POST-TRAUMATIC RESPONSES OF ABUSED WOMEN TO MARITAL VIOLENCE

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The objectives of this study were to explore the post-traumatic responses of abused women to marital violence and to examine the correlation between these responses and demographics. This study aimed to raise awareness of post-traumatic responses in abused women among health care providers, who are supposed to pay more attention to this problem. A cross-sectional survey-interview with structured questionnaires was used. Subjects were recruited from the Kaohsiung area. Of the 127 women who participated in this study, 109 (85.8%) completed the questionnaires. The most frequent post-traumatic response was: "I had a strong feeling toward this thing." The least frequent response was: "I felt it seemed that this thing had never happened or it was not true." The standardized mean score of the intrusion subscale (3.12) was higher than that of the avoidance subscale (1.84). The more children an abused woman had, the fewer avoidance responses she exhibited. Of the abused women, 93.6% had a high post-traumatic response score (≥ 19). The results indicate that marital violence leads to post-traumatic responses in abused women in Taiwan. The results can help health care providers to identify post-traumatic responses of abused women at an early stage and can also provide information for planning further treatment strategies for abused women.

Key Words: post-traumatic responses, abused women, marital violence
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According to previous reports, most victims of marital violence are women [1,2]. Abused women suffer physical, psychologic, or sexual abuse [3,4], and most experience more than one abusive behavior [3,5,6]. Many abused women (46%) suffer from marital violence at least once a month, and this violence is life-threatening in an estimated 18% of women [7]. The prevalence of partner abuse in the USA has been estimated at one in five women [8]. The lifetime prevalence of sexual and physical abuse in women in the USA is 37% [9]. Previous studies indicate that marital violence is a serious and recurrent public health problem [3,10,11]. It results in serious physical and psychologic health sequelae [1,10], of which the most serious is suicide or homicide [3]. Even when there is no serious physical injury, marital violence that causes severe stress can leave indelible psychologic trauma in abused women.

Post-traumatic response is a state in which the individual experiences a sustained painful process to one or more overwhelming traumatic events that have not been assimilated [12]. Horowitz reported five phases of response to stressful life events: outcry, denial, intrusion, working through, and completion [13]. An individual uses a defensive mechanism to adjust in the process. Appropriate psychologic adjustment can release stress. When psychologic adjustment is excessive or insufficient, the process is obstructed, and the individual remains in the denial or intrusion phase. As a result, they cannot confront and

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deal with real life situations and resort to intrusion and avoidance reactions [13]. According to Horowitz et al, intrusion is characterized as unbidden thoughts and images, troubled dreams, strong pangs or waves of feelings, and repetitive behavior [14]. Avoidance responses include ideational constriction, denial of the meanings and consequences of the event, blunted sensation, behavioral inhibition or counterphobic activity, and awareness of emotional numbness [14]. These reactions are initially viewed as normal responses, but if the duration of the reactions goes beyond an individual's load, they may result in pathologic conditions such as panic, maladaptive avoidance (e.g. suicide and drug abuse), delayed stress reaction, and depression [14].

Rollstin and Kern showed that the severity of physical and psychologic abuse is positively related to the severity of psychologic disturbance, and greater numbers of children are significantly associated with increased psychologic disturbance [15]. Hence, if abused women are not guided and assisted appropriately, they may suffer from individual, interpersonal, and social distress, which would increase the chance of post-traumatic stress disorder (PTSD) and other psychosomatic symptoms. Many studies show that the health care system is usually the first place where abused women seek help after marital violence [3,4,6,16,17]. Abused women usually fear facing the traumatic experience and are unwilling to seek medical assistance. In order to prevent the physical or psychologic problems of abused women from worsening, the impact of marital violence on abused women needs to be understood in depth. In Taiwan, there are few studies that focus on the post-traumatic responses of abused women to marital violence. Therefore, the objectives of this study were to explore the post-traumatic responses of abused women to marital violence and to examine the correlation between these responses and demographics. From the results, health care providers can develop effective treatment strategies based on related data and help these women get through the critical stage.

Materials and Methods

Subjects

A cross-sectional survey-interview with structured questionnaires was used to collect data. Subjects were recruited from the Kaohsiung area. Women were included if they: had suffered physical, psychologic, and/or sexual abuse from their husband, ex-husband, or former or current intimate heterosexual partner within the last year; could verbally communicate in Mandarin or in Taiwanese; and were clearly conscious and consented to participate in the study.

