



DOCTOR OF CLINICAL PSYCHOLOGY (DCLINPSY)

Doctorate in Clinical Psychology: Main Research Portfolio.

1) Gender, Sex and Complex PTSD Clinical Presentation: A Systematic Review; 2) Are Clients of the AWP Solution Focused Family Service Receiving a Service They Would Recommend to Others?; 3) How Do People Make Sense of Intimate Partner Violence (IPV) in the Context of Perpetrator PTSD Diagnostic Status and Gender Identity?

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Research Portfolio Submitted in Part
Fulfilment of the Requirements for the
Degree of Doctorate in Clinical Psychology

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Doctorate in Clinical Psychology

University of Bath
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COVID-19 Impact Statement

I was able to design my main research project with COVID-19-related restrictions in mind and produce an entirely online study. Fortunately, this did not deviate from the intended delivery of this research project. My service-related project, however, was affected by COVID-19. The NHS Trust in which I conducted the research did not permit audio recording for research purposes due to COVID and related service pressures. This meant having to identify an alternative outcome measure with only closed questions, which could be administered verbally without the need for audio recording, thereby changing the data I was able to collect. COVID-19 indirectly affected the research projects contained in this portfolio by significantly affecting work-life balance through online teaching, remote working and being isolated from peers.

Word Counts

Systematic Literature Review	5,982
Service-Related Project	5,522
Main Research Project	8,821
Executive Summary	959
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Abstract for Systematic Literature Review

Background: Post-traumatic stress disorder (PTSD) prevalence and clinical presentation reportedly vary with gender and/or sex. Equivalent complex PTSD (CPTSD) research is in its relative infancy and to date no systematic review has been conducted on this topic. *Objective:* To systematically review the literature and provide a narrative addressing the question of whether gender and/or sex differences exist in CPTSD prevalence and clinical presentation. *Method:* Embase, APA PsycNET, PTSDpubs, PubMed, Web of Science, EThOS and Google Scholar were searched. Sixteen papers were eligible for inclusion. Data were extracted and synthesised narratively. *Results:* Four themes were identified: (i) the reporting of gender and/or sex; (ii) index trauma; (iii) CPTSD prevalence rates; and (iv) CPTSD clinical presentation. Findings were mixed. Nine papers reported prevalence rates: eight found no gender and/or sex differences; one found higher diagnostic rates among women and/or females. Eight papers reported clinical presentation: five reported higher cluster-level scores among women and/or females; two used single gender and/or sex samples and one found higher scores in two clusters in men and/or males. Most papers failed to report in gender- and/or sex-sensitive ways. *Conclusions:* Gender- and sex-sensitive research and clinical practice is needed. Awareness in research and clinical practice is recommended regarding the intersect between identity and the experience and expression of complex trauma.

Keywords: complex post-traumatic stress disorder; gender; sex; presentation; trauma

Abstract for Service-Related Project

The study describes a service evaluation of the Avon and Wiltshire Mental Health Partnership Trust (AWP) Solution Focused Family Service (SFFS). The SFFS receives up to 50 referrals a year and typically sees clients as couples or families. AWP encourages the collection of client feedback. Thought to reflect an active and equitable collaboration between clients and professionals, client involvement encompasses the role of clients in the planning, implementation and evaluation of services, policy, training and research. Challenges in the SFFS's collection of client feedback were discussed and a possible remedy identified. The Experience of Service Questionnaire (ESQ), plus four SFFS-specific items, was administered, forming the SFFS Questionnaire (SFFSQ). Feedback data were collected from SFFS clients and their family members. Findings were largely positive: median responses to 12 of the 16 items were the most favourable response available. Findings from the remaining four items are discussed, and highlights and recommendations considered.

Keywords: family therapy; service evaluation; client involvement

Abstract for Main Research Project

Background: Intimate partner violence (IPV) has profound effects on victim physical and mental health, considerable social and economic costs and is a significant public health concern. Research suggests that the way the public make sense of IPV may vary in different contexts, where 'conditional logics' may be used to explain, excuse or legitimise IPV (Lelaurain et al., 2018). PTSD diagnostic status (Mackinnon, 2020) and perpetrator gender (Carlson & Worden, 2005) may be conditional logics, but little research exists in this area. *Objectives:* This study explored how the public make sense of IPV in the context of perpetrator diagnostic status (PTSD or no PTSD) and gender identity (female, male or nonbinary) by exploring IPV ratings and IPV discourses. *Methods:* Two hundred and sixty-five (265) community participants were recruited via snowball sampling and presented one of six versions of the same story containing an account of IPV. Stories were identical across conditions bar perpetrator diagnostic status and gender identity. Participants rated the degree to which they thought the behaviour in the story constituted IPV. Approximately half the participants also completed a story completion task. *Results:* IPV ratings were weighted towards abuse and did not vary with diagnostic status or gender identity. Reflexive thematic analysis analysed IPV discourses in the story completion task. Five themes were identified in participant stories: (i) characterise the behaviour; (ii) trajectory of IPV; (iii) show compassion towards victim of IPV; (iv) hold victim of IPV responsible; and (v) context influences decision-making. Limitations, implications and directions for future research are discussed.

Keywords: intimate partner violence; IPV; gender identity; PTSD; trauma

Systematic Literature Review

Gender, Sex and Complex PTSD Clinical Presentation: A Systematic Review

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The American Psychiatric Association's fifth edition of the Diagnostic and Statistical Manual (DSM-5; APA, 2013) and the World Health Organisation's 11th edition of the International Classification of Diseases (ICD-11; WHO, 2019) diverge in their conceptualisations of post-traumatic stress disorder (PTSD). The DSM-5 conceptualises PTSD as a broad diagnosis characterised by trauma re-experiencing, avoidance, negative alterations in cognitions and mood (NACM) and hyperarousal (APA, 2013). The ICD-11 outlines two 'sibling' diagnoses: PTSD and complex PTSD (CPTSD) (Karatzias et al., 2017). PTSD encompasses re-experiencing, avoidance and persistent threat (hyperarousal and hypervigilance); CPTSD includes the above criteria plus three pertaining to disturbances in self-organisation (DSO): emotion dysregulation, negative self-concept and interpersonal difficulties (Hyland et al., 2018).

DSO items intend to encompass the profound difficulties related to prolonged or repeated trauma, often interpersonal in nature, from which escape is difficult (e.g. child abuse, captivity) (Karatzias et al., 2017). The DSM-5's PTSD diagnostic criterion D (NACM) is thought to pertain to such difficulties, measuring negative beliefs, negative emotions, reduced interest in activities and feeling detached from others (APA, 2013). Although dropped in the DSM-5 in favour of the broader PTSD conceptualisation, the diagnostic category 'disorders of extreme stress not otherwise specified' (DESNOS) in the DSM-4 was thought to reflect trauma of this nature (Friedman, 2013).

Research into the construct validity of ICD-11 PTSD and CPTSD diagnoses supports distinctions between the two in adult clinical samples (Hyland et al., 2018), university undergraduates (Rink & Lipinska, 2020), homeless adults (Armstrong et al., 2020), foster children (Haselgruber et al., 2019), adult survivors of childhood institutional abuse (Knefel et al., 2015) and refugees (Vang et al., 2019). CPTSD diagnoses are strongly associated with childhood trauma and functional impairment (Karatzias et al., 2017; Karatzias et al., 2020; Rink & Lipinska, 2020). Comparisons between DSM-5 PTSD and ICD-11 PTSD and CPTSD diagnosis rates are not always consistent, with some evidence for comparable rates (Kuester et al., 2017) and some for higher rates according to DSM-5 criteria (Heeke et al., 2020; Hyland et al., 2018). This might be expected given the intentional broadness of the DSM-5 diagnostic criteria (Hyland et al., 2018).

Factors pertinent to PTSD diagnosis rates include gender and sex (Kimerling et al., 2018). Lifetime prevalence is reportedly higher among women (Kimerling et al., 2017), with US studies reporting rates of approximately 10–12% in women and 5–6% in men (Olf, 2017). The clinical presentation of this diagnosis may also vary with gender. Men may experience more irritability and reckless behaviour (Green, 2003), and women may experience more avoidance and hyperarousal (Fullerton et al., 2001). Whether

figures pertain to sex (based on anatomy, chromosomes and typically assigned at birth; Gender Spectrum, 2019) or gender (one's own identity and internal sense of self, which may or may not correspond with sex; Gender Spectrum, 2019), however, is not always clear, and research has tended to adopt a binary approach to both (Ollf, 2017).

Prevalence rates among gender nonbinary individuals may be higher still, with reported rates of up to 42% (Livingston et al., 2020). Gender nonbinary individuals reportedly experience higher rates of sexual abuse, harassment and trauma exposure than cisgender individuals (whose gender identity corresponds with sex assigned at birth) (Lefevor et al., 2019), so elevated PTSD diagnoses may not be surprising.

Research into CPTSD prevalence rates is in its relative infancy given the recency of this diagnostic classification (Hyland et al., 2018). Women may be more likely to experience sexual and intimate violence and sexual trauma (Kimerling et al., 2018; Ollf, 2017). Indeed, one form of violence, intimate partner violence (IPV), is thought to disproportionately affect women (and racial, gender and sexual minorities) (McLeod et al., 2020). The interaction between these different social identities is thought to position individuals within social structures that either afford them power and privilege, or oppress and marginalise based on systemic oppression (e.g. sexism, cisgenderism) (McLeod et al., 2020). Women and gender nonbinary individuals may, therefore, be more at risk of receiving this diagnosis (Hyland et al., 2017).

Whether there are routine sex and/or gender differences or similarities in prevalence and clinical presentation of CPTSD diagnoses, however, is unclear and to date no systematic review exists on this topic. Prevalence and presentation of this diagnosis in gender nonbinary individuals is also relatively unknown. Such knowledge would have significant implications for diagnostic tools, therapeutic approach and gender-responsive services (Hyland et al., 2018).

Current Review

This paper aimed to systematically review and synthesise CPTSD literature to establish whether gender and/or sex differences exist in the prevalence and clinical presentation of this diagnosis. The review differentiated between gender and sex in line with the definitions outlined above (Gender Spectrum, 2019) and relevant literature was reviewed and synthesised accordingly.

Method

Search Strategy

Searches were conducted between 28th April and 1st May 2023. Embase, APA PsycNET, PTSDpubs, PubMed, Web of Science, EThOS and Google Scholar were searched. Titles, abstracts and key words were searched using a core search strategy adapted to each database structure. Searches were filtered by publication date (2013

to present to reflect the 2013 DSM-5 publication date). The strategy was overseen and approved by a specialist librarian. Search terms are below.

Table 1.1

Search Terms

Review element	Search terms
Gender, Sex	1. Gender 2. Sex 3. Nonbinary 4. Male 5. Female 6. Men 7. Women 8. (Gender AND differences)
CPTSD	9. (Complex PTSD) 10. CPTSD 11. C-PTSD 12. Complex posttraumatic* 13. (Complex symptoms of PTSD) 14. (Complex trauma) 15. DESNOS 16. (Complex posttraumatic stress disorder)
Clinical presentation	17. Symptom* 18. Presentation 19. Phenomenology 20. (Symptom AND profile)
Combination terms	21. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 22. 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 23. 17 OR 18 OR 19 OR 20 24. 21 AND 22 AND 23

Search terms in Table 1.1 were used for all databases bar EThOS and Google Scholar. The searches ‘gender differences in complex PTSD presentation’, ‘sex differences in complex PTSD presentation’ and ‘gender differences in complex PTSD symptoms’ were employed for these databases owing to their different search structure. Established from scoping searches, the first four pages of Google Scholar results were searched.

Eligibility Criteria

Study inclusion criteria were: i) child or adult clinical or non-clinical samples; ii) diagnosis of CPTSD, DESNOS or DSM-5 PTSD that specifies CPTSD component (NACM); iii) use of accepted diagnostic tool (see Table 1.2); iv) clear, specific discussion of CPTSD presentation; v) CPTSD presentation separated by gender or sex, or in one gender or sex only; vi) qualitative or quantitative empirical study; vii) any location; viii) written in or translated to English; and ix) published 2013 onwards (see Table 1.2 for summary).

Table 1.2**Eligibility Criteria**

	Inclusion criteria	Exclusion criteria
Sample	Child or adult, clinical or non-clinical	-
Diagnosis	Diagnosis of CPTSD, DESNOS* or DSM-5 PTSD that specifies CPTSD component (NACM)	No diagnosis of CPTSD, DESNOS or DSM-5 PTSD DSM-5 PTSD diagnosis does not specify CPTSD component (NACM)
Measures	ITQ, ICD-TQ, PCL-5, CAPS-5, SIDES, SIDES-A, HTQ-5	No use of accepted measure
Content	Clear, specific discussion of CPTSD presentation CPTSD presentation separated by gender or sex or in one gender or sex only	CPTSD presentation not specifically and clearly discussed CPTSD presentation not separated by gender or sex
Methodology	Qualitative or quantitative empirical study	Not an empirical study
Location	Any	-
Language	Written in or translated to English	Not written in or translated to English
Date	Published 2013 onwards	Published before 2013

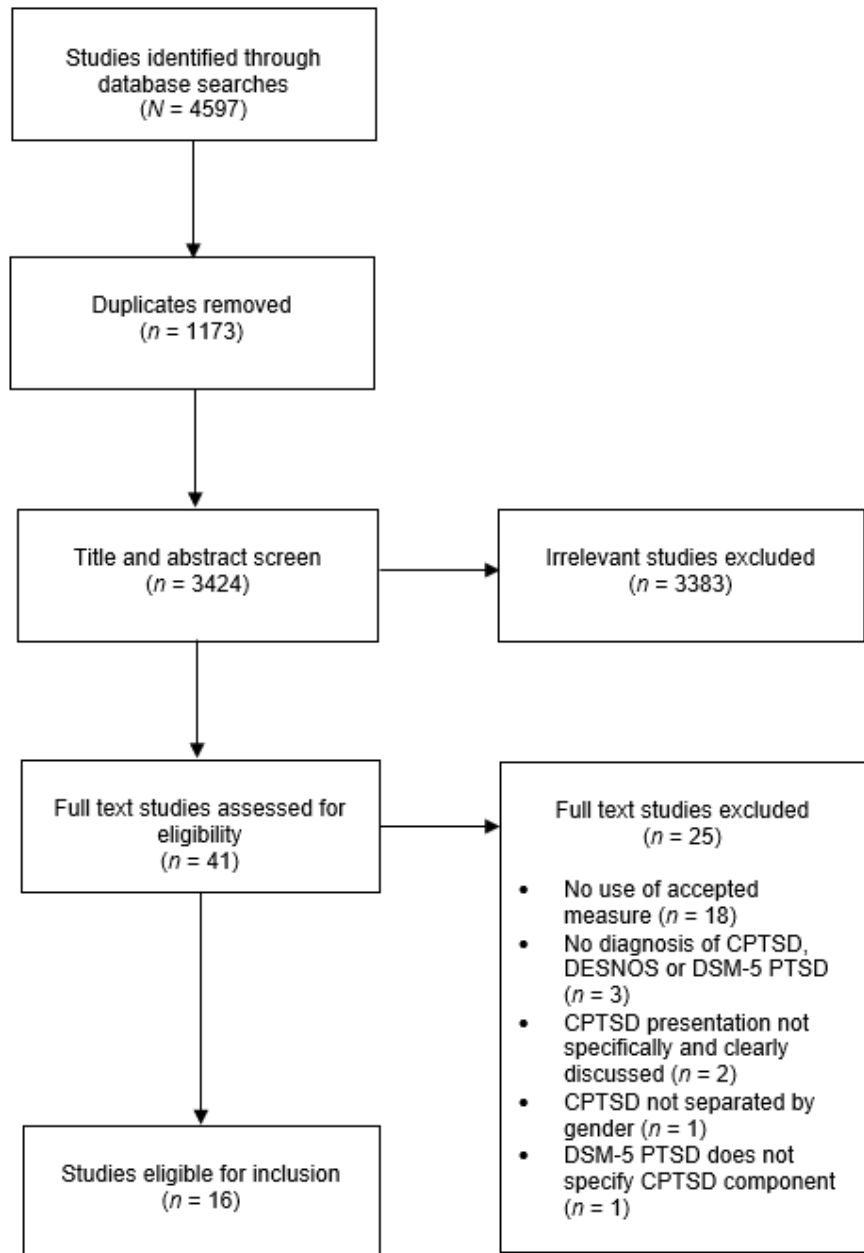
Note. CAPS-5 = Clinician Administered PTSD Scale-5 (Weathers et al., 2015). HTQ-5 = Harvard Trauma Questionnaire-5 (Berthold et al., 2018). ICD-TQ = ICD-11 Trauma Questionnaire (Karatzias et al., 2016). ITQ = International Trauma Questionnaire (Cloitre et al., 2018). PCL-5 = PTSD Checklist for DSM-5 (Weathers et al., 2013). SIDES = Structured Interview for Disorders of Extreme Stress and SIDES-A = Structured Interview for Disorders of Extreme Stress-Adolescent Version (Polcovitz et al., 1997).

*DESNOS was included due to the construct overlap with CPTSD (Friedman, 2013).

Study Selection

The initial search identified 4597 papers. Titles and abstracts were imported into Covidence, an online review site, and duplicates were automatically removed ($n = 1173$). Titles and abstracts were screened and excluded if they did not clearly report on gender and/or sex and CPTSD ($n = 3383$). Papers were retained at this stage if there was insufficient evidence to exclude them. Inter-rater reliability with an independent second reviewer was conducted on 10% of titles/abstracts with 97.4% agreement. Discussion took place between first author and independent reviewer to reach consensus. A total of 41 papers were subject to full text review and assessed for eligibility, of which 25 were excluded (Figure 1.1; Appendix B). Inter-rater reliability was conducted at full text review on 10% of papers with 100% consensus. A total of 16 papers were eligible for inclusion (Figure 1.1).

Figure 1.1
PRISMA Flowchart



Quality Assessment

Quality of included papers was assessed by the first author using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). Suitable for qualitative, quantitative and mixed methods studies, the MMAT assesses the quality of studies against five criteria relevant to each of five study designs. The tool encourages a descriptive summary of each criterion's rating to provide context rather than for exclusion purposes (see Appendix C for full descriptive summary). To aid interpretation, papers were additionally scored 0 where a criterion was not met and 1 where a

criterion was met. Scores were converted into a percentage (see Table 1.3 for summary scores).

Data Extraction

Data were extracted from eligible papers by the first author. Extracted data included authors, country, study focus, sample, gender or sex, participant demographics, relevant measures, trauma type and key relevant findings (see Tables 1.4 and 1.5).

Data Synthesis

Data synthesis was conducted by the first author using a process akin to thematic analysis. Key relevant data were summarised during data extraction. Themes were identified across the summarised data in relation to gender, sex and CPTSD diagnosis. Themes intended to capture trends in the research pertaining to both gender and/or sex and CPTSD. Narrative synthesis was used to describe themes in the data.

Table 1.3*MMAT Quality Assessment Scores*

Study	Criterion					Overall %
	4.1	4.2	4.3	4.4	4.5	
Bramblett (2017)	1	0	1	1	0	60
Charak et al. (2023)	1	0	1	0	1	60
Cloitre et al. (2019)	1	1	1	0	1	80
de Vries et al. (2018)	1	0	1	0	0	40
Farhood et al. (2018)	1	0	1	1	1	80
Fernandez-Fillol et al. (2021)	1	0	1	1	1	80
Giarratano et al. (2020)	1	1	1	1	1	100
Gilbar et al. (2018)	1	0	0	0	1	40
Guina et al. (2019)	0	0	0	0	1	20
Hecker et al. (2018)	1	1	1	1	1	100
Ho et al. (2021)	1	1	1	0	1	80
Hyland et al. (2018)	1	0	1	0	1	60
Karatzias et al. (2019)	1	1	1	1	1	100
Liu et al. (2020)	0	0	1	0	0	20
McGinty et al. (2021)	1	1	0	0	1	60
Søegaard et al. (2021)	1	0	0	1	1	60

Table 1.4*Data Extraction*

Author(s)	Country	Focus	Sample	Gender or sex	Demographics	Relevant measures	Relevant findings	Quality rating %
Bramblett (2017)	USA	Gender differences in presentation of PTSD symptoms	Community sample with DSM-5 PTSD diagnoses (<i>N</i> = 15)	Not specified – refers to ‘male’ and ‘female’ in paper	Age: no data. 80.7% F; 13.3% M. Ethnicity: no data	PCL-5	<ul style="list-style-type: none"> Females reported more severe overall criterion D (NACM) symptoms than males 	60%
Charak et al. (2023)	Spain	Associations between lifetime trauma exposure, minority stress and CPTSD among LGBTQ+ adults	Community sample of LGBTQ+ adults with cumulative lifetime trauma exposure (<i>N</i> = 225)	Gender – specifies cisgender, gender diverse and transgender participants	Age: 18-60 (M=31.35). 33.3% women (incl. trans women); 46.3% men (incl. trans men); 13.5% gender nonbinary; 6.8% ‘gender identity not listed’. Ethnicity: 82.5% White; 10.3% Latinx; 2.2% Biracial/Multiracial; 0.4% Asian, 4.5% ‘additional category not listed’	ITQ	<ul style="list-style-type: none"> 19.1% met diagnostic criteria for CPTSD (<i>n</i> = 43): <i>n</i> = 23 gender diverse or transgender, <i>n</i> = 20 cisgender Similar rates of CPTSD diagnoses in cisgender and gender diverse or transgender participants Cissexism related to gender expression was positively associated with DSO factors ($r = .365, p < .01$) 	60%

Cloitre et al. (2019)*	USA*	Prevalence of ICD-11 PTSD and CPTSD diagnoses	Nationally representative household sample of community adults (N = 1839)	Specifies sex – refers to ‘male’ and ‘female’ in demographics and ‘men’ and ‘women’ in results	Age: 18-70 (M=44.50). 52% F; 48% M. Ethnicity: 63.8% White; 36.2% ‘non-White’	ITQ, LEC	<ul style="list-style-type: none"> Women had significantly higher rates of CPTSD diagnoses than men (OR = 1.82, 95% CI [1.10, 3.01]) 	80%
de Vries et al. (2018)	USA	Relationship between homelessness, gender and PTSD and CPTSD diagnoses	Homeless adults (N = 90)	Specifies gender – refers to ‘male’ and ‘female’ in demographics and ‘men’ and ‘women’ in results	Age: 18-61 (M=37.64). 58% F; 42% M. Ethnicity: 37% White; 28.9% Hispanic; 18.9% African American; 8% ‘other’; 7.8% did not respond	SIDES	<ul style="list-style-type: none"> No significant relationship found between gender and CPTSD or DESNOS scores 	40%
Farhood et al. (2018)	Lebanon	Gender differences in trauma types, PTSD symptom clusters and PTSD risk factors	Community civilian adults (N = 991)	Specifies gender – refers to ‘male’ and ‘female’ in paper	Age: 20-60+ (M=41). 52.7% F; 47.3% M. Ethnicity: no data	HTQ-5	<ul style="list-style-type: none"> Females scored higher on overall criterion D (NACM) cluster than males Females scored higher on 3 of 4 criterion D items (difficulty concentrating, less interest in activities, sudden emotional/physical reaction when reminded of trauma [all $p < .001$]); no significant difference on 4th item (no future) 	80%

Fernandez -Fillol et al. (2021)	Spain	CPTSD in survivors of IPV	Adult women survivors of IPV (<i>N</i> = 162)	Not specified – paper refers to ‘women’	Age: 20-75 (M=41.42). 100% women. Ethnicity: data not provided	ITQ	<ul style="list-style-type: none"> • 39.5% met CPTSD diagnostic criteria • 85.2% met criteria for AD; 64.8% met criteria for DR; 61.1% met criteria for NSC • High fear was associated with DR (<i>OR</i> = 1.27, 95% CI [1.03-1.57]) • Low resilience was associated with AD (<i>OR</i> = .93, 95% CI [0.89-0.97]), NSC (<i>OR</i> = 0.93, 95% CI [0.90-0.96]) and DR (<i>OR</i> = 0.96, 95% CI [0.93-0.99]) 	80%
Giarratano et al. (2020)	USA	Gender differences in CPTSD symptoms, mental health and substance abuse in incarcerated adults	Incarcerated adults (<i>N</i> = 497)	Specifies gender – refers to ‘men’ and ‘women’ in paper	Age: M=31.64. 39.4% women; 60.6% men. Ethnicity: 43.1% White; 34.8% Black; 21.5% Hispanic; 0.6% missing	SIDES, CAPS	<ul style="list-style-type: none"> • Women had significantly higher levels of CPTSD symptomatology than men, <i>t</i> (444) = 2.15, <i>p</i> = .032, <i>d</i> = .20, 95% CI = [-0.02, -0.38] 	100%
Gilbar et al. (2018)	Israel	ICD-11 CPTSD among Israeli male perpetrators of IPV	Israeli male perpetrators of IPV (<i>N</i> = 234)	Not specified – paper only refers to ‘males’	Age: no data. 100% M. Ethnicity: no data	ITQ, LEC-5	<ul style="list-style-type: none"> • Frequency of CPTSD symptom endorsements were: 53% feelings easily hurt (AD3); 48.7% guilt (NSC4); 42.1% long time to calm (AD2); 32.3% reckless behaviour (AD5); 31.4% uncontrollable anger (AD4); 30.5% intense reactions (AD1); 30.4% numb (AD6); 	40%

							25.7% difficulty feeling pleasure (AD7); 25.1% difficulty staying close to others (DR2); 24.9% shame (NSC3); 23.2% world is distant (AD8); 23.2% failure (NSC1); 21.3% cut-off from others (DR1); 20.3% avoiding relationships (DR3); 17.9% worthless (NSC2); 10.7% feeling outside of body (AD9)	
Guina et al. (2019)	USA	Gender differences in DSM-5 PTSD symptomatology and sexual trauma	Adult outpatients in a military medical centre (N = 775)	Specifies gender – refers to ‘men’ and ‘women’ in paper	Age: M=38.60. 46.7% women; 53.3% men. Ethnicity: 77.5% White; 11.7% Black; 4% Hispanic; 2.2% Asian; 0.3% Native American; 2.4% Multiracial; 1.3% ‘other’; 0.6% not specified	PCL-5	<ul style="list-style-type: none"> Women scored higher than men on criterion D (NACM) items: trouble remembering ($p < .001$); negative beliefs ($p < .001$); blame ($p < .001$); negative feelings ($p < .001$); loss of interest ($p < .05$); feeling cut-off ($p < .05$); trouble experiencing positive feelings ($p < .05$) 	20%
Hecker et al. (2018)	Switzerland	PTSD and CPTSD symptoms and traumatic experiences among refugees	Adult refugees resettled in Switzerland (N = 94)	Specifies gender – refers to ‘male’ and ‘female’ in paper	Age: 18-61 (M=31.60). 14.9% F; 85.1% M. Ethnicity: no data	ITQ, HTQ-5	<ul style="list-style-type: none"> 21.3% ($n = 20$) met diagnostic criteria for CPTSD Gender not significantly associated with DSO symptom severity, ($F(1,86) = 1.10, p = .297$) 	100%
Ho et al. (2021)*	Ireland*	Gender-specific examination of ICD-11 CPTSD and psychosis	Community sample of nationally	Specifies gender in title and results, but also refers to sex in	Age: 18-87 (M=43.10). 51% F; 49% M. Ethnicity: no data	ITQ, ITEM	<ul style="list-style-type: none"> Females had significantly higher levels of CPTSD symptoms than males ($t(1018) = 5.81, p < .001, d = .36$) 	80%

			representative adults ($N = 1020$)	results tables – appears to use sex and gender interchangeably (refers to ‘male’ and ‘female’ in paper)			<ul style="list-style-type: none"> No significant differences in overall CPTSD diagnoses between females and males ($p = .13$) 	
Hyland et al. (2018)	Lebanon	PTSD and CPTSD diagnoses among Syrian refugees living in Lebanon	Syrian refugees living in Lebanon ($N = 101$)	Specifies gender – refers to ‘male’ and ‘female’ in paper	Age: $M=33.02$. 80.2% F; 19.8% M. Ethnicity: no data	ITQ Arabic Version	<ul style="list-style-type: none"> No significant gender differences in diagnostic rates of CPTSD ($\chi^2 = .031$, $df = 1$, $p = .578$, $OR = 1.31$) 	60%
Karatzias et al. (2019)*	UK*	ICD-11 PTSD and CPTSD diagnostic risk factors and comorbidity	Trauma-exposed population-based sample of adults ($N = 1051$)	Specifies sex – refers to ‘male’ and ‘female’ in paper	Age: 18-90 ($M=47.18$). 68.4% F; 31.6% M. Ethnicity: no data	LEC-5, ITQ	<ul style="list-style-type: none"> 12.9% of N met CPTSD diagnostic criteria No significant relationship between sex and CPTSD diagnosis 	100%
Liu et al. (2020)	China	Gender differences in PTSS during COVID-19 outbreak in China	Community sample of adults ($N = 285$)	Specifies gender – refers to ‘male’ and ‘female’ in demographics and results and ‘men’ and ‘women’ elsewhere in paper	Age: no data. 54.5% F; 45.5% M. Ethnicity: no data	PCL-5	<ul style="list-style-type: none"> Females scored significantly higher on criterion D (NACM) items than males ($p < .05$) 	20%

McGinty et al. (2021)*	Israel, Ireland*, USA*, UK*	Differences in ICD-11 PTSD and CPTSD	Nationally representative community sample of adults (Israel <i>N</i> = 1003)	Specifies sex – refers to ‘male’ and ‘female’ in paper	Age: 18-70 (M=40.62). 51.7% F; 48.3% M. Ethnicity: no data	ITQ, LEC-5	<ul style="list-style-type: none"> No significant relationship between sex and CPTSD diagnosis in Israel sample 	60%
Søegaard et al. (2021)	Norway	Gender differences in trauma symptoms after victimisation and accidental traumas	Community sample of traumatised adults (<i>N</i> = 110)	Specifies gender – refers to ‘men’ and ‘women’	Age: 18-60 (M=40.4). 61.8% women; 38.2% men. Ethnicity: no data	SIDES, LEC	<ul style="list-style-type: none"> No significant relationship between gender and overall DESNOS diagnosis Men had significantly higher scores in 2 out of 7 DESNOS clusters: negative self-perception ($p = .043$) and alterations in systems of meaning ($p = .003$) In Ps with VT, men had higher negative self-perception ($p = .022$) and alterations in systems of meaning ($p = .006$); in Ps with AT, women had higher scores on affect and impulses ($p = .011$) 	60%

Note: AD = affect dysregulation. CAPS-5 = Clinician Administered PTSD Scale-5 (Weathers et al., 2015). DR = disturbances in relationships. DSO = disturbances in self-organisation. HTQ-5 = Harvard Trauma Questionnaire-5 (Berthold et al., 2018). IPV = intimate partner violence. ITEM = International Trauma Exposure Questionnaire (International Trauma Consortium). ITQ = International Trauma Questionnaire (Cloitre et al., 2018). LEC-5 = Life Events Checklist for DSM-5 (Weathers et al., 2013). NACM = negative alterations in cognition and mood. NSC = negative self-concept. PCL-5 = PTSD Checklist for DSM-5 (Weathers et al., 2013). SIDES = Structured Interview for Disorders of Extreme Stress (Polcovitz et al., 1997).

*Papers use same samples: only findings from McGinty et al.’s (2021) Israel sample, which does not overlap, reported in the current review.

Table 1.5*Data Extraction: Trauma Type*

	All	Women or females	Men or males	Significant differences (where included in paper)
Bramblett (2017)	-	20% sexual trauma, 13.3% combat, 6.7% assault, 46.7% 'other'	100% combat	-
Charak et al. (2023)	73.3% reported 2+ traumas. 51.5% unwanted sexual experience; 38.7% physical assault; 30.2% sexual assault; 28.4% life-threatening illness/injury; 28% transportation accident; 27.1% sudden unexpected death of someone close; 18.4% severe human suffering; 16.9% natural disaster; 13.8% sudden violent death; 12.6% assault with weapon; 11.1% fire/explosion; 6.7% serious accident; 4% exposure to toxic substance; 1.8% combat/warzone; 1.8% captivity	-	-	-
Cloitre et al. (2019)	Not specified	Not specified	Not specified	-
de Vries et al. (2018)	-	Only data on childhood abuse collected: 53.8% childhood emotional abuse; 52.9% childhood sexual abuse; 52.9% childhood physical abuse	Only data on childhood abuse collected: 41.2% childhood physical abuse; 38.2% childhood emotional abuse; 23.5% childhood sexual abuse	-

Farhood et al. (2018)	-	71.1% confined to home due to danger outside, 61.5% forced evacuation under life-threatening situation, 59% forced to hide, 58.4% deprived of food/water, 35.8% lacked shelter, 32.4% tortured, 32.4% property looted/confiscated/destroyed, 27% near-death experience, 25.3% ill-health without medical care, 11.5% combat exposure, 8.2% 'any other life-threatening situation', 5.9% robbed, 5.6% confined forcibly under watch, 5.4% present while someone searched for people/things in home, 4.4% forced deprivation from family, 4.2% exposed to severe firing, 2.5% death of family member/friend, 2.1% kidnapped, 1.3% physically harmed, 0.8% battered, 0.6% unnatural death of family/friend, 0.4% death of a stranger, 0.2% sexual abuse or rape, 0.2% imprisoned/hostage	65% confined to home due to danger outside, 58.2% ill-health without medical care, 58.2% deprived of food/water, 57.4% forced evacuation under life-threatening situation, 52.7% forced to hide, 35.4% tortured, 35.4% property looted/confiscated/destroyed, 32.8% lacked shelter, 28.1% near-death experience, 10.4% combat exposure, 6.8% confined forcibly under watch, 6.8% 'any other life-threatening situation', 5.1% forced deprivation from family, 4.9% robbed, 4.7% present while someone searched for people/things in home, 3.2% exposed to severe firing, 2.3% physically harmed, 1.9% kidnapped, 1.9% death of family member/friend, 1.7% battered, 1.3% imprisoned/hostage, 0.4% unnatural death of family member/friend, 0.4% sexual abuse or rape, 0.2% death of a stranger	Males were significantly more likely to have experienced ill-health without access to medical care and imprisonment/hostage
Fernandez-Fillol et al. (2021)	-	98.2% psychological violence, 71% physical violence, 33.3% sexual violence, 49.9% 'other trauma', 27.8% 'other interpersonal trauma'	-	-
Giarratano et al. (2020)	-	60.2% childhood abuse, 13.3% adult interpersonal trauma, 5.1% childhood loss/caregiver separation, 5.1% childhood accident/illness/disaster, 3% adult accident/illness/disaster, 2% adult witness trauma, 11.2% no traumatic experiences	41.5% childhood abuse, 12.3% adult interpersonal trauma, 8.3% childhood accident/illness/disaster, 7.3% childhood loss/caregiver separation, 5% adult accident/illness/disaster, 4.3% adult witness trauma, 21.3% no traumatic experiences	<ul style="list-style-type: none"> • Women were significantly more likely than men to have experienced childhood abuse ($p < .01$) • Child abuse history mediated association

between gender and CPTSD, $B = 1.76$, $p < .001$, 99% CI = [0.789, 2.743]

Gilbar et al. (2018)

Not specified

Not specified

Not specified

-

Guina et al. (2019)

-

26.8% sexual assault, 20.7% witnessed violence, 20.7% life-threatening illness/injury, 18.5% physical assault, 18.2% childhood sexual abuse, 15.5% childhood physical abuse, 9.1% violent death of loved one, 8.8% childhood neglect, 6.1% motor vehicle collision, 6.1% natural disaster, 4.7% combat, 2.5% terrorism

30.5% combat, 25.5% witnessed violence, 22.3% life-threatening illness/injury, 15.5% motor vehicle collision, 11.9% terrorism, 11.9% physical assault, 10.9% natural disaster, 7.5% violent death of loved one, 7.5% childhood neglect, 7.3% childhood physical abuse, 5.3% childhood sexual abuse, 3.4% sexual assault

- Women were significantly more likely to have experienced sexual assault, physical assault, childhood sexual abuse and childhood physical abuse
- Men were significantly more likely to have experienced combat, motor vehicle collision, terrorism and natural disaster

Hecker et al. (2018)	-	71.4% lack of food/water, 57.1% lack of shelter, 57.1% warzone exposure, 57.1% violent attack by stranger, 42.9% natural disaster, 42.9% forced separation from family, 36.1% serious accident/fire/explosion, 36.1% murder of family member/friend, 36.1% violent attack by family member, 28.6% torture, 28.6% enforced isolation from others, 28.2% witness murder of 1+ strangers, 21.4% sexual assault by stranger, 21.4% sexual assault by family member, 21.4% imprisonment, 21.4% ill-health without medical care, 14.3% unnatural death of family member/friend, 7.1% life-threatening illness	76.3% lack of shelter, 75% lack of food/water, 75% warzone exposure, 72.5% serious accident/fire/explosion, 70% violent attack by stranger, 63.8% imprisonment, 62.5% torture, 61.3% witnessed murder of 1+ strangers, 56.3% murder of family member/friend, 51.3% unnatural death of family member/friend, 47.5% enforced isolation from others, 47.5% forced separation from family, 40% ill-health without medical care, 27.5% natural disaster, 25% violent attack by family member, 20% life-threatening illness, 8.8% sexual assault by stranger, 3.8% sexual assault by family member	-
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Ho et al. (2021)	-	<p>65% emotional abuse, 56.5% unloved/emotional rejection, 53.8% life-threatening illness/accident-other, 45.2% sexual harassment, 44.2% physical/emotional neglect, 40% someone close died in awful manner, 39% bullied, 33.5% physical assault by parent/guardian, 32.1% physical assault by someone else, 24.2% witnessed extreme suffering/death, 21.9% stalked, 18.6% sexual assault by someone else (not parent/guardian), 17.9% life-threatening accident, 15.8% life threatened with weapon, 12.1% life-threatening illness-self, 6.5% natural disaster, 6.4% life-threatening human-caused disaster, 5% war/combat, 4.6% sexual assault by parent/guardian, 4.6% torture/captivity, 2.7% caused extreme suffering/death</p>	<p>55.6% emotional abuse, 49.8% life-threatening illness/accident-other, 46.8% physical assault by someone else (not parent/guardian), 39.4% unloved/emotional rejection, 37.4% someone close died in awful manner, 36.8% bullied, 34.4% physical/emotional neglect, 28.4% physical assault by parent/guardian, 27.6% life-threatening accident, 25.8% life threatened with weapon, 25% witnessed extreme suffering/death, 16.4% sexual harassment, 16.2% life-threatening illness-self, 14.6% stalked, 10.6% life-threatening human-caused disaster, 9.6% war/combat, 9.6% natural disaster, 8.8% sexual assault by someone else (not parent/guardian), 6.8% torture/captivity, 6.4% caused extreme suffering/death, 4.6% sexual assault by parent/guardian</p>	<ul style="list-style-type: none"> • Females were significantly more likely than males to have been sexually assaulted by someone other than parent/guardian, sexually harassed, stalked, emotionally abused, emotionally rejected/unloved and physically/emotionally neglected (all $p < .001$) • Males were significantly more likely than females to have experienced life threatened with a weapon, physical assault by someone other than parent/guardian, life-threatening accident (all $p < .001$), war/combat ($p = .005$), causing extreme suffering/death to other ($p = .004$) and life-threatening human-made disaster ($p = .015$)
Hyland et al. (2018)	18.5% forced displacement, 10.2% exposure to bomb	-	-	-

	blasts, 10.2% sudden unexpected death of loved one, 7.4% exposure to warfare, 2.7% childhood sexual or physical abuse			
Karatzias et al. (2019)	Only data on most common childhood and adulthood traumatic event reported: 32.4% physical assault (childhood); 47.4% sudden unexpected death of loved one (adulthood)	-	-	-
Liu et al. (2020)	Not specified	Not specified	Not specified	-
McGinty et al. (2021) – Israel sample	Not specified	Not specified	Not specified	-
Søgaard et al. (2021)	-	Victimisation trauma: 27.9% sexual assault or rape; 27.9% physical assault; 13.2% assault with lethal weapon; 7.4% torture or captivity; 2.9% unwanted/uncomfortable sexual experience; 2.9% combat/warzone; 1.5% witnessed homicide. Accidental trauma: 4.4% accidental fire/explosion; 7.4% accident (transportation or other); 4.4% sudden accidental death of close person	Victimisation trauma: 26.2% combat/warzone; 26.2% physical assault; 11.9% assault with lethal weapon; 11.9% sexual assault or rape; 4.8% torture or captivity; 2.4% witnessed homicide. Accidental trauma: 9.5% accident (transportation or other); 4.8% sudden accidental death of close person; 2.4% severe human suffering	<ul style="list-style-type: none"> • Women were significantly more likely to have experienced sexual assault ($p = .04$) • Men were significantly more likely to have experienced combat or warzone ($p = .04$)

Results

Overview

Papers spanned the United States of America ($n = 5$), Spain ($n = 2$), Lebanon ($n = 2$) and one each from China, Ireland, Israel, Norway, the United Kingdom and Switzerland. The final paper (McGinty et al., 2021) used samples from Ireland, Israel, the USA and the UK. These appeared to be the same samples as the papers pertaining to each individual country bar Israel. This paper was included in the current review, but only findings from the Israel sample were reported. Samples were mostly community adults ($n = 10$). Remaining papers included refugee samples ($n = 2$), homeless samples ($n = 1$), incarcerated adults ($n = 1$) and perpetrators ($n = 1$) and survivors ($n = 1$) of intimate partner violence (IPV). Ages ranged from 18 to 90. Sample size varied from 15 to 1839. Most ($n = 11$) did not provide data on participant ethnicity. Of those that did ($n = 5$), White was the majority. Quality assessment ratings ranged from 20% to 100%.

Most papers ($n = 9$) directly and specifically looked at gender and/or sex differences. Five had gender and/or sex as one component part but not the focus (i.e. in general prevalence studies). The remaining two papers indirectly studied gender and/or sex (i.e. the sample was single gender or sex, so this element was implicit). Nine papers studied ICD-11 CPTSD, four studied DSM-5 PTSD and three studied DESNOS or 'CPTSD' measured with the SIDES. Most ($n = 13$) used self-report measures such as the ITQ and/or the PCL-5. Three employed interviews such as the CAPS and/or the SIDES.

Data synthesis anchored to the research question led to the identification of four themes pertaining to gender and/or sex: i) how gender and/or sex were reported; ii) index trauma(s); iii) CPTSD prevalence rates; and iv) CPTSD clinical presentation (see Table 1.6 for papers relevant to each theme). Results in the current review adopted gender- and/or sex-based language consistent with each included paper.

Table 1.6*Main Themes and Relevant Studies*

Theme	Relevant papers	Details
Reporting of gender and/or sex	All papers:	
	Bramblett (2017)	Not specified
	Charak et al. (2023)	Specifies gender
	Cloitre et al. (2019)	Specifies sex
	de Vries et al. (2018)	Specifies gender
	Farhood et al. (2018)	Specifies gender
	Fernandez-Fillol et al. (2021)	Not specified
	Giarratano et al. (2020)	Specifies gender
	Gilbar et al. (2018)	Not specified
	Guina et al. (2019)	Specifies gender
	Hecker et al. (2018)	Specifies gender
	Ho et al. (2021)	Uses gender and sex interchangeably
	Hyland et al. (2018)	Specifies gender
	Karatzias et al. (2019)	Specifies sex
	Liu et al. (2020)	Specifies gender
McGinty et al. (2021)	Specifies sex	
Søgaard et al. (2021)	Specifies gender	
Index trauma(s) by gender and/or sex	Bramblett (2017) de Vries et al. (2018) Farhood et al. (2018) Fernandez-Fillol et al. (2021) Giarratano et al. (2020) Guina et al. (2019) Hecker et al. (2018) Ho et al. (2021) Søgaard et al. (2021)	See Table 1.5 for all details

CPTSD prevalence rates by gender and/or sex	Charak et al. (2023)	Similar CPTSD diagnostic rates among cisgender and gender diverse Ps
	Cloitre et al. (2019)	Higher CPTSD diagnostic rates among women
	de Vries et al. (2018)	No relationship between gender and CPTSD scores
	Hecker et al. (2018)	No relationship between gender and DSO severity
	Ho et al. (2021)	Higher CPTSD symptom levels among females, but no gender difference in CPTSD diagnoses
	Hyland et al. (2018)	No gender difference in CPTSD diagnostic rate
	Karatzias et al. (2019)	No relationship between sex and CPTSD diagnosis
	McGinty et al. (2021)	No relationship between sex and CPTSD diagnosis in Israel sample
	Søgaard et al. (2021)	No relationship between gender and overall DESNOS diagnosis
CPTSD clinical presentation by gender and/or sex	Bramblett (2017)	Higher criterion D scores in females
	Farhood et al. (2018)	Higher criterion D scores in females (greater difficulty concentrating, loss of interest, sudden emotional/physical reaction when reminded of trauma)
	Fernandez-Fillol et al. (2021)	Approx. % of women met DSO criteria: 85% AD; 65% DR; 61% NSC
	Giarratano et al. (2020)	Higher CPTSD symptoms in women
	Gilbar et al. (2018)	5 highest symptoms (approx. %): 53% feelings easily hurt (AD3); 49% guilt (NSC4); 42% long time to calm down (AD2); 32% reckless behaviour (AD5); 31% uncontrollable anger (AD4)
	Guina et al. (2019)	Higher criterion D scores in women (greater amnesia, negative beliefs, blame, negative feelings, loss of interest, feeling cut off, trouble experiencing positive feelings)
	Liu et al. (2020)	Higher criterion D scores in females
	Søgaard et al. (2021)	Higher scores in two DESNOS clusters in men (negative self-perception and alterations in systems of meaning)

Reporting of Gender and/or Sex

Nine papers referred to 'gender' differences, three referred to 'sex' differences, three did not specify and one used 'gender' and 'sex' interchangeably. Of the papers that specified gender, only one (Charak et al., 2023) differentiated between cisgender, gender diverse and transgender individuals. This paper scored 60% in quality assessment. All remaining papers adopted a binary approach to gender and sex, where only 'male' and 'female' or 'men' and 'women' were reported. Bar Charak et al. (2023), no papers specified how participants were asked about gender and/or sex, and whether participants were provided options or asked about one or the other or both.

Index Trauma(s) by Gender and/or Sex

Twelve of the 16 papers reported index trauma(s), nine of which reported index trauma(s) by gender and/or sex. Of those nine, five conducted statistical analyses on trauma type by gender and/or sex. Women were significantly more likely than men to have experienced childhood abuse in the paper by Giarratano et al. (2020), but abuse type was not specified. Child abuse history mediated the association between gender and CPTSD (Giarratano et al., 2020), and this paper scored 100% in quality assessment. Women were significantly more likely to have experienced sexual assault, childhood sexual abuse, physical assault and childhood physical abuse in another paper (Guina et al., 2019), whereas rates of combat, motor vehicle collisions, terrorism and natural disasters were significantly higher in men (Guina et al., 2019). This paper scored only 20% in quality assessment.

Number of experiences of sexual assault, sexual harassment, being stalked, emotional abuse and physical or emotional neglect were all significantly higher in females in another paper (Ho et al., 2021). Males reported significantly higher rates of physical assault, life-threatening accident or disaster, life threatened with a weapon, war or combat and causing extreme suffering to someone else (Ho et al., 2021). This paper scored 80% in quality assessment. A similar finding was reported in Søegaard et al. (2021): number of sexual assault experiences were significantly greater among women; experiences of combat were significantly higher among men. This paper scored 60% in quality assessment. The final paper that reported significance testing was Farhood et al. (2018), who adopted the HTQ-5 measure of DSM-5 PTSD in refugee populations. The only significant difference by gender and/or sex was imprisonment or hostage and ill-health without access to medical care, which were both significantly greater among males.

Four papers reported index trauma(s) by gender and/or sex without statistical analyses. In Bramblett (2017), the most reported trauma among females was 'sexual trauma'. There were only two males in this study, but both reported their index trauma

as combat. In de Vries et al. (2018), who reported on childhood abuse, most women reported emotional abuse, followed by sexual abuse then physical abuse. Among men, physical abuse was most common and sexual abuse least common.

Fernandez-Fillol et al. (2021) had an all-women sample of survivors of IPV. Nearly all experienced psychological violence; nearly three-quarters experienced physical violence; a third experienced sexual violence and nearly half also reported 'other trauma'. In Hecker et al.'s (2018) paper on CPTSD diagnoses and traumatic experiences among refugees, there were few differences by gender and/or sex in the most reported events (lack of shelter, lack of food/water and warzone exposure). There were differences in sexual trauma rates, as sexual assault by a stranger and sexual assault by a family member were each endorsed by 21.4% of females, compared to 8.8% and 3.8% of males, respectively.

CPTSD Prevalence Rates by Gender and/or Sex

Nine papers reported only CPTSD diagnostic rates by gender and/or sex. There were two subthemes: no gender and/or sex differences, and higher rates among women or females. Eight studies found no gender and/or sex differences in CPTSD diagnostic rates (Charak et al., 2023; de Vries et al., 2018; Hecker et al., 2018; Ho et al., 2021; Hyland et al., 2018; Karatzias et al., 2019; McGinty et al., 2021 [Israel sample]; Søegaard et al., 2021). Most of these papers scored between 60% and 100% in quality assessment (one scored 40%).

Although Ho et al. (2021) found no gender difference in overall CPTSD diagnostic rates, the paper reported higher cluster-level CPTSD scores among females, suggesting a symptom-level difference that did not reach diagnostic threshold. Charak et al. (2023) did not report CPTSD diagnostic rates by individual gender but reported similar diagnostic rates among cisgender and gender diverse participants more broadly. The remaining paper reported significantly higher CPTSD diagnostic rates among women (Cloitre et al., 2019). This paper scored 80% in quality assessment.

CPTSD Clinical Presentation by Gender and/or Sex

Eight papers reported CPTSD clinical presentation by gender and/or sex. Of these, four reported DSM-5 criterion D (NACM) scores and four reported CPTSD presentation (either ICD-11 CPTSD or DESNOS). Two papers that reported CPTSD clusters had single-gender and/or sex samples, so comparisons were not possible. Bramblett (2017) and Liu et al. (2020) reported significantly higher overall DSM-5 criterion D scores in women or females but did not report item-level scores. Farhood et al. (2018) and Guina et al. (2019) reported significantly higher overall DSM-5 criterion D scores in women or females and higher item-level scores for all criterion D items bar 'no future' in the HTQ-

5 (Farhood et al., 2018). Two of these papers scored 20% for quality; the remaining two scored 60% and 80%.

The remaining four studies reported mixed findings regarding CPTSD clinical presentation. Giarratano et al. (2020) reported higher overall CPTSD symptoms among women but did not specify on which items scores were higher. In Søgaard et al. (2021), where there were no overall differences in DESNOS scores, men had significantly higher cluster scores for negative self-perception and alterations in systems of meaning. Fernandez-Fillol et al. (2021) and Gilbar et al. (2018) both used single gender and/or sex samples. Percentages of women meeting specific DSO criteria were: 85% affective dysregulation (AD); 65% disturbances in relationships (DR); and 61% negative self-concept (NSC) (Fernandez-Fillol et al., 2021). In Gilbar et al. (2018), the five most reported CPTSD items were feelings easily hurt (AD3), guilt (NSC4), long time to calm down (AD2), reckless behaviour (AD5) and uncontrollable anger (AD4). Although direct comparisons from these findings were not possible, there were similarities as AD scores were highest in the women-only sample and four of the five AD items featured in the top five endorsed DSO items in the male-only sample.

Discussion

This was the first known paper to systematically review and synthesise literature on gender, sex and CPTSD to establish whether gender and/or sex differences exist in the prevalence and clinical presentation of this diagnosis. Broad themes by gender and/or sex identified from data synthesis were the reporting of gender and/or sex, index trauma, CPTSD prevalence rates and CPTSD clinical presentation.

Reporting of Gender and/or Sex

Only one of the 16 papers in this review included nonbinary gender options and differentiated between cisgender and gender diverse participants (Charak et al., 2023). The remaining 15 papers employed a mix of language: some used 'gender' and others 'sex'; some 'male' and 'female'; and some 'men' and 'women'. Most papers used these categories interchangeably, and one used the terms 'gender' and 'sex' interchangeably, suggesting a conflation of the two constructs. Interchangeable use is not necessarily a problem in of itself had all participants stated that their gender corresponds with their sex, but no papers (bar Charak et al., 2023) specified how participants were asked about gender and sex and all these papers adopted a binary approach to gender and sex. This supports findings that researchers often mix terminology pertaining to sex and gender (Westbrook & Saperstein, 2015).

This is problematic given that research highlights empirical evidence affirming that gender is a nonbinary spectrum (Cameron & Stinson, 2019). Sex also exists on a spectrum, as some individuals are intersex due to their sex characteristics not fitting

the 'female' or 'male' medical norms (Cameron & Stinson, 2019). In their review, the authors found that psychological research still largely adopts a binary approach to asking about and reporting on gender (Cameron & Stinson, 2019). They cite ethical principles and exclusionary practices as pertinent concerns. Indeed, Olf (2017) strongly advocates for more gender- and sex-sensitive research and reporting (regarding trauma research specifically, although this would apply more broadly).

Index Trauma(s) by Gender and/or Sex

Across all nine studies that reported index trauma(s) by gender and/or sex, rates of sexual trauma (e.g. sexual assault, childhood sexual abuse, sexual harassment) were consistently higher among women and/or females. In the five papers that conducted statistical analyses on trauma type by gender and/or sex, these differences were significant. In the remaining four studies, these differences were consistent if not significant. This aligns with previous findings that women are more likely to experience sexual trauma (Olf, 2017), sexual and intimate violence and childhood trauma (Kimerling et al., 2018). This is significant, as these types of prolonged interpersonal traumas have been strongly associated with many items measured by CPTSD diagnostic criteria such as shame, guilt, low self-esteem, emotional dysregulation and attachment or relational difficulties (Karatzias et al., 2017).

Important factors related to trauma type and the reporting of trauma experiences are worth consideration. Research with men who experienced sexual assault highlighted barriers to disclosure (Donne et al., 2018; Petersson & Plantin, 2019). Both qualitative studies reported themes of masculinity norms and gender roles in relation to disclosures. Petersson and Plantin (2019) highlighted the difficulties faced by men in being perceived as 'powerless victims of sexual violence', as this violates traditional masculinity norms of power, assertiveness and strength. Donne et al. (2018) identified similar themes: men cited internalised masculinity norms, which perpetuate the idea that men who experience sexual violence are 'weak', as barriers to disclosure. This gender norm intersected with sexual orientation-based discrimination for gay men: being both men and part of a sexual minority group served as a double-disadvantage for gay men who reported not being supported to seek help (Donne et al., 2018).

It is possible that gender norms and roles also bias research. It may be the case that research is biased towards studying and reporting sexual trauma among women and combat or motor vehicle collisions among men. Indeed, these traumas align with dominant gender roles and expectations that masculinity encompasses aggression, thrill-seeking and risky behaviours, and femininity encompasses submissiveness and sensitivity (Street & Dardis, 2018). If pervasive gender norms influence rates of disclosure by men via the denial of certain experiences that do not fit said norm, it is

entirely feasible that they also shape how research is conducted and on what research focuses. This would continue to perpetuate the perceived bias in trauma type by gender and/or sex. Both factors are likely to influence figures regarding gender-based experiences of trauma.

CPTSD Prevalence Rates by Gender and/or Sex

Eight of the nine papers that reported CPTSD diagnostic rates found no gender and/or sex differences, although one reported higher cluster-level CPTSD scores among females. The remaining paper reported higher diagnostic rates among women.

All but two of these papers used self-report measures to capture CPTSD diagnostic status, which may be vulnerable to the influence of gender norms and roles as above. For example, it is possible that men may be underreporting difficulties they experience due to pervasive norms that perpetuate the idea that men must appear to be strong and unemotional (Donne et al., 2018). Donne et al. further highlighted problematic correlates of such gender norms, such as the perceived lack of systems to facilitate the processing of trauma and related emotional responses in men, and societal narratives that perhaps are not ready to accept men as affected by traumatic experiences (Donne et al., 2018).

Indeed, it may be the case that prevalence rates are entirely accurate, which would appear to suggest that, currently, there are no reliable and consistent gender- and/or sex-based differences in CPTSD diagnostic rates. One cannot help but wonder, however, about the accuracy of prevalence rates when they exist within systems mediated by context-dependent socially constructed stories about what constitutes trauma and how and in whom it manifests.

CPTSD Clinical Presentation by Gender and/or Sex

Of the eight papers that reported CPTSD clinical presentation, four found higher cluster-level and item-level DSM-5 NACM scores among women or females. Another study found higher overall CPTSD symptoms among women. Of the remaining three papers, one found higher scores for negative self-perception and alterations in systems of meaning among men. The other two included single gender and/or sex samples only, but both reported high levels of emotion dysregulation items.

Issues of gender roles and expectations may be relevant here too. In a comprehensive review of gender as a social construct in relation to PTSD diagnosis and trauma, Street and Dardis (2018) highlighted gender-based differences in the experience and expression of emotions and cognitions consistent with feminine and masculine gender roles. They reported that women tend to experience more self-blame, more negative beliefs about the self, others and the world and higher levels of related emotions such as helplessness, fear and shame following trauma. They argue

that such experiences are consistent with dominant feminine gender roles and their correlates, such as threat-based interpretations of stressors (Street & Dardis, 2018). Of course, expression does not necessarily equate to experience: men, and indeed gender nonbinary individuals, may experience NACM but express these difficulties in other (perhaps gender role-congruent) ways (Street & Dardis, 2018). Indeed, qualitative findings seem to support this, with women tending to internalise emotional pain and men tending to externalise it following complex trauma (Sigurdardottir et al., 2014).

Study Limitations

Papers mostly adopted a binary approach to gender and/or sex, thereby excluding gender diverse and intersex individuals and failing to address gender diversity. Relatedly, many papers appeared to conflate sex and gender, and all but one failed to specify how participants were asked about these constructs.

Many papers lacked ethnicity data and those that did had predominantly White samples. One paper even reduced their demographics section down to percentages of 'White' and 'non-White' participants. This use of language serves to centre White participants as the norm, thereby othering participants whose identities do not fit this description. Studies were also predominantly conducted with Western samples. This is important given that both geography and ethnicity may pertain to cultural narratives about trauma experiences and expression, which may have influenced findings.

Of the studies that reported clinical presentation of CPTSD diagnosis, most only reported cluster-level presentation. Item-specific presentation would clarify findings and provide insight into gender- and sex-based expressions of trauma.

Review Limitations

Current review limitations include the process of inter-rater reliability. Although inter-rater review took place at title/abstract screen and full text review, only 10% of papers were reviewed at each stage. This was deemed appropriate given the scope of the current review, number of papers and related time constraints, but future research would ideally see a greater proportion undergo inter-rater reliability testing.

Future Research

The adoption of gender- and sex-sensitive practices within research should be prioritised. Findings regarding the binary approach to gender and/or sex and the conflation of gender and sex in many cases suggests researchers have much room for improvement regarding these constructs. Researchers would do well to reflect gender and sex diversity in their samples, or at least demonstrate awareness of the diversity in these constructs.

Although not a new concept (Herman, 1992), research on CPTSD diagnoses is in its relative infancy given the recency of this official diagnostic classification. Research should continue to study the experience, development and manifestation of complex trauma to develop further insights into the impact of such experiences. Diverse samples should be studied to enable thorough examination of the intersect between identity factors such as ethnicity, sexual orientation, geography and race and the experience and expression of complex trauma. Qualitative studies would also enable rich insights into the nuances and idiosyncrasies of such experiences.

Recommendations for Practice

Findings suggest that attention should be paid to gender- and sex-sensitive research, and this also applies clinical practice. If research adopts binary approaches to gender and sex, clinicians ought to be aware of biases this may perpetuate in the understanding of complex trauma and its effects. After all, evidence-based practice starts with evidence, so if the evidence is biased then it would figure that practice may also follow in this vein.

Relatedly, clinicians ought to be aware of the potential intersect between elements of identity and complex trauma experience and expression. The findings of this review largely suggest there are currently no consistent gender and/or sex differences in rates of CPTSD diagnosis, and that cluster-level NACM scores tend to be higher in women and/or females. Both findings, however, may be shaped by societal narratives regarding gender roles and the experience and expression of complex trauma depending on other elements of individuals' identities. This is not to suggest that similarities and/or differences in CPTSD diagnosis rates should be overlooked or ignored. Rather, clinicians should hold both the prevalence and presentation data alongside an awareness of gender and/or sex-based scripts that may shape or influence them.

Conclusions

This was the first known paper to systematically review and synthesise literature on gender, sex and CPTSD to examine whether gender and/or sex differences exist in the prevalence and clinical presentation of this diagnosis. Findings were mixed. Few studies reported higher prevalence rates among women or females and most reported no gender and/or sex differences. Some studies reported higher NACM scores among women or females. Most studies did not report in gender- and/or sex-sensitive ways. Gender- and sex-sensitive research and clinical practice is needed. Awareness, both in research and clinical practice, is recommended regarding the intersect between identity and the experience and expression of complex trauma.

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Service-Related Project

Are Clients of the AWP Solution Focused Family Service Receiving a Service They Would Recommend to Others?

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Client involvement in mental health care is not a new phenomenon (Millar et al., 2015). Borne out of critiques of the biomedical model, institutionalisation and clients as passive recipients of care (Millar et al., 2015), the involvement of clients in their own care is thought to reflect an active and equitable collaboration between clients and professionals (Lathlean et al., 2006). Referring to more than care alone, client involvement also encompasses clients' roles in the planning, implementation and evaluation of policy, services, training and research (Millar et al., 2015). To further clarify this definition, Millar et al. (2015) conducted concept analysis and identified five key attributes of client involvement in mental health care: a person-centred approach; informed decision-making; advocacy; obtaining client views and feedback; and partnership working.

Client involvement is also thought to improve client choice and promote shared decision-making (Ocloo & Matthews, 2016), a process that positions client and professional knowledge more equally (Beyene et al., 2018). Clients are experts by experience yet are often reportedly left feeling disempowered by involvement with mental health services (Newton et al., 2013). Indeed, even the term 'client involvement' has been criticised for being synonymous with the process of mental health professionals involving clients, rather than clients involving themselves (Newton et al., 2013). This speaks to the power imbalance often inherent in client-professional relationships, and to the power dynamics that can characterise mental health services (Brosnan, 2012).

Issues of power underpin some of the principles of systemic therapy, and the shift that positions client and professional knowledge more equally is in some ways akin to the shift in systemic therapy from first- to second-order cybernetics (Howe & von Foerster, 1974). This saw the therapist's position change from 'expert' to being part of the client system, and therapy to a process of collaborative co-creation of meaning rather than something 'done' to the client (Smyly, 2006). Client involvement in systemic and family therapy is thought to provide services a means to assess the process and progress of the care it provides (Tilden, 2017) and enable client and service to co-construct a process that meets the needs of the client system (Haber et al., 2014). Crucially, client involvement in family therapy must widen the perspective to span the entire family system, rather than just the referred client alone (Lappan et al., 2018).

Obtaining client feedback provides invaluable insight into client experience of mental health services and promotes the evaluation of services. Crucially, it enables client voices to be heard and its systematic use is described as a rich resource in family therapy settings (Rober et al., 2020).

The Service

The Solution Focused Family Service (SFFS) is part of the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). It has seven part-time staff members and has received between 14 and 45 referrals annually over the past four years. Clients typically attend sessions as couples or families, although some attend alone. To gather client experience feedback, AWP indicates that its services use the 'Community Friends and Family Test' questionnaire. Consultation with service leads highlighted that while this questionnaire was routinely sent to clients and families online or via post, response rates were very low and, in many cases, non-existent. The service had no means to collect these data electronically in sessions, and clinicians typically did not remember to give paper copies. The SFFS therefore had limited, if any, client feedback on their experience of the service, without which it was unable to evaluate the care it provided to clients.

Consultation: People with Personal Experience

To consider these challenges, consultation took place with an individual who was a previous SFFS client and whose work focused on client involvement. Alternative means of feedback collection were explored. Based on its successful use in another service in AWP, telephone was identified as a viable data collection method. Consultation also emphasised the importance of including multiple members of the client system.

Aims

The primary aim of the service evaluation was to collect feedback from clients via telephone regarding their experience of the SFFS. The secondary aim was to provide the SFFS with client feedback on which it could build and make improvements should it choose to. The project aimed to evaluate the SFFS by answering the question 'Are clients receiving a service they would recommend to others?'. This project was approved by AWP (Appendix E).

Method

Eligibility Criteria

Index Clients

'Index' clients were individuals for whom the initial referral to mental health services was made. Index clients were from families on the SFFS's active case load at the time of data collection (approximately 40). As the evaluation was based on care received, families who had not yet begun sessions were excluded from this total. Owing to time and resource constraints on data collection, families who had completed sessions and/or been discharged from the service were not contacted, a factor revisited under recommendations.

Family Members

Family members who (i) attended sessions with the index client and (ii) were over the age of 18 were included. Due to the already limited number of child family members of index clients, the lengthier approval procedures for the inclusion of children in research and simultaneous time and resource constraints on data collection, participants under the age of 18 were excluded from the study. All clients and family members had provided prior consent to be contacted for research purposes.

Participants

After exclusion, 15 index clients were included. All bar one index client attended sessions with one or more family member(s). One index client attended with family members who were under the age of 18 and were therefore excluded. All eligible index clients and family members were contacted. No more than two attempts were made to contact clients at the service's request. Data were collected from a total of 19 participants. Of these 19, 10 were index clients and nine were family members. Of the nine family members, four were parents and five were partners of the index client.

Measures

AWP indicate the use of the 'Community Friends and Family Test'. This measure includes open-ended questions, the responses to which would need to be audio recorded to mitigate against possible data collection biases. Due to COVID-19 and related service pressures, however, AWP were not approving the use of audio recording in research. Given the identified data collection method for the current study (telephone), an alternative, telephone-friendly measure with closed questions was identified for accuracy, quality and to reduce bias.

Experience of Service Questionnaire (ESQ)

The Experience of Service Questionnaire (self-report version) (ESQ) (Attride-Sterling, 2002) was identified in consultation as a feasible alternative (see Appendix F). The ESQ is a 12-item measure of client experience. Responses are rated on a three-point scale: *not true* (0); *partly true* (1); *certainly true* (2); and an option for *don't know*. Open-ended questions in this measure were omitted for reasons outlined above. Four additional SFFS-specific items, scored on the same three-point scale, were added: 'The team's approach was a good fit for me'; 'We worked on and talked about what I wanted to work on and talk about'; 'The comments from the reflecting team were useful'; and 'The purpose of the reflecting team was clear to me'. Additional items were developed collaboratively with service leads and separately with an individual with personal experience of the service and were piloted with the latter. The resulting questionnaire was named the SFFS Questionnaire (SFFSQ) (Appendix G). The ESQ measures two underlying constructs: satisfaction with care and satisfaction with

environment (Brown et al., 2014). Brown et al. (2014) found good construct validity and reported that the ESQ differentiated well between more and less satisfied participants.

Telephone ‘Script’

A telephone ‘script’ was used for consistency and quality purposes. The script made explicit that: feedback would contribute towards a service evaluation that would be shared with the NHS Trust and the University of Bath; feedback would be recorded anonymously; the provision of feedback was voluntary; neither the decision to provide feedback nor the feedback itself would affect care received; and responses could be withdrawn up to one month after they were given. The script also outlined that the purpose of the call was to collect feedback only.

Procedure

Index clients and family members were contacted via telephone primarily by a psychology undergraduate student on placement with the AWP Psychological Therapies Service. Three participants were contacted by the study author after the student’s placement ended. Participants were read the information in the script and offered the opportunity to ask questions. Informed consent was obtained. Participants were given (i) a unique code to ensure that names were not linked to responses and (ii) contact details if they decided afterwards that they wanted to withdraw. The SFFSQ was administered. Data were scanned and paper copies destroyed. Data were stored in a secure file on the AWP network. The study was presented to SFFS staff and associated clinicians.

Results

Results are shown in Table 2.1 below as percentage of responses to each item for whole sample and index client versus family members. Index clients constituted 52.6% of the sample. Of the family members (47.4%), 21.1% were parents and 26.3% were partners of the index client.

Table 2.1

SFFSQ Responses

SFFSQ Item	Responses (%)				
	(client / family member)				
	Not true	Partly true	Certainly true	Don’t know	N/A
1. I feel that the people who saw me listened to me.	0	10.5 (10 / 11.1)	89.5 (90 / 88.9)	0	0
2. It was easy to talk to the people who saw me.	0	21.1 (20 / 22.2)	78.9 (80 / 77.8)	0	0
3. I was treated well by the people who saw me.	0	15.8 (10 / 22.2)	84.2 (90 / 77.8)	0	0

4.	My views and worries were taken seriously.	0	10.5 (20 / 0)	89.5 (80 / 100)	0	0
5.	I feel the people here know how to help.	5.3 (10 / 0)	47.4 (40 / 55.6)	42 (50 / 33.3)	5.3 (0 / 11.1)	0
6.	I have been given enough explanation about the help available here.	0	63.2 (50 / 77.8)	36.8 (50 / 22.2)	0	0
7.	I feel that the people who have seen me are working together to help.	0	15.8 (30 / 0)	84.2 (70 / 100)	0	0
8.	The team's approach was a good fit for me.	0	47.4 (50 / 44.4)	47.4 (40 / 55.6)	5.2 (10 / 0)	0
		Not true	Partly true	Certainly true	Don't know	N/A
9.	We worked on and talked about what I wanted to work on and talk about.	0	47.4 (40 / 55.6)	47.4 (50 / 44.4)	5.2 (10 / 0)	0
10.	The comments from the reflecting team were useful.	5.3 (10 / 0)	26.2 (30 / 22.2)	57.9 (60 / 55.6)	5.3 (0 / 11.1)	5.3 (0 / 11.1)
11.	The purpose of the reflecting team was clear to me.	0	10.5 (20 / 0)	84.2 (80 / 88.9)	0	5.3 (0 / 11.1)
12.	The facilities here are comfortable.	0	10.5 (10 / 11.1)	63.2 (60 / 66.7)	5.3 (10 / 0)	21 (20 / 22.2)
13.	My appointments are usually at a convenient time.	5.3 (0 / 11.1)	10.5 (20 / 0)	84.2 (80 / 88.9)	0	0
14.	It is quite easy to get to the place where I have my appointments.	0	21 (20 / 22.2)	73.7 (70 / 77.8)	0	5.3 (10 / 0)
15.	If a friend needed this sort of help, I would suggest to them to come here.	0	15.8 (10 / 22.2)	78.9 (80 / 77.8)	5.3 (10 / 0)	0
16.	Overall, the help I have received here is good.	0	10.5 (10 / 11.1)	84.2 (80 / 88.9)	5.3 (10 / 0)	0

For 12 items, the most favourable response was given by most participants. Items one and four were endorsed most strongly overall. Items five, six, eight and nine received varied response patterns overall. Clients and family members responded similarly to most items. Response patterns between clients and family members differed for items five, six, eight and nine. Overall, 78.9% of participants said they would recommend the service to a friend if they needed similar help, and 84.2% agreed

that the help they received was good. Average responses to each item from clients versus family members are shown in Table 2.2.

Table 2.2

Average SFFSQ Item Responses (Client vs. Family Member)

SFFSQ Item	Responses (median)	
	Client	Family member
1. I feel that the people who saw me listened to me	2	2
2. It was easy to talk to the people who saw me	2	2
3. I was treated well by the people who saw me	2	2
4. My views and worries were taken seriously	2	2
5. I feel the people here know how to help	1.5	1
6. I have been given enough explanation about the help available here	1.5	1
7. I feel that the people who have seen me are working together to help	2	2
8. The team's approach was a good fit for me	1	2
9. We worked on and talked about what I wanted to work on and talk about	2	1
10. The comments from the reflecting team were useful	2	2
11. The purpose of the reflecting team was clear to me	2	2
12. The facilities here are comfortable	2	2
13. My appointments are usually at a convenient time	2	2
14. It is quite easy to get to the place where I have my appointments	2	2
15. If a friend needed this sort of help, I would suggest to them to come here	2	2
16. Overall, the help I have received here is good	2	2

Table 2.2 shows responses were largely positive. The average response to 12 of the 16 items was the maximum (most favourable) response. Items five and six were endorsed overall less favourably than other items, and relatively more favourably by clients than family members. Item eight was endorsed by family members equally as strongly as other items on average, but relatively less strongly by clients. Item nine was endorsed by clients equally as strongly as other items on average, but relatively less strongly by family members.

Data were presented to, and discussed among, staff within the service. The findings generated several reflections during a reflective space immediately following the presentation. Specific reflections are discussed below.

Discussion

The current study sought to collect client feedback on their experience of the AWP SFFS and evaluate the SFFS by answering the question 'Are clients receiving a service they would recommend to others?'. Data were collected from 19 participants, of whom 10 were index clients and nine were family members. Responses were largely positive. Most clients and family members endorsed the most favourable response on

12 of the 16 items, including that they would recommend the SFFS to a friend and that the help they received at the SFFS was good. Four items (five, six, eight and nine) received mixed responses. Most participants only partly agreed that they had been given enough explanation about the help available at the SFFS (item six). Further information about the service may remedy this and, as such, this is revisited in the recommendations below.

Item five ('I feel the people here know how to help') received mixed responses from both clients and family members. Further consideration may point to some possible explanations. The concept of help, and a sense that services know how to help, rests on the conceptualisation of what is being helped (i.e. a definition or perception of the 'problem'). The questions 'Who wants what for whom?' and 'For whom is the current referral issue a problem?' may be useful to consider (Anderson & Johnson, 2010; Smyly, 2006). System members may respond differently to these questions. They may have divergent perceptions of the 'problem' and therefore divergent ideas about what appropriate help looks like and whether services know how to offer and deliver that. The perception that a service knows how to help may emerge from a sense that the service is helping the thing one perceives to be the problem, which may be different for different people.

Beliefs and expectations about help may also vary depending on previous experience(s) of help (Reder & Fredman, 1996). As these authors point out, the process of giving and receiving help is influenced by the stories that clients (and professionals) construct about it, and the expectations and meanings they ascribe to it. Stories about help-seeking may differ from person to person. Reflections among SFFS staff also raised queries about how the service can consolidate potential client expectations of the service as the 'expert' with the service's solution-focused approach that the family is the expert. Clients and family members may not feel the service knows how to help if, indeed, they position the service as the expert, then arrive to unexpectedly find themselves to be in that position. Families may perceive this positioning as a lack of knowledge or competence on the part of the service.

Items eight ('The team's approach was a good fit for me') and nine ('We worked on and talked about what I wanted to work on and talk about') refer to the challenges presented by family therapy: multiple alliances; multiple perspectives; and multiple outcomes (Lappan et al., 2018). Interestingly, item eight was endorsed equally as strongly by family members as other items on average, but less so by clients. The opposite was true for item nine, which was endorsed equally as strongly by clients as other items on average, but less so by family members. This suggests that more family

members than clients thought the team's approach was a good fit for them, but more clients than family members talked about what they wanted to talk about.

Responses to items eight and nine suggest family members had hopes or expectations for therapy that were not being met. A good therapeutic fit is highly personal. Likewise, goals and intentions for therapy likely differ from person to person. In a review of client feedback in family therapy, Lappan et al. (2018) highlighted that feedback loops and predictable client feedback collection facilitate collaborative conversations about hopes and expectations for therapy, which enhances client outcomes. Therapeutic focus and therapeutic fit may not suit each member of a family system. Lappan et al.'s findings suggest routine client feedback would enable further exploration of this. This was reflected on by SFFS staff, who wondered how to continue to incorporate systemic reflexivity when working virtually due to the COVID-19 pandemic, and how to usefully check-in with clients and families about what may or may not be working for them. Discussions were also held amongst staff regarding the process of feedback collection when therapy is virtual.

Limitations

This service evaluation has limitations worth consideration. First, number of sessions attended at the point of data collection varied, which may have biased responses. Second, some questionnaire items were arguably ambiguous. For example, 'It was easy to talk to the people who saw me' could have referred both to the ease with which participants were able to talk to clinicians and how easy they found it to talk about difficulties in general. Relatedly, few studies have evaluated the psychometric properties of the ESQ. Another tool may have been more appropriate. At the time of writing, however, no such alternative was known. Fourth, the sample was relatively small. The SFFS is a small service, and the potential N was therefore inevitably low. Future remedies could include a longer data collection period and data collection from completed, discharged and child clients. Finally, participant demographics were not collected. Such information may have enabled further insights into the data (e.g. participant age may be related to cohort beliefs regarding help-seeking behaviours).

What the Service is Doing Well

Participants reported largely positive experiences of the SFFS. Both clients and family members felt that clinicians listened to them. They found it easy to talk to their clinicians, thought they were treated well and thought their views and worries were taken seriously. The latter was particularly true for family members. Clients and family members thought clinicians were working together to help them. The reflecting team was experienced positively by many participants, with the majority reporting that the team's purpose was clear to them and that their comments were useful. Appointments

were at convenient times for both clients and family members. Overall, most clients and family members agreed that the help they received at the SFFS was good, and that they would recommend the service to a friend.

Recommendations

Data in this study were based on responses from a limited number of clients and little prior feedback data exists. It is recommended that the service prioritises regular client feedback in its service delivery. Feedback could be obtained online, via telephone or paper (either post or in person) and should be collected from all referred clients, including those who are discharged post-completion and those who do not go on to commence sessions. The latter may have important and relevant feedback that may not pertain to the sessions themselves (e.g. communication, wait times etc). An alternative questionnaire with more relevant items (i.e. not specifically regarding sessions with clinicians) might be more appropriate in this instance. The service is also encouraged to collect feedback from children under the age of 18. Regular client feedback may promote and facilitate collaborative client discussions regarding expectations for therapy.

Most clients and family members only partly agreed that they had been given enough explanation about the help available at the SFFS. The service is encouraged to further investigate what information clients would find useful. Family member responses were particularly mixed, so family members should be a key focus.

Finally, although the purpose of the reflecting team was clear to most participants, a fifth of index clients rated this only partly true. It may be beneficial to explore this further with clients beforehand and revisit this to check understanding. This final recommendation was considered in the SFFS's reflections, where they discussed the importance of revisiting scripts and the ways the reflecting team is described and spoken about. Discussions focused on reflexivity and the possibility of asking clients and family members what they would prefer from the reflecting team (e.g. one reflection from each team member).

Conclusions

This study evaluated the AWP SFFS to answer the question 'Are clients of the SFFS receiving a service they would recommend to others?'. Clients on the active caseload and their family members were contacted and the SFFSQ was administered. Findings were largely positive: average responses to 12 of the 16 items were the most favourable option available. Findings from the remaining four items were somewhat mixed. Consistent collection of client feedback is recommended to enable collaborative discussions with clients and family members regarding therapy expectations and the therapy process. Adaptations can be made accordingly. Further investigation is

recommended into the types of service information clients and family members would find useful. Finally, revisiting client, family member and service scripts about the reflecting team would be useful.

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Main Research Project

How Do People Make Sense of Intimate Partner Violence (IPV) in the Context of Perpetrator PTSD Diagnostic Status and Gender Identity?

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Intimate partner violence (IPV) is behaviour in an intimate relationship that causes physical, psychological or sexual harm (World Health Organisation, 2012). IPV encompasses physical and sexual violence, psychological abuse (e.g. humiliation) and controlling behaviours (e.g. isolating) (WHO, 2012). Reportedly experienced by 2.4 million adults (5%) in England and Wales in 2021-2022 (Office for National Statistics [ONS], 2022), IPV has profound effects on victim physical and mental health (Campbell, 2002), considerable social and economic costs (Home Office, 2019) and is a public health concern.

Often unreported, IPV is a concealed problem, and few reported cases are recorded as crimes (ONS, 2020). Official figures are, therefore, likely to be misleading. Several possible reasons are worth consideration. Variation remains in public sense-making of IPV. IPV has been considered a private matter (Montalvo-Liendo, 2008). Physical abuse is often appraised as IPV, but non-physical abuse may be considered less abusive (Carlson & Worden, 2005; Minto et al., 2020). Indeed, individuals in emotionally, economically or verbally abusive relationships reportedly did not consider this abuse (Cravens et al., 2015).

Common in media headlines (Lloyd & Ramon, 2016), IPV discourses tend to blame victims (Waltermaurer, 2012). This is concerning, as helping agencies such as criminal justice and healthcare systems share contexts with these discourses. Indeed, victim-blaming tendencies reportedly exist among some healthcare professionals (Sprague et al., 2012). Police may be more likely to arrest perpetrators of physical abuse over other forms (Myhill, 2017) and arrests reportedly depend on victim gender (Fagerlund, 2021).

One important factor is perceived acceptability of IPV (Waltermaurer, 2012). IPV sense-making varies with context, as individuals reportedly use 'conditional logics' to legitimise abuse (Lelaurain et al., 2018). This is significant, as those who maintain that IPV is admissible are less likely as victims to report it and more likely to self-blame (Tran et al., 2016). Possible conditional logics include perpetrator substance use (Javaid, 2015), mental health difficulties (Varshney et al., 2016) and gender (Carlson & Worden, 2005).

Abuse perpetrated by men may be considered admissible in some contexts (Hayes & Boyd, 2017), and abuse perpetrated by women is less likely to be appraised as IPV (Carlson & Worden, 2005). This indicates an ambiguous relationship between IPV and gender. Factors relevant to IPV legitimisation may pertain to cisgender stereotypes (Scarduzio et al., 2016), while the context in gender nonbinary communities is more uncertain. Abuse is reportedly more common in gender nonbinary communities (Peitzmeier et al., 2020), but research is lacking regarding sense-making of IPV committed by gender nonbinary individuals. Such findings may be considered in the

context of intersectionality. Thought to be one of many social identities (e.g. gender identity, sexual orientation, race, class) that intersect to either marginalise and oppress or privilege individuals within social structures fraught with hierarchy and systemic oppression (e.g. sexism, cisgenderism) (McLeod et al., 2020), gender identity may serve as a marginalising or privileging factor in IPV legitimisation.

Research highlights a relationship between post-traumatic stress disorder (PTSD) diagnoses and IPV perpetration (Shorey et al., 2021). Whether this is a conditional logic, however, is uncertain, although research suggests IPV appraisals may vary with this diagnosis (Mackinnon et al., 2023). Further research is needed regarding perceived admissibility of IPV in this context.

Public sense-making of IPV is nuanced, something the UK government aimed to address via the Domestic Abuse Bill 2020 (Home Office, 2020a). Detailing a revised description of abuse to include coercive control, psychological and financial abuse, the bill hoped to improve public understanding, victim safeguarding and legal system responses. However, gaps exist in the literature regarding public sense-making of IPV and factors that facilitate its justification. Narratives may be internalised by victims of IPV and their communities, and may affect disclosures, responses and management. Research is, therefore, necessary to explore public discourses of IPV.

Aims

This study aimed to explore how people make sense of IPV in the context of perpetrator diagnostic status (PTSD or no PTSD) and gender identity (female, male or nonbinary) by exploring IPV ratings and IPV discourses. The study differentiated between sex and gender. Sex refers to anatomy, chromosomes and hormones and is typically assigned at birth; gender refers to an individual's identity (a deep, self-defined internal sense of self) and a social construct (societal perceptions including roles, norms and expectations) (Gender Spectrum, 2019). Gender may or may not correspond with sex. The word 'victim' was chosen for individuals experiencing IPV, but the author acknowledges some may prefer 'survivor'.

The study explored effects of perpetrator qualities only. It built upon research conducted by a previous University of Bath trainee clinical psychologist, which investigated public IPV discourses regarding military background and PTSