-victimizing response of intervention agents.

This negative response is also related to the difficulties and frustrations that professionals encounter in attending the victims, such as, rejecting treatment, retracting the accusations, and withdrawing protection orders. It has been observed clinically and empirically that some of these behaviors of the victims, as we said above, have to do in large part with the adaptation responses to relational traumatization, such as the intense attachment and dependence that characterized the traumatic bond (Roberts, Wolfer & Mele, 2008; Montero, 2001).

3.- The Concept of Structural Vulnerabilities

According to the Operationalized Psychodynamic Diagnosis system (OPD), the psychic structure is understood as an organization of interdependent functions which articulates and allows the individual to manage with external and internal experiences. These functions or self-capacities allow the individual to adapt and regulate emotional stress. The structure is dynamically understood as an evolving organization, in which even though, changes are slow, the functions and self-capacities can be found more or less integrated and available to the individual in different circumstances and life requirements (Grupo de Trabajo OPD, 2008).

An adequate structural development would be characterized by an autonomous and differentiated self, with the ability to recognize itself, refer to itself, have positive

internal images, control internal experiences and develop satisfactory interpersonal relationships. The availability of the structural capacities is equivalent to the internal resources of the subject (Grupo de Trabajo OPD, 2008).

The construct of self-impairments has been focused on by Briere and Rickards (2007), considering three types of alterations: identity alterations, affect regulation problems, and interpersonal difficulties. With respect to the identity, the alterations would have to do with the difficulty of referring to herself and being able to maintain a stable image of herself. The affective deregulations has to do with difficulty to tolerate and handle emotional stress and negative emotions, and the interpersonal difficulties have to do with the problems to develop and maintain significant relationships.

The OPD distinguishes between structural deficits and structural vulnerabilities. The structural deficits arise from the fact that the self hasn't been able to achieve an appropriate differentiation and the structural functions have not been sufficiently integrated. The self is not autonomous, it is not able to differentiate from the object, and it lacks internal positive representations that would help it to regulate internally.

Structural vulnerabilities occur when the structure was developing but did not achieve sufficient stability, so that when faced with highly stressed situations, either internal or external, states of anxiety and disintegration are activated, and the structural capacities developed are either lost or less available (Grupo de Trabajo OPD, 2008).

The structural capacities and their vulnerabilities according to the OPD present a double orientation. On one hand, they refer to the functioning with respect to the self, in its internal world; and on the other, in relation to the objects and the external world. These self-functions can be grouped into four types of capacities (OPD structural functions): Cognitive functions, Affective regulation functions, Emotional communication functions and, Attachment functions.

Structural functions are described in more detail in article 2 of this thesis entitled “Vulnerability in Self capacities of Chilean women victims of domestic violence with diverse levels of childhood relational adversity: Clinical implications”

There are not many empirical studies regarding self-capacities and their alterations. This has been explained in part because of the complexity of these constructs and their operationalization, and also the lack of standardized instruments to evaluate them (Briere & Rickards, 2007).

In the same way, there are few studies published that treat the relation between different types of victimizations and their impact on the development or functioning of self-capacities, and that focus most specifically on the association between the different types of adverse relationship experiences (whether as a child or an adult) and the disturbances of different functions of the self (Briere & Rickards, 2007; Messman-Moore, Brown & Koelsch, 2005). Thiel (2007), using the evaluation of structural functions of the OPD system, found that distinct types of child abuse were related with vulnerabilities in the different self-capacities.

4.- Dysfunction in Interpersonal Relationships and Intra-Psychic Conflicts

The maladaptive relationship patterns and the internal conflicts that could underlie these, are also aspects of the psychodynamic functioning that is described in the victims studied in this thesis.

With respect to dysfunctional relational patterns, it is necessary to remember that domestic violence happens in the context of a significant relationship with a is dominion and submission pattern, in which the aggressor exercises coercive control over the victim, who develops a bond of extreme emotional dependence, also known

as a traumatic bond, with the perpetrator being simultaneously the source of comfort and degradation (Herman, 1992; Montero, 2001).

The OPD System refers to the dysfunctional relational patterns as constellations of interpersonal behavior which produce distress and suffering in the individual, and that result from his/her habitual relational behavior and the reaction of others (Grupo de Trabajo OPD, 2008). The study of these patterns in victims of domestic violence can contribute to the identification of those relational behaviors that maintain the abuse and the cycles of revictimization.

The intrapsychic conflicts develop as a result of the tension between needs or desires and anxieties or fears with respect to those desires. They produce again and again the same reactions, and the individual is not aware of it or able to change it voluntarily, resulting in suffering and symptoms. The capacity to resolve the conflicts unfolds on the basis of the structure (Grupo de Trabajo OPD, 2008).

In this study, the conflicts described in the OPD system were evaluated. These conflicts are: 1.- Individuation v/s Dependency; 2.- Control v/s submission; 3.- Need for care v/s self-sufficiency; 4.- Self-worth; 5.- Guilt; 6.- Oedipal; 7.- Identity

For each conflict a lead affect is described and the predominant mode of processing the conflict is evaluated in the individual. A detail of the relational diagnostic carried out according to the OPD system and a more detailed description of the conflicts and their mode of resolution are presented in article 3, entitled "Dysfunctional relational patterns and intra-psychic conflicts in Chilean women victims of domestic violence".

The dysfunctional relational patterns which include the relational behaviors of the victims and others in a maladaptive cycle; the underlying intrapsychic conflicts; and the structural characteristics of the victims, can jointly help to understand the cycles of

revictimization in domestic violence. These personal factors form part of the complex interaction of variables which determine the victim's responses to the relational trauma, among which are found cultural and socio-demographic variables, type and severity of the violence, the history of previous victimizations and the psychiatric symptomatology.

In the light of the preceding background, it is possible to think that certain functioning and behaviors of the victims of violence (e.g., to return to the aggressor, to discontinue treatment) could be seen as part of the adaptive responses faced with relational traumatization (identification with the aggressor, dissociation, among others) and these, in turn, tend to maintain the abusive patterns in the relations.

In order to have a more profound knowledge of the victims of domestic violence, the psychological traits of women who suffer domestic violence should be described in depth by means of diagnostic instruments that come close to capturing the complexity and richness of the psychic and relational dimensions in this population. Then the clinically relevant relationships between these traits and the nature of the violence should be analyzed. This would contribute to the formulation of more precise therapeutic orientations, thus avoiding the stigmatizations due to static diagnoses and judgments that lead to secondary victimization, favoring the perpetuation of the violence.

This investigation contributes to this field of knowledge in victims of domestic violence, by means of a differentiated study of the structural functions of the self, the interpersonal dysfunctional patterns in which the victims participate, and of the principal intrapsychic conflicts, considering the types and severity of abuse in the victim, as well as the history of previous abusive experiences in childhood.

1. Complex relational traumatization: a useful notion to understand the psychological functioning in domestic violence victims

Abstract

The notion of complex relational traumatization is developed, focusing on intimate partner violence against women. This approach intertwines psychodynamic contributions, with the evolution of trauma concept and posttraumatic stress disorder within psychiatry and, studies on interpersonal trauma. A perspective that emphasizes the notion of process (traumatization) over event (trauma) is developed, in the context of a meaningful relationship which signifies and prescribes the abusive dynamic, leading to complex consequences in victims, who tend to maintain re-victimization behaviors, provoking frustration among intervention agents. It is proposed that this could be a useful notion to enrich the comprehension of victims functioning and to guide interventions.

Key words: relational trauma – domestic violence – re -victimization

Background

Domestic violence (DV) can be understood as emotional, physical or sexual violent behaviors that occur in the context of an abusive relationship characterised by a coercive interpersonal pattern that transgresses the woman's freedom, thereby submitting her and placing her in an undesired position (World Health Organization, 2000; Velasquez, 2003; Loketek, 1997; Ravazzola, 1996).

It is a highly prevalent public health problem (Garcia Moreno, Jansen, Ellsberg, Heise & Watts, 2006). The social and economic consequences, as well as the impacts in physical and mental health of the victims, are severe and they have been broadly

described in the literature (Humphreys & Thiara, 2003; Campbell, 2002; World Health Organization, 2002).

The research on DV shows associations to depression, anxiety, and post-traumatic stress disorder, among other mental disorders (Ellsberg, Jansen, Heise, Watts y García Moreno, 2008; Campbell, 2002; World Health Organization, 2000). The interactions between domestic violence, personality structure, self-functioning and the impact of prolonged traumatization and the history of re-victimization has been less studied (Pico-Alfonso, Echeburúa, Martínez, 2008; Briere & Rickards, 2007; Frankel, 2002; Sluzki, 1994).

In Chile, a study of the National Depression Treatment Program found that 51.4% of depressed women had suffered an episode of domestic violence in the past two months. The presence of violence was associated with increased severity of depression and the desertion rate of program participants was 5 times higher in victims of DV (Universidad de Chile, 2002).

Humphreys & Thiara (2003) proposed that it would be possible to establish a causal relation between domestic violence and emotional disorders, in such a way, that these could be understood as “symptoms of abuse”.

Clinical psychology has had some difficulties in addressing the problem. On one hand, the psychopathology approach tends to stigmatize victims, reducing the complexity of the phenomenon, and on the other hand, this perspective does not include the structural variables of gender and power in family relationships. In addition, certain traditional therapeutic concepts such as neutrality, confidentiality, and/or circularity have contributed to the perpetuation and legitimization of violence in families (Ravazzola, 1996; Goodrich, Rampage, Ellman & Halstead, 1989). Another difficulty seems to be the insufficient consideration, of the impact of relational violence in the

psychological functioning and behavior of the victim, which often leads professionals to blame domestic violence victims for their ambivalent and contradictory behaviors. It is frequent that victims are re-victimised by intervention agents and others.

Treatments that exclusively focus on symptoms have proven to be insufficient in patients with prolonged and repeated trauma (Schottenbauer, Glass, Arnkoff & Hafter Gray, 2008). The possibility of providing understanding and meaning to mental and behavioral symptoms by their connection to relational trauma may be relevant for victim's reparation and healing.

The development of Trauma concept in Psychiatry

The concept of trauma has been historically associated with the nosological category of posttraumatic stress disorder (PTSD), characterized mainly by:

- 1) occurring after exposure to a severe trauma event, involving death or threats to their integrity or that of others, generating persistent fearful responses, helplessness or intense horror;
- 2) re-experiencing, through intrusive memories, dreams, or a sense of reliving the experience as if it were happening again (flashbacks);
- 3) permanent avoidance of stimuli associated with the trauma and psychic numbing or emotional anesthesia; or
- 4) a persistent increase in arousal manifested in symptoms such as hypervigilance, insomnia, and difficulty concentrating, among others (American Psychiatric Association, 2000).

The DSM-IV-TR introduces a significant change in the notion of trauma. Earlier versions emphasized the idea of trauma as an uncommon catastrophic event, but numerous studies suggest that the typical triggers of post-traumatic stress syndrome are relatively common personal events, so that this latest version emphasizes the

threatening and fear triggering quality of trauma (subjective aspect) rather than the nature of the objective event (Kaplan, Sadock & Sadock, 2005). This latest version includes the systematic experiencing of physical or sexual abuse.

In the contemporary discussion about trauma and PTSD, there is a clear controversy over these constructs. Some authors suggest that diagnosis of PTSD has been over including a number of nonspecific symptoms, bringing confusion to the comprehension of trauma (McHugh & Treisman, 2007; Bodkin, Pope, Detken & Hudson, 2007).

For another group of researchers, PTSD has a limited range in its ability to capture and describe the complexity of the traumatic experience, suggesting that some important clinical phenomena such as dissociation, somatization and emotional deregulation, which are part of the spectrum of responses to the trauma, would remain outside the framework of PTSD or have been considered separated from each other, when there is a high association among them. Clinical manifestations of trauma would be more extensive, varied and interconnected (Rodríguez Vega, Fernández Liria & Bayón Pérez, 2005; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996; Herman, 1992).

In their research about trauma experience in war, Fernández Liria and Rodríguez Vega (2000) described the limitations of the concept of PTSD which focuses upon the event (and its impact) and not the process of prolonged traumatization, which requires to the victim the development of adaptation mechanisms.

Herman (1992) developed a proposal especially relevant for this study when she suggested the existence of a complex form of PTSD in survivors of prolonged and repeated trauma. She noted that this situation can only occur in the context of

subordination to the coercive control of a perpetrator, which creates a psychological impact that has common traits, either that the trauma occurred in the public or political sphere or in the intimacy of family or sexual relationships, such as child abuse and domestic violence.

The Evolution of the Psychodynamic Concept of Trauma

The concept of trauma is as old and fundamental in the history of psychology and psychopathology as it is controversial and complex. The difficulty in defining and understanding the concept seems to be inherent in the phenomenon itself (Balint 1969). What is trauma? What makes it traumatic? Is it external events? Is it the subjective response to a stimulus?

At first Freud (1893-1895) developed a theory of trauma understanding it as an external stimulus, primarily sexual in nature, whose intensity surpassed quantitatively the ability of the psychic structure to work it through. Later, Freud (1920), moved toward a dynamic theory of trauma, where fantasies and internal conflicts could trigger trauma, emphasizing on the intra-psychic experience.

For Ferenczi (1949), in all psychopathology there is always a real traumatic situation which acts as a trigger. Unlike Freud, he highlights the role of external reality in the conformation of the psychic structure and the genesis of trauma, indicating the traumatogenic aspect of the psychic reality of the other when the latter has the power to impose its own meanings, within the traumatic event and to the entire existence of the subject.

Balint (1969) points out, however, that Freud did not completely abandon the idea of traumatic etiology of the neuroses, recognizing that trauma actually contains both a real aspect of the experience itself, as an intrapsychic subjective aspect involving the memory and re-experience of the event. This is an idea that has

considerable consensus currently. Psychic trauma always implies interaction between the external and internal world. Trauma would result from an interaction between the real external event and how that is experienced by the subject's psyche (Tutté, 2004).

A significant contribution for the conceptual proposal of this article, is the concept of cumulative trauma developed by Khan (1963), namely, the effect of systematic failures by the mother in her role as protective shield of the stimuli and environmental demands to which the child has been repeatedly exposed during her/his development.

What is interesting in this conceptualization is that each isolated failure the mother made would not necessarily have a traumatic effect that the systematic accumulation of these failures would. In the idea of cumulative trauma, we find a vision that emphasizes, rather than the magnitude of the event, the systematic quality of the failure in a meaningful relationship. That is, it would be the recurrence, the chronic nature of this failure in a relationship, which generates the trauma as a process.

While for psychoanalysis, trauma always refers to a situation in the child's development involving the external world, particularly the caregivers (Tutté, 2004), in this study it seemed relevant to include these psychodynamic notions with the hope of shedding light on traumatization processes in adult life, considering that certain experiences in adulthood can also be devastating for the individual generating helplessness and having an impact on how the person comes to experience her/himself and the world, even on the same level that they had attachment experiences in childhood (Fernández Liria, 2008).

Studies on Interpersonal Trauma

Herman (1992) described the concept of complex PTSD, a form of trauma developed in the context of a permanent state of submission to the coercive control of a

perpetrator to whom the victim becomes dependent. This has been refined by subsequent studies on interpersonal trauma (Sahin, Timur, Ergin, Taspinar, Balkaya & Cubukcu, 2010; Briere y Spinazzola, 2005; Van der Hart, Nijenhuis & Steele, 2005; Messman-Moore, Brown, Koelsch, 2005).

Complex PTSD is characterized by:

- 1) a multiplicity of symptoms, which include various forms of somatization, dissociation and emotional symptoms, which combine and enhance each other;
- 2) the development of permanent changes in personality in the spheres of identity and interpersonal relationships;
- 3) a high risk of re-victimization.

Submission produces profound changes in victim's identity. The image of herself, her body image, the internalized images of others, her own values that give her a sense of coherence are invaded and broken (Sahin et al, 2010).

The perpetrator becomes the most powerful person for the victim, who develops a pathological attachment or *traumatic bonding*, of extreme emotional dependence, to the abuser, who simultaneously becomes a source of comfort and humiliation. Chronically traumatized people are often judged as passive and insecure, but this has to do with the fact that any independent action would be viewed as insubordination, which is very threatening considering that the perpetrator is part of the inner world of the victim (Sahin et al, 2010; Frankel, 2002; Montero, 2001; Herman, 1992).

These changes in personality may be associated to the concept of identification with the aggressor described by Ferenczi (1949). As a way of surviving the relationship, the victim anticipates the wishes and expectations of the aggressor and makes them her owns', canceling herself, dissociating from her own feelings as a way of adapting and controlling the threat. Thus, the victim gives up her own sense of self, her own

feelings and needs, to fit an image that conforms to the mind of her abuser as a way of protecting herself (Frankel, 2002).

Montero (2001) became interested in the problem of why women stay in abusive relationships so long; he was also interested in the development of traumatic bonds. From these studies he proposed the Syndrome of Paradoxical Adaptation to Domestic Violence. This would start with a psycho-physiological reaction and a series of cognitive modifications in the domestic referential context. It would operate as an active mechanism of adaptation, developed in stages that culminate in the formation of a dependent relationship that paradoxically serves a protective function for the mental integrity of the victim.

Researchers in interpersonal trauma suggest that in complex trauma, survivors are at risk of repeat victimization, not only in re-experiencing the trauma, but also as a systematic and stable form of relating with themselves and others. It would be interesting to be able to identify in different levels: structural functioning, prevalent intrapsychic conflict and dysfunctional relationship patterns of the victim (Grupo de trabajo OPD, 2008), the predisposing elements to the risk of re-victimization in its various forms, which would support the orientation of the therapeutic intervention.

In the same vein, Van der Kolk (1989) has pointed out that re-victimizations' behaviors would tend to decrease or end, when its meanings can be understood by the victim in the context of the history of the traumatization.

Van der Hart, Nijenhuis and Steele (2005) state that complex PTSD would involve symptomatic constellations that bring lasting changes in personality, characterized by a wide range of alterations in regulating emotions and impulses, in the perception of the self, the perception of the perpetrator, interpersonal relationships, dissociation and somatization (Briere y Spinazzola, 2005; Van der Hart, Nijenhuis y

Steele, 2005; Messman-Moore, Brown, Koelsch, 2005; Pelcovitz, Van der Kolk, Roth, Mandel, Kaplan & Resick, 1997; Roth, Newman, Van der Kolk, Mandel, 1997; Van der Kolk et al, 1996; Herman, 1992).

Briere & Spinazzola (2005) suggest that responses to stressful, devastating stimuli may be located in a complexity continuum; at one end would be the responses to traumatic events occurring rarely in the adult life of people with a proper childhood development and a normal reactive nervous system without co-morbidity of psychic disturbances. On the other side of the continuum would be those early, multiple, chronic and very invasive experiences, often interpersonal in nature, involving shame and stigma and which occur in individuals who for various reasons may be more vulnerable to the effects of stress. The cited authors propose a set of symptoms called “alterations of the capacities of the self,” which have to do with the skills to manage their internal experience and interaction with others. These individuals would be more likely to experience a variety of posttraumatic symptoms, negative moods and difficulties in regulating their emotions in interpersonal relationships (Lang, Aarons, Gearity, Laffaye, Satz, Dresselhaus, Murray & Stein, 2008; Vatnar & Bjorkly, 2008; Herman, 1992).

More severe and complex consequences are often associated with a life history of multiple experiences of interpersonal victimization, which often begin with abuse or neglect in childhood (Ford & Kidd, 1998; Zlotnick, Zakriski, Shea, Costello, Begin & Pearlstein, 1996). These experiences predispose the individual to the risk of future re-victimization (Neumann, Houskamp, Pollock & Briere, 1996).

Domestic Violence as a Phenomenon of Complex Relational Traumatization

From the previous studies there are some elements that seem important to note,

considering the consequences of domestic violence in the victims, and how these consequences could explain part of the difficulty in stopping the violence.

In these reflections it is proposed to speak of “traumatization” as this concept emphasizes the nature of “process” of the domestic violence phenomenon, which occurs consistently over time and in the context of a close and meaningful relationship. It is necessary to differentiate the impact of events or the “acts of violence” from the impact of staying in an abusive dynamic in which the complementary positions of dominance and submission are perpetuated, trapping victims and offenders in the traumatizing circuit of domestic violence.

The focus is then on the qualities of the “abusive relationship” rather than on the observable manifestations of violence. It is not merely the type or severity of the violent episodes which makes them potentially traumatic, but also, the domination-subordination interpersonal pattern and the repeated and cumulative experience, which would result in a process that places some of the feelings that characterize responses to trauma in women suffering domestic violence, e.g. isolation, hopelessness, and helplessness (Sahin et al, 2010; Briere and Spinazzola, 2005; Van der Hart, Nijenhuis and Steele, 2005; Messman-Moore, Brown, Koelsch, 2005; Herman, 1992; Khan, 1963; Larrain, 1994; and Walker, 1979).

The notion of “complexity” is linked to the particular difficulties that supplies this type of traumatization developed in a meaningful relationship, where the attachment between victim and perpetrator, makes it difficult for her to leave the abusive relationship. The aggressor is at the same time the source of calm or comfort for the victim. The *traumatic bonding* is an active mechanism of adaptation, a survival strategy and a way to gain control over the experience, it serves as a protective function for the mental integrity of the victim. The victim becomes attached to her assailant, adheres to

his wishes, identifying with him and justifying him (Velasquez, 2003; Frankel, 2002; Montero, 2001; Herman, 1992; Ferenczi, 1949).

Chronically traumatized people are often judged and labeled with diagnoses such as personality disorders. Domestic violence, besides being frequently systematic and chronic, develops as processes that cyclically alternate violent episodes with promises of change, regret with reward. In very early and important observations in this field, Walker (1979) described the cycles of domestic violence and moved the focus from intra-psychic characteristics of the victims, to the consequences of violence in them (passivity, hopelessness and low self-esteem). Current studies on interpersonal trauma (cited above) support and enrich the observations of Walker from the standpoint of explaining the mechanisms by which re-victimization occurs.

It would be possible to understand this as a recursive circuit where relational traumatization leads the victim to maintain certain psychological and behavioral adaptive mechanisms which are indeed a part of the obstacles and sources of stagnation in the interruption of violence.

Some of the mechanisms of re-victimization could be understood from the perspective of the impairment of psychic functions, such as self-perception, perception of the other and, problems with emotional regulation (Van der Hart, Nijenhuis & Steele, 2005; Briere and Spinazzola, 2005). It is conceivable that these altered functions tend to develop behavioral and interpersonal repetitive patterns that contribute to the perpetuation of violence.

Discussion

Domestic violence, as a complex phenomenon, should be observed from a variety of descriptive and comprehensive angles, some of the most important of which are the Ecological Model (Bronfenbrenner, 1987), the Violence Cycle (Walker, 1979) and

the Abusive Systems Perspective (Ravazzola, 1996). The notion of Complex Relational Traumatization contributes to focus on the internal and interpersonal characteristics of women who suffer intimate-partner violence, which allows for the understanding of the victims' behavior as part of a vulnerable functioning in which psychic capacities are altered or less available as a response to the traumatization process, rather than static personality disorder manifestations, associated to psychopathologizing stigmas. Such vulnerabilities may constitute mechanisms through which re-victimization develops (Herman, 1992).

Inherent phenomenon in the complex relational traumatization, such as identification with the aggressor, traumatic bond, alterations on the victim's identity, on the perception of self and other, affective regulation difficulties; joined with social and emotional isolation, the lack of a support network or difficulties in perceiving and using it, all contribute to understand a victim remaining for a long period of time in an abusive relationship (Montero, 2001). This is not because intrinsic personality traits limit her, but rather because her *current psychic resources* are less available as a consequence of violence. It is suggested that this view could favor empathy in intervention agents of different sectors (psycho-social, political, judicial, health system), helping them to understand the victims' passivity, their tendency to abandon treatment, their difficulty in sustaining a legal report or withdraw protection orders to support them (Roberts, Wolfer, Mele, 2008).

The intervention agents' relational proposal to the victims may, in many cases, appeal to psychic functions that are temporarily weakened in these women, and are often followed by judgments that attribute lack of cooperation or static psychopathological labels to the victims. What is normally less considered is the series of adaptive responses that sustain the traumatic bond with the aggressor on one hand,

and the internal mental maps that facilitate the repetition of similar relationships, on the other.

We might hypothesize that the impairment of psychic functions and the dysfunctional interpersonal patterns acquired through a history of relational traumas, somehow mediate in the occurrence of such repetition, which is, rather than a self-destructive tendency, an impossibility to access internal and external resources, and a learned adaptive mechanism turned autonomous in the relation forms with self and others (Sahin et al, 2010; Frankel, 2002).

The proposed notion may thus contribute to decrease the secondary victimization of women by professionals and intervention agents. If the traumatization occurred in an inter-personal relationship, it is possible to think that reparation takes place in the relational context as well, in the form of a corrective emotional experience that could occur on the different levels of intervention with the victims; the police receiving the report, in health attention and injury verification, in psychological and therapeutic support, in the legal process.

Furthermore, at the clinical intervention level it is imperative to consider the structural vulnerabilities present in domestic violence victims and their inclusion in the therapeutic process. The interruption of violence is undoubtedly a basic necessity for the repair and recuperation of internal resources, thus initial intervention is directed towards protecting the victim, avoiding new violent situations and handling the risk. However, vulnerabilities of psychic functions constitute internal obstacles that limit the victim's capacity to break the violence cycle, even when external resources are available. Therefore, it seems necessary to find a dynamic balance between interventions oriented toward protection and those oriented toward the victim's awareness and comprehension of the internal difficulties that exist as consequence of

the violent relationship. Consequently, therapy should also focus on the recuperation and strengthening of vulnerable psychic capacities.

The inclusion of these focuses in the treatment requires an evaluation of self-capacities of the victim to distinguish between the most impaired functions and the areas that could constitute resources for the therapeutic progress.

Thus, for example, a joint exploration of therapist and patient into how her self-image has been reduced to partial aspects of herself that tend to be negative, and how her capacities have become less visible to her, may encourage a reflexive attitude about herself, a differentiation between self and other, and consequently, her autonomy and a higher possibility to internally regulate her self-esteem (recuperating the function of self-perception). Moreover, working on a more complete perception of the other and the distinction between the needs of the other and of oneself, may contribute to the elaboration and dissolution of the traumatic bond pattern.

To sum up, the notion of *Complex Relational Traumatization* in domestic violence suggests and implies, in the violence health care domain, a diagnose of the victim's internal vulnerabilities, and a focusing on her most damaged psychic functions and her internal resources. This could increase the treatment's efficiency, speed up the violence interruption and decrease the secondary victimization risk, given that it offers a deeper understanding of the victim's obstacles for her progress in stopping violence.

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2. Vulnerabilities in self-capacities in Chilean victims of domestic violence, with diverse levels of childhood abuse. Clinical Implications

Abstract

Domestic violence is associated to the presence and severity of mental disorders and to childhood trauma antecedents. There are few empirical studies concerning the relationship between victimization and self-capacities functioning. Some of these capacities (self and object perception, self-regulation, attachment to internal objects, among others) were studied in their association to domestic violence and childhood adverse relational experiences, in 28 Chilean women attending domestic violence intervention centers. Significant associations were found, among several self-functions vulnerabilities and the severity of domestic violence, especially sexual violence, which stands out because of the extend of its association to self-capacities impairments. Sexual abuse in adults' intimate partner relationships and in childhood, was associated to a poor capacity to develop and maintain attachment to positive internal objects. Clinical implications are discussed, such as the need to detect sexual violence in victims of domestic violence because of its relation to more internal obstacles, the utility of strengthening impaired self-capacities in treatments and, to consider the therapeutic relationship as an opportunity to generate new positive internal objects which serve to regulate and elaborate experiences and stress and to prevent re-victimization.

Key words: Domestic violence – self capacities – structural functions- childhood adversity

Domestic violence (DV) against women is an extremely prevalent public health problem throughout the world (García Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; Organización Mundial de la Salud, 2002). In Chile, studies carried out in different regions

of the country show that between 36% and 50% of women have experienced some form of domestic violence in their life (Universidad de Chile, 2001; DESUC, 2004, 2006).

DV occurs in the context of an abusive relationship and is characterised by a coercive pattern of interpersonal behaviour that transgresses the woman's freedom, thereby subjugating her and placing her in an undesired position. It is part of a wider global problem known as gender violence, which refers to the violence exercised against women as a result of their social subordination to men (DESUC, 2006; Velásquez, 2003; WHO, 2000; Ravazzola, 1996).

Several studies show a positive association between DV and childhood trauma, particularly physical and sexual abuse (Sahin, Timur, Ergin, Taspinar, Balkaya & Cubukcu, 2010; Lang, Aarons, Gearity, Laffaye, Satz, Dresselhaus, Murray & Stein, 2008; Briere & Jordan, 2004; Universidad de Chile, 2001)

There is strong evidence of the association between DV and depression, anxiety, PTSD and attempted suicide (Ellsberg, Jansen, Heise, Watts y García Moreno, 2008; Humphreys y Thiara, 2003; Campbell, 2002; WHO, 2000). Studies have mainly focussed on the associations between DV and the diagnostic categories of DSM Axis 1. There has been less research done on the interactions between DV and the functioning of personality and self (Pico-Alfonso, Echeburúa, Martínez, 2008). The shortage of empirical studies of self functions in part has to do with the complexity of these constructs and the lack of standardised instruments to evaluate them (Briere y Rickards, 2007).

Conceptualisations and studies on interpersonal trauma have contributed to the understanding of associations between adult domestic violence, child abuse and self functions. One central idea of these developments is that systematic and prolonged trauma developed in an interpersonal context of domination and subjugation presents

consequences that are not captured in the nosological category of post-traumatic stress disorder (PTSD) and must be understood from the perspective of complex trauma (Herman, 1992).

This would be characterised by symptomatic constellations that include alterations in self-capacities (self-perception, affect regulation, interpersonal relationships), somatisations, dissociation and a re-victimization proneness (Herman, 1992; Briere & Spinazzola, 2007, 2005; Van der Hart, Nijenhuis y Steele, 2005; Messman Moore, Brown, Koelsch, 2005; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996).

More severe post-traumatic consequences are frequently associated with a history of multiple experiences of interpersonal victimisation, which often begin in childhood and create a predisposition to future re-victimisation (Ford & Kidd, 1998; Zlotnick, Zakriski, Shea, Costello, Begin & Pearlstein, 1996; Neumann, Houskamp, Pollock, & Briere, 1996).

There are antecedents of a correlation between severity and length of violence and *severity of personality disorder* (Shields, Resick, Hanneke, 1990). Briere & Rickards (2007) found that childhood interpersonal trauma had a greater association to self-impairments when comparing it to adults'. Nevertheless, it has also been found a greater presence of personality disorders symptoms in DV victims (especially sexual violence), even controlling for child abuse (Pico-Alfonso, Echeburúa, Martínez, 2008). Another study showed that sexual abuse in adult women presented a direct association with greater self-dysfunctions, compared with childhood abuse (Messman-Moore, Brown & Koelsch, 2005).

Self-image and self-esteem are impoverished and weakened in survivors of relational trauma. The victim develops a pathological attachment or *traumatic bonding*, of extreme

emotional dependence to the perpetrator, whereby the subjugation becomes an adaptive mechanism for the victim (Sahin, Timur, Ergin, Taspinar et al, 2010; Frankel, 2002; Montero, 2001; Herman, 1992).

The Operationalised Psychodynamic Diagnostic (Grupo de Trabajo OPD, 2008) proposes that psychic structure is an organisation of interdependent functions that allow the individual to adapt to and regulate internal and external stress. This conception is dynamic, because it understands the structure in an evolving process in which, even though the changes are slow, the self-functions can be more or less available to the individual in different vital circumstances.

This diagnostic system (that will be presented in more detail later), is characterised by a differentiated evaluation of diverse aspects of self-functioning which are described in terms of structural “vulnerabilities”. This differentiated evaluation could contribute to the orientation and management of treatment difficulties, focusing on the more vulnerable self-capacities and utilising the victims’ personal resources.

Aims

To explore self-capacities vulnerabilities and establish associations between these and DV severity and early relational victimisation.

It is expected that with an increase in severity of child relational trauma experiences, there will be an increased severity in adult victimisation and a greater vulnerability of structural functions. Likewise, it can be hypothesised that the more severe the domestic violence, the more impaired the self-capacities will be found to be.

Variables Operational Definition

Domestic Violence (DV) Emotional violence. Partner behaviours that provoke emotional suffering, in the context of an abusive relationship (e.g. controlling personal activities, humiliation, economic control).

Physical violence. Partner behaviours that provoke threat, suffering or damage to the victim's physical integrity (e.g. slapping, kicking, striking with an object, use of weapons).

Sexual violence. Behaviours where the partner, by means of physical force, emotional coercion or intimidation, forces the woman to undesired sexual activity.

Structural functions or Self-capacities (Grupo de Trabajo OPD, 2008).

Cognitive functions.

Self-perception: The ability to perceive and refer to oneself in a reflexive and coherent way, to maintain a stable self-image over time, to identify and differentiate different aspects of self and one's own feelings.

Object-perception: To recognise the other as separated from the self. To be able to see the other in a realistic way, recognising their different aspects, To be able to distinguish the thoughts, needs and impulses of others from one's own.

Affective Regulation Functions.

Self-regulation: The ability to identify and distance oneself from one's own feelings and impulses. Regulation of emotions and self-esteem, integration of impulses.

Object Relation Regulation: The ability to consider both the other and the self in the relationship. To protect the relationship from one's own disturbing impulses while, at the same time, protecting one's own interests. To anticipate the consequences of one's own relational behaviour and the reactions of the other.

Emotional Communication Functions.

Internal emotional communication: The ability to allow one's own feelings to emerge and to experience them, to sustain inner dialogues and use one's own fantasies in order to reflect on and guide actions. The ability to experience one's own corporality.

External emotional communication: The ability to develop emotional contact with others, to express one's own feelings and receive others' affection. To be able to feel empathy.

Attachment functions.

Attachment to internal objects: To develop, maintain and use inner representations of significant others, to emotionally charge them with positive and varied feelings in such a way that they help to calm, alleviate and protect the self.

Attachment to external objects: To connect oneself emotionally with others, to experience varied feelings in respect to the other. To be able to receive support and guidance, as well as to be able to separate and farewell.

Adverse childhood experiences (Smith, Lam, Bifulco, Checkley, 2002).

Antipathy and Neglect.

Parental antipathy refers to the criticism, rejection or emotional distance expressed by the father or mother towards the child. Neglect is the abandonment or absence of the parental figure, in the care of the child's basic needs (material, educational, emotional).

Physical Abuse

Repeated physical punishments by a parental figure or any other person in the home environment (slapping, kicking, striking with an object, or other attacks).

Sexual Abuse

Undesired or disturbing sexual experiences with an adult, whether they be a family member or not (touching private body parts, touching an adult's private parts, rape).

Method

This is a non-experimental, correlational, cross-sectional study.

Participants. 28 Chilean women patients attending to DV treatment centres, in Santiago, Chile, during 2009 and 2010. They were contacted through the centres' staff, and those who agreed to participate were included consecutively. An economic compensation, equivalent to US \$12.00 was given. The interviews were videotaped and coded

according to the manual of Operationalized Psychodynamic Diagnosis (OPD). Six interviews were coded by 3 independent trained raters, in order to calculate inter-rater reliability. The rest of the interviews were coded by the principal researcher, who obtained good reliability.

Measures.

1) OPD Clinical Interview (Grupo de Trabajo OPD, 2008)

The OPD is a multi-axial diagnostic system, developed with the aim of complementing and enriching descriptive diagnostics with psychodynamic dimensions relevant to clinical use and for therapeutic planning.

The 5 axes that it outlines are: Axis I: Subjective perception of the patient about the problem and prerequisites for treatment; Axis II: Interpersonal relationships; Axis III: Conflicts; Axis IV: Structure; Axis V: Syndrome diagnostic

In this study, Axes I and IV were used.

Axis I: Evaluates length and severity of the problem from the observer perspective and subjective experience of the patient, personal concept of the problem and change, resources and obstacles to change. These variables were explored, while for the objectives of this study, the variables of type, severity and length of violence were included in the analyses.

A specific application of Axis I, the Module for Domestic Violence Assessment, was developed by the author for this study. The module was checked by DV experts in order to evaluate the validity of its content. Experts' observations were included. The inter-rater reliability was very good (ICC= 0,834 (0,483 – 0,972)).

The items are judged in a Likert scale from 0 to 4, where 0 (zero) indicates absence or minimal presence of the variable and 4 maximum presence.

Axis IV Structure: Evaluates the availability and level of integration of mental functions. The structure refers to specific self-capacities and their relation to objects. The differentiated evaluation of these functions allows the observation of personality vulnerabilities. Considering the difficulty of the empirical measurement of these constructs, the operationalization of the structural functioning dimensions allows us to approach a less inferential observation of them.

Using a Likert scale, each function and the total structure are coded by trained raters with operationalised criteria in the manual. The scale ranges from 1 to 4, with intermediate points (0.5 points), where 1 (one) is the highest functioning level and 4 (four) the highest vulnerability of structural functions.

The inter-rater reliability of the axis in this study was good (ICC= 0,718 (0,258 – 0,949)).

The validity and reliability indexes of the OPD in previous studies are satisfactory and good (Cierpka, Stasch, Dahlbender and OPD Task Force, 2006).

2) Child Experience of Care and Abuse Questionnaire (CECA-Q; Smith, Lam, Bifulco, Checkley, 2002). This questionnaire retrospectively explores childhood care and abuse experiences. It deals with a diversity of childhood experiences with relation to parent figures or primary caregivers. These variables were described above.

Antipathy (e.g. Item 9 “Sometimes he/she made me feel that I was a nuisance”) and neglect (e.g. Item 14 “He/she looked after me if I was ill”) scales were used. This is a Likert scale that ranges from 1 (one) to 5 (five). A higher score indicates higher antipathy and/or neglect. The test is repeated for the mother and the father figure.

Childhood physical and sexual abuse is also evaluated. Both scales present screening questions and evaluate the severity of the abuse. The higher score, the greater the abuse.

The instrument presents appropriate psychometric qualities. Validation studies in Chile are in progress (Alvarez, Crempien, Castillo, Ceric, in progress).

3) Mini International Neuropsychiatric Interview (M.I.N.I.; Lecrubier, Sheehan, Weiller, Amorim, Bonora, Harnett Sheehan & Janavs, 1997).

Short structured diagnostic interview that explores 17 psychiatric disorders according to DSM-III-R criteria. Focus on presence of current disorders. Validity and reliability are high or very high for the disorders evaluated in this study (Lecrubier, Sheehan, Weiller, Amorim et al, 1997).

The following modules were applied: Major Depressive Episode, Dysthymia, Post-Traumatic Stress Disorder, Alcohol Dependence / Alcohol Abuse, Substance Dependence / Substance abuse.

4) Beck Depression Inventory (BDI- II; Beck, Steer & Brown (1996)

Self-reporting questionnaire used extensively worldwide, validated in Chile (Melipillán, Cova, Rincón, Valdivia, 2008). Evaluates current depressive symptomatology, by means of 21 items, with higher scorings indicating more severity of depressive symptomatology.

Ethical aspects

The study has attained the approval of the Ethics Committee of the Psychology Department of Pontificia Universidad Católica de Chile. The participants agreed to participate in the study by signing an informed consent letter.

Data analysis

Univariate analyses were performed to describe the behaviour of variables in the sample group. Bivariate correlations between interest variables were analysed. A t-test was performed to compare means of structural functions in women with and without sexual violence. Multivariate analyses by way of ANCOVA were carried out to adjust associations between Childhood Relational Adversity, Domestic Violence and Structural

Functions (self-capacities) vulnerability. Adjustment variables were socio-demographics (educational level, marital status, family income, number of people per household, number of children, employment status), psychiatric co-morbidity and depressive symptomatology.

Statistical analysis was carried out using the SPSS program, Version 19.0.

Sample description

The sample was made up of 28 women evaluated by psychosocial teams at the above-mentioned centres, all of whose cases had DV incidence confirmed. The average age was 38.46 (DS: 8.29). 39.3% of the women were married or living with their partner, 21.4% were single and 39.3% separated. The average number of children was 2.29 (DS: 1.08) and the number of people per household 4.07 (DS: 1.74). 14.3% of the women had not completed high school studies, 35.7% had completed high school, 32.1% had technical studies and 17.9% had University studies. Income levels were: 21.4% in the first quintile of family income, 32.1% in the second quintile, 25% in the third quintile, 3.6% in the fourth quintile and 17.9% in the fifth quintile of family income. This means that the majority of the participants (78.5%) belonged to the lowest income group of the country's population (MIDEPLAN, 2009). The distribution of employment status was: 28.6% in active full-time employment, 28.6% active part-time employment, 21.4% occasional employment, 17.9% housewives and 3.6% unemployed.

It was found that 71.4% of cases presented some psychiatric disorder. The most frequent was Major Depressive Episode (46.4%), as a single diagnosis (21,4%) or associated with another pathology; 21,4% presented MDE and PTSD, 3,6% presented MDE and alcohol abuse. 25% of the participants presented more than one mental disorder.

In reference to the types of domestic violence presented in the sample, 100% of the participants were victims of emotional violence, 96.4% had experienced physical violence and 46.4% had experienced sexual violence. All those who had experienced physical violence had also experienced emotional violence and all those who were victims of sexual violence had experienced physical and emotional violence. Means and standard deviations of the severity of the violence, and its duration, are presented in Table 1.

Table 1

Domestic Violence Severity and Duration Means

N=28	Media	SD	Min.-Max
Emotional Violence	2,82	0,819	1 - 4
Physical Violence	2,21	1,101	0 - 4
Sexual Violence	1,04	1,285	0 - 4
Global Violence Severity	2,79	0,917	1 - 4
DV duration (years)	11,67	8,213	1 - 30

With regard to the experiences of child abuse, 46.5% of the participants suffered childhood sexual abuse and 42.9% experienced physical abuse. Table 2 shows the means, standard deviations and percentage of cases that present clinically relevant histories of maternal and paternal antipathy and neglect, and severity of physical and sexual abuse considering cut-off points established for the CECA.Q (Smith, Lam, Bifulco, Checkley, 2002).

Table 2

Childhood Adverse Relational Experiences (CECA.Q scorings)

N=28	Media	SD	Cut-off	Freq.	%
Physical Abuse (severity)	1,36	1,74	≥ 1	12	42,9%
Sexual Abuse (severity)	1,64	2,18	≥ 1	13	46,9%
Maternal Neglect	17,21	8,39	≥ 22	9	32,1%
Paternal Neglect	20,82	8,44	≥ 24	10	35,7%
Maternal Antipathy	20,11	8,95	≥ 25	11	40,3%
Paternal Antipathy	19,8	8,99	≥ 25	6	21,4%

Results

With regard to the association between Childhood Relational Adversity and severity of DV (emotional, physical, sexual and Global DV), significant correlations were found between: maternal antipathy and partner physical violence ($r = -0,544$ $p < 0,05$), as well as between childhood physical abuse and intimate partner sexual violence ($r = 0,394$ $p < 0,05$). After variables adjustment, it was found that when the educational level and severity of maternal antipathy was lower, the severity of partner physical violence was higher. For sexual violence, the explicative variable selected by the model was the seriousness of the childhood physical abuse, a direct relationship was found, the greater the child abuse, the more severe the sexual violence. The Global Severity of Violence was associated to maternal antipathy and psychiatric disorder, the global DV is greater when the maternal antipathy is lower and it is associated with the presence of MDE, DD, PTSD and the combination of these diagnoses (refer Table 3).

Table 3

ANCOVA models of DV and Structural Functions in function of Childhood Adversity

N=28	Multivariate Analysis		
Physical DV	B	IC (95%)	Adj.R2
Maternal Antipathy	-0,063	(-0,101; -0,025)	
Educational level	-0,152	(-0,293; -0,011)	0,425**
Sexual DV			
Childhood Physical Ab.	1,011	(0,039; 1,983)	0,121*
Global DV			
Maternal Antipathy	-0,40	(-0,075; -0,004)	
Psychiatric diagnosis			
MDE	2,004	(0,428; 3,581)	
Dys	2,321	(0,559; 4,084)	
PTSD	2,167	(0,590; 3,744)	
MDE/ D + TEPT	2,631	(1,061; 4,202)	
MDE/ D + Alcohol Ab.	3,397	(1,340; 5,455)	0,439**
Self-regulation vulnerability			
Childhood Physical Ab.	0,292	(0,015; 0,568)	0,12*
Attachment to Internal Objects			
Childhood Sexual Ab.	0,125	(0,037; 0,213)	0,217**

* p < 0,05 **p < 0,01

Regarding the relationship between the severity of Childhood Relational Adversity and Vulnerability of Structural Functions, it was found that there was a direct and significant correlation between childhood physical maltreatment and self-regulation capacity ($r=0,386$ $p<0,05$). There were also found associations between childhood sexual abuse and vulnerability in the Attachment to Internal Objects ($r=0,401$ $p<0,05$) and to External

Objects ($r=407$ $p<0,05$). After variables adjustment, the association between physical maltreatment and self –regulation was maintained, with physical abuse explaining 12% of the variance of self-regulation impairment. As well, the relation between sexual abuse and the Attachment to Internal Objects deficit was maintained, and it was found that 21.7% of the vulnerability variance can be explained by the severity of childhood sexual abuse. In the case of Attachment to External Objects function, the association with child sexual abuse was not significant anymore, with the adjustments (refer Table 3).

With regard to the relation between severity of DV and Vulnerability of Structural Functions, direct and significant correlations were found among diverse structural functions and sexual violence. The self-functions means of women who suffered sexual violence were compared to those who didn't by means of a t test. Except for the capacities of external emotional communication and attachment to external objects, all the other structural functions were significantly more impaired in victims of sexual violence.

In the multivariate analysis (ANCOVA), for self-regulation function, the childhood physical abuse variable was added for adjustment and, for attachment to internal objects function, it was added the childhood sexual abuse variable.

The model that consists of emotional violence, sexual violence and marital status explains 75.3% of variance in vulnerabilities in the object relation regulation function. There is a direct association between sexual violence, emotional violence and the vulnerability of this function. The statuses of "single" and "separated" relate inversely to the vulnerability of this function, i.e. there is a better functioning of relation regulation when the woman is single or separated. Sexual violence was also associated to the following capacities: self-perception, object-perception and self-regulation, explaining 32.4%, 38.5% and 19.4% of their vulnerability. The association was always direct,

whereby when the sexual violence was more serious, the deficits in these functions were higher. In the case of self-regulation, sexual violence remained significant even controlling childhood physical abuse. Regarding to the function of attachment to internal objects, sexual violence and child sexual abuse explained 33.7% of its variance. Both variables are directly related to higher vulnerability of this self-capacity. Finally, 26.2% of the variance in vulnerability of the Global Structure was explained by the Sexual Violence variable, whereby when the severity of the latter is greater, the vulnerability of the global structural functioning is higher (refer Table 4).

Table 4

ANCOVA Models of Structural Functions in function of DV and adjust variables

N=28		B	IC (95%)	adj.R2
Self-Perception				
	Sexual DV	0,214	(0,094; 0,334)	0,324**
Object Perception				
	Sexual DV	0,207	(0,105; 0,310)	0,385**
Self-regulation				
	Sexual DV	0,126	(0,030; 0,222)	0,194*
Object Relation Regulation				
	Emotional DV	0,115	(0,000; 0,229)	
	Sexual DV	0,125	(0,052; 0,199)	
	Marital status			
	Single	- 0,247	(-0,476;-0,018)	
	Separate	- 0,478	(-0,710; -0,245)	0,753**
Attachment to Internal Objects				
		0,173	(0,019 – 0,201)	
	Sexual DV +	0,110	(0,027 – 0,318)	0,337**
	Childhood Sexual Abuse			
Global Structure				
	Sexual DV	0, 184	(0,065; 0,303)	0,262**

*p < 0,05 **p < 0,01

Discussion

In this study, the DV victims presented a high rate of mental disorders and the seriousness of the violence was directly related to the presence of depressive disorders and PTSD. It was also found a high presence of childhood adverse relational experiences within the participants. These findings coincide with the results of previous research in this field (Ellsberg, Jansen, Heise, et al, 2008; Briere y Spinazzola, 2004).

A direct correlation was found between severity of childhood physical abuse and severity of intimate partner sexual violence. Contrary to expectations, maternal antipathy was inversely associated with severity of physical and global violence. In principal, there seems to be no clinical explanations for this finding, which could imply methodological limitations in the study such as small sample size.

In regard to socio-demographic variables, lower educational level is positively associated with greater severity of physical violence, which supports previous results in Chilean studies (Universidad de Chile, 2001). Better functioning in object relation regulation capacity was found in single and separated women. Even though, it is not possible to conclude whether the physical distance of the aggressor favours the mentioned capacity or whether a better functioning of this allows the woman to maintain her distance from the partner, it may be possible to suggest that physical distance protects from daily control and, that these women are less isolated from their social environment, which could make possible to establish non abusive and more egalitarian relationships.

When observing self-capacities by means of the OPD, it stands out the association between the vulnerability of functions and sexual trauma experiences, as much in childhood as in adulthood; these capacities are found to be more damaged when the severity of sexual abuse is greater.

Particularly, the quality of internal objects is found to be impoverished when sexual abuse in childhood and/or in intimate-partner relationships has been more severe. Given the antecedents, we could think that the early development of positive and protective internal representations, which favour the appropriate management of emotional stress, has been significantly interfered in those who have suffered childhood sexual abuse experiences, associated with the development of complex traumas (Zlotnick, Zakriski, Shea, Costello et al, 1996).

This finding confirms and emphasizes once more on the serious impairments associated to sexual abuse, contributing with new evidence to the less studied relationship between self-capacities alterations and sexual violence in adulthood (Pico-Alfonso, Echeburúa, Martínez, 2008; Messman-Moore, Brown & Koelsch, 2005). These results suggest the need to detect the presence of sexual violence, for the clinical implications of its association with greater vulnerability in self capacities of victims.

Global structural functioning in victims of sexual violence is found to be more impaired than in the other victims and, it presents vulnerability in a variety of specific capacities. One possible explanation to this finding could be that the women who presented sexual violence were also victims of physical and emotional violence, and therefore it could be suggested that there exists an accumulation of multiple traumas, with sexual violence being a particularly serious form of abuse.

It is not possible to establish if the structural vulnerabilities are priori or posterior to the DV, but chronic exposure to relational violence, according to interpersonal trauma studies, would allow us to hypothesise that these impairments could be a response to trauma.

Given the emotional burden, it is possible to think that self-functions in these women could be found to be within the lower level of availability (Grupo de Trabajo OPD, 2008).

It could be expected that the interruption of violence and reparation processes would permit the victim to recover internal resources, whereas considering the psychic structure as a dynamic organisation.

Whether the structural vulnerabilities are previous to violence or a consequence of it, these represent internal obstacles of the victim to regulate her emotional experience and stress. Including the strengthening of impaired psychic functions in the treatment could contribute to the management of treatment obstacles such as the high rate of desertion and secondary victimisation and to prevent re-victimisation.

One strength of this study is that evaluates in a differentiated way, diverse self-capacities, by means of a methodology that operationalizes these constructs. These capacities show relevant aspects of the psychological and relational functioning of the victim and, therefore, contribute to enrich comprehension of their difficulties and the treatment obstacles. Working through with the victim on these aspects, could lead to a more complete and realistic perception of herself and the others', as well as promote her reflective function and affective regulation.

The therapeutic relationship could be an opportunity of a corrective relational experience, by offering an external bond to develop positive internal representations which could give support and in somehow a basis to regulate experiences and emotional stress.

A limitation of this study is its cross-sectional nature which impedes the establishment of temporal relations between the studied variables. Future research could try to figure out if structural vulnerabilities are a consequence of domestic violence, by studying the self-capacities, posterior to victims' reparation therapy and interdisciplinary interventions.

Another limitation is the small sample size, as it might be possible to find other clinically relevant associations among the studied variables, for example between childhood

neglect and structural vulnerabilities, but it could be that these correlations were not found because of the small sample size. It is recommendable to include a larger number of participants in order to go further in the study of these possible associations.

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3. Dysfunctional relational patterns and intra-psychoic conflicts in Chilean women victim of domestic violence

Abstract

Domestic violence victimization corresponds to a complex relational trauma process, characterized by self-alterations, the development of an extremely dependent interpersonal pattern and high risk of re-victimization. The diagnosis of dysfunctional relational patterns and intra-psychoic conflicts associated to them, would be relevant for treatment by improving the comprehension of behaviors that perpetuate re-victimization and, by guiding the selection of therapeutic foci. Clinical interviews based on Operationalized Psychodynamic Diagnosis System (OPD), were carried in 28 women victims of domestic violence who attended Domestic Violence intervention centers in Santiago, Chile. The dysfunctional interpersonal patterns and internal conflicts identified correspond in a great amount to those described in literature and clinical observations. The diagnosis of dysfunctional interpersonal patterns, which include the victims' unconscious relational proposal and the therapist counter-transferential response, may contribute to the understanding of secondary victimization phenomenon. As well as dependency related conflicts, control-submission and self-esteem conflicts are observed. The latter would also perpetuate re-victimization. Clinical implications of these findings are discussed.

Key words: domestic violence – interpersonal patterns – intra-psychoic conflicts - OPD diagnosis

Victimisation due to domestic violence has been considered a complex trauma process which develops in the context of a significant relationship, within an interpersonal pattern of domination and submission, in which the aggressor exercises a

coercive control over the victim and she, in turn, develops an emotional dependence, also known as traumatic bonding, whereby the perpetrator is simultaneously the source of consolation and humiliation (Herman, 1992; Montero, 2001; Crempien, in press).

Complex trauma presents particular characteristics that differentiate it from other types of trauma. It is developed in a repetitive and systematic way; it is associated with alterations in self-capacities and a tendency towards repeat trauma or re-victimisation. Therefore, more than a response to trauma, the victim has to adapt to it (Herman, 1992; Briere & Spinazzola, 2005; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996; Van der Hart, Nijenhuis & Steele, 2005; Messman-Moore, Brown, Koelsch, 2005; Vatnar & Bjorkly, 2008; Fernández Liria y Rodríguez Vega, 2000).

Intimate partner violence tends to be systematic and chronic, the maltreatment goes through cycles in which violence episodes alternate with remorse and recompense; this has been described as the “cycle of violence” (Walker, 1979). This causes psychic helplessness, hopelessness, desperation and astonishment as a result of the chronic suffering and powerlessness to control the situation (Velásquez, 2003; Walker, 1979). As a survival strategy and a way to gain control over the experience, the victim anticipates the aggressor’s desires and becomes submissive, identifying herself with him and justifying him. These would be adaptive responses to the interpersonal trauma, but at the same time, would tend to maintain the abusive patterns in the relationships (Montero, 2001; Frankel, 2002). It has been observed that when victims of interpersonal trauma are encouraged to understand and make sense to re-victimisation behaviours, by recognising her traumatic history, these behaviours tend to diminish (Van der Kolk, 1989).

Nevertheless, the social network and intervention agents (including mental health workers) tend to criticize, blame, devalue and stigmatize women for their victimization.

This phenomenon is known as secondary victimization and is a predictor of negative outcomes (Calle Fernandez, 2004).

There are not many studies regarding the mechanisms that explain re-victimization. Some have tackled this issue from the perspective of attachment style, concluding that anxious and avoiding attachment styles in victims are related with suffering domestic violence (Kuijpers, Van der Knaap, & Winkel, 2011; Dumas, Pearson, Elgin, & McKinley; Bond & Bond, 2004; Bartholomew, Henderson & Dutton, 2001).

This study focuses on the re-victimization phenomenon by observing dysfunctional interpersonal patterns and intra-psychic conflict in victims, from a psychodynamic perspective. The aim is to shed light on re-victimisation mechanisms and prevent secondary victimization.

Operationalised Psychodynamic Diagnosis (OPD)

All diagnostic perspectives attempt to respond to the question of what is happening to the patient and what are the necessary elements for better patient attention, since the clinician's task is to formulate a coherent therapeutic plan (Bernardi, 2010).

The OPD is a multiaxial diagnostic system, developed with the aim of enriching the traditional descriptive diagnoses of mental disorders with psychodynamic dimensions relevant to clinic and useful for therapeutic planning. This system offers a cross-sectional view of the patient and is also oriented to processes, through the determination of foci that consider the patient's resources and factors that contribute to maintain or resolve the symptoms (Grupo de Trabajo OPD, 2008).

The OPD evaluates dysfunctional interpersonal patterns, intrapsychic conflicts, structural self-capacities, as well as the subject's perception of the problem and psychiatric disorders, through a clinical interview that is codified afterwards in forms according to operationalised criteria in a manual. This operationalisation permits an

increase in observation reliability, above and beyond clinical intuition or theoretical approximation.

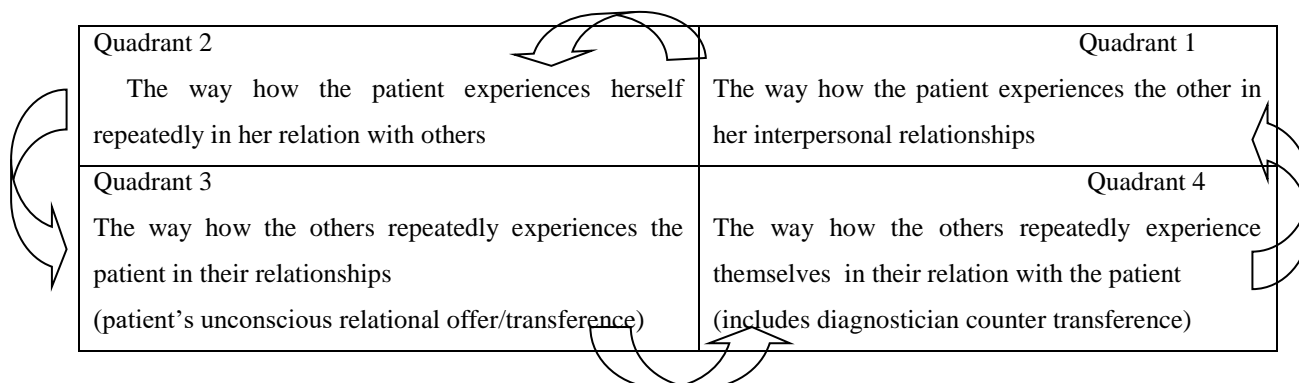
This study forms part of an investigation that includes the 5 OPD axes in the evaluation of Chilean victims of domestic violence. The study presents the findings that correspond to Axes II and III of the OPD: dysfunctional interpersonal patterns and intrapsychic conflicts, respectively. The results in relation to Axis IV (structural vulnerabilities), will be presented in another publication.

Dysfunctional interpersonal patterns (Axis II, OPD)

Interpersonal relationships are the direct object of therapeutic work, as well as being the sphere in which advances are most observable and experientially possible for the patient (Grupo de Trabajo OPD, 2008). The *habitual interpersonal behaviour* is the dominant attitude that an individual presents in her interaction with others. *Dysfunctional interpersonal patterns* would be constellations of interpersonal behaviours that cause unease and suffering, resulting from the individual's habitual interpersonal behaviour and the others' reaction (OPD Grupo de Trabajo, 2008). They constitute a relevant factor in the formation, maintenance and severity of psychic disorders (Dahlbender, 2002; Cierpka, Strack, Benninghoven, Staats, Dahlbender, Pokorny, Frevert, Blaser, Kaechele, Geyer, Koerner & Albani, 1998).

In the OPD, the interpersonal diagnostic takes into account the patient's experience in their interactions with others including their unconscious problematic offer of relationship (*transference*) and others' experience in reaction to the patient's behaviour, including the experience of the diagnostician him/ (*counter transference*). *Four (4) interpersonal positions* are identified, and subsequently articulated in a dynamic-interpersonal formulation that allows the dysfunctionality of the interaction and its repetition to be understood (refer to Figure 1).

Figure 1. Interpersonal positions (based in OPD Manual, Grupo de Trabajo OPD, 2008, pg 225)



The development of the OPD's interpersonal relational axis is based on the "Structural Analysis of Social Behaviour - SASB" model, which analyses the dyadic social interactions in terms of complementary positions in two orthogonal dimensions: 1) Affiliation (Attachment / Hostility poles) and, 2) Interdependence (Autonomy/ Control and submission poles) (Benjamin, 1974, 1982). Furthermore, it borrows from the "Core Conflictual Relationship Themes - CCRT" model (Luborsky, Crits-Christoph, 1990) and the "Cyclical Maladaptive Pattern – CMP" model (Strupp & Binder, 1993), the individual behaviour and "object reaction" dimensions, as well as the "relational episodes" description method.

A standardised list of 32 items is used, from which the diagnostician selects those that are most representative of the observed interpersonal behaviour; these are then grouped into Relationship Themes. These behaviours are rated as dysfunctional if the tendency to view the self and the other is rigid and is positioned too close to either pole, in the Affiliation and Interdependence dimensions.

The 4 basic interpersonal themes are related to: personal and others' autonomy granting; self-worth and the other's worth; affection and aggression; and finally, care of self and the other. In Figure 2, the relationship themes (RT) are specified in the object-directed position and the self-referred position (OPD Task Force, 2008).

The interpersonal diagrams may correspond to the expression of intrapsychic conflicts, in the same way as internal conflicts can determine the development of dysfunctional interpersonal behaviours.

Figure 2. Relationship Themes (RT) (Grupo de Trabajo OPD, 2008)

In relation to the other	In relation to herself
1. - To guide others. To concede autonomy to the other and let him/her develop v/s dominate and control him/her	5.- To be autonomous in the relationship v/s give up one owns autonomy and adapt
2.- To value and recognize the other v/s devaluing and reproach	6.- Recognize the self-value in front of the other v/s self-devaluate and self-blame
3.- Show affection v/s show aggression	7.- To be open to affection, accept the other v/s protect from the other
4.- Caring and worrying for others appropriately v/s neglect	8.- To show one owns needs, lean and trust others v/s not showing needs, and be totally self-reliant

Intrapsychic conflicts (Axis III, OPD)

Psychodynamic conflict is the result of the tension between needs or desires, and anxieties or fears with respect to these. These lead to repetitive behaviours, without the person being aware of or being able to change it, and generate suffering and symptoms. The continuous dimensional model permits the differentiation between normal conflictive tensions and conflicts that are clinically relevant (Grupo de Trabajo OPD, 2008).

It is necessary to distinguish between tensions caused by conflicts themselves and those derived from the patient's structural deficits. When the structure is well-integrated, conflicts show up clearly, but when the structure is fragile, it is more difficult to detect them, and rather it is the deficit of structural capacities that is observed (Grupo de Trabajo, 2008).

The conflicts systematised in the OPD are:

1) *Individuation versus dependency*. Tension between the desire for a relationship with symbiotic intimacy and closeness (dependency), and the desire for a (pseudo) independence from the other, as a defense mechanism against the former (individuation). The central theme of the conflict is to be able to be together with others and, to be able to be on one's own and separate. The lead affect is *anxiety* and existential threat when faced with separation.

2) *Submission versus control*. Tension between the need to dominate the other (control) versus the need to submit to the other (submission). It is the non-adaptive expression in the continuum that goes from being able to guide others and being able to be guided. The lead affect is *anger*, impotence because of submission or aggressiveness in defiance of domination.

3) *Need for care versus self-sufficiency*. Tension between the wish to be cared for and be assured of attention, and the wish to be self-sufficient and not need the other. The lead affect are mourning and depression with fear of losing the other. In contrast to *Conflict 1*, in which the theme is the ability to attach and separate, in *Conflict 3* it is presupposed the capacity to form attachments. The central theme is the dependence on the other's *affection*.

4) *Self-worth conflict*. The conflict appears when the efforts to obtain recognition and self-worth are very intense or fail. Polarity is established between self-worth and the

other's worth. The self feels *less or more* than the other. The lead affect is *shame*, or anger when faced with questioning one's personal worth.

5) *Guilt conflict*. The tension oscillates between assuming the guilt, blaming oneself, or blaming others. It is expressed through constant and submissive acceptance of guilt, and in the opposite pole, through the permanent rejection of responsibility and blame, externalising it in others.

6) *Oedipal conflict*. Reflects the tension between the desire to be recognised, to be desired as a man or a woman and to enjoy corporality; versus rejecting these needs, stepping back from competition and repressing sexuality. There is no specific lead affect; there could be feelings of modesty, fear, shame of sexuality, or extreme agitation.

7) *Identity conflict*. Diverse self-images co-exist in the individual, including gender, family and national identity. The conflict arises when there are contradictory representations of self that generate insecurity and displeasure.

The "lead affects" tinge and predominate in conflicts, facilitating their identification. Efforts to resolve the conflict give rise to the "modes of processing conflicts", in a continuum that moves from a predominantly passive mode to a predominantly active mode, with the possibility of a combination of passive and active expressions of the needs in tension; the mixed mode (OPD Grupo de Trabajo OPD, 2008).

Situations exist where it is not possible to carry out the conflicts diagnostic: 1) Lack of diagnostic security, the patient is uncooperative or suffering an acute reaction as a result of stress; 2) low level of structural integration; 3) defence mechanisms are an obstacle to the perception of affects and conflicts; 4) the observed symptoms basically derive from a stressor induced conflict which over burdens the patient.

In the case of domestic violence victims, the abuse experience can lead to an adaptive disorder or post-traumatic stress. Nevertheless, it was decided to evaluate intrapsychic conflicts, given that domestic violence is related to chronic traumatization more than current acute stressors and, on the other hand, stressor induced conflict also brings out pre-existent conflictive tensions. The biographical material obtained through the interviews would permit us to identify these tensions.

Aim: The aim of this study is to describe dysfunctional interpersonal patterns and to identify predominant intrapsychic conflicts in victims of domestic violence, and to formulate possible clinical relationships that might contribute to explain re-victimisation processes.

The hypothesis formulated are the following:

1. - It will be found that there are dysfunctional interpersonal patterns characterised by strong attachment and dependency with respect to the aggressor, personal subjugation, self-devaluation and guilt on the part of the victim and the respective complementary positions in the other.
2. - It is expected that it will be found the main conflicts of: "Need for care versus self-sufficiency" (3) and, "Individuation versus dependency" (1). The possibility of there being a predominance of one over the other will be explored. It is expected that the "Submission versus control" (2) will frequently be present as a secondary conflict (subsidiary to the main conflict).

Method: This is an exploratory, non-experimental, descriptive and cross-sectional study.

Participants. The sample included 28 patients attending centres specialised in the treatment of domestic violence victims, in Santiago Municipality, Chile. The participants were contacted through these centres' professional staff. Those who agreed to

participate voluntarily were included consecutively in the study, which took place during 2009 and 2010. The participants received an economic compensation, equivalent to US \$12.00.

Ethical aspects: The study has attained the approval of the Ethics Committee of the Psychology Department of Pontificia Universidad Católica de Chile. The participants agreed to participate in the study by signing an informed consent letter.

Instruments and Procedure

OPD Clinical Interview (Grupo de Trabajo OPD, 2008)

The aim of the interview is to generate the necessary material to estimate, in a reliable way, the dimensions of the OPD axes. It has a psychodynamic base that further includes more structured strategies to explore specific themes. The unstructured and open conversation allows the patient's emotional experiences and interpersonal offer to emerge.

The domestic violence experience was specifically explored. The conversation with the patient was structured by explicitly stating this objective from the beginning: "I would like you to tell me, in your own words, about the domestic violence experiences and situations you have been through, so that we can better understand your problem".

The interviews lasted about an hour and a half, and were videotaped for subsequent coding according to the OPD manual. The interviews were carried out by the principal researcher who received formal training in OPD, and fulfils the requirements for its use: clinical and psychological assessment experience, and psychodynamic understanding (Grupo de Trabajo OPD, 2008).

A list of 32 items that describe recurrent interpersonal experiences is presented for the coding of Axis II. The evaluator selects 3 items per quadrant (interpersonal positions), and these in turn are grouped into clusters that make up Relationship Themes. For the

diagnostic of quadrant 3, (patient's problematic relational offer); the relational episodes and, reactions displayed by the patient during the interview are used (scenic re-enactments). For the quadrant 4, the relational episodes, and *especially* the reactions, emotions and tendencies of the interviewer (eg. to demand things from her or to overprotect her, etc) are observed.

For Axis III (Conflict) coding, a Lickert scale is presented for each conflict, ranging from 0 (zero) to 3, where 0 corresponds to the absence of conflict and 3 to a very significant presence of conflict. The evaluator selects a "Main Conflict" which is the predominant one, and a "Secondary Conflict". Finally, the evaluator estimates the conflict processing mode (passive, active or mixte).

The OPD has presented adequate indexes of validity and reliability (Cierpka, Stasch & Dahlbender, 2006).

Data analysis: The frequencies of the Relational Themes and Conflicts were determined. In order to establish the significance of the frequencies, the chi-square test for homogeneity was applied. Statistical data analysis was carried out using the SPSS program 19.0 and STATA.

Sample description: The average age of participants was 38.46 (DS: 8.29); 39.3% of the women were living with their partner, 60.7% were not living with him. The average number of children was 2.29 (DS: 1.08) and the number of people per household was on average 4.07 (DS: 1.74). The majority of the participants (78.5%) belonged to the first three quintiles of family income within the country's population (MIDEPLAN, 2009). With respect to the educational level, 14.3% of the participants had not completed high school studies, 35.7% had completed high school, and 50% had technical or university studies. In reference to the type of domestic violence experienced, all of the participants had experienced emotional and physical violence and, all those who were victims of sexual

violence had also experienced physical and emotional violence. In terms of the length of the DV, although dispersion is high, it is important to highlight that in 71.5% of the cases the length of the violence was greater or equal to 5 years, thus indicating the chronic nature of the phenomenon.

Results

Dysfunctional Interpersonal Patterns. In each interpersonal position (*quadrant*) the relational themes (RT) of highest frequency were selected. The criterion was to select the three most common themes, in order to show greater amplitude in the interpersonal behaviour. It was found a significant difference between the frequency of predominant themes and the frequency of rest of the themes (see Table 1).

Table 1

Relationship Themes (RT) frequencies. Chi square test for homogeneity.

N = selected items per each quadrant

Quadrant	(RT)	Frequency	Percentage	χ^2	p value
Quadrant 1	1-2-3-4	75	91,46%	54,74	<0,001
(N= 82)	5-6-7-8	7	8,54%		
Quadrant 2	3-4-5	50	62,5%	4,52	<0,05
(N=80)	1-2-6-7-8	30	37,5%		
Quadrant 3	2-7-8	49	64,47%	5,8	<0,05
(N=76)	1-3-4-5-6	27	35,53%		
Quadrant 4	1-2-4	47	65,3%	6,12	<0,05
(N= 72)	3-5-6-7-8	25	34,7%		

In *quadrant 1*, which refers to how the women usually perceive others in relation to themselves, 4 recurrent relational themes presented: RT1, RT2, RT3 and RT4. The predominant experience is that others again and again tend to control them and restrict their personal autonomy (RT1), to devalue, reproach and blame them (RT2), to attack them (RT3) and to abandon and neglect them (RT4). The *other* is recurrently perceived as having taken away autonomy, recognition, affection and care from them. This observation is expected in the studied group, since it corresponds to the characteristic expressions of domestic violence.

Quadrant 2. The women experienced themselves in their relationships with others, as repeatedly harmonising, avoiding conflicts and aggression (RT3), caring very much for the other (RT4), over-adapting themselves and giving up their personal freedom, but also, trying to recover their autonomy by putting up resistance (RT5).

Quadrant 3. The women's interpersonal offer, that is, the way in which others experience the woman, but of which she is less aware, appeared in themes RT2, RT7 and RT8. The *others* (including the interviewer) perceive that the women tend to admire, idealise and excuse them (RT2). Women are easily confused and become lost when the other expresses affection and, as a result, they protect themselves insufficiently and expose themselves to danger (RT7). They excessively cling and look to the other for support; allowing him too much proximity and failing to establish personal boundaries (RT8).

The quadrant 3 position is particularly of interest since it expresses those interpersonal behaviours of which the victim is less conscious in the interpersonal relationship, and which could be part of re-victimisation pattern, as they are part of a maladaptive cycle.

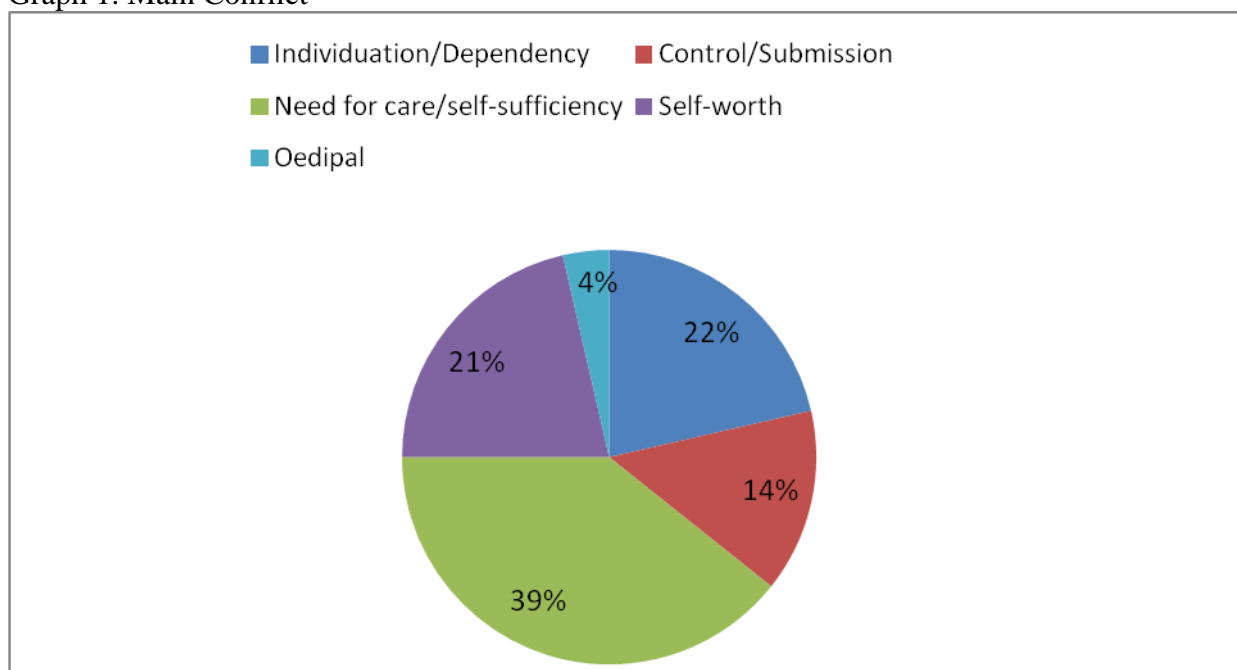
Quadrant 4. The experience of others (the evaluator as well) as a response to the patient's interpersonal offer is expressed in a tendency to pressure her and control her,

by over-protecting and restricting personal autonomy, for example, giving her instructions about what she should do (RT1); devaluing and reproaching her (T2), and a tendency to neglect her and abandon her (T4).

Predominant conflicts.

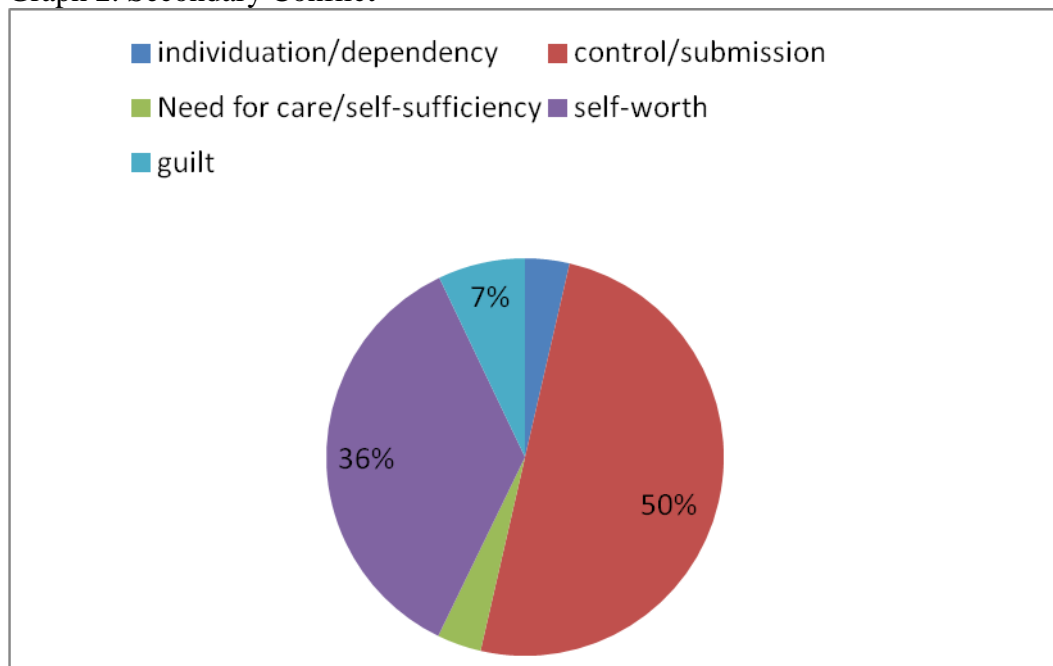
Main Conflict. In the diagnosis of conflicts, there were two conflicts that did not appear as “main” in any of the cases; these were the Guilt Conflict (5) and the Identity Conflict (7); the latter was always coded as absent. Graph 1 shows the frequency of the main conflicts. It can be seen that the most frequent conflict is the Need for Care versus Self-sufficiency (3), followed by the Individuation versus Dependency (1) and Self-worth Conflicts (4). On comparing the frequencies of the main conflicts, it was found that the prevalence of these three conflicts, differ significantly from the rest of the conflicts’ frequencies ($p < 0.05$), nevertheless the difference among these 3 main conflicts was not statistically significant. This means that it is not possible to establish that one predominates significantly over the other two.

Graph 1. Main Conflict



Secondary Conflict. In Graph 2, the distribution the Secondary Conflicts can be observed. The most frequent was the Submission / Control conflict (2), followed by the Self-worth conflict (4). On comparing the frequencies of the most frequent (2 and 4) with the rest of the conflicts, these differ significantly ($p < 0.001$). It was not found, however, a significant difference between these 2 conflicts. With respect to the *mode of processing* the conflicts, the participants mainly used a passive or mixed passive processing mode (64.3%), and the predominantly active mode presented a low frequency (11%).

Graph 2. Secondary Conflict



Discussion

This study is a first attempt to explore and describe, through an operationalised psychodynamic diagnosis, the interpersonal patterns and intrapsychic conflicts in domestic violence victims. Its aim is to support theoretical and clinical observations,

and contribute to the understanding of relational and internal victim's functioning that could have a bearing on re-victimisation.

In order to initiate discussion, it is necessary to point out that in the interpersonal diagnosis, the victim's experience regarding aggression and control within the abusive relationship will be assumed to be a "real" perception. The subjective perception that could be tainted by internal conflicts should be distinguished from the victim's report about the situations that constitute domestic violence expressions, these should be recognised and validated. The aim of this distinction is to avoid blaming judgements that are the basis for secondary victimisation.

In accordance to the results obtained, it can be observed that when the victim is faced with aggression, devaluation, control and abandonment, she perceives herself as having an over-protective and conciliatory attitude in order to avoid aggression, she over-adapts herself and submits to the other's needs. In spite of this, she also feels that she makes an effort to recover her personal freedom, by opposing and resisting the other's requirements.

The victim's "interpersonal offer" (quadrant 3) shows what she does in the relationship, but of which she is less conscious. According to the operationalised behaviours in the OPD, she doesn't realise that she tends to self-devalue herself and present herself in an inferior position in front of the other, at the same time as she admires and idealises him, and tends to justify his actions even when these cause her harm.

As well, she is also not completely aware that when the other shows her his affection and care, she tends to accept him and quickly become involved and cling to him, thereby allowing him to get too close, without establishing protective boundaries. This difficulty in creating distance doesn't allow her to perceive the relationship risks and exposes her to the danger of new aggressions, that is, to re-victimisation.

The other tends to respond in a complementary way to the victim's unconscious relational offer with devaluation, reproaches, control and abandonment. It is important to highlight that "the other" includes the interviewer, who infers the "other's" reaction, by observing his/her own counter transference. The OPD proposes that this *counter transferential* awareness allows the clinician to identify with the people with whom the patient interacts, thereby completing the observation of the "cyclical maladaptive pattern". It is not the intention of this study to explain the aggressor's behaviour, neither to justify the violence; but rather to contribute to the understanding of re-traumatisation, particularly in the process of help-seeking. If the therapist is not aware of his/her counter transferential reaction, he/she can end up devaluating the patient as a response to victim's idealization; controlling her by giving her authoritarian instructions about what she should do or what is good for her; and abandoning her when she doesn't fulfil their demanding expectations, for example, if she doesn't abandon the aggressor. This could be expressed in premature referral (Calle Fernández, 2004).

This interpersonal dynamic can be associated to the main conflicts that were found; on one hand, dependency related conflicts (1 and 3) and, on the other hand, the self-worth conflict (4). These conflicts are mainly expressed in the passive processing mode; dependency tendencies predominate as a way of avoiding loneliness and lost. Self-devaluing and idealizing the other would protect the self of being devalued and humiliated, or could serve to justify the other and not judge the relationship, in order to avoid separation (Grupo de Trabajo OPD, 2008). The patient's unconscious offer, probably expresses her demands to be cared for or to rely on the other; as well as to be recognised by him, but this exposes her to repeat victimization, as the other relational response tends to devalue, control, abandon and reject her.

According to the OPD, and general psychodynamic comprehension, one pole of the conflict always hides the other. In this way, it can be reasoned that behind the desires to be cared for and symbiotic dependency, are the desires for self-sufficiency and individuation, aspects that probably led these patients to seek help, which is the moment they were in when being interviewed for the current study.

We could hypothesise that the victims also tend to defend themselves against their own “being cared” needs, when faced with the unconscious threat of being disillusioned or frustrated by the other, who will not be able to care for them and give them the affection they expect; this would be the other pole of conflict 3. This intrapsychic dynamic could be explained by the systematic lack of care received in frequent histories of childhood abandonment and abuse in this population.

On the other hand, the intimate partner relationship is an opportunity to repair this history, and as such is idealised. The permanency in the violent relationship can be understood as a search for intimacy at any cost, because separation and loss are experienced with fear and anxiety. The victim prioritises the security of being in a relationship whatever the cost, and subordinates her personal needs to those of the other so as to not endanger the relationship. Submission, as secondary conflict could be understood from this perspective; she subjugates herself in order to receive affection (conflict 3); or, she subjugates herself in order to remain in the relationship. In both cases it seems to be a way to adapt to her more basic needs.

From a therapeutic perspective, we could reason that helping the victim to become aware of her participation in the dysfunctional relational pattern, would give her back some control over the situation, empowering her and permitting her to generate changes that could lead to protect her and break re-victimization cycle. As well, the

therapist's (or other intervention agents) awareness of their unconscious response to the victim could help in preventing re-victimisation behaviours.

The exploration of the OPD interpersonal axis refers to the dysfunctional interpersonal patterns. Nevertheless, it is also possible to evaluate the interpersonal resources, the adaptive interpersonal behaviours. One limitation of the study is that it did not evaluate these resources. Further research could include them to add knowledge on victims' adaptive coping. Another limitation is the small sample size; it would be recommendable to study relational patterns and internal conflicts in larger samples. It would be also interesting to explore the association of certain patterns and conflicts with other variables, such as structural functioning and types of violence, among others. Studying perpetrators relational patterns and conflicts would undoubtedly enrich the presented findings.

Through the OPD system it has been possible to report on cyclical maladaptive patterns and main conflicts in a group of women victims of domestic violence. This is an exploratory study that contributes to shed light on re-victimisation mechanisms from a psychodynamic and interpersonal perspective. The findings presented above add new evidence to understand and tackle a relevant and high risk problem in domestic violence victims.

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4. Psychological functioning in women victims of intimate partner violence attending domestic violence centers in Santiago de Chile

Abstract

Domestic violence is a prevalent social and public health problem. It is associated to childhood victimization and to social and cultural variables which contribute to its perpetuation. The consequences in the victim's physical and mental health are severe and have been broadly studied.

Intimate partner victims present diverse chronic symptoms corresponding to complex traumatisation, one of its most relevant characteristic is the re-victimization proneness. The study of psychological vulnerabilities in victims with childhood abuse experiences, considering social and cultural factors, is relevant for a more profound understanding of victims and, for the inclusion of these vulnerabilities in the treatment strategies.

This study explores the associations among domestic violence features, childhood trauma and psychological vulnerabilities in Chilean women victims of domestic violence. Because of their relevance to the comprehension of the phenomenon, several social and cultural variables were studied as well.

The main finding of the study refers to the significant and direct association between sexual violence and diverse psychological impairments and, the associations between social factors as poverty and education with violence severity, internal obstacles in victims and their perception of the utility of external resources to solve the problem. Implications of these results are discussed below.

Background

Domestic violence (DV) is a manifestation of abuse of power in families; it is grounded in a cultural ideology, characterised by patriarchal beliefs and myths that have legitimised and perpetuated violence (Ravazzola, 1996).

Partner violence against women is part of a wider global problem known as gender violence, which refers to the violence exercised against women as a result of their social subordination to men (Pontificia Universidad Católica de Chile, 2006; Velásquez, 2003; World Health Organization, 2000).

The gender perspective in domestic violence studies has proposed that sex-role ideology, that is, the roles, meanings and valuation culturally attributed to the male and the female, has fostered inequality of rights and power between men and women, contributing to the legitimisation of violence as a means of maintaining male supremacy (Velásquez, 2004).

According to national and international studies, domestic violence is a serious and extremely prevalent public health problem ((García Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; Organización Mundial de las Salud, 2005).

Chilean epidemiological studies, carried out in different regions of the country, show that between 36% and 50% of women have experienced some form of domestic violence in their life (DESUC, 2004; 2006; Universidad de Chile, 2001).

A number of studies show that women who suffer from partner violence have a high probability of reporting a diminished level of health as well as specific health problems such as gynaecological disorders, chronic pain, difficulty in carrying out daily tasks and a greater use of health services (Ellsberg, Jansen, Heise, Watts & García-Moreno, 2008; Campbell, 2002; OMS, 2005; Heise & García Moreno, 2002).

In regards to consequences for the victims' mental health, there is abundant evidence of associations with depression, anxiety, post-traumatic stress disorder and attempted suicide (Ellsberg, Jansen, Heise, Watts et al, 2008; OMS, 2005; Humphreys y Thiara, 2003; Campbell, 2002).

DV is associated with a history of childhood trauma, particularly physical and sexual abuse within the family. There is plenty of evidence to suggest that abusive experiences during childhood predispose victims to a higher risk of later re-victimisation (Sahin, Timur, Ergin, Taspinar, Balkaya & Cubukcu, 2010; Lang, Aarons, Gearity, Laffaye, Satz, Dresselhaus, Murray & Stein, 2008; Vatnar & Bjorkly, 2008). In Chilean studies, abuse before the age of 15 and being a witness to violence against their mother during childhood, were significant predictors of partner violence in adult life (DESUC , 2004, 2006; Universidad de Chile, 2001).

In these same studies it was found that a higher probability of partner violence existed in lower socio-economic levels; physical and sexual violence were significantly more prevalent in the low and very low levels, in comparison with the middle and upper middle levels. On the other hand, the higher the educational level, the lower the DV; in particular, physical and sexual violence were more prevalent in women who had not completed secondary studies. International studies have found that education provides a protector effect, which seems to begin from tertiary studies on and which is independent of income or age (WHO, 2005).

In the Chilean studies it was also found that, when there is less family support, there is a higher prevalence of partner violence and the victims tend to have a hierarchical couple ideology, in which the male exerts the authority and there is a greater acceptance of physical and sexual violence. This shows the relevance of social

and cultural factors, such as underlying gender ideology and the importance of support networks.

DV intervention is oriented towards interrupting the violence, repairing its consequences and preventing the repetition of abuse patterns (Martínez y colaboradores, 1997). Nonetheless, the intervention and its objectives, have different complexities. For example, in an evaluation of the Chilean National Depression Treatment Program it was found that the program desertion rate in women suffering from domestic violence was 5 times higher than those without a history of DV (Universidad de Chile, 2002).

The social and institutional response to victims continues to be inadequate. An integrated approach is needed in government policy – between the different levels of intervention – that includes the *specificity of the DV phenomenon* and the consideration of its complexities, such as economic and emotional dependence on the aggressor, and the phenomena of victims retracting complaints and deserting treatments (Larrain, 2008).

Associations between DV and psychiatric diagnostic categories have been studied, but less research has been done on the interactions between DV and the functioning of personality and self (Pico-Alfonso, Echeburúa, Martínez, 2008; Briere & Rickards, 2007). Nevertheless, the study of these mechanisms seems to be relevant for a better understanding of phenomena such as re-victimisation, treatment desertion and retraction (Crempien, 2011 in press).

Systematic and prolonged trauma developed in an interpersonal context of domination and submission presents different characteristics and consequences to those described in post-traumatic stress. Herman (1992) developed a conceptualisation that would better encompass the characteristics of prolonged

interpersonal trauma; this is characterised by symptomatic constellations that include alterations in self-capacities in order to regulate internal experience and the relation with the other, somatisations and dissociative phenomena (Briere y Spinazzola, 2005; Van der Hart, Nijenhuis y Steele, 2005; Messman-Moore, Brown, Koelsch, 2005; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996; Herman, 1992).

In survivors of relationship trauma such as domestic violence, self-image and self-esteem are impoverished and debilitated (ref). The victim develops a pathological attachment of extreme emotional dependence on the aggressor. Independent actions are experienced as insubordination; therefore submission constitutes an adaptive mechanism for the victim (Sahin, Timur, Ergin, Taspinar, Balkaya & Cubukcu, 2010).

More severe post-traumatic consequences are associated with a life history of multiple experiences of interpersonal victimisation, which often begin with childhood abuse or neglect (Ford & Kidd, 1998; Zlotnick, Zakriski, Shea, Costello, Begin & Pearlstein, 1996). Some experiences during adulthood can have a devastating effect on the self, generating helplessness and alterations in the way the woman experiences herself and the world (Fernández Liria, 2008).

The purpose of this research is to deepen and enrich the understanding of the psychological functioning of domestic violence victims, through the *differentiated* exploration of *self-capacities*, and their associations with the characteristics of violence and childhood abuse experiences. Also, variables associated with poverty and sex-role ideology are considered as adjustment variables, in order to establish comparisons between interest sub-groups, taking into account their relevance in the findings of previous research.

Hypothesis

It is expected that domestic violence in its different manifestations, will be more severe in women who have experienced more severe childhood abuse, and that the vulnerability of self capacities will be associated with greater severity of violence in childhood and adulthood.

Variables

Domestic Violence (SERNAM (National Women's Service, Chile), 1995; WHO, 2005). DV will be understood to be partner behaviours that, by action or omission, provoke threat, suffering and/or harm to the woman's emotional, physical and/or sexual integrity, in the context of an abusive relationship. Some manifestations of emotional violence are: controlling daily activities, belittling, insults, economic restrictions, threats. Physical violence can be expressed through acts such as: pushing, slapping, kicking, striking with objects, attempting to strangle, threatening or use of weapons. Sexual violence refers to behaviours where, by means of physical force, emotional coercion or intimidation, the woman is forced to commit undesired sexual acts.

Type, severity and length of violence were evaluated. Variables of the victim's subjective perception of the problem were also evaluated: level of subjective suffering, personal explanation of the problem, concept of change related to environmental and/or internal factors, resources and obstacles to change (internal and/or external).

Childhood abuse (Smith, Lam, Bifulco, Checkley, 2002)

There are diverse situations in the family that violate the well-being of children and adolescents, including parental neglect, emotional mistreatment, as well as physical and sexual abuse. In this study, the history of physical mistreatment and sexual abuse that occurred up until the age of seventeen (17) was investigated. In the category of mistreatment, recurrent physical punishment that causes pain or physical damage, committed by a parental figure or carer was considered (e.g. slapping, kicking or hitting

with objects). Sexual abuse refers to any undesired or perturbing sexual experience with an adult; whether they are a family member or outside the family (e.g. touching private body parts, touching an adult's private parts, rape).

Structural functions or Self capacities (Grupo de Trabajo OPD, 2008).

Cognitive functions.

Self-perception: The ability to perceive and refer to oneself in a reflexive and coherent way, to maintain a stable self-image over time, to identify and differentiate different aspects of self and one's own feelings.

Object-perception: To recognise the other as separated from the self, to be able to recognise the thoughts, needs and impulses of others and to be able to distinguish them from one's own. To be able to see the other in a realistic way, recognising their different aspects.

Affective Regulation Functions.

Self-regulation: The ability to identify and distance oneself from one's own feelings and impulses. Regulation of emotions and self-esteem, integration of impulses.

Object Relation Regulation: The ability to consider both the other and the self in the relationship. To protect the relationship from one's own disturbing impulses while, at the same time, protecting one's own interests. To anticipate the consequences of one's own relational behaviour and the reactions of the other.

Emotional Communication Functions.

Internal emotional communication: The ability to allow one's own feelings to emerge and to experience them, to sustain inner dialogues and use one's own fantasies in order to reflect on and guide actions. The ability to experience one's own corporality.

External emotional communication: The ability to develop emotional contact with others, to express one's own feelings and receive others' affection. To be able to feel empathy.

Attachment functions.

Attachment to internal objects: The ability to develop, maintain and use inner representations of significant people, to emotionally charge them with positive and varied feelings in such a way that they help to calm, alleviate and protect the self.

Attachment to external objects: To connect oneself emotionally with others, to experience varied feelings in respect to the other. To be able to receive support and guidance, as well as to be able to separate and farewell.

Adjustment variables

Marital status, education, income, employment status, number of children, number of people per household, psychiatric co-morbidity, cultural variable of sex-role ideology.

Method

This is a non-experimental, correlational, cross-sectional study.

Participants. 28 Chilean women patients in specialist DV victim treatment centres, in Santiago, Chile, during 2009 and 2010. They were contacted through the centres' staff, and those who agreed to participate were included consecutively. Each participant was given an economic compensation, equivalent to US \$12.00. The interviews were videotaped and coded according to the manual of Operationalised Psychodynamic Diagnosis (OPD). Six interviews were coded by 3 independent trained raters, in order to calculate inter-rater reliability. The rest of the interviews were coded by the principal researcher, who obtained good reliability.

Measures.

1) OPD Clinical Interview (Grupo de Trabajo OPD, 2008). The OPD is a multiaxial diagnostic system, developed with the aim of complementing and enriching descriptive

diagnostics with psychodynamic dimensions relevant to clinical use and for therapeutic guidance and training.

The 5 axes that it outlines are: Axis I: Subjective perception of the patient about the problem and prerequisites for treatment; Axis II: Dysfunctional relational patterns; Axis III: Intrapsychic conflicts; Axis IV: Structure; Axis V: Syndromal diagnostic ICD or DSM. In this study, Axes I and IV were used.

Axis I: Evaluates length and severity of the problem from the observer perspective and subjective experience of the patient, personal concept of the problem and change, expectations with regard to treatment, resources and obstacles to change. All these variables were explored, while for the objectives of this study, the variables of type, severity and length of violence were included in the analyses.

A specific application of Axis I was developed by the author, the Module for the Evaluation of Domestic Violence and its corresponding manual. This module was checked by professional DV experts in order to evaluate the validity of its content. Experts' observations were included. The inter-rater reliability was very good (ICC= 0,834 (0,483 – 0,972)).

The items are judged in a Likert scale from 0 to 4, where 0 (zero) indicates absence or minimal presence of the variable and 4 maximum presence.

Axis IV Structure: Evaluates the availability and level of integration of mental functions. The structure refers to specific self-capacities and their relation to objects. The differentiated evaluation of these functions allows the observation of personality vulnerabilities. The structural functions present a self-referred dimension and a dimension directed towards object relation (others). Considering the difficulty of the empirical measurement of these constructs, the operationalization of the structural

functioning dimensions of the self allows us to approach a less inferential observation of the same.

Using a Likert scale, each function and the total structure are coded (with operationalised criteria in the instrument manual. The scale ranges from 1 to 4, with intermediate points (0.5 points), where 1 (one) is the highest functioning level and 4 (four) the highest vulnerability or function deficit.

The inter-rater reliability of the axis in this study was good (ICC= 0,718 (0,258 – 0,949).

The validity and reliability indexes of the OPD in previous studies are satisfactory and good (Cierpka, Stasch, Dahlbender and OPD Task Force, 2006).

2) Child Experience of Care and Abuse Questionnaire (CECA-Q; Smith, Lam, Bifulco, Checkley, 2002). This questionnaire retrospectively explores childhood care and abuse experiences. It deals with a diversity of childhood experiences with relation to parent figures or primary caregivers. In this study two abusive experiences were studied: Childhood physical and sexual abuse. Both scales present screening questions and evaluate the severity of the abuse. The higher score, the greater the abuse.

The instrument presents appropriate psychometric qualities. Validation studies in Chile are in progress (Alvarez, Crempien, Castillo, Ceric, unpublished).

3) Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan, Janavs, Baker, Harnett-Sheehan, Knapp, Sheehan, 1992).

Short structured diagnostic interview that explores 17 psychiatric disorders according to DSM-III-R criteria. Focus on presence of current disorders.

Validity and reliability are high or very high for all the disorders evaluated in this study (Sheehan, Lecrubier, Harnett-Sheehan, Janavs, Weiller, Bonora, Keskiner, et al, 1997).

The following modules were applied: Major Depressive Episode, Dysthymia, Post-Traumatic Stress Disorder, Alcohol Dependence / Alcohol Abuse, Substance Dependence / Substance abuse.

4) Beck Depression Inventory (BDI- II; Beck, Steer & Brown (1996)

Self-reporting questionnaire used extensively worldwide, validated in Chile (Melipillán, Cova, Rincón, Valdivia, 2008). Evaluates current depressive symptomatology, by means of 21 items, with higher scorings indicating more severity of depressive symptomatology.

5) Battery of Multidimensional Cultural Variables (BMCC Spanish version; Olhaberry, Crempien, Biedermann, Cruzat, Martinez, Martinez & Krause, in press)

This is made up of an adaptation of the following scales: Self-Construal Scale (SCS; Singelis, 1994), Sex-Role Ideology Scale (SRIS; Kalin y Tilby, 1978) and Tightness-Looseness Scale (TLS; Gelfand et al, 2007). It includes a section that records socio-demographic characteristics.

In this study, the socio-demographic data section was used as well as SRIS, which evaluate the sex-role ideology in a continuum that goes from the *traditional* pole to the *egalitarian* pole. Also, the TLS was used, this scale explores presence, strength and clarity of social norms, and the level of tolerance to deviation within the group, in a continuum that goes from the *tightness* pole to the *looseness* pole (Gelfand, Nishii & Raver, 2006). The *family* TLS is an adaptation of the former, applied to the norms within the family group (Freund, Zimmermann, Pfeiffer, Conradi, Hunger, Riedel, Boysen, Schwinn, Rost, Cierpka, & Kämmerer, 2010).

Ethical aspects

The study has attained the approval of the Ethics Committee of the Psychology Department of Pontificia Universidad Católica de Chile. The participants agreed to participate in the study by signing an informed consent letter.

Data analysis

Univariate analyses were performed to describe the behaviour of variables in the sample group and bivariate correlations between interest variables, as well as to compare sub-groups within the sample by means of Student t-test . Multivariate analyses by way of ANCOVA were carried out to adjust variables.

Adjustment variables were: marital status, educational level, family income, number of people per household, number of children, employment status, psychiatric co-morbidity and depressive symptomatology.

Statistical analysis was carried out using the SPSS program, Version 19.0.

Sample description

The sample was made up of 28 women evaluated by psychosocial teams at the above-mentioned centres, all of whose cases had DV incidence confirmed. The average age was 38.46 (DS: 8.29). 39.3% of the women were married or living with their partner, 21.4% were single and 39.3% separated. The average number of children was 2.29 (DS: 1.08) and the number of people per household 4.07 (DS: 1.74). 14.3% of the women had not completed high school studies, 35.7% had completed high school, 32.1% had technical studies and 17.9% had University studies. Income levels were: 21.4% in the first quintile of family income, 32.1% in the second quintile, 25% in the third quintile, 3.6% in the fourth quintile and 17.9% in the fifth quintile of family income. This means that the majority of the participants (78.5%) belonged to the lowest income group of the country's population, corresponding to the first three quintiles of family income (MIDEPLAN, 2009). The distribution of employment status was: 28.6% in active full-time employment, 28.6% active part-time employment, 21.4% occasional employment, 17.9% housewives and 3.6% unemployed.

It was found that 71.4% of cases presented some psychiatric disorder. The most frequent was Major Depressive Episode (46.4%), as a single diagnosis or associated with another pathology. 25% of the participants presented more than one mental disorder (refer Table 1). 53.57% of participants presented clinically relevant depressive symptomatology considering a score of 19 as the cut-off point (Beck, Steel & Brown, 1996).

Table 1

Psychiatric Diagnosis and Depressive Symptoms			
N=28	Freq.	%	Accumulated %
None	7	25,0	25,0
Major Depressive Episode (MDE)	6	21,4	46,4
Dysthymia (Dys)	2	7,1	53,6
Post-Traumatic Stress Disorder (PTSD)	5	17,9	71,4
MDE/DD+PTSD	6	21,4	92,9
MDE + alcohol/substance abuse	1	3,6	96,4
Missing data	1	3,6	100,0
Total	28	100,0	100,0

In reference to the types of domestic violence presented in the sample, 100% of the participants were victims of emotional violence, 96.4% had experienced physical violence and 46.4% had experienced sexual violence. One of the participants had only experienced emotional violence; all those who had experienced physical violence had also experienced emotional violence and all those who were victims of sexual violence had also experienced physical and emotional violence. Means and standard deviations of the severity of the violence, as well as its duration, are presented in Table 2.

Table 2

Domestic Violence types. Severity and duration means

DV Severity			
N=28	Media	SD	Min.-Max
Emotional Violence	2,82	0,819	1 - 4
Physical Violence	2,21	1,101	0 - 4
Sexual Violence	1,04	1,285	0 - 4
Global Violence Severity	2,79	0,917	1 - 4
DV duration (years)	11,67	8,213	1 - 30

With regard to the experiences of child abuse, more than a half of the participants (57,1%) had antecedents of child abuse, physical or sexual. 46.5% of the participants suffered childhood sexual abuse and 42.9% experienced physical abuse. 39,3% of the sample presented both, physical and sexual abuse.

The means and standard deviations of cultural variables (tightness-looseness and sex role ideology) are presented in Table 3.

Table 3

Means and SD cultural variables

N= 28	Mean (DS)	Min.-Max
Tightness-Looseness Scale (Social)	22,19 (DS:3,32)	6 - 36
Tightness-Looseness Scale (Family)	23,53 (DS: 4,73)	6 - 36
Sex role ideology Scale (SRIS)	50,30 (DS:7,77)	9 - 63

Results

It was observed that the women with lower incomes (first three quintiles) presented a longer duration of DV with respect to those participants with higher

incomes ($t=2.335$ $p<0.05$). At the same time, the length of violence presented a direct correlation with higher number of children ($r=0.522$ $p<0.001$). On the other hand, the sub-group of lowest income women (first three quintiles) presented more internal obstacles to solving their problem ($t=2.784$ $p<0.05$), and their concept of change was less directed to environmental resources, compared with the higher income sub-group ($t=-2.171$ $p<0.05$). This means that in the group of poorest women, external measures (social, legal) are not perceived as pivotal in confronting and resolving the problem of violence.

In relation to the ideology of gender roles, it was found that women who belong to the first two income quintiles presented a more traditional gender ideology than those who belong to the 3rd, 4th and 5th quintiles ($t=2.165$ $p<0.05$). No significant associations were found between the perception of tightness versus looseness of social or family norms (TLS) and the different variables studied.

Considering educational level, the sample was divided between women with technical or university education, and women whose educational level corresponds to completed secondary or less, and significant differences were found for all types of domestic violence and for the global severity index of the violence, whereby the severity was greater in all cases, in women who do not have technical or university education (emotional violence $t=2.223$ $p<0.05$; physical violence $t=2.660$ $p<0.05$; sexual violence $t=2.462$ $p<0.05$; global violence $t=3.403$ $p<0.01$).

It was also found that there was an inverse correlation between years of education and severity of physical violence and global domestic violence. Years of education explain 23.4% of the variance in severity of physical violence and 17.8% in global severity of DV. In short, the greater the education, the lower the violence, even when this is

adjusted for the remaining socio-demographic variables and childhood abuse experiences (refer Table 4).

In relation to the associations between domestic violence and childhood abuse, it was found that severity of physical mistreatment in childhood was directly associated to severity of sexual violence in the adult couple. As can be observed in Table 4, severity of physical mistreatment in childhood explains 12.1% of the variance in severity of partner sexual violence, including adjustment variables in the analyses.

Table 4.

ANCOVA models of DV in function of Childhood abuse and Socio-demographics

N=28 IC (95%)	Bivariate Analysis	Multivariate analysis		
	Spearman Rho	adj. R2	B	
Physical violence				
Years of education	-0,513**	0,234	-0,250	(-0,418; -0,081)
Sexual violence				
Physical Ch. abuse	0,394*	0,121	1,011	(1,983; 039)
Global DV				
Years of education	-0,457*	0,178	-0,185	(-0,331; -0,048)

*p < 0,05

**p > 0,01

In relation to the associations between childhood abuse and vulnerability of structural functioning, a significant and direct correlation was found between severity of childhood sexual abuse and a greater vulnerability in the structural functions of Attachment to Internal Objects ($r=401$ $p<0.05$) and External Objects ($r=407$ $p<0.05$). After adjusting the socio-demographic, psychiatric and cultural variables, the association between deficit of Attachment to Internal Objects and childhood sexual

abuse was maintained. 21.7% of the variance in this function can be explained by the severity of childhood sexual abuse variable ($r^2_{aj} = 0.217$ $B = 0.125$ $p < 0.01$). In the case of Attachment to External Objects, the association with childhood sexual abuse ceases to be significant, once adjustments have been made.

For the analysis of the relationship between DV and vulnerability of structural functions, in the case of the Attachment to Internal Objects capacity, childhood sexual abuse was included within the adjustment variables. Direct and significant associations were found between severity of sexual violence and vulnerabilities in the majority of the structural functions and the global functioning of the structure.

In the ANCOVA analyses, the model composed of the Emotional Violence, Sexual Violence and Marital Status variables explains 75.3% of the variance of deficits in the (Object) Relation Regulation function. There is a direct association between sexual violence, emotional violence and the vulnerability of this function. The marital statuses of “single” and “separated” relate inversely with vulnerability of the above-mentioned function. That is, the condition of “single” and “separated” (not living with a partner) would be related to a better capacity to regulate the relation with the object, and therefore to have an adequate balance between own needs and others’ needs.

As far as Sexual Violence is concerned, this was significantly associated with a more vulnerable or deficient functioning of the following capacities: Self-perception, Object-perception and Self-regulation, explaining 32.4%, 38.5% and 19.4% of the variance in vulnerability of these capacities, respectively. In the case of these structural capacities, the association with severity of sexual violence was always direct, the greater the severity of sexual violence, the greater the deficit in self-perception, object-perception and the capacity for self-regulation. This means that the victims of violence in this sample, when they presented more severe sexual violence, have a less stable and

complete self-image, greater difficulty to refer to themselves, and less capacity for self-reflection; similarly, they find it hard to differentiate themselves from the object, and to see the object in a realistic and integrated way; and they had greater difficulty in controlling, calming and protecting themselves through affect self-regulation.

In the case of vulnerability in the Attachment to Internal Objects function, the Sexual Violence and Childhood Sexual Abuse variables explain 33.7% of its variance. Both variables directly relate to greater vulnerability of Attachment to Internal Objects. These women have a lower development of positive and diverse internal objects that support self-regulation capacity. No significant associations were found between the Attachment to External Objects function and the explanatory variables introduced in the analysis. Finally, 26.2% of the variance in vulnerability of the Total Structure was explained by the Sexual Violence variable, whereby when the severity of the latter is greater, the vulnerability of the global structural functioning is higher (refer Table 5).

Table 5

ANCOVA Models of Structural Functions in function of DV and adjust variables

N=28		B	IC (95%)	adj.R2
Self-Perception				
	Sexual DV	0,214	(0,094; 0,334)	0,324**
Object Perception				
	Sexual DV	0,207	(0,105; 0,310)	0,385**
Self-regulation				
	Sexual DV	0,126	(0,030; 0,222)	0,194*
Object Relation Regulation				
	Emotional DV	0,115	(0,000; 0,229)	
	Sexual DV	0,125	(0,052; 0,199)	
	Marital status			
	Single	- 0,247	(-0,476;-0,018)	
	Separate	- 0,478	(-0,710; -0,245)	0,753**
Attachment to Internal Objects				
		0,173	(0,019 – 0,201)	
	Sexual DV +	0,110	(0,027 – 0,318)	0,337**
	Childhood Sexual Abuse			
Global Structure				
	Sexual DV	0, 184	(0,065; 0,303)	0,262**

*p < 0,05 **p < 0,01

Discussion

In this study it was observed that the majority of the women belong to the lowest quintiles of the population, and the majority also present some psychiatric disorder associated with domestic violence, with the most prevalent diagnostic being Major Depressive Episode and the combination of this with Post-Traumatic Stress Disorder. These findings are in accord with the results of previous studies.

On the other hand, almost all of the women in the sample presented a combination of at least two forms of violence, practically half of the participants suffered from the three

types of violence evaluated: emotional, physical and sexual. Likewise, a high percentage of the victims presented experiences of childhood physical mistreatment and/or sexual abuse, which supports previous findings about the high frequency of sexual abuse in this population.

Severity of childhood physical maltreatment was seen to be positively associated with severity of adult sexual violence. No other significant associations were found between *severity* of child abuse and *severity* of DV; this does not contradict in any way the association between these variables, since it is the presence of abuses that predicts partner violence and there is no previous evidence with respect to a lineal relationship between their severity. On the other hand, the fact that certain associations between variables are not reflected in this study could be a result of the small size of the study sample.

Considering the socio-demographic variables, lower income and lower educational levels are seen to be associated with severity of violence and difficulty of finding a way out of the violent relationship. The relationship between poverty, education and severity of violence confirms the results of previous studies in this subject.

After observing the inverse relationship between income and victims' internal obstacles, which refers to less adaptive *coping* mechanisms, it is feasible to propose that poverty brings with it important obstacles to breaking the cycle of violence, obstacles arising from the victims' internal mechanisms and, including cognitive and emotional limitations as well as risky behaviours including cognitive and emotional limitations as well as risky behaviours.

Furthermore women from lowest quintiles present lower expectations of being able to resolve the problem through external measures, which leads to the hypothesis that they have lower knowledge or access to social support networks and/or a lower level of

trust towards the environmental response. These findings suggest that there is a need to think about DV intervention strategies that more specifically consider and tackle internal obstacles in victims with limited economical resources, and their relationship with social support networks.

The direct association between number of children and length of violence is interesting data insofar as it could lead to the supposition that the greater economic requirements and the limitation to consider leaving home, hinder the woman's autonomy and the possibility of her leaving an abusive relationship.

As far as cultural variables are concerned, it was found that a more conservative sex-role ideology that attributes greater status and power to the male in the couple, was directly associated with a lower level of income in participants. Although this variable was not associated to severity of violence, it is relevant in that the modification of cultural beliefs that have legitimised and fostered partner violence is a central element in the intervention as well as in the prevention of domestic violence. It would be necessary to pay attention to this factor and especially keep it in mind when working with victims who belong to lower income groups.

With regard to the relationship between severity of childhood abuses and vulnerability of structural functioning, childhood sexual abuse was seen to be significantly associated with greater vulnerability in the development of positive, varied and stable internal representations that allow the women to calm down and look after themselves (attachment to internal objects). This makes sense considering that this capacity is developed during childhood through bonds with stable protective figures, bonds which are clearly violated through sexual abuse experiences.

With regard to structural vulnerabilities and their association with socio-demographic variables, only the statuses of single or separated are associated with better

functioning of self-capacity to regulate object relation. A possible explanation is that the possibility to keep living without the partner is enabled by the capacity to protect one's own interests and anticipate the other's behaviour. Or rather, it could be that physical distance, the fact of not living with the aggressor, has a bearing on developing a better capacity to distance oneself from the relationship and take care of both needs and interests, and those of the other.

In terms of adult domestic violence, a significant association was striking between lack of availability of the majority of structural functions and global functioning of the structure with severity of sexual violence, even when childhood adversity variables were adjusted.

Given the cross-sectional nature of the study, it is not possible to establish causal relationships between the studied variables. Nevertheless, considering chronic exposure to relationship violence associated with complex trauma developments, vulnerability or lower current availability of psychic capacities could correspond to trauma responses.

Both in childhood as in adulthood, sexual abuse is associated with altered development of attachment to positive and varied internal objects that facilitate the victims' emotional regulation capacities.

Sexual violence seems to be a particularly severe manifestation of violence associated with disturbances in self-capacities. Sexual violence could be considered as a *severity indicator* in partner violence, it could also constitute a sign of the sum of traumas that include emotional and physical violence as well.

The association of sexual violence with greater dysfunctions in different structural capacities has relevant clinical implications considering that vulnerabilities in the previously described functions can be related to obstacles in intervention and support

for victims (re-victimisation, high rate of treatment desertion). These results suggest the need to check presence and severity of partner sexual violence and to include reparation work and strengthening of these capacities in the planning of therapeutic foci.

Some limitations of this study are the small sample size that gives the results low statistic potency, its cross-sectional nature which impedes the establishment of temporal or causal relations between the variables, and the non-inclusion of certain variables that may be relevant for a deeper understanding of the studied phenomena, such as: the experience of witnessing parents' violence; parents' alcoholism or the quality versus quantity of education received.

Subsequent studies could include these relevant variables. Similarly, future longitudinal research could try to figure out the relation between predictors and effects with respect to the associations found between the variables in this study.

Some clinical and psycho-social questions remain opened, such as what is the likelihood that victims could recover structural functions availability after stopping violence and after working through reparation therapeutic processes; and, which would be the elements of these processes that could give account of these changes. The contribution of this study lays in the differentiated evaluation of the types of violence and self-vulnerabilities, and to explore relationships among them, taking in account variables that have been relevant in previous studies in domestic violence; childhood abuse, social vulnerabilities and, victim' sex role beliefs.

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This study aimed to understand the psychic and interpersonal functioning of intimate partner violence victims who attended specialized attention centers in Santiago de Chile. The studies presented were intended to identify and describe psychodynamic characteristics such as dysfunctional relational patterns and the victims' main intrapsychic conflicts, and to establish associations between the types and magnitudes of the violence experienced, the severity of adverse relational childhood experiences, and the vulnerability of the structural self-capacities in the present. The clinical implications of the results are discussed.

The study was based on intimate partner violence regarded as a complex relational traumatization process with specific characteristics and consequences, common to all interpersonal trauma survivors, and which differ from other types of trauma fundamentally due to their occurrence within an intimate and significant relationship, their systematic and chronic nature, and their tendency to re-victimization (this ideas were developed in the first article presented). This quality was used to support the notion that the study of the prolonged effects of this kind of processes in the victim's psychological and interpersonal functioning can contribute to the understanding and prevention of re-victimization, from the perspective of the victim's variables.

Explaining the perpetuation of intimate partner violence as a prevalent problem in our society involves paying attention to social and cultural variables which have been shown to play a significant part in the phenomenon (Jewkes, 2002; Ravazzola, 1996). Thus, some of them have been included in the study.

In this section, the main findings of the study are presented and discussed, attempting to integrate psychodynamic diagnostic dimensions with other variables

corresponding to the victim, such as the current psychopathology and childhood trauma history, and social characteristics in the sample.

Regarding the association between the severity of intimate partner violence, the severity of adverse childhood experiences, and other psychopathological and socio-cultural variables, the study found that the general severity of violence is associated with the presence of mental disorders, especially depression and post-traumatic stress disorder. These results are consistent with previous findings which suggest that intimate partner violence has consequences for women's mental health (Campbell, 2002; Universidad de Chile, 2002). An implication of these results from a therapeutically perspective, lead us to think that the victims' mental symptoms can be seen as an obstacle to escaping from violent relationships. For example, it would be expectable for women undergoing a depressive episode to display higher levels of despair, low-spiritedness, and/or feelings of uselessness, which would make it more difficult for them to escape the circuit of violence. Therefore, it seems to be crucial to include these aspects in an interdisciplinary intervention.

Regarding the connection between childhood adversity and intimate partner violence, women who are victims of domestic violence often have childhood abuse backgrounds (Briere & Jordan, 2004; Pontificia Universidad Católica de Chile, 2006, 2004). In this study, over half of the victims reported experiences of physical and/or sexual abuse, being the rate of childhood sexual abuse in general population about 25% (Briere, 2004). This finding corresponds to previous studies which show that the likelihood of having childhood abuse experiences in victims of intimate partner is higher than in non victims.

A direct association was found between physical childhood abuse and sexual violence by adult partners. Except for this finding and an inverse association between

maternal antipathy and intimate partner violence, no other significant connections were found between the severity of childhood and adulthood abuse. This result does not contradict the fact that childhood abuse can predict re-victimization in adult women; instead, it only reveals that maybe it doesn't exist a linear relationship between the severity of both. It must be pointed out that this result may also be a result of the methodological limitations of the study, such as its small sample, which may have made it unable to find associations that do exist in practice. That is to say, there is some probability of encountering a type II error.

On the other hand, evaluating the variables of adversity in childhood via a retrospective self-report instrument (CECA.Q; Smith, Lam, Bifulco, Checkley, 2002) reveals the victims' subjective perception of their family relationships in childhood. It could have worked here a memory bias, or a possible idealization of certain significant figures such as the mother. Idealization showed up in this investigation to be part of interpersonal patterns in the victims of this sample.

Regarding the association between intimate partner violence and structural vulnerabilities (according to OPD), the most relevant finding of this study is the direct association between sexual violence and the vulnerability of structural self capacities. More impairment was observed in the global functioning of the victims' psychic structure when sexual violence was more serious, which explained 26.2% of the variance in this vulnerability even when controlling for the childhood abuse variable. This supports the findings of Messmann- Moore et al (2005).

Specifically, the severity of sexual violence was directly associated with increased vulnerability in self-perception, object perception, self-regulation, regulation of the relationship with objects, and attachment to internal objects. In the case of the last function, the impairment of internal attachment was associated with sexual violence in

intimate partner relationship and in childhood. A specific contribution of this research is the differentiation of the studied self-capacities, which permit to think in therapeutic foci selection more precisely in the intervention with victims.

Internal attachment, that is, the internal representations of positive objects which allow a person to calm down, restrain him/herself, and attain an adequate regulation of experiences, are significantly more deteriorated depending on the severity of the victim's sexual abuse experiences both in childhood and in adulthood.

This suggests that sexual abuse is a particularly serious type of relational victimization which has relevant implications for victims' functioning. Although this is a cross-sectional study, and thus cannot establish causal relationships between variables, considering the antecedents found in the literature, the structural limitations observed can be considered to be responses to trauma (Pico-Alfonso, Echeburúa, Martínez, 2008; Humphreys & Thiara, 2003).

Similarly, the higher vulnerability of these functions may be connected with the severity of sexual violence as an indicator of the seriousness of intimate partner violence in general, as it involves an accumulation of other traumas, including physical and emotional violence, considering that all the women who suffered sexual violence in this study were also subjected to the other forms of violence. This indicates that sexual violence must always be evaluated as an expression of severe intimate partner violence, and also suggests that it is necessary to check for the presence of this type of abuse in the evaluation of victims.

On the other hand, the severity of emotional violence was also positively associated with a higher level of deterioration of victims' regulation of their relationship with objects. Single and divorced victims displayed a better functioning of this function.

It seems that, when victims are not living with their aggressors, they manage the relationship better, which may be partly explained by the fact that physical distance can reduce dependency within the relationship and aggressors' control over victims, which allows the latter to develop more autonomy and focus on their own needs. Control over everyday activities, isolation, verbal abuse, etc. are some of the manifestations of emotional violence to which victims may be less daily exposed when not living with their aggressors.

Relational traumatization processes in intimate partner violence victims involve a great emotional overload, which tests the victim's ability to adapt to and manage internal and external stress. This overload is taxing for the structure. It can be hypothesized that women subjected to this stressor are at their lowest level of structural functioning, and that they may reach a better functioning. This can be supported by regarding self-capacities as dynamic. Although their level of functioning remains relatively constant, they can be more or less available depending on the demands and requirements of an individual's life circumstances (Grupo de Trabajo OPD, 2008).

In this regard, it is relevant to study the potential recovery of damaged psychic capacities and the victims' (possibly higher) functioning level when not being stressed by intimate partner violence. Even though this is a frequent observation in clinical practice, future longitudinal studies may approach this question empirically by assessing victims during their follow-up process after violence has stopped, and by observing the treatments for repairing its consequences.

With respect to the dysfunctional interpersonal patterns and the main intrapsychic conflicts in the victims assessed, this study is a first step for exploring and describing them through an operationalized psychodynamic diagnosis. In general terms, the results confirm and provide new evidence to support the available theoretical

developments and the clinical experience about abusive partner relationships, regarding the relational behaviors observed and described in women subjected to violence (Montero, 2001). An original point of view shown by the results of this study is the identification of less conscious relational behaviors in the victims, thought to be part of their "problematic relational offer", and other people's induced response to this offer, including the observer's counter transference reactions, which may somehow resemble the experience of other people with respect to the victim, and which can, as a whole, contribute to maintaining violence.

The relational dynamics observed more frequently in the participants shows that they perceive hostility and control by the aggressor and that they see an accommodative attitude in themselves, used to avoid conflict, which is consistent with the description of the "accumulation of tension" stage in the intimate partner violence cycle, described by Walker (1979). Relinquishing their freedom and submitting to the other's needs matches the idea that intimate partner violence victims tend to adhere to the other's needs, identify with him, and submit as a form of adaptation and survival in a violent relationship, as a way of gaining control without actually rebelling (Frankel, 2002; Ferenczi, 1964).

In this study, we can observe that the participants are aware of these behaviors and their adaptive mechanisms in the relationship. These women are seeking help to escape an abusive relationship. In other phases of the cycle of violence, victims may be less aware of these relational responses. Probably for the same reason, women also perceive that they are making an effort to recover their freedom by opposing and resisting their aggressors' control.

The elements that complete the maladaptive interpersonal pattern are the other's experience with respect to the victim, and his experience of himself regarding the

"unconscious relational offer" that she proposes (OPD, 2008). The results indicate that the victim tends to undervalue herself and considers herself inferior to the other person, while at the same time she admires and idealizes him, even justifying and excusing him for the actions that she regards as aggressive. The other party responds by undervaluing and scolding her. The victim does not realize that this process exaggerates the aggressor's worth and attributes a great power to him, while the same time it makes her feels belittled.

On the other hand, she is also unaware of the fact that part of her relational offer is to accept the other when he expresses concern or affection. She gets involved without setting a distance or limits, gets confused with the other's closeness, and stops seeing the relationship realistically in all its aspects, exposing herself to further violence.

This interpersonal relationship is quite coherent with the most frequently observed conflicts: "need for care-self-sufficiency" (conflict 3) and "individuation-dependence" (1). These two conflicts refer to the bond with the other: conflict 3 concerns the dependence on the other's affection, while conflict 1 pertains the dependence on the relationship as a way to avoid the existential anguish of losing the object. Both conflicts are fundamentally expressed through passive elaboration, as there is predominance of symbiotic dependence and of the need to "be taken care of" (OPD, 2008).

A series of systematic failings in the care received in childhood, and a history of early abuse may be a possible source of conflicts related with bonding, love, and care. These experiences may generate tensions between the profound desire to bond and the fear of losing the other, the wish to receive affection and protection, and the fear of losing the other's affection or being disappointed.

In intrapsychic conflict, one pole always conceals the other. Thus, it is possible that the desires of symbiotic dependence and being taken care of hide the wish for independence and individuation present in these women when seeking help.

The passive elaboration of the conflict explicitly manifests their need of dependence. These needs are probably much more exposed in the aggressor's eyes, which can facilitate manipulation and the circle of violence.

On the other hand, the mixed elaboration of these conflicts also appears and reveals the active pole. In this case, we may think that some victims tend to defend themselves from their own necessity to be taken care of and depend on the other when facing the unconscious threat of being disappointed or frustrated by him, who will be unable to take care of her and provide the affection that she expects.

On the other hand, women with deficiencies early in their life histories regard intimate partner relationships as a chance for reparation, and thus idealize them. Staying in a violent relationship may also be understood as a search for intimacy at all costs, because separation and loneliness are experienced with fear and anguish. The victim privileges the safety of being in a relationship above all things, subordinating her personal wishes to those of the other in order to preserve the relationship.

It can be advanced that the conflicts “being taken care of versus autarchy” (3) and “individuation versus dependence” (1) are articulated with the “control versus submission” conflict (2), so that submission may correspond to the wish of being taken care of –the victim is submissive in order to receive affection– or, from the perspective of the individuation conflict, she submits to safeguard the relationship, because losing it would generate more anguish for her. In both cases, it appears to be a form of adaptation to fundamental needs of the woman (primary conflicts).

The clinical relevance of focusing on the dysfunctional relational pattern is associated with the chance of observing these behaviors and understanding their participation in the re-victimization pattern. Helping the victim to become aware of these relational behaviors which maintain violence may allow her to be attentive, understand their meaning, and gain some influence and control in order to generate a more adaptive response to the situation. The possibility of giving sense to her re-enactments may lead, as it has been stated by interpersonal trauma authors, to diminish re-victimization and “personality disorder” symptoms observed in victim (van der Volk, 1989; Trippany, Helm & Simpson, 2006).

In contrast, regarding the reactions of others, secondary victimization responses observed in professionals and institutions of the social network, tend to blame the victim, minimizing, doubting, or discrediting her perception.

The lack of understanding of the mechanisms of adaptation to victimization, that generate obstacles to find a way out of the abusive relationship, lead the intervention agents to expect from the victim behaviors which are temporally unavailable to her, due to structural weakness or to maladaptive patterns in which she is involved. This may account for the exigent and control practices of intervention agents and for the abandonment of victims through hasty and unjustified referrals (Calle Fernández, 2004).

For the therapist, paying attention to counter-transferential reactions may contribute to protecting the victim, basically by alerting her not to repeat the relational pattern and providing a meaning to others' reactions towards her.

At this point of the discussion, it is necessary to consider a limitation of the study. Having tested the inter-raters reliability in the four axis of OPD; Axis I (Domestic Violence Assessment); Axis III (conflicts) and Axis IV (structure) obtained an adequate

or very good inter-raters reliability. Nonetheless, in case of Axis II (interpersonal relationships) the reliability was low, so the results regarding this axis should be observed with prudence and they constitute just a first attempt to evaluate domestic violence victims with this instrument in Chile. So far, there aren't other studies reporting reliability of Axis II in Chile, this seems to be necessary to obtain statistically reliable results and improve its utilization.

The psychodynamic aspects of intimate partner violence victims found in this study must be observed in the participants' social context.

Most of the women who participated belonged to the three first quintiles of the Chilean population (as defined by MIDEPLAN, 2009), and it was found that poverty and low educational levels are associated with the severity of violence and difficulties to escape violent relationships. The connection between poverty, education, and violence severity also supports the results of previous studies (Pontificia Universidad Católica de Chile 2006; 2004; Universidad de Chile, 2001).

It was found that women from the poorest quintiles displayed more internal obstacles for dealing with their problem and generating changes in their situation (according to the Module for the Assessment of Intimate Partner Violence, Axis I of OPD); that is, compared with women from the highest quintiles (four and five), they displayed less adaptive coping mechanisms, which may be a result of the structure or internal conflicts and how they are managed in social contexts. These obstacles may include cognitive and emotional impairments, less adaptive defense mechanisms, and risk behaviors.

It can be advanced that poverty is an obstacle or limitation to breaking the circuit of violence which even affects the internal mechanisms of its victims. Similarly, women from the poorest quintiles showed lower expectations about solving the problem through

external measures, which suggests less knowledge of available social support networks or lack of access to them, and/or a lower degree of confidence in their environment's response, or a negative experience with it.

Regarding cultural variables, it was observed that a more conservative gender role ideology (according to the SRIS scale, adapted; Freund et al, 2010), was directly associated with a lower income level of the participants. This means that the victims from the poorest quintiles had more traditional stereotypes about gender roles and meanings; women stay at home and take care of their family, while men are considered more powerful and hierarchically superior in the couple. Although this cultural variable was not associated with violence severity, it is relevant as the modification of cultural beliefs which have legitimized and fostered intimate partner violence is a central element in the intervention as well as in the prevention of the problem. This factor must be taken into account and should be highlighted when working with low-income females.

These findings stress the necessity of creating intervention policies for intimate partner violence in Chile which specifically consider these and other possible obstacles for poor women.

Although intimate partner violence is a complex phenomenon, and should be approached from different angles using several models, the notion of complex relational traumatization provides a way of understanding the characteristics of women subjected to violence which makes it easier to recognize victims' behaviors as more than just static manifestations of their personalities (associated to psycho-pathological stigmatization), or as a lack of willpower or intention to change (linked to myths about violence, Ravazola, 1994), as part of a vulnerable functioning in which psychic capacities are thought to be altered or less readily available in response to the traumatization process.

These alterations may constitute mechanisms through which re-victimization develops, but they are not necessarily fixed and unmodifiable.

Regardless of whether such vulnerabilities predate violence or are a consequence of it, they are internal obstacles for dealing with experience and overload. Strengthening the damaged psychic functions, visualizing dysfunctional relational patterns, and understanding the conflicts expressed through them may a way to stop the abuse, prevent re-victimization, and manage obstacles to the intervention, such as high dropout rates, non-compliance of legal protection measures, and the subsequent secondary victimization by the agents of the intervention.

The relational proposal of those in charge of the intervention to the victims can often refer to psychic functions which are temporally weakened in the women; also, the former can pass judgment on the latter, ascribing a lack of cooperation to them or using static psychopathological terms to label them. Two elements are often overlooked: the series of adaptive responses which support the traumatic bond with the aggressor and the internal mental frameworks which facilitate the repetition of similar relationships.

When the victims are limited to a coherent perception of themselves, they have trouble identifying and differentiating their needs and feelings with respect to those of the other, are extremely afraid of being abandoned by him, or risk starting relationships which expose them to abuse.

We could hypothesize that the psychic functions damaged and the dysfunctional relational patterns acquired as a result of intimate partner violence mediate in the occurrence of this repetition, which, rather than a manifestation of a self-destructive tendency, results from the inability to access internal and external resources, and from a learned adaptive mechanism which has become autonomous in her relationship with

herself and with the other (Herman, 1992). This hypothesis could be tackled in future investigations on the topic.

The integration of the diagnostic material explored in the participants reveals the resources and structural limitations upon which are laid out the organization of their conflicts, their interpersonal relational patterns, the victims' subjective experience about their problems, and their mental symptomatology. Structural vulnerabilities affect the weakest or most rigid relational patterns depending on the acuteness of the victim's limitations.

Dysfunctional interpersonal patterns, a result of tension between wishes and fears, are a maladaptive attempt to regulate conflicts and structural vulnerability (OPD, 2008). This is consistent with clinical observations and theoretical constructs about the traumatic bond and identification with the aggressor, which refer to behaviors which have an adaptive meaning for the victim's survival in an abusive relationship, and which nonetheless damage her (Frankel, 2002; Montero, 2001).

It is necessary to make a clarification about the diagnosis of intra-psychic conflicts in this study. First, it must be pointed out that conflicts are expressed in a continuum which goes from mere "sketches" of conflicts, with less integrated structures, to clear-cut conflicts, delimited in better functioning structures. Second, a pre-requisite for evaluating conflicts is that they must not be the consequence of current acute stressors (OPD, 2008). In this study, the identification of conflicts may have been limited by the victims' overload when being assessed and by the level of structural functioning of the participants (usually, an intermediate integration level). This was especially relevant in the case of women who suffered sexual violence, who display the most severe vulnerabilities.

For instance, in the case of the very frequent identification of self-worth conflict in the victims, it must be established to which extent it results from the tension between their efforts to be recognized and appreciated and the defense against this need, versus structural vulnerabilities in the victims' self-perception and internal self-esteem regulation capacity.

With respect to the ability to recover damaged psychic functions, a way of measuring the degree to which self-capacities may be activated and re-established at a higher integration level is the assessment of relational patterns or structural functioning in other areas of the victim's life which are less conflict-laden, for instance, at work or in other significant relationships. As the interview was mostly concerned with the violent relationship, conflict-free areas, the most adaptive relational behaviors, were not analyzed in depth. Future studies may focus on these resources.

A strength of this study is that it separately assesses self-capacities, the main significant internal conflicts, and the other's relational behaviors and responses. The methodology defines and operationalizes these constructs, which are hard to observe and measure in practice. These characteristics reveal relevant aspects of the victims' psychological and relational functioning, which contribute to understanding some of their difficulties, the risk of re-victimization, and some obstacles in the treatment. In the therapy, the methodology makes it possible to work on structural vulnerabilities and specific conflicts, using the capacities of the structure and the areas with the best interpersonal functioning.

Regarding the therapeutic implications of these findings, we can state that the possibility of seeing together with the victim how these aspects of herself function, and working on them, can result in a more complete and realistic perception of herself and of

the other, bolster her reflexive skills, and enable her to become aware of her personal resources and difficulties.

On the other hand, the therapeutic relationship can be a chance to have a different, corrective relational experience and offer a bond that promotes the development and establishment of representations of positive internal objects, which foster the victim's ability to help, accompany, calm, and protect herself, in order to improve her regulation and elaboration of overload and her experiences.

As traumatization occurs in the interpersonal relationship, reparation is also likely to occur in the interpersonal experience, which can be developed in diverse instances of help seeking process: when denouncing the aggressor, while receiving health assistance and identifying physical injuries, during psycho-social and therapeutic support, or during the legal process.

Among the phases of the intervention, is clear that the interruption of violence is a fundamental requisite for the reparation and recovery of the victim's internal resources. In this regard, interventions first attempt to protect the victim, avoid new violent situations, and control risks. However, we also know that vulnerabilities in physical functions an interpersonal relationships, recursively, are internal obstacles which limit the victim's ability to protect herself, even when she is supported by external resources.

It is necessary to reach a dynamic balance between protection-centered interventions and those aimed at helping the victim visualize and understand the internal difficulties which emerge due to the violent relationship. Therefore, the therapy must also focus on the recovery and strengthening of the victim's vulnerable psychic capacities.

The inclusion of these aspects in the treatment requires an evaluation of self-capacities, in order to identify those that have sustained the most damage and those which can be used as resources for therapeutic progress.

For instance, the joint work of the patient and the therapist about how the former's self-image has been restricted to partial aspects of herself, which tend to be devalued, and how her capacities have become less visible for her, fosters a reflexive attitude in the patient. The differentiation between the self and the other, and promotion of her autonomy and the possibility of regulating her self-esteem internally, can be enhanced in the therapeutic relationship scene, by helping the victim to recognize her own feelings, needs and emotions and differentiate them from the others'. This, instead of forcing her to make what the therapist considers best for her. Along with this, working on a more complete and realistic perception of the other and separating his needs from those of the victim may contribute to elaborating and "dissolving" the pattern of the traumatic bond.

One of the limitations of this study is its cross-sectional nature, which makes it impossible to establish temporal relationships between the variables studied. Longitudinal studies may establish whether the structural vulnerabilities associated with intimate partner violence, and especially sexual violence, are an effect of it, by studying the structural functioning and the availability of self-capacities, after the therapeutic and interdisciplinary interventions for repairing the victims' capacities.

Another of its limitations is the small sample analyzed. Other clinically relevant associations may be found between the variables studied, for example, between caregiver neglect in infancy and structural vulnerabilities, but these associations are not likely to be observed due to the small size of the sample. It would be recommendable to include a larger number of participants to study the association between these variables in future research.

Finally, we must not forget that the characterization of the victims' functioning was done based on a sample of women who attended an assistance center, mostly referred by a judge after denouncing their aggressors. This indicates that the information was obtained in the context of help seeking process, that is the initial recognition of the problem leading to a solution with institutional support, and that the situation may be different in the case of women who have not asked for help or denounced their aggressors.

In summary, the notion of *complex relational traumatization* in intimate partner violence contributes to understanding victims' difficulties by identifying their psychic and relational vulnerabilities associated with the traumatic processes experienced by them. The studies presented have detailed the maladaptive cyclic patterns, the main intra-psychic conflicts, and the structural vulnerabilities of a group of women subjected to intimate partner violence with varying levels of relational adversity in their childhood. The present study is an attempt to improve victim assistance by systematizing and providing tools to prevent re-victimization and the responses that facilitate secondary re-traumatization by the therapist and other professionals who support the victims of intimate partner violence.

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Annexes

1. Participant's Identification Form

ID N°

NAME: _____

AGE: _____

R.U.T.: _____

ADDRESS: _____

PHONE NUMBER: _____

E MAIL: _____

INSTRUMENTS	APLICADO	DATE	TIME	NOTES
1.- BCCH				
2.- BDI II				
3.- CECA-Q				
4.- ENTREVISTA OPD				
5.- MINI				

2. OPD-2 Scoring Form

Spanish versión (Grupo de Trabajo OPD, 2008)

Eje II – Relación

Perspectiva A: vivencia del paciente			
<i>CUADRANTE 2: El paciente se vivencia a sí mismo</i>		<i>CUADRANTE 1: El paciente vivencia a otros</i>	
Ítem N.º	Texto	Ítem N.º	Texto
1.	_____	1.	_____
2.	_____	2.	_____
3.	_____	3.	_____

Perspectiva B: vivencia de los otros (también del evaluador)			
<i>CUADRANTE 3: Otros vivencian al paciente</i>		<i>CUADRANTE 4: Otros se vivencian a sí mismos</i>	
Ítem N.º	Texto	Ítem N.º	Texto
1.	_____	1.	_____
2.	_____	2.	_____
3.	_____	3.	_____

Formulación dinámica relacional:

Describe por favor,	
... cómo el paciente vivencia repetitivamente a los otros ↓
... cómo reacciona él respecto a eso: ↓
... qué tipo de oferta relacional (inconsciente) le hace a otros con su reacción ↓
... qué tipo de respuesta induce inconscientemente en otros: ↓
... qué vivencia el paciente cuando los otros responden a lo inducido por él

Eje III – Conflicto

Preguntas para clarificar las precondiciones para la evaluación del conflicto

A) Los conflictos no pueden ser inferidos, falta seguridad diagnóstica.	sí = ①	no = ②
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B) Debido a un bajo nivel de integración estructural los temas de conflicto encontrados no corresponden a patrones disfuncionales de conflicto sino más bien a esbozos de conflicto.	sí = ①	no = ①
C) Debido a defensas frente a la percepción de conflictos y emociones, el eje del conflicto no puede ser evaluado.	sí = ①	no = ①
D) Conflicto por estrés (conflicto actual), que no corresponde a patrones disfuncionales de conflicto.	sí = ①	no = ①

Conflicto disfuncional repetitivo	Ausente	Poco significativo	Significativo	Muy significativo	No evaluable
1. Individuación versus dependencia	①	①	②	③	⑨
2. Sumisión versus control	①	①	②	③	⑨
3. Deseos protección y cuidado versus autarquía (autosuficiencia)	①	①	②	③	⑨
4. Conflicto de autovaloración	①	①	②	③	⑨
5. Conflicto de culpa	①	①	②	③	⑨
6. Conflicto edípico	①	①	②	③	⑨
7. Conflicto de identidad	①	①	②	③	⑨

Conflicto principal: _____ **Segundo conflicto más importante:** _____

Modo más importante de la elaboración del conflicto	Predomina n-temente activo	Mixto preferente-mente activo	Mixto preferente-mente pasivo	Predomina n-temente pasivo	No evaluable
	①	②	③	④	⑨

Eje IV – Estructura

	Nivel Alto	1,5	Nivel Medio	2,5	Nivel Bajo	3,5	Nivel Desintegrado	No evaluable

	Nivel Alto	1,5	Nivel Medio	2,5	Nivel Bajo	3,5	Nivel Desintegrado	No evaluable
1a Percepción de sí mismo	①		②		③		④	⑨
1b Percepción del objeto	①		②		③		④	⑨
2a Autorregulación	①		②		③		④	⑨
2b Regulación de la relación con el objeto	①		②		③		④	⑨
3a Comunicación hacia adentro	①		②		③		④	⑨
3b Comunicación con hacia afuera	①		②		③		④	⑨
4a Vínculo con objetos internos	①		②		③		④	⑨
4b Vínculo con objetos externos	①		②		③		④	⑨
5 Estructura total	①		②		③		④	⑨

3. Domestic violence module (manual)

(English version, July 2010)

Developed by Carla Crempien R. (Adapted from OPD-II Axis 1)

Introduction

In clinical, psycho-social, and psychotherapeutic contexts, the victims of domestic violence tend to present special challenges for the professionals who assist them. Thus, they are often regarded as **difficult patients** who generate frustration and intense countertransferential feelings which hinder their recovery.

The paradox is that these women are subjected to violence and abuse in meaningful affective relationships in which they are intensely involved, so it is very difficult for them to put an end to the situations that victimize them and make them suffer. In addition to the social and economic difficulties they experience, they run real risks in the relationship with their abusers. Finally, the psychological state of the victims and the effects of violence in their mental health pose another problem that keeps them from **acting effectively** towards change and their wellbeing.

Therefore, the clinical assessment of these patients requires a more specific evaluation of the characteristics of violence, both in its **objective** and **subjective** aspects, the identification of the victims' personal explanations regarding the issue of violence and change, and a thorough observation of their available resources and the obstacles they encounter when attempting to solve their problem.

This manual is aimed at supporting the assessment of the specific characteristics of **female victims of couple violence**, in the context of a **clinical interview**. The terms "domestic violence" or "couple violence" will be used interchangeably to refer to the same phenomenon, namely violence or abuses by a man against a woman in a couple.

Domestic violence is a **complex phenomenon** whose etiology and continuance are connected to a series of factors, including cultural, familial, relational, and individual characteristics of both victims and assailants. To fully understand a case of domestic abuse, it is not enough to glance at each of these elements in isolation. It is fundamental, for example, to consider aspects such as the beliefs, values, and ideologies present in a culture that have legitimized and perpetuated violence in families and couples. In this respect, the social construction of genders and their roles in society has historically fostered power inequality between men and women, and has placed women in a position of disadvantage and subordination. Domestic violence will be

understood as a social phenomenon related to a culture's structures of power inequality between men and women.

Couple violence is a subcategory of gender-based violence, and entails a repetitive pattern of abuse by the male which includes **coercive** behaviors that may be expressed physically or non-physically. It is understood as a **relationship involving the abuse of power** and not as a "conflict in the couple", since the idea of conflict presupposes a false symmetry of the genders. Being an **abusive relational pattern**, it is not equivalent to an isolated episode of aggression, although such an episode may be part of an abusive pattern. The key element is the abuse underlying the relationship, and which can be recognized by the inequality in terms of power, the victim's fear, and her resulting responses of avoidance, adaptation, and submission.

One characteristic of couple violence is its **cyclic nature**: it entails sequences of events that repeat themselves over time, and which go through three phases: accumulation of tension, acute episode or crisis, and reconciliation or "honeymoon". Although this model does not account for all the different shapes that domestic violence may take, it is quite useful because the characteristics of each phase are easily observable. Thus, during the tension accumulation phase, victims display behaviors and verbalizations aimed at buffering and avoiding conflict; in the acute episode, more intense manifestations of violence occur and terror, hopelessness, anguish, dissociation or emotional numbness begin to appear; finally, in the so-called reconciliation or honeymoon stage, minimization and denial of violence reappear, together with hope, forgiveness, and the wish to believe in the other's promises of change. It is important to be aware of the cycle of violence and recognize it through the variations observable in the victim's speech, emotions, and behavior at different moments of the sequence.

Objective assessment of the problem

1. - Severity of the violence

Type and severity of the violence

These items refer to the different forms of expression or **manifestations** that domestic violence may have, and to the **severity level** of each type of violence, as well as to the gravity of violence as a whole.

In general terms, three types of violence can be described **emotional** or psychological violence, **physical** violence, and **sexual** violence. They do not appear in isolation very often: it is common for women to report one type of violence and omit others, either due to minimization or

embarrassment. Thus, it is useful to investigate and ask directly about the different expressions of violence.

The evaluation of the severity of violence requires the consideration of two aspects: on the one hand, the **intensity** of the manifestation, which is connected to the level of harm or risk it involves; on the other hand, the **habitualness** of the violent events, that is, their recurrence over time. This second element includes the chronicity or duration of the events and also their frequency.

1.1.- Emotional Violence

Emotional or psychological violence includes all the manifestations or couple abuse aimed at controlling, discrediting, and/or humiliating the other. It includes verbal abuse such as insults, offenses, and threats, but it is not a synonym of it; emotional violence is a wider category which also contains behavioral manifestations such as jealousy, the control of personal activities, and economic abuse and/or restrictions. Emotional or psychological violence in a couple comprises behaviors which, through their presence or absence, result in the emotional suffering of the other, in the context of an abusive relationship.

Gradation and examples	
Level 0 Absent/barely present	Expressions of emotional abuse are not perceptible or are present to a a very small degree . Example: A woman says that, during an argument, her couple yelled at her that he could not stand her anymore, that he was tired of her demands, and that he was sick of all problems. Her account reveals that this was a rather isolated situation resulting from a crisis. The woman is not afraid after this expression of her couple, although she may complain and be upset with him.
Level 2 Intermediate	The woman's account displays some of the manifestations of emotional or psychological abuse, such as: humiliating, underestimating, discrediting, insulting, or ridiculing her; yelling at her, threatening her with physical violence or harming her or others, denying her economic support or setting conditions for providing it, controlling her activities, and behaving jealously. Example: A woman reports that her husband repeatedly tells her that she is " useless " and can do nothing well, tells her off because the house is not clean, or blames her for their children's problems: "you're not even capable of educating your children". Another woman states that her husband says she has lovers whenever arrives home a bit later, when they go out together and she takes more care of her appearance, or when he gets home drunk. Second example: a woman points out that her husband makes it difficult for her to work and gets upset when she visits her friends or relatives.
Level 4 Very high	This level is characterized by the description of very serious manifestations of emotional violence, which become a " terrorism " of sorts in the couple. Another possibility is that the expressions of emotional abuse described in level two become very intense, frequent, and chronic, or become combined with others. Example: In a context where discredit, insults, and intimidation are frequent, the male throws the female out of the house with her young children in the middle of the night. Example: The male threatens to kill the female, or warns her that he is going to harm one of her children, destroy her possessions, or burn down the house. Frequent displays of jealousy, he swears at her: "you slut, you'll go to bed with anyone", the control of the woman's personal activities is very coercive, and if she does not obey, the results are scandals, humiliations before other people, etc.

1.2.- Physical Violence

Physical violence includes all behaviors that cause suffering or bodily harm to the other.

Gradation and examples	
Level 0 Absent/barely present	No expressions of physical mistreatment are found. Example: A woman is permanently controlled and restricted in her personal freedom by her husband, who is constantly watching her. The mechanisms of control and domination consist in blaming her of having lovers, threatening to abandon her, and making scenes in public; however, there have never been any expressions of physical violence.
Level 2 Intermediate	There are evident manifestations of physical abuse . Actions in which the couple uses physical force and which can result in injuries, or less intense acts (such as pushing, shoving, or cornering her), but which have occurred chronically throughout the relationship. Example: Blows with the hand (slaps, punches), kicks, twisting or squeezing her arms, throwing objects, hitting her with an object (stick), biting her, etc.
Level 4 Very high	This level is characterized by very serious physical abuse, with a high risk of producing injuries or even death, or by the actual presence of serious injuries (fractures, wounds). Example of indicators of maximum severity, regardless of their frequency: use of firearm or knife, or threats made with them, burns made with a cigarette or other elements, attempts to choke the woman. Other examples at this level are: beatings that include kicks and punches, or dragging the woman across the floor. In addition, physical abuse described in level two when it is frequent (weekly) , and when its intensity has escalated or has resulted in serious injuries.

1.3.- Sexual Violence

Sexual violence in the relationship comprises all manifestations of relational abuse or acts in which the male, either through physical force, emotional coercion, or intimidation, makes the female engage in sexual acts against her will.

Gradation and examples	
Level 0 Absent/barely present	No manifestations of sexual violence are observed; although harassment may be present, it does not involve coercion or intimidation. Example: The male occasionally insists and "bugs" the female for her to agree to have intercourse with him when she has already said no. The woman manages to stop the situation and, although it annoys her, she does not feel intimidated or forced to do anything she does not want to.
Level 2 Intermediate	This level is reached when the woman's account reveals manifestations of sexual violence, which include coercion or intimidation to force some sort of sexual contact. Example: the male demand s to have intercourse even when the female does not want to, and uses psychological manipulation or threats such as "I'll go and seek other women", or withholds the money she needs if she does not agree to his requirements.
Level 4 Very high	At this level, sexual aggressions are serious due to the harm they produce, the psychological damage they cause, and/or their recurrence. Example: rape, forcing intercourse by means of physical force. Forcing the female to engage in humiliating sexual acts such as having intercourse with another person while he watches or having intercourse after a physical aggression.

1.4.- Global violence severity index

The global severity index of domestic violence is **not** a sum or linear average of the specific manifestations of violence. The criterion is that when **any** of the forms of violence described reach their **maximum degree, the highest level of global severity applies (4)**.

As stated in the introduction, the combination of the different types of violence is frequent, and it is clear that psychological violence is inherent to the rest of the manifestations of domestic violence. The most serious combination is that of physical and sexual violence: if both are at an average level, it means that global severity index 4 (maximum) has been reached.

In global terms, the severity level of domestic violence increases when:

- the victim has a disability
- there was violence during pregnancy

2.- Duration of the domestic violence problem

This is an indicator of the **chronicity** of domestic violence, so it also provides important information about the **gravity** of the problem. The key criterion will be the time during which the victim has suffered violence from her couple, even if it was not in the same relationship. In other words, if a woman says that her current couple has been violent for a few months, but adds that her previous couple also abused her, the length of the previous situation will be summed to the current one in order to obtain a more realistic record of the duration of this person's domestic violence problem. Violence is recorded according to the following table:

≤6 months	6-24 months	2-5 years	5-10 years	≥ 10 years
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It expresses, in years, the age of the first manifestation of couple violence. This item complements the previous one. It is an indicator of the chronicity of the problem, and also indicates the start of the woman's victimization in the relationship.

3. Subjective experience of the problem by the patient

3.1.- Intensity of subjective suffering

This item refers to the **subjective suffering expressed** by the victim due to the violence exercised by her couple. This suffering must be verbalized by the woman or expressed via her gestures and/or behavior. It is possible for these two levels (verbal and non-verbal) to show discrepancies; in such cases, suffering expressed in one level (for instance, verbal) will be coded even if the other does not match. Given that the victims of domestic violence tend to **minimize**

the problem, and dissociative mechanisms are common, this may be a difficult item to assess, since the woman's account may seem flat and "detached" from her emotions. However, special attention must be paid to the restrictions that the woman perceives in her daily life and how she adapts to them (i.e., she does not visit her relatives), as this may be related to her **fear** of her couple and to the potential consequences of challenging his coercive control. This is an indicator of couple abuse.

The non-expression of subjective suffering resulting from violence is an indicator of the adaptation mechanisms that characterize the victims of domestic violence, and which have to do with their difficulties to register their own suffering; thus, it is clinically very relevant to focus on this item to plan the victim's treatment.

Gradation and examples	
Level 0 Absent/barely present	This level is characterized by an absence of signals of suffering and few or no limitations due to violence. This level is also used for women who, due to their minimization or denial of violence, or as a result of dissociative mechanisms, do not express any subjective suffering. Example: A woman describes an episode of violence in which her couple punched her on the back and dragged her across the floor, but does so as if she did not care, and is more concerned about the fact that he may be having an affair.
Level 2 Intermediate	The patient states that she has suffered or is suffering due to the domestic violence that she has experienced or is experiencing and its resulting limitations. Example: A woman who has been chronically abused in her marriage is deeply moved while she gives her report, cries when she describes the cycle of abuse in which she has been caught, mentions things she no longer does due to fear or because she feels that she is unable to, and expresses her suffering through her gestures. Another woman says that she has not visited her sister for years for fear of her couple, who forbids her to do so. She also describes situations of grave physical abuse, but does not express her suffering non-verbally.
Level 4 Very high	This level is reached when the woman is intensely affected by the situation of violence, due to either fear or pain. Anguished, she says that she needs help, although she may feel hopeless at the same time. Example: A woman finds it difficult to speak during the interview, expresses her desperation or pain both verbally and non-verbally, and says that she has considered killing herself and her children -- she cannot take it anymore. Or, for instance, a woman says that she would be willing to enter a home for victims of domestic violence.

3.2.- Presentation of complaints about couple violence

This item refers to the degree to which the woman speaks spontaneously about the situation of violence she is experiencing, or, rather to how much information regarding the violent acts she provides the interviewer when he or she asks her about them. It is relevant to assess the level of attention that the woman pays to the situation of violence, the degree to which she describes the abuse, and the evolution of the problem through the couple's history.

The space taken by these representations in the victim's account is an indicator of the importance that the woman ascribes to the problem and to the connection she observes between her distress and violence.

Gradation and examples	
Level 0 Absent/barely present	While presenting her complaints or reasons for requesting help, the woman does not refer to the situations of violence, or does so minimally and superficially. Example: A woman sent to a specialized center for domestic violence victims by the court, due to a situation of physical violence involving her husband, detailedly describes a set of conflicts connected to her husband's family. When asked about the violent acts, she answers that her husband does not defend her, and that it is all her mother-in-law's fault, but she does not focus on the physical violence episode --she barely mentions it.
Level 2 Intermediate	This level must be chosen when the woman devotes a considerable part of the interview to describing the situations of violence that she has experienced. The interviewer does not need to be very active to clarify these situations. Example: A woman gives the interviewer extensive information about her history of couple violence and the different manifestations of abuse that she has experienced: "I've gone through a lot of abuse... both physical and verbal, at the beginning it was psychological abuse, humiliations, then came the blows, he even broke my nose". The patient also refers to other topics: she talks about her childhood or her housing problems, but when the interviewer focuses on violence, she returns to the issue and gives him or her more information.
Level 4 Very high	This level is recommended when references to the situations of violence dominate the interview. The woman enumerates and describes the mistreatments in depth, without requiring the interviewer's influence, and labels them acts of violence or abuse. Everything seems to revolve around the abuse as she barely mentions other subjects. Example: In the clinical interview, when asked about her reasons to seek help, a woman says that she came because of the situation of violence that she experienced in her relationship (she refers to "violence", "mistreatment", or "abuse"). When inquired about what the violent acts involved, she enumerates or describes manifestations of psychological, physical, and/or sexual abuse. She focuses her account on these experiences, and although she touches upon other subjects, she always returns to her domestic violence situation.

4.- Personal concept or explanation of the domestic violence problem

This element refers to the reasons the woman provides to **explain herself or others** why she is currently experiencing or has experienced couple violence. It includes the theories or concepts that the woman has about her problem; in a way, it answers the questions: why do you think this situation has occurred? or, how can you explain this problem, what do you ascribe it to? It involves a **causal attribution** of the violence or abuse. Reasons can be oriented to **external motives**, that is, to other problems of the environment or of her couple which may "explain the violence" (for instance, the consumption of alcohol); also, there may be a causal orientation that will be referred to as **relational or psychological**, which attempts to explain violence through the characteristics of the relationship and/or of its members, their personal history, and the role that she plays in the relationship.

4.1.- Oriented towards external factors

Gradation and examples	
Level 0 Absent/barely present	Regarding her explanation of the domestic violence she is experiencing, the woman does not refer to external causes, or does so to a minimum degree. Example: When asked about the reasons of this couple violence problem, she says she does not know, attributes it to the internal characteristics of the relationship: "I'm very shy and he has a strong personality", or tends to seek an explanation in herself and her weaknesses: "I always wonder what it is that I've done wrong". External elements, such as an overload of social

	problems or her husband's alcoholism are not mentioned, and when she is asked about them, she brushes them aside or says they are unimportant.
Level 2 Intermediate	An intermediate level should be considered when the domestic violence victim includes at least one external element, neither psychological or relational, in her explanation of the problem, even if she does not regard it as essential. Also, admitting or hinting at the influence of these factors should prompt the selection of this level. Example: A woman explains the domestic violence that she has experienced in her relationship through cultural factors: "in my family this was something usual... I thought that this was what women had to bear with". Second example: A woman believes that her permanence in a violent relationship has been influenced by factors such as economic dependence and housing problems, and states that her couple's excessive alcohol intake has fostered domestic violence.
Level 4 Very high	The maximum level is reached when the woman explains the violence she is experiencing, or her long-term permanence in the relationship, mostly through external and social factors, without considering personal psychological variables or the characteristics of the relationship. Example: A woman states that she would not be experiencing this violence if she had a job, and thinks that she would not have been abused if she were a professional and had money; she does not mention other possible factors such as fear or attachment to her couple.

4.2.- Oriented towards relational or personal psychological factors

Gradation and examples	
Level 0 Absent/barely present	The woman has no theories about why she has been subjected to violence and tends to describe facts without attempting to understand them, or provides explanations that do not refer to herself or her participation in an abusive relationship. However, she may attempt to explain the events on the basis of the assailant's characteristics. Example: A woman describes her husband's physical abuse and says that "he does it when he drinks" or "he's like that because his father was the same", but does not reflect on her own role in the situation that she is experiencing.
Level 2 Intermediate	The woman is capable of incorporating one or more elements that involve characteristics of her own or of her past experience to explain the domestic violence that she has been subjected to. Example: A woman states that she thinks that she has always had a self-esteem problem and that it has led her to "tolerate lots of things" in the relationship. Second example: A woman explains the violence by describing her abusive relationship with her couple: "I think he's taken advantage of me, because whenever he got mad, he left me without lunch money... and I was afraid of him, so I didn't dare stand up to him"
Level 4 Very high	This level applies when the woman manages to refer to the domestic violence that she has experienced in a clear way, including herself in it, and focusing on personal psychological factors and on the characteristics of the relationship. Example: Explanations focused on personal problems: "I was born into a violent family, I didn't learn to value myself, just like my mom" or "I think that, like other women who experience violence we have given up our will, not really for love, but for fear or for feeling unable to do things alone."

5.- Concept of change

The victim's personal concept of change has to do with what she thinks that she *would need to* put an end to the situation of violence that she is experiencing. It is **connected to her personal concept or explanation of the problem** --to how she explains the domestic violence she has to withstand-- and influences how she thinks that she could stop it, that is, what could be done to change her situation. The person's concept of change can be oriented towards **external aspects**, such as legal measures, work or financial reasons and/or towards **more internal or**

psychological aspects of the victim and her violent relationship. These reasons for change can present themselves **combined**, or one may **predominate** over the other.

5.1.- Oriented towards external changes or measures

Gradation and examples	
Level 0 Absent/barely present	This level applies when the victim of violence does not think that external, social, or legal measures can be useful, does not mention them spontaneously, or does not assign them any importance if the interviewer suggests them. This position may signal that the woman believes that change in her situation depends on internal or personal changes, that she feels hopeless and sees no way out, or that there is resistance against measures of this type (perception of inefficiency of external measures). Example: An abused woman does not consider the possibility of denouncing the situation because she does not think it will be useful. When she is suggested to get in contact with her close ones, she also dismisses this, saying that it would not help because her couple does not fear justice or respect her family, so she would just be in more trouble.
Level 2 Intermediate	This category applies when the victim considers that external measures or certain parts of her environment are necessary to overcome the domestic violence situation that she is inserted in. She may not believe that the whole of the change must rely on these aspects, but she regards them as necessary and actively supports them. Example: A woman seeks psychological help to cope with the domestic violence that she has experienced for several years. She says that this type of help will be very important to overcome her problem, but she also asks for information about her rights and points out that she has considered filing a lawsuit to get protective measures.
Level 4 Very high	This level applies when the woman's only hope is that changes occur in her environment (including her couple) and that external measures (social or legal) put an end to violence. She does not consider receiving therapeutic support as part of her idea of change. Example: A woman asks for her husband to be seen by a doctor, or says that "somebody must speak to him", because she wants "him to change". Second example: A woman says that if she could get a job or receive economic support of some sort to buy or rent a place to live, her problem would be solved, because she would be independent from her couple; however, she does not consider the psychological aspects of her dependency on him. Third example: A woman who sets all her hopes of change on legal measures "that will expel him from the house", even when this has already happened and she has not been able to sustain such measures.

5.2.- Oriented towards personal aspects

This item refers to the degree to which the victim of domestic violence has the psychological openness to reflect on her situation and to see herself as part of the interactional explanations of the abusive relationship, as well as of its solution.

Gradation and examples	
Level 0 Absent/barely present	Level 0 applies when the woman does not think that personal changes, such as increasing her confidence or taking decisions, are really important or necessary to overcome couple violence. Example: A woman refers to external measures only, such as that her husband be expelled from the house, getting a new house and moving there, that he be forced to receive treatment, etc., but she does not consider getting psychological support, or does not show that she can see herself as a member of the violent relationship.
Level 2 Intermediate	At the intermediate level, the victim of violence includes herself in her concept or explanation of domestic violence. She may not have a clear idea of what she needs, but says that she knows that personal work, along with social or legal measures can help her escape or overcome the situation of violence that she is immersed in. Example: A woman states "I don't know why it's been so hard for me to divorce him... in spite of all that I always come back to him... I don't know if it's affective dependence... but I have to pay

	attention to that". Another woman says "I think that denouncing him is not enough, I have to be stronger, I need to believe again, I need to value myself, love myself more".
Level 4 Very high	The maximum level applies when the woman does not only think that certain personal aspects can help her overcome the situation of violence, but also has given thought to the matter and knows what she must change to escape the violence she is subjected to: she is present in the solution in a concrete manner. Example: "I've thought hard about this, and it's shocking to see that I've lived this way for so long. I think it has to do with my self-esteem... and with having grown up in a family where abuse was common... I have to regain my health to keep going, I have to take my own decisions, overcome fear... that's why I came to this center". Second example: "I realize it's not just him... he got used to my obedience... I find it hard to say what I think, to say no, it's not just when I'm with him, but I'm learning."

6.- Change: resources and obstacles

The following items are aimed at **assessing**, first, the **internal and external (environmental) resources** that a victim of couple violence has for stopping the violence or overcoming the problem. Their objective is to evaluate the resources and their current **degree of availability** (in the last six months), which involves exploring the **woman's perception** of her possession of such resources, and her ability of using them. Their second goal is to estimate the **level of the obstacles, both internal and external**, that keep the woman from generating changes in the situation of violence and hinder her escape from it.

6.1.- Overcoming violence: internal resources

Internal resources include the healthy and adaptive capabilities and behaviors that allow the victim of violence to deal with her situation in an active, flexible, and constructive way. They are a measure of how she, in spite of her limitations, manages to cope with stressors and overloads in her daily life --they include everything that she does that helps her. Her level of psychological openness, along with her reflective and mental preparation capabilities are also regarded as part of her personal resources.

Gradation and examples	
Level 0 Absent/barely present	This level should be chosen when it is very difficult to visualize personal resources in the victim that can help her deal with the situation. Example: A woman with strong feelings of helplessness and hopelessness sees no alternatives to improve her situation, possesses no areas of personal development (such as getting a job), perceives no help networks or discards them, and is not fully aware of the risks that she and her children run in the violent relationship. She resists psychosocial or legal interventions, or is or is minimally receptive to them.
Level 2 Intermediate	A woman has an intermediate level of personal resources when at least certain personal areas are maintained or in development, and/or when she makes an effort to solve her problems actively. Example: A woman with a history of chronic couple abuse manages to keep a job that is a source of income and of personal and social development. Second example: A woman dares to denounce her situation of violence and joins a support group. She values this change and reflects on the possibility of a better future for her and her children.
Level 4 Very high	This level applies when the woman has a wide range of internal resources to deal with her problem and, despite the adverse conditions that she may encounter, sees life in a positive light and activates behaviors that support her wellbeing. She has well-developed emotional and social capabilities,

	<p>which makes it easier for her to construct support networks.</p> <p>Example: A woman, despite her history of domestic violence, has managed to go to school and complete her secondary education, which is a source of self-esteem and empowerment for her. She has also developed significant social relationships and reciprocal support bonds. During the interview, she establishes a genuinely cooperative contact with the interviewer, is willing to reflect on her problem and tries to understand it.</p>
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6.2.- Overcoming violence: internal obstacles

This item refers to the maladaptive mechanisms and behaviors derived from the victim's structure or intra-psychic conflicts. It includes cognitive and emotional limitations, risk behaviors, maladaptive defensive mechanisms (for instance, an extreme dissociation that does not allow her to protect herself), a poor affective regulation, and the risk of violent actions against herself or others.

Gradation and examples	
<p>Level 0 Absent/barely present</p>	<p>No relevant internal obstacles present.</p> <p>Example: A woman has been subjected to couple violence and, as a result, is disempowered with respect to herself and feels rather isolated both emotionally and socially; however, she is eager to reflect on her problem, has a strong motivation, is receptive to institutional support, does not have a history of risk behaviors and, against all odds, has managed to protect her children adequately.</p>
<p>Level 2 Intermediate</p>	<p>Some internal obstacles can be identified, or at least a very relevant one.</p> <p>Example: A woman with a long history of domestic violence has denounced her problem to the police and the court, but has not accomplished any significant changes in her situation. An external exploration of the issue reveals that she has a major emotional dependence conflict which keeps her from requesting precautionary measures, but she is oblivious to this and tends to blame the institutions "because they didn't do anything for her". Second example: A woman is subjected to violence in a relationship in which she and her couple are heavy drinkers. She started some treatments but promptly dropped out of them.</p>
<p>Level 4 Very high</p>	<p>The maximum level of internal obstacles applies when a series of very relevant personal obstacles are observed.</p> <p>Example: A woman provides a very confusing account of her violence problem, and when asked to clarify some points, she becomes hostile and discredits the interviewer, thus revealing a type of aggressive and maladaptive type of relationship with others. Her account also displays her negligence in the care of her children, along with a history of self-mutilation and two grave suicide attempts.</p>

6.3.- External resources for change

This item focuses on the external or environmental resources that the victim has, expressed through the **availability and use of primary and/or secondary support networks**. Social backing may consist in **instrumental** support, which includes practical aspects such as having close neighbors or a nearby police station in case of an episode of violence, and in **emotional support**, which includes the affection or help of someone who can share the victim's overload verbally and emotionally. Resources are evaluated considering their objective existence and the victim's subjective perception of them.

Gradation and examples	
Level 0 Absent/barely present	It is not possible to identify any instrumental or emotional resources in the woman's social environment. Example: A woman who lives in a rural area, with no neighbors, health centers, or police stations nearby, cannot contact her relatives, who live in another region, because of her couple. She has three children under ten years of age, and is devoted to their care.
Level 2 Intermediate	A woman is considered to have an intermediate level of external resources when it is possible to identify some instrumental and/or emotional resources, however scarce, or if the woman cannot perceive or use them efficiently. Example: A woman participates in her local church and feels accompanied and appreciated due to her social work. She also participates in activities at her children's school. These are the only relationships that she has apart from her husband and children, but she has never mentioned her violence problem because she does not want to be judged and does not think that anyone can help her.
Level 4 Very high	This level applies when there are several external resources and protective factors which the woman is able to use to deal with her problem. Example: A woman who is able to work because her mother helps her care for her children. She is experiencing couple violence but her coworkers are aware of it and support her legal actions. She has already filed a lawsuit and there is an ongoing trial about her couple's behavior.

6.4.- External obstacles to change

This item refers to the objective external stressors that make it difficult for the victim to deal with her problem and overcome the domestic violence situation. These external obstacles include, for instance, economic dependence, a lack of social support networks, having to bring up young children, etc.

Gradation and examples	
Level 0 Absent/barely present	No relevant external obstacles present. Example: A woman requests psychological support at a center for victims of domestic violence and joins a therapeutic group. She has a steady job and two adult sons who still live with her. As a precautionary measure, the court has requested her husband to leave the house, which he has already done. There are familial and social networks available.
Level 2 Intermediate	There are moderate or isolated external obstacles, which can be solved. Example: A woman has decided to separate from her couple, and has denounced him for domestic violence, but she is worried because she has underage children and her salary is not enough to cover all her expenses. She fears that her couple will not give her money to support their children, so she is referred to the court for family matters to obtain child support from him.
Level 4 Very high	There are major external obstacles in the victim's situation. Example: A woman is subjected to serious domestic violence by her couple, who takes drugs and is unemployed. They have two school-age children and a baby, and her only family contact is a brother with whom she can seldom talk. The rest of her family live in the south of the country.

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Valdez-Santiago, R., Hjar Medina, M., Salgado, N., Rivera-Rivera, L., Avila Burgos, L., Rojas, R. (2006) “Escala de Violencia e Índice de Severidad: Una propuesta metodológica para medir violencia intrafamiliar en mujeres mexicanas”, Salud Pública México V.48 Sept. 2

4. Domestic violence module Scoring Form

Objective assessment of Domestic Violence Problem

1.- Type and severity of violence	0	1	2	3	4	9
Emotional						
Physical						
Sexual						
Global Severity Index						

2. – Duration of domestic violence problem Age at first episode _____

≤6 months	6-24 months	2-5 years	5-10 years	≥ 10 years
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Subjective experience, presentation of the problem and personal concept

3.- Intensity of subjective suffering	0	1	2	3	4	9

4.- Presentation of complaints on DV	0	1	2	3	4	9

5.- Personal explanation of DV	0	1	2	3	4	9
Oriented to external causes						
Oriented to psychological/interpersonal causes						

6. - Change concept	0	1	2	3	4	9
Oriented to external modifications						
Oriented to personal changes						

7. - Personal resources and obstacles to change	0	1	2	3	4	9
Personal resources						
Personal obstacles						
External resources						
External obstacles						

5. Child Experience of Care and Abuse Questionnaire (Smith, N., Lam, D., Bifulco, A. & Checkely, S. (2002).
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Spanish adaptation (Avarez, Crempien, Castillo, Ceric, 2009; unpublished)

CECA – Q

RELACIONES CON LA FAMILIA DURANTE LA INFANCIA

Este cuestionario se refiere a varios aspectos de su infancia.
Estamos interesados tanto en las experiencias típicas como en
las atípicas.
Le agradecemos por contestar todas las preguntas acerca de

Sexo: ___Masculino ___Femenino

Edad actual: _____años

Fecha hoy: _____
(día/mes/año)

1. ¿Con quien se crió hasta antes de los 17 años?

Marque a las personas que lo cuidaron en su infancia por lo menos durante un año o más.

Marque todos los que correspondan.

Figura(s) materna(s)	Figura(s) paterna(s)
0. Madre biológica, natural	0. Padre biológico, natural
1. Madrastra	1. Padrastro
2. Una pariente	2. Un pariente
3. Amigo de la familia (incluyendo a la madrina)	3. Un amigo de la familia (incluyendo al padrino)
4. Madre sustituta	4. Padre sustituto
5. Madre adoptiva	5. Padre adoptivo
6. Otra persona.....	6. Otra persona.....

¿Estuvo alguna vez en un hogar para niños u otra institución semejante antes de los 17 años?
(encierre en círculo) **SI / NO**

En caso de que la respuesta sea SI, ¿cuánto tiempo estuvo allí en total? _____ años

2. Pérdida de padre o madre antes de los 17 años

	MADRE	PADRE
¿Alguno de sus padres murió antes de que usted cumpliera los 17 años?	SI / NO	SI / NO
En caso de que sí hubiera muerto ¿Qué edad tenía usted?	Edad___	Edad___
¿Alguna vez vivió separada de alguno de sus padres durante un año o más antes de los 17 años?	SI / NO	SI / NO
Si hubo separación ¿A qué edad empezó ese período de separación?	Edad___	Edad___
¿Cuánto tiempo duró la separación?	___ años	___ años
¿Cuál fue la razón de esa separación? (encierre en un círculo)	1. Enfermedad	1. Enfermedad
	2. Trabajo	2. Trabajo
	3. Divorcio o separados	3. Divorcio o separados
	4. Nunca conocí a mi madre	4. Nunca conocí a mi padre
	5. Abandono	5. Abandono
	6. Otra razón	6. Otra razón

Por favor, describa cómo reaccionó Usted a estos eventos

3. Al recordar a su figura materna durante los primeros 17 años de su vida:

Por favor encierre en un círculo el número que incluye la respuesta más adecuada. Si tuvo más de una figura materna, escoja aquella con la que vivió durante más tiempo o con la que tuvo más dificultades.

¿QUÉ FIGURA MATERNA ESTÁ USTED DESCRIBIENDO EN LAS SIGUIENTES ORACIONES?

1. Madre biológica
2. Madrastra o conviviente
3. Otra pariente, por ejemplo tía, abuela.
4. Otra mujer, no pariente, por ejemplo madre sustituta, madrina
5. Otra persona (indique quién)

Respecto de la persona elegida, encierre el número que representa mejor la afirmación. Por ejemplo, 5 cuando está definitivamente de acuerdo con la oración y 1 cuando definitivamente no está de acuerdo.

	SI, definitivamente	No estoy segura		NO, definitivamente No	
1. Era muy difícil complacerla.	5	4	3	2	1
2. Se preocupaba por mis inquietudes	5	4	3	2	1
3. Se interesaba en cómo me iba en la escuela	5	4	3	2	1
4. Me hizo sentir que no me quería	5	4	3	2	1
5. Trataba de que me sintiera mejor si yo estaba alterada	5	4	3	2	1
6. Siempre me estaba criticando	5	4	3	2	1
7. Me dejaba sola (sin un adulto responsable) antes de cumplir los 10 años	5	4	3	2	1
8. Generalmente tenía tiempo para hablar conmigo	5	4	3	2	1
9. A veces me hacía sentir que yo era una molestia.	5	4	3	2	1
10. A veces me provocaba sin razón alguna.	5	4	3	2	1
11. Podía contar con ella si la necesitaba.	5	4	3	2	1
12. Se interesaba en quienes eran mis amigos.	5	4	3	2	1
13. Se preocupaba por saber dónde andaba yo.	5	4	3	2	1
14. Me cuidaba si estaba enferma.	5	4	3	2	1
15. Ella era descuidada con mis necesidades básicas (alimento, ropa)	5	4	3	2	1
16. Ella me quería menos que a mis hermanos o hermanas (no conteste si no tuvo hermanos)	5	4	3	2	1

¿Desea añadir algo acerca de su madre? _____

4. **Al recordar a su figura paterna durante los primeros 17 años de su vida:** Por favor encierre en un círculo el número de la respuesta más adecuada. Si tuvo más de una figura paterna, escoja la persona con la que vivió durante más tiempo o con quien tuvo más dificultades.

¿QUÉ FIGURA PATERNA ESTÁ USTED DESCRIBIENDO EN LAS SIGUIENTES ORACIONES?

Padre biológico

1. Padrastro o conviviente
2. Otro pariente, por ejemplo tío, abuelo.
3. Otro hombre, no pariente, por ejemplo padre adoptivo, sustituto, padrino
4. Otra persona (indique quién) _____

	Definitivamente Si	No estoy segura		Definitivamente No	
1. Era muy difícil complacerlo.	5	4	3	2	1
2. Se preocupaba por mis inquietudes	5	4	3	2	1
3. Se interesaba en cómo me iba en la escuela	5	4	3	2	1
4. Me hizo sentir que no me quería	5	4	3	2	1
5. Trataba de que me sintiera mejor si yo estaba alterada.	5	4	3	2	1
6. Siempre me estaba criticando.	5	4	3	2	1
7. Me dejaba sola (sin un adulto responsable) antes de cumplir los 10 años	5	4	3	2	1
8. Generalmente tenía tiempo para hablar conmigo	5	4	3	2	1
9. A veces me hacía sentir que yo era una molestia	5	4	3	2	1
10. A veces me provocaba sin razón alguna.	5	4	3	2	1
11. Podía contar con él si lo necesitaba.	5	4	3	2	1
12. Se interesaba en quienes eran mis amigos.	5	4	3	2	1
13. Se preocupaba por saber dónde andaba yo.	5	4	3	2	1
14. Me cuidaba si estaba enferma.	5	4	3	2	1
15. Él era descuidado con mis necesidades básicas (alimento, ropa)	5	4	3	2	1
16. Él me quería menos que a mis hermanos o hermanas (no conteste si no tuvo hermanos)	5	4	3	2	1

¿Desea añadir algo acerca de su padre? _____

5.- Relaciones estrechas durante su infancia

(Por favor, marque sus respuestas con un círculo)

Cuando era niña o adolescente ¿Había algún ADULTO a quien Usted podía acudir si tenía algún problema o hablar de cómo se sentía? **SI / NO**

En caso afirmativo ¿Quién era esa persona? (marque con círculo más de una persona si ese fue su caso)

1. Madre, figura materna
2. Padre, figura paterna
3. Otro pariente
4. Amigo(a) de la familia
5. Profesor(a), sacerdote, vecino, etc.
6. Otra persona, describa quién _____

¿Desea comunicar algo acerca de esa (s) relación (es)? _____

Durante su infancia o adolescencia, ¿había otros NIÑOS O ADOLESCENTES con quienes Usted podía hablar de sus problemas o sus sentimientos? **SI / NO**

En caso afirmativo ¿Quién era esa persona? (marque con círculo más de una persona si ese fue su caso)

1. Hermana
2. Hermano
3. Otro pariente (primo, etc.)
4. Un amigo o amiga cercano(a)
5. Otros amigos menos cercanos a mí
6. Otra persona, descríbala _____

Con qué personas consideraría que tuvo una relación más estrecha cuando Ud. era niña o adolescente (puede marcar hasta dos personas)

1. Madre-figura materna
2. Padre-figura paterna
3. Hermana o hermano
4. Otro pariente
5. Amigo o amiga de la familia (adulto)
6. Un amigo o amiga de su edad
7. Otra persona, describa _____

¿Desea comentar algo acerca de estas relaciones?

6. Castigos físicos antes de cumplir los 17 años por parte de una figura parental o de otra persona que vivía en la casa.

Cuando era niña o adolescente ¿alguien que vivía en su casa la golpeaba repetidamente con algún objeto (cinturón, palo, etc.) o le daba puñetazos, patadas o la quemaron por castigo?

SI / NO

En caso de que la respuesta sea NO, proceda a la pregunta 7 en la página siguiente.

Si la respuesta es SI, por favor complete las siguientes preguntas:

	Figura materna	Figura paterna
¿Qué edad tenía usted cuando comenzaron esos castigos físicos?	Edad ____	Edad ____
¿La golpearon en más de una ocasión?	SI / NO	SI / NO
¿Cómo la golpearon?	1. Cinturón o palo 2. Puñetazos, patadas 3. Palmadas 4. Otra forma	1. Cinturón o palo 2. Puñetazos, patadas 3. Palmadas 4. Otra forma
¿Resultó lesionada alguna vez? Por ejemplo, con moretones, ojo morado, huesos rotos.	SI / NO	SI / NO
La persona que la golpeó, ¿parecía tan enojada que había perdido el control?	SI / NO	SI / NO

¿Puede describir estas experiencias?

¿Alguien más en la casa la trató de esa manera? **SI / NO**

En caso afirmativo, por favor descríbalo

7. Experiencias sexuales no deseadas antes de cumplir los 17 años

(Por favor, encierre en un círculo la respuesta que corresponda)

Cuando era niña o adolescente ¿tuvo alguna vez una experiencia sexual no deseada?

SI / NO / NO ESTOY SEGURA

¿Alguien la forzó o la convenció a tener una relación sexual (penetración) contra su voluntad antes de cumplir los 17 años?

SI / NO / NO ESTOY SEGURA

¿Puede recordar algún tipo de experiencia sexual perturbadora con un adulto, antes de los 17 años, ya sea pariente o alguien en posición de autoridad, por ejemplo un profesor?

SI / NO / NO ESTOY SEGURA

Si contestó NO, pase a la página siguiente.

Si contestó SI o NO ESTOY SEGURA, por favor conteste a las siguientes preguntas:

	Primera experiencia	Otra experiencia
¿Qué edad tenía Usted cuando esto comenzó?	Edad_____	Edad_____
La persona que hizo esto, ¿era alguien que Usted conocía?	SI / NO	SI / NO
La persona ¿era un pariente?	SI / NO	SI / NO
La persona ¿vivía en la casa de Usted?	SI / NO	SI / NO
Esta persona ¿le hizo tales cosas a Usted en más de una ocasión?	SI / NO	SI / NO
¿La experiencia incluyó tocar las partes privadas de su cuerpo?	SI / NO	SI / NO
¿Incluyó el que Usted tocara las partes privadas de esa persona?	SI / NO	SI / NO
¿Hubo relación sexual, es decir, coito (penetración)?	SI / NO	SI / NO

Gracias por responder a estas preguntas. Sabemos que es difícil dar una descripción exacta de sus experiencias infantiles tales como sucedieron a través de un cuestionario. Por eso, si hay algún comentario o algo que quisiera añadir, por favor escríbalo en esta hoja. Se guardará la confidencialidad de sus respuestas.

6. Beck Depression Inventory (BDI-II) (Beck, Steer & Brown, 1996)

Spanish version

Por favor lee con atención cada una de las afirmaciones.

Señala cuál describe mejor cómo te has sentido **DURANTE LAS DOS ÚLTIMAS SEMANAS INCLUYENDO HOY.**

Marca con una X la afirmación que elegiste.

1	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	No me siento triste habitualmente. Me siento triste gran parte del tiempo. Me siento triste continuamente. Me siento tan triste o tan desgraciado que no puedo soportarlo
2	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	No estoy desanimado sobre mi futuro. Me siento más desanimado sobre mi futuro que antes. No espero que las cosas me salgan bien. Siento que mi futuro es desesperanzador y que las cosas sólo empeorarán.
3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	No me siento fracasado. He fracasado más de lo que debería. Cuando miro atrás, veo fracaso tras fracaso. Me siento una persona totalmente fracasado
4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Disfruto tanto como antes de las cosas que me gustan. No disfruto de las cosas tanto como antes. Obtengo muy poco placer de las cosas con las que antes disfrutaba. No obtengo ningún placer de las cosas con las que antes disfrutaba.
5	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	No me siento especialmente culpable. Me siento culpable de muchas cosas que he hecho o debería haber hecho. Me siento bastante culpable la mayor parte del tiempo. Me siento culpable constantemente.
6	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	No siento que esté siendo castigado. Siento que puedo ser castigado. Espero ser castigado. Siento que estoy siendo castigado
7	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	Siento lo mismo que antes sobre mí mismo. He perdido confianza en mí mismo. Estoy decepcionado conmigo mismo.

	3 <input type="checkbox"/>	No me gusto.
8	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No me critico o me culpo más que antes. Soy más crítico conmigo mismo de lo que solía ser. Me critico por todos mis defectos. Me culpo a mi mismo por todo lo malo que sucede.
9	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No tengo ningún pensamiento de suicidio. Tengo pensamientos de suicidio, pero no los llevaría a cabo. Me gustaría suicidarme. Me suicidaría si tuviese la oportunidad
10	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No lloro más de lo que solía hacerlo. Lloro más de lo que solía hacerlo. Lloro por cualquier cosa. Tengo ganas de llorar continuamente, pero no puedo.
11	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No estoy más inquieto o tenso que de costumbre. Me siento más inquieto o tenso que de costumbre. Estoy tan inquieto o agitado que me cuesta estar quieto. Estoy tan inquieto o agitado que tengo que estar continuamente moviéndome o haciendo algo.
12	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No he perdido el interés por otras personas o actividades. Estoy menos interesado que antes por otras personas o actividades. He perdido la mayor parte de mi interés por los demás o por las cosas. Me resulta difícil interesarme en algo.
13	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	Tomo decisiones como siempre. Tomar decisiones me resulta más difícil que de costumbre. Tengo mucha más dificultad en tomar decisiones que de costumbre. Tengo problemas para tomar cualquier decisión.
14	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No me siento inútil. No me considero tan valioso y útil como solía ser. Me siento inútil en comparación con otras personas. Me siento completamente inútil.
15	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/>	Tengo tanta energía como siempre. Tengo menos energía de la que solía tener. No tengo suficiente energía para hacer muchas cosas.

	3 <input type="checkbox"/>	No tengo suficiente energía para hacer nada.
16	0 <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2a <input type="checkbox"/> 2b <input type="checkbox"/> 3a <input type="checkbox"/> 3b <input type="checkbox"/>	No he experimentado ningún cambio en mi patrón de sueño. Duermo algo más de lo habitual. Duermo algo menos de lo habitual. Duermo mucho más de lo habitual. Duermo mucho menos de lo habitual. Duermo la mayor parte del día. Me despierto 1 ó 2 horas más temprano y no puedo volver a dormirme.
17	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No estoy más irritable de lo habitual. Estoy más irritable de lo habitual. Estoy mucho más irritable de lo habitual. Estoy irritable continuamente.
18	0 <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2a <input type="checkbox"/> 2b <input type="checkbox"/> 3a <input type="checkbox"/> 3b <input type="checkbox"/>	No he experimentado ningún cambio en mi apetito. Mi apetito es algo menor de lo habitual. Mi apetito es algo mayor de lo habitual. Mi apetito es mucho menor que antes. Mi apetito es mucho mayor que antes. He perdido completamente el apetito. Tengo ganas de comer continuamente
19	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	Puedo concentrarme tan bien como siempre. No puedo concentrarme tan bien como habitualmente. Me cuesta mantenerme concentrado en algo durante mucho tiempo. No puedo concentrarme en nada.
20	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No estoy más cansado o fatigado que de costumbre. Me canso o fatigo más fácilmente que de costumbre. Estoy demasiado cansado o fatigado para hacer muchas cosas que antes solía hacer. Estoy demasiado cansado o fatigado para hacer la mayoría de las cosas que antes solía hacer.
21	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No he notado ningún cambio reciente en mi interés por el sexo. Estoy menos interesado por el sexo de lo que solía estar. Estoy mucho menos interesado por el sexo ahora. He perdido completamente el interés por el sexo

7. M.I.N.I. International Neuropsychiatric Interview ((Sheehan, Lecrubier, Harnett-Sheehan, Janavs, Weiller, Bonora, Keskiner, Schinka, Knapp, Sheehan & Dunbar, 1997)

Spanish version. Only the chapters used in the dissertation are included.

A. EPISODIO DEPRESIVO MAYOR

(SIGNIFICA: IR A LAS CASILLAS DIAGNÓSTICAS, CIRCULAR **NO** EN CADA UNA Y CONTINUAR CON EL SIGUIENTE MÓDULO)

A1	¿En las últimas dos semanas, se ha sentido deprimido o decaído la mayor parte del día, casi todos los días?	NO SI
A2	¿En las últimas dos semanas, ha perdido el interés en la mayoría de las cosas o ha disfrutado menos de las cosas que usualmente le agradaban?	NO SI
	¿MARCÓ SÍ EN A1 <u>O</u> EN A2?	NO <input type="checkbox"/> SÍ <input type="checkbox"/>

A3 En las últimas dos semanas, cuando se sentía deprimido o sin interés en las cosas:

- a** ¿Disminuyó o aumentó su apetito casi todos los días? **NO** **SI**
¿Perdió o ganó peso sin intentarLO, POR EJ. variaciones en el último mes de + 5% de su peso corporal ó + 8 libras ó + 3.5 kgr., para una persona de 160 libras/ 70 kgr.)? (marcar SÍ, SI CONTESTÓ SÍ EN ALGUNA)
- b** ¿Tenía dificultad para dormir casi todas las noches (dificultad para quedarse dormido, se despertaba a media noche, se despertaba temprano en la mañana o dormía excesivamente)? **NO** **SÍ**
- c** ¿Casi todos los días, hablaba o se movía usted más lento de lo usual, o estaba inquieto o **NO** **SÍ** *tenía dificultades para permanecer tranquilo?
- d** ¿Casi todos los días, se sentía la mayor parte del tiempo fatigado o sin energía? **NO** **SÍ**
- e** ¿Casi todos los días, se sentía culpable o inútil? **NO** **SÍ**
- f** ¿Casi todos los días, tenía dificultad para concentrarse o tomar decisiones? **NO** **SÍ**
- g** ¿En varias ocasiones, deseó hacerse daño, se sintió suicida, o deseó estar muerto? **NO** **SÍ**

¿MARCÓ SÍ EN 5 O MAS RESPUESTAS (A1-A3)?

NO	SÍ *
EPISODIO DEPRESIVO MAYOR ACTUAL	

SI EL PACIENTE MARCA **POSITIVO** PARA UN EPISODIO DEPRESIVO MAYOR ACTUAL CONTINUE CON A4, DE LO CONTRARIO CONTINUE CON EL MODULO B:

A4 a ¿En el transcurso de su vida, tuvo otros períodos de dos o más semanas, en los que **NO** se sintió deprimido o sin interés en la mayoría de las cosas y que tuvo la mayoría de los problemas de los que acabamos de hablar? **SÍ**

b ¿ Ha tenido alguna vez un período de por lo menos dos meses, sin la depresión falta de interés en la mayoría de las cosas y ocurrió este período entre dos episodios depresivos?

NO	SÍ	1
EPISODIO DEPRESIVO MAYOR Recidivante		

- Si el paciente tiene Episodio Depresivo Mayor Actual, marque SI en la pregunta correspondiente en la pagina 6.

B. TRASTORNO DISTÍMICO

(SIGNIFICA: IR A LAS CASILLA DIAGNÓSTICA, CIRCULAR **NO** Y CONTINUAR CON EL SIGUIENTE MÓDULO)

SI LOS SÍNTOMAS DEL PACIENTE ACTUALMENTE CUMPLEN CON LOS CRITERIOS DE UN EPISODIO DEPRESIVO MAYOR, NO EXPLORE ESTE MÓDULO

B1	¿En los últimos dos años, se ha sentido triste, desanimado o deprimido la mayor parte del tiempo?	<input type="checkbox"/>
		NO
		SÍ

B2 ¿Durante este tiempo, ha habido algún período de dos meses o más, en que se ha sentido bien?

NO **SÍ**

B3 Durante este período en el que se sintió deprimido la mayor parte del tiempo:

a ¿Cambio su apetito de una manera significativa cambio? **NO** **SÍ**

b ¿Tuvo dificultad para dormir o durmió en exceso? **NO** **SÍ**

- c ¿Se sintió cansado o sin energía? NO SÍ
- d ¿Perdió la confianza en sí mismo? NO SÍ
- e ¿Tuvo dificultades para concentrarse o para tomar decisiones? NO SÍ
- f ¿Se sintió desesperado? NO SÍ

¿MARCÓ SÍ EN 2 O MÁS RESPUESTAS DE B3?

NO SÍ

- B4 ¿Estos síntomas de depresión , le causaron gran angustia o han interferido con su función en el trabajo, socialmente o de otra manera importante? NO SI

¿MARCÓ SÍ EN B4?

I. ESTADO POR ESTRÉS POSTRAUMÁTICO

(SIGNIFICA: IR A LAS CASILLA DIAGNÓSTICA, CIRCULAR NO Y CONTINUAR CON EL SIGUIENTE MÓDULO)

- I1 ¿Ha vivido o ha sido testigo de un acontecimiento extremadamente traumático, en el cual otras personas han muerto y/o otras personas o usted mismo han estado amenazadas de muerte o en su integridad física? NO SÍ
- EJEMPLOS DE ACONTECIMIENTOS TRAUMÁTICOS: ACCIDENTES GRAVES, ATRACO, VIOLACIÓN, ATENTADO TERRORISTA, SER TOMADO DE REHÉN, SECUESTRO, INCENDIO, DESCUBRIR UN CADÁVER, MUERTE SÚBITA DE ALGUIEN CERCANO A USTED, GUERRA O CATÁSTROFE NATURAL.**
- I2 Reaccionó con un miedo intenso, desamparado ó horrorizado? NO SÍ
- I3 ¿Durante el pasado mes, ha revivido el evento de una manera angustiada (ej. lo ha soñado, ha tenido imágenes vívidas, ha reaccionado físicamente o ha tenido memorias intensas)? NO SÍ

I4 En el último mes:

- a ¿Ha evitado usted pensar o hablar de este acontecimiento? NO SÍ
- b ¿Ha evitado actividades, lugares o personas que le recuerden este acontecimiento? NO SÍ
- c ¿Ha tenido dificultad recordando alguna parte del evento? NO SÍ
- d ¿Ha disminuído su interés en las cosas que le agradaban o en las actividades sociales? NO SÍ
- e ¿Se ha sentido usted alejado o distante de otros? NO SÍ
- f ¿Ha notado que su estado emocional esta entumecido? NO SÍ
- g ¿Ha tenido la impresión de que su vida se va a acortar debido a este trauma o que va a morir NO SÍ

antes que otras personas?

¿MARCÓ SÍ EN 3 O MÁS RESPUESTAS DE I4?

NO SÍ

I5 Durante el último mes:

- a ¿Ha tenido usted dificultades para dormir? NO SÍ
- b ¿Ha estado particularmente irritable o le daban arranques de coraje? NO SÍ
- c ¿Ha tenido dificultad para concentrarse? NO SÍ
- d ¿Ha estado nervioso o constantemente alerta? NO SÍ
- e ¿Se ha sobresaltado fácilmente por cualquier cosa? NO SÍ

¿MARCÓ SÍ EN 2 O MÁS RESPUESTAS DE I5?

NO SÍ

I6 ¿En el transcurso de este mes, han interferido estos problemas en su trabajo, en sus actividades sociales, o han sido causa de gran ansiedad

NO	SÍ
ESTADO POR ESTRÉS POSTRAUMÁTICO ACTUAL	

J. ABUSO Y DEPENDENCIA DE ALCOHOL

(SIGNIFICA: IR A LAS CASILLAS DIAGNÓSTICAS, CIRCULAR NO EN CADA UNA Y CONTINUAR CON EL SIGUIENTE MÓDULO)

J1	¿En los últimos doce meses, ha tomado 3 ó más bebidas alcohólicas en un período de 3 horas en 3 ó más ocasiones?	<input type="checkbox"/>	
		NO	SÍ
		1	

J2 En los últimos doce meses:

a ¿Ha consumido mas alcohol para conseguir los mismos efectos que cuando usted comenzó a beber? NO SÍ
2

b ¿Cuando reducía la cantidad de alcohol, le temblaban sus manos, sudaba, o se sentía agitado? NO SÍ
3

¿Bebía para evitar estos síntomas o para evitar la resaca, (ej. temblores, sudores, o agitación)?
MARCAR SÍ, SI CONTESTÓ SÍ EN ALGUNA

c ¿Durante el tiempo en el que bebía alcohol, acababa bebiendo más de lo que en un principio había planeado? NO SÍ
4

d ¿Ha tratado de reducir o dejar de beber alcohol pero ha fracasado? NO SÍ
5

e ¿Los días en los que bebía, empleaba mucho tiempo en procurarse alcohol, en beber y en recuperarse de sus efectos? NO SÍ
6

f ¿Pasó menos tiempo trabajando, disfrutando de sus pasatiempos, o estando con otros, debido a su uso de alcohol? NO SÍ
7

g ¿Continuó bebiendo a pesar de saber que esto le causaba problemas de salud, físicos o mentales? NO SÍ
8

¿MARCÓ SÍ EN 3 Ó MAS RESPUESTAS DE J2?

* SI AFIRMATIVO, SALTAR PREGUNTAS J3, MARQUE UN CIRCULO N/A EN RECUADRO DE ABUSO Y PASAR AL SIGUIENTE TRANSTORNO (DEPENDENCIA Y ABUSO DE SUSTANCIAS).

NO	SÍ *
DEPENDENCIA DE ALCOHOL ACTUAL	

J3 En los últimos doce meses:

- a ¿Ha estado usted intoxicado, embriagado, o con resaca en más **NO SÍ**
9
de una ocasión, cuando tenía otras responsabilidades en la escuela, el trabajo o la casa? ¿Esto le ocasionó algún problema?
MARQUE SÍ, SOLO SI ESTO LE HA OCACIONADO PROBLEMAS
- b ¿Ha estado intoxicado en alguna situación en la que corría **NO SÍ**
10
un riesgo físico, (ej. conducir un automóvil, motocicleta, bote, utilizar una máquina, etc.)?
- c ¿Ha tenido problemas legales debido a su uso de alcohol, **NO SÍ**
11
ej. un arresto, perturbación del orden público?
- d ¿Ha continuado usted bebiendo a pesar de saber que esto le **NO SÍ**
12
ocasionaba problemas con su familia u otras personas?

¿MARCÓ SÍ EN 1 Ó MÁS RESPUESTAS DE J3?

NO	N/A	SÍ
ABUSO DE ALCOHOL ACTUAL		

**K. TRASTORNOS ASOCIADOS AL USO DE SUSTANCIAS PSICOACTIVAS
NO ALCOHÓLICAS**

(SIGNIFICA: IR A LAS CASILLAS DIAGNÓSTICAS, CIRCULAR NO EN CADA UNA Y CONTINUAR CON EL SIGUIENTE MÓDULO)

Ahora le voy a enseñar / leer una lista de sustancias ilícitas o medicinas.

- K1 a ¿En los últimos doce meses, tomó alguna de estas drogas, en mas de una ocasión, **NO**
para sentirse mejor o para cambiar su estado de ánimo? **SÍ**

CIRCULE TODAS LAS DROGAS QUE HAYA USADO:

Estimulantes: anfetaminas, “speed”, cristal, dexedrine, ritalina, píldoras adelgazantes.

Cocaína: inhalada, intravenosa, crack, “speedball”.

Narcóticos: heroína, morfina, Dilaudid, opio, Demerol, metadona, codeína, Percodan, Darvon.

Alucinógenos: LSD (ácido) mescalina, peyota, PCP (polvo de ángel, “peace pill”), “psilocybin”, STP, hongos, éxtasi, MDA, MDMA.

Inhalantes: pegamento, “éther”, óxido nitroso, (“laughing gas”), “amyl” o “butyl nitrate” (“poppers”).

Mariguana: hashish, THC, pasto, hierba, mota, “reefer”.

Tranquilizantes: Qualude, Seconal (“reds”), Valium, Xanax, Librium, Ativan, Dalmane, Halción, barbitúricos, “Miltown”
 Tranquimazin, Lexatin, Orfidal.
 Otras drogas: Esteroides , pastillas dietéticas o para dormir sin receta. ¿Cualquier otra droga?

ESPECIFIQUE LA DROGA (S) USADA MÁS A MENUDO:

SOLO UNA DROGA / CLASE DE DROGAS QUE HA SIDO UTILIZADA

SOLO LA CLASE DE DROGAS USADAS MÁS A MENUDO , SON REVISADAS.

CADA DROGA ES EXAMINADA INDIVIDUALMENTE. (FOTOCOPIAR K2 Y K3 SEGUN SEA NECESARIO)

b. SI EXISTE USO CONCURRENTENTE O SUCESIVO DE VARIAS SUSTANCIAS O DROGAS, ESPECIFIQUE QUE DROGA / CLASE DE DROGAS VA A SER REVISADA EN LA ENTREVISTA A CONTINUACIÓN: _____

K2 Considerando su uso de (NOMBRE DE LA DROGA / CLASE DE DROGAS SELECCIONADA), en los últimos doce meses,

a **¿Ha notado que usted necesitaba utilizar una mayor cantidad de (NOMBRE DE LA DROGA / CLASE DE DROGAS SELECCIONADA) para obtener los mismos efectos que cuando comenzó a usarla?** NO SÍ
1

b **¿Cuándo redujo la cantidad o dejó de utilizar (NOMBRE DE LA DROGA / CLASE DE DROGAS SELECCIONADA) tuvo síntomas de abstinencia? (dolores, temblores, fiebre, debilidad, diarreas, náuseas, sudores, palpitaciones, dificultad para dormir, o se sentía agitado, ansioso, irritable o deprimido)? Utilizó alguna droga (s) para evitar enfermarse (síntomas de abstinencia) o para sentirse mejor?** NO SÍ
2

MARCAR SÍ, SI CONTESTÓ SÍ EN ALGUNA

c **¿Ha notado que cuando usted usaba (NOMBRE DE LA DROGA / CLASE DE DROGAS SELECCIONADA) terminaba utilizando más de lo que en un principio había planeado?** NO SÍ

d **¿Ha tratado de reducir o dejar de tomar (NOMBRE DE LA DROGA / CLASE DE DROGAS SELECCIONADA) pero ha fracasado?** NO SÍ
4

d; Ha continuado usando (NOMBRE DE LA DROGA / CLASE DE DROGAS SELECCIONADA)
a pesar de saber que esto le causaba problemas con su familia u otras personas?

NO
SÍ

¿MARCÓ SÍ EN 1 Ó MÁS RESPUESTAS DE K3?

ESPECIFICAR LA DROGA(s):

NO N/A SÍ

**ABUSO DE
SUSTANCIAS
ACTUAL**

8. Battery of Multidimensional Cultural Questionnaires ((Freund et al, 2010)

Spanish adaptation Olhabery, Crempien, Biedermann, Martínez, Cruzat, Martínez, Krause, in press).

A continuación encontrará algunas preguntas relativas a diferentes temas, como cultura, familia, valores y normas.

Al inicio de cada nueva área temática encontrará una breve instrucción para completar las respuestas. Por favor lea atentamente las preguntas y responda de manera espontánea. No existen respuestas correctas ni incorrectas. Conteste todas las preguntas.

A continuación se realizarán algunas preguntas orientadas a su persona. Por favor haga una cruz en la respuesta que lo(a) represente.

Edad: _____ años

1 masculino

2 femenino

Estado civil actual:

1 soltero/a

4 separado/a (de hecho)

2 viviendo en pareja

5 divorciado/a (legalmente)

3 casado/a

6 viudo/a

Sí

No

En caso de que tenga hijos, por favor indique cuántos: _____

Nivel educacional alcanzado:

1 cursando educación escolar

5 educación técnica completa

2 educación escolar incompleta

6 educación universitaria completa

3 educación básica completa

4 educación media completa

¿Qué actividad desarrolla actualmente?

Por favor elija la alternativa que represente mejor su situación laboral (con excepción de licencia médica y pre- y postnatal)

1 <input type="checkbox"/> laboralmente activo (jornada completa)	06 <input type="checkbox"/> en formación/cambio de actividad
2 <input type="checkbox"/> laboralmente activo (media jornada)	07 <input type="checkbox"/> servicio militar
3 <input type="checkbox"/> laboralmente activo (ocasionalmente)	08 <input type="checkbox"/> cesante
4 <input type="checkbox"/> dueña de casa (sin actividad laboral)	09 <input type="checkbox"/> jubilado/a
5 <input type="checkbox"/> estudiante	10 <input type="checkbox"/> otro: _____

¿Cuánto es el ingreso mensual líquido de la totalidad de personas que conforman su hogar?

1 <input type="checkbox"/> menos de \$ 191.000	5 <input type="checkbox"/> entre \$ 715.000 y \$ 1.850.000
2 <input type="checkbox"/> entre \$ 191.000 y \$ 330.000	6 <input type="checkbox"/> más de \$ 1.850.000
3 <input type="checkbox"/> entre \$ 330.000 y \$ 480.000	
4 <input type="checkbox"/> entre \$ 480.000 y \$ 715.000	

¿En qué país nació?

1 <input type="checkbox"/> en Chile
2 <input type="checkbox"/> en otro país: _____

¿En caso que no haya nacido en Chile, hace cuántos años vive en este país?

¿De qué país proviene su madre?

1 <input type="checkbox"/> de Chile
2 <input type="checkbox"/> de otro país: _____

De qué país proviene su padre?

1 <input type="checkbox"/> de Chile
2 <input type="checkbox"/> de otro país: _____

¿En qué idioma se crió?

1 <input type="checkbox"/> castellano
2 <input type="checkbox"/> otro idioma: _____
3 <input type="checkbox"/> castellano y el otro idioma

¿Cuál es la nacionalidad que indica su cédula de identidad?

1 <input type="checkbox"/> chilena
2 <input type="checkbox"/> otra nacionalidad

Por favor haga una cruz **SOBRE LA LÍNEA**, según su estimación personal entre las dos opciones

Ejemplo:



¿Qué tan relevante es para usted su pertenencia nacional?

Nada importante		Muy importante
-----------------	--	----------------

¿Qué tan ligado/a se siente a la cultura chilena?

Nada ligado(a)		Muy ligado(a)
----------------	--	---------------

¿Cuánto se ha dedicado a conocer la cultura chilena?

Nada		Mucho
------	--	-------

TLS

Este Cuestionario se refiere a las normas o reglas sociales y familiares. Lea detenidamente cada afirmación antes de decidirse por una de las posibles respuestas. Marque con una cruz en alguno de los números desde el 1 al 6, de acuerdo al que mejor se ajuste a su opinión.

1. En Chile hay muchas reglas sociales que cumplir.	1	2	3	4	5	6
2. En Chile es muy claro lo que se espera de cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
3. Las gente en Chile está de acuerdo en qué es comportarse correctamente y qué no, en la mayoría de las situaciones.	1	2	3	4	5	6
4. Las personas en Chile tienen amplia libertad para decidir cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
5. Cuando en Chile alguien se comporta de manera inadecuada, los demás lo desapruaban fuertemente.	1	2	3	4	5	6
6. Las personas en Chile casi siempre cumplen con las reglas sociales.	1	2	3	4	5	6

Ahora continúan las 6 afirmaciones relativas a su familia. Haga nuevamente una cruz en el corresponde mejor a su opinión.

7. En mi familia hay muchas reglas que cumplir.	1	2	3	4	5	6
8. En mi familia es muy claro lo que se espera de cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
9. En mi familia estamos de acuerdo en que es comportarse correctamente y qué no, en la mayoría de las situaciones.	1	2	3	4	5	6
10. Los miembros de mi familia tienen amplia libertad para decidir cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
11. Cuando alguien en mi familia se comporta de manera inadecuada, los demás lo desaprueban fuertemente.	1	2	3	4	5	6
12. En mi familia casi siempre cumplimos con las reglas.	1	2	3	4	5	6

SRIS

A continuación se presentan 9 afirmaciones sobre hombres y mujeres. Indique en qué medida está de acuerdo con estas opiniones. Para ello **marque con una cruz en el número que más represente su opinión.**

	Totalmente en desacuerdo	Moderadamente en desacuerdo	Levemente en desacuerdo	Ni acuerdo ni desacuerdo	Levemente de acuerdo	Moderadamente de acuerdo	Totalmente de acuerdo
1. El marido debería ser considerado el representante de la familia para todos los asuntos legales	1	2	3	4	5	6	7
2. Es igual de feo que una mujer diga garabatos que si lo hace un hombre.	1	2	3	4	5	6	7
3. Cuando un hombre y una mujer viven juntos, es la mujer la que debería realizar las labores del hogar y el hombre las tareas físicamente exigentes.	1	2	3	4	5	6	7
4. Una mujer debería preocuparse de su aspecto físico, porque influye en lo que las demás personas piensan de su marido.	1	2	3	4	5	6	7
5. Las parejas homosexuales deberían ser igualmente aceptadas que otras las parejas.	1	2	3	4	5	6	7
6. Las mujeres deberían tener permitida la misma libertad sexual que los hombres.	1	2	3	4	5	6	7
7. El trabajo de un hombre es demasiado importante como para que se quede haciendo las labores del hogar.	1	2	3	4	5	6	7
8. El principal deber de una mujer con niños pequeños es con su hogar y su familia.	1	2	3	4	5	6	7
9. La mujer debería preocuparse más por apoyar el trabajo del marido, en lugar de desarrollar su propio trabajo.	1	2	3	4	5	6	7

SCS

A continuación encontrará una serie de afirmaciones, que se refieren a distintos sentimientos y formas de comportarse en diferentes situaciones. Lea cada afirmación y **marque con una cruz en el número que mejor represente su opinión personal.**

Totalmente en desacuerdo	Moderadamente en desacuerdo	Levemente en desacuerdo	Ni acuerdo ni desacuerdo	Levemente de acuerdo	Moderadamente de acuerdo	Totalmente de acuerdo
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1. Me gusta ser único(a) y diferente de los demás en muchos aspectos.	1	2	3	4	5	6	7
2. Puedo hablar abiertamente con alguien que acabo de conocer, aunque sea mucho mayor que yo.	1	2	3	4	5	6	7
3. Aunque esté fuertemente en desacuerdo con los demás miembros del grupo, no lo digo para evitar tener una discusión.	1	2	3	4	5	6	7
4. Respeto a las personas que ocupan un lugar de autoridad con las que me relaciono (por ejemplo un jefe).	1	2	3	4	5	6	7
5. Yo hago lo que a mí me parece bien, sin tomar en cuenta lo que piensan los demás.	1	2	3	4	5	6	7
6. Respeto a las personas que tienen una forma de ser sencilla y modesta.	1	2	3	4	5	6	7
7. Yo siento que es importante ser una persona independiente.	1	2	3	4	5	6	7
8. Yo puedo dejar de lado mis propios intereses por el beneficio del grupo en que estoy.	1	2	3	4	5	6	7
9. Prefiero decir directamente que "no", que arriesgarme a ser malinterpretado(a).	1	2	3	4	5	6	7
10. Para mí es importante ser muy imaginativo(a) o creativo(a).	1	2	3	4	5	6	7
11. Debería tomar en cuenta el consejo de mis padres al planificar mis estudios o mi trabajo.	1	2	3	4	5	6	7
12. Mi futuro y el de las personas que está a mi alrededor están relacionados.	1	2	3	4	5	6	7
13. Prefiero ser directo(a) y franco(a) cuando trato con personas que acabo de conocer.	1	2	3	4	5	6	7
14. Me siento a gusto cuando colaboro con los demás.	1	2	3	4	5	6	7

15 Me siento a gusto cuando soy escogido(a) para recibir felicitaciones o un premio.	1	2	3	4	5	6	7
16. Si mi hermana o hermano fracasa, me siento responsable.	1	2	3	4	5	6	7
17 Frecuentemente siento que mis relaciones con los demás son más importantes que mis propios logros.	1	2	3	4	5	6	7
18 Hablar en frente de los demás en una clase o reunión no es un problema para mí.	1	2	3	4	5	6	7
19 Yo le ofrecería mi asiento en el bus a mi profesor o a mi jefe.	1	2	3	4	5	6	7
20 Actúo de la misma manera esté con quien esté.	1	2	3	4	5	6	7
21 Mi felicidad depende de la felicidad de los que me rodean (para sentirme feliz necesito que los que me rodean también estén felices).	1	2	3	4	5	6	7
22 Valoro más que cualquier cosa tener buena salud.	1	2	3	4	5	6	7
23. Me quedaría en un grupo si me necesitaran, aunque no me sienta contento(a) dentro de él.	1	2	3	4	5	6	7
24. Trato de hacer lo que es mejor para mí, sin tomar en cuenta cómo le podría afectar a los demás.	1	2	3	4	5	6	7
25. Poder cuidarme bien es lo más importante para mí.	1	2	3	4	5	6	7
26. Es importante para mí, respetar las decisiones tomadas por el grupo.	1	2	3	4	5	6	7
27. Mantener mi propia identidad, independiente de los demás, es algo muy importante para mí.	1	2	3	4	5	6	7
28. Es importante para mí poder mantener las buenas relaciones dentro de mi grupo.	1	2	3	4	5	6	7
29. Actúo de la misma manera en mi casa y en mi lugar de estudio o trabajo.	1	2	3	4	5	6	7
30. Normalmente hago lo que los demás quieren hacer, aún cuando me gustaría hacer otra cosa.	1	2	3	4	5	6	7

9. Informed Consent letter for participants



Pontificia Universidad Católica de Chile

Universidad de Chile

Universidad de Heidelberg

Programa de Doctorado Internacional

en Investigación en Psicoterapia

Consentimiento de participación en un estudio (consultantes)

Yo, he sido invitada a participar en el estudio denominado “**Estudio del funcionamiento psicológico y relacional de mujeres víctimas de violencia doméstica y el rol de las experiencias infantiles**”. Este es un proyecto de investigación científica acerca de las características psicológicas y en sus relaciones interpersonales que presentan mujeres que sufren violencia de pareja. La realización de este proyecto se enmarca en el desarrollo de la tesis de doctorado de la investigadora principal y cuenta con la aprobación de la Pontificia Universidad Católica de Chile y del Centro de la Mujer de la comuna de Santiago.

Entiendo que en este estudio **se grabará en una cinta de video una entrevista diagnóstica** realizada por una psicóloga, en la cual yo participaré en calidad de entrevistada. Esta entrevista abordará los problemas por los que llegué a este centro y otras experiencias de mi vida.

Entiendo también que contestaré:

- un cuestionario sobre experiencias de cuidado y/o descuidos que recibí en mi infancia ,
- un cuestionario sobre mis ideas acerca del ser chilena, de las diferencias entre hombres y mujeres y otras características culturales
- un cuestionario sobre cómo me he sentido psicológicamente en las últimas semanas
- una entrevista breve que aborda también mi estado emocional y psicológico.

Estoy informada de que la información será almacenada **confidencialmente**, no será publicada en su versión original ni en forma alguna que permita mi identificación y que será utilizada con fines de investigación y de docencia especializada.

También estoy informada de que **mi participación es voluntaria** y, que participe o no en este estudio, **recibiré todas las atenciones regulares** que realiza este Centro de Atención y que si acepto participar o no, no tendrá ninguna consecuencia negativa para mi proceso de tratamiento. Asimismo, se que **puedo negarme a participar o retirarme** en cualquier momento del estudio, sin que esta decisión tenga ningún efecto negativo sobre la atención que yo recibo en este Centro, o sobre la posibilidad que tengo de ser atendida nuevamente en otras ocasiones. contactarme con emociones de pena o inquietud al responder preguntas que pueden referirse a experiencias difíciles de mi vida.

El beneficio para mi es que la rica información acerca de mi misma que resultare de este proceso de entrevista y cuestionarios, podría ser entregada a petición de mi terapeuta en este centro, quien podría utilizarla para enriquecer la atención que recibo. También, es posible si lo deseo, tener una entrevista de devolución con la entrevistadora.

Si, he leído y entiendo esta carta de consentimiento y estoy de acuerdo en participar en este estudio.

.....

Firma

Fecha

Si tiene alguna pregunta puede comunicarse con Carla Crempien Robles, investigadora responsable del proyecto, al teléfono 3541240 , Oficina de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad católica de Chile, Vicuña Mackenna 4860, Comuna de Macul, Santiago.

CARTA DE CONSENTIMIENTO INFORMADO JUEZAS OPD

Yo _____, de profesión _____ participo voluntariamente como jueza entrenada en OPD, en la investigación desarrollada por Carla Crempien Robles titulada “Estudio del funcionamiento psíquico y relacional de mujeres víctimas de violencia doméstica: El rol de las experiencias infantiles”, correspondiente a su Tesis Doctoral en el Programa de Doctorado en Investigación en Psicoterapia de la Pontificia Universidad Católica de Chile.

Mi participación consiste en la codificación de entrevistas videadas realizadas por la misma investigadora Carla Crempien R. a mujeres víctimas de violencia doméstica. Esta codificación es realizada de acuerdo al Sistema de Diagnóstico Psicodinámico Operacionalizado (OPD Task Force, 2008) y realizare las codificaciones entre el año 2009 y 2010.

Cumpliendo con los requerimientos éticos exigidos en la investigación en Psicología en Chile, me comprometo a utilizar los videos sólo para ejecutar la codificación y, a cuidar y devolver el material entregado. No realizaré copias de los videos ni mostraré el material ni los resultados a otras personas, y no utilizaré la información obtenida para docencia o fines académicos personales, entendiendo que debo cumplir con el cuidado de la estricta confidencialidad de la información y con el respeto a la autoría de la investigadora.

CONSENTIMIENTO:

Declaro haber leído y aceptar las condiciones de este documento, y en conocimiento de ello, acepto participar en el estudio realizado por la Psicóloga Carla Crempien Robles, en el marco del desarrollo de su tesis doctoral.

Nombre y Firma Codificador

Nombre y Firma Investigador

Si tiene alguna pregunta o duda puede comunicarse con Carla Crempien Robles PhD(c), cecrempi@uc.cl o al teléfono 3547294, Escuela de Psicología, Pontificia Universidad Católica de Chile, Vicuña Mackenna 4860, Comuna de Macul, Santiago.

Erklärung gemäß § 8 Abs. 1 Buchst. b) und c) der Promotionsordnung
der Fakultät für Verhaltens- und Empirische Kulturwissenschaften

**Promotionsausschuss der Fakultät für Verhaltens- und Empirische
Kulturwissenschaften der Ruprecht-Karls-Universität Heidelberg**

Doctoral Committee of the Faculty of Behavioural and Cultural Studies, of Heidelberg University

**Erklärung gemäß § 8 Abs. 1 Buchst. b) der Promotionsordnung der Universität
Heidelberg für die Fakultät für Verhaltens- und Empirische Kulturwissenschaften**

Declaration in accordance to § 8 (1) b) and § 8 (1) c) of the doctoral degree regulation of
Heidelberg University, Faculty of Behavioural and Cultural Studies

Ich erkläre, dass ich die vorgelegte Dissertation selbstständig angefertigt, nur die angegebenen
Hilfsmittel benutzt und die Zitate gekennzeichnet habe.

I declare that I have made the submitted dissertation independently, using only the specified tools and
have correctly marked all quotations.

**Erklärung gemäß § 8 Abs. 1 Buchst. c) der Promotionsordnung
der Universität Heidelberg für die Fakultät für Verhaltens- und Empirische
Kulturwissenschaften**

Ich erkläre, dass ich die vorgelegte Dissertation in dieser oder einer anderen Form nicht
anderweitig als Prüfungsarbeit verwendet oder einer anderen Fakultät als Dissertation
vorgelegt habe.

I declare that I did not use the submitted dissertation in this or any other form as an examination paper
until now and that I did not submit it in another faculty.

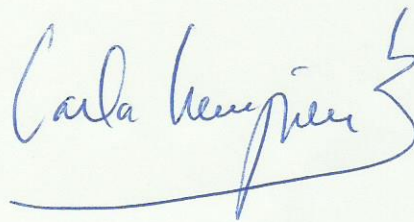
Vorname Nachname

First name Family name Carla Crempien

Datum, Unterschrift

Date, Signature

July 15th 2015



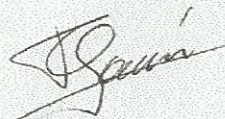
Authorizations for the publication-based dissertation

Buenos Aires, 25/08/15

To whom concern:

As editor of the Journal Revista Argentina de Clínica Psicológica, I authorize Carla Crempien to publish her paper "Traumatización relacional compleja: Una noción útil en la comprensión del funcionamiento de mujeres víctimas de violencia doméstica" that was published in the number XXI in our journal, the year 2012. This paper is part of the author's dissertation thesis, and University of Heidelberg has request to publish the thesis.

Sincerely



Dr. Fernando García

Editor

Revista Argentina de Clínica Psicológica



PONTIFICIA
UNIVERSIDAD
CATÓLICA
DE CHILE

CARLA ERIKA FEDERICA CREMPIEN <cecrempi@uc.cl>

Authorization of publication

1 mensaje

Marlene Mesina <marlene.mesina@superacionpobreza.cl>
Para: CARLA ERIKA FEDERICA CREMPIEN <cecrempi@uc.cl>
Cc: mauricio.rosenbluth@superacionpobreza.cl

30 de noviembre de 2015, 16:58



Dear Mrs. Crempien,

We authorize the library of University of Heidelberg, Germany to upload and publish the article named below:
Crempien, C. (2011). Psychological functioning in women victims of intimate partner violence attending domestic violence centers in Santiago de Chile. Published in our annual publication, Thesis Country 2011: Thinks a country without poverty.

Best regards,

Marlene Mesina Jofré

Coordinadora Programa Tesis País

Fundación Superación Pobreza

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