Instruments

The Demographic Inventory included age, education, occupation, marital status, number of children, economic status, year of marriage, length of time in violent relationship, and the last time of being abused. The Post-Traumatic Responses Scale (PTRS), a Chinese version translated from Horowitz et al's Impact of Event Scale (IES) [14], was used to measure the subjective impact of marital violence on abused women within the past week. The instrument was a 15-item self-report rating scale that included two subscales: the intrusion subscale (7 items) and the avoidance subscale (8 items). Ratings based on all items were endorsed by frequency (0 = not at all; 1 = rarely; 3 = sometimes; and 5 = often). Total PTRS scores could range from 0 to 75, with intrusion subscale scores ranging from 0 to 35, and avoidance subscale scores ranging from 0 to 40. A higher score indicated a more severe post-traumatic response. According to Horowitz, the overall PTRS score (intrusion plus avoidance scores) can be divided into three levels: low (< 8.5), medium, and high (≥ 19) [13].

The split-half reliability coefficient of the original PTRS was 0.86, and Cronbach's α coefficients, measuring the internal consistency of the scales, were 0.78 for the intrusion subscale and 0.82 for the avoidance subscale [14]. The instrument was translated and back-translated with the consent of the original author. When the Chinese version of the IES was completed, researchers invited five experts in the field to examine the scale's content validity. In order to build up surface validity, the researchers asked three abused women to fill out the questionnaire and to suggest phraseology and wording. Cronbach's α coefficients were 0.76 for the PTRS, 0.83 for the intrusion subscale, and 0.61 for the avoidance subscale.

Procedure

Permission to conduct this study was obtained from each research setting. Staff explained the purpose and method of the study to participants and obtained their consent to participate. Before the interview, the

researcher explained the study's purpose, procedure, and the subject's rights to each participant. Data were collected in a cross-sectional survey-interview using structured questionnaires. During the interview, the researcher's attitude toward participants was one of support, respect, and empathy, not judgment. If participants needed help, the relevant information or appropriate assistance was given by the researcher.

Results

Of the 127 women invited to participate in the study, nine did not meet inclusion criteria and nine did not finish the questionnaires; 109 (85.8%) completed the questionnaires. Most patients (41.3%) were aged between 30 and 39 years (mean ± standard deviation, 36.42 ± 8.67 years). Most subjects had completed junior or high school (51.4%), were employed (63.3%), were married (88.1%), had two children (40.4%), and earned barely enough to live on (43.1%). The age of the subjects' children ranged from 1 to 31 years (11.2 ± 7.6 years). Subjects had been married for between 3 months and 32 years (11.8 ± 8.4 years). Most subjects (41.3%) had been married for between 1 and 9 years, followed by 10 to 19 years (33.9%), more than 20 years (18.4%), and less than 1 year (6.4%). Subjects had been in the violent relationship with the abuser for between 1 month and 32 years (8.8 ± 8.2 years). Most subjects (46.8%) had been in the violent relationship for between 1 and 9 years, followed by 10 to 19 years (22.9%), less than 1 year (11.9%), more than 20 years (11.0%), and others (7.3%). The most recent abuse was generally within the last week (34.9%), followed by 1 week to 1 month (30.3%), 1 to 3 months (14.7%), 3 months to 1 year (13.8%), and others (6.4%).

The mean PTRS score was 36.51 ± 12.14 (range, 6–67), with a mean intrusion subscale score of 21.83 ± 8.15 (range, 1–35), and a mean avoidance subscale score of 14.69 ± 7.68 (range, 0–36). The standardized mean intrusion subscale score (3.12) was higher than the standardized mean avoidance subscale score (1.84). When subjects were divided according to Horowitz's categorization [13], most had high scores (93.6%), followed by medium (3.7%) and low scores (2.8%). The five most frequent post-traumatic responses were: "I had a strong feeling toward this thing" (4.06); "I would be driven to rethink of this thing" (3.89); "Pictures about this thing would often pop into my mind" (3.55); "I could not sleep or did not sleep well" (3.20); and "Other things would make me think of this thing" (3.02) (Table 1). All mean scores were more

Table 1. Mean scores of the Post-Traumatic Responses Scale in abused women (n = 109)

Rank	Item	Mean	SD
Intrusion subscale			
1	I had a strong feeling toward this thing	4.06	1.53
2	I would be driven to rethink of this thing	3.89	1.70
3	Pictures about this thing would often pop into my mind	3.55	1.83
4	I could not sleep or did not sleep well	3.20	1.97
5	Other things would make me think of this thing	3.02	1.81
6	Anything associated with this thing would evoke my feelings about this thing	2.61	1.84
13	I had dreams related to this thing	1.50	1.85
Avoidance subscale			
7	When I thought of this thing, I would try to avoid letting myself feel annoyed or bothered	2.53	2.03
8	I would try not to think of this thing	2.37	1.99
9	I stayed away from reminders of this thing	2.31	1.92
10	I wished to forget this thing	2.22	2.13
11	I avoided talking about this thing	1.86	1.86
12	I had a lot of feelings toward this thing, but I did not want to manage these feelings	1.61	1.78
14	My feeling about this thing was numb	1.27	1.78
15	I felt it seemed that this thing had never happened or it was not true	0.52	1.27

SD = standard deviation.

than three, indicating that the frequency of these five responses were between sometimes and often. The least frequent response was: "I felt it seemed that this thing had never happened or it was not true" (0.52). The mean score of this item was less than 1, indicating that the frequency of the response was between not at all and rarely.

Correlation analysis was used to examine the relationships between demographic variables and post-traumatic responses. The number of children had a significant negative association with avoidance (n = 103, r = –0.26, $p < 0.01$). There were no statistically significant differences among other variables and no correlation with total post-traumatic responses, intrusion, or avoidance. Among the 109 subjects, 103 had children. The women were divided into two groups according to the number of children they had (1 or 2 children and 3 or 4 children) to examine the relationship with the year of marriage, mean age of the children, mean age of the subjects, and mean intrusion and avoidance scores. Subjects who had three or four children had been married for longer, had older children (higher child mean age), and were older (higher subject mean age) than those who had one or two children. The mean intrusion score was not significantly different between the two groups, but the mean avoidance score was significantly lower in the group with three or four children than in the group with one or two children (Table 2).

Discussion

The large proportion of subjects with high PTRS scores (93.6%) indicated that the abused women had severe post-traumatic responses. All of the five most frequent post-traumatic responses in this study were intrusion responses. The least frequent response was: "I felt it seemed that this thing had never happened or it was not true." Abused women expressed that marital violence had made a profound impression on them and caused suffering. Therefore, they could not accept the description that it had never happened or was not true.

A study on PTSD in battered women showed that 81% of battered women met the criteria for PTSD [18]; even post-abused women who had not been in the abusive relationship for an average of 9 years continued to experience PTSD symptoms [19]. A previous study, which used the same questionnaire as this study (IES) to predict the development of PTSD, indicated that intrusion reactions could effectively predict PTSD [20]. Our study found that 93.6% of abused women had high PTRS scores (≥ 19), and the top six items of the mean score were all intrusion reactions. In addition, the standardized mean intrusion score was higher than the standardized mean avoidance score. Compared to previous studies [18–20], abused women in this study had a higher rate of developing PTSD. Therefore, we need to follow up psychologic conditions in abused women over the long term.

The more children an abused woman had, the fewer avoidance responses she had. Children are the major force that keeps abused women in abusive relationships [6]. This study showed that, on average, subjects who had three or four children had been married for longer, were older, and their children were older, than women with one or two children. When the family cycle progresses to the "empty nest" stage, i.e. when the children have left home, women become free from the stress and heavy burden of motherhood [21]. During this family developmental stage, abused women might begin to reflect on their own marital problems. In our study, some subjects stated that they were even encouraged by their older children to end the abusive relationship. This may be

Table 2. Comparisons of the means of key variables by number of children (n = 103)

Variable	1 or 2 children* (n = 71)	3 or 4 children* (n = 32)	t value
Years of marriage	9.51 (6.67)	18.74 (7.81)	6.17†
Age of children (yr)	8.67 (6.45)	16.72 (7.00)	5.71†
Age of subjects (yr)	34.23 (7.86)	42.00 (7.88)	4.64†
Intrusion responses	22.15 (8.26)	21.44 (7.75)	0.42
Avoidance responses	16.25 (7.65)	12.06 (7.36)	2.60‡

*Values are mean (standard deviation); †$p < 0.01$; ‡$p < 0.05$.

why abused women with older and more independent children demonstrated fewer avoidance responses.

Health care providers in primary health care are in a unique position to assess whether women are being abused. To prevent psychologic trauma from becoming worse, they should initiate talks about marital violence and provide opportunities for discussion to these women, encouraging them to express their questions and feelings. If needed, the relevant information and appropriate assistance should then be provided. Health care providers could use therapeutic strategies for PTSD to reduce fear and anxiety in abused women. In addition to treating abused women, the most important intervention is to protect the lives of these abused women and to prevent further abuse.

Most of our subjects had high PTRS scores. This indicated that they still had obvious impact symptoms. Further studies are necessary to evaluate factors that influence the severe level of post-traumatic responses. Moreover, a prospective follow-up study should be developed to explore the process of post-traumatic responses.

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References

1. Bullock L, McFarlane J, Bateman LH, Miller V. The prevalence and characteristics of battered women in a primary care setting. *Nurse Pract* 1989;14:47–56.
2. Fishwick NJ. Assessment of women for partner abuse. *J Obstet Gynecol Neonatal Nurs* 1998;27:661–70.
3. Smith PH, Gittelman DK. Psychological consequences of battering: implications for women's health and medical practice. *N C Med J* 1994;55:434–9.
4. Tyson S, Fleming B. Conceptualizing battered women as a vulnerable population: a case study report. *Nurs Clin North Am* 1999;34:301–12.
5. Campbell JC, Soeken K. Forced sex and intimate partner violence: effects on women's risk and women's health. *Violence Against Women* 1999;5:1017–35.
6. Lin FF. *Study on the Process for Battered Women to Seek Help from Official Agencies*. Master's Thesis. Taipei, Taiwan: Soochow University, 1998.
7. Chen R. The nature, process, and influence of marital violence in Taiwan. *J Women Gend Stud (Taiwan)* 1992;3:117–47.
8. Flitcraft A. From public health to personal health: violence against women across the life span. *Ann Intern Med* 1995; 123:800–2.
9. Jones AS, Gielen AC, Campbell JC, et al. Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Womens Health Issues* 1999;9:295–305.
10. Campbell JC, Lewandowski LA. Mental and physical health effects of intimate partner violence on women and children. *Psychiatr Clin North Am* 1997;20:353–74.
11. McFarlane J, Parker B, Soeken K. Abuse during pregnancy: frequency, severity, perpetrator, and risk factors of homicide. *Public Health Nurs* 1995;12:284–9.
12. Carpenito LJ. Post-trauma response. In: Carpenito LJ, ed. *Nursing Diagnosis: Application to Clinical Practice*, 6th ed. Philadelphia: JB Lippincott, 1995:675–81.
13. Horowitz M. *Stress Response Syndromes: Treatment Manual.* San Francisco: University of California, 2000.
14. Horowitz M, Wilner N, Alvarez W. Impact of event scale: a measure of subjective stress. *Psychosom Med* 1979;41:209–18.
15. Rollstin AO, Kern JM. Correlates of battered women's psychological distress: severity of abuse and duration of the postabuse period. *Psychol Rep* 1998;82:387–94.
16. Loring MT, Smith RW. Health care barriers and interventions for battered women. *Public Health Rep* 1994;109:328–37.
17. Sansone RA, Wiederman MW, Sanson LA. Health care utilization and history of trauma among women in a primary care setting. *Violence Vict* 1997;12:165–72.
18. Kemp A, Green BL, Hovanitz C, Rawlings EI. Incidence and correlates of posttraumatic stress disorder in battered women: shelter and community samples. *J Interpers Violence* 1995; 10:43–55.
19. Woods SJ. Prevalence and patterns of posttraumatic stress disorder in abused and postabused women. *Issues Ment Health Nurs* 2000;21:309–24.
20. Houskamp BM, Foy DW. The assessment of posttraumatic stress disorder in battered women. *J Interpers Violence* 1991;6:367–75.
21. Gormly AV, Brodzinsky DM. Middle adulthood: family and occupational development. In: Gormly AV, Brodzinsky DM, eds. *Lifespan Human Development*, 4th ed. Florida: Driscoll, 1989:458–87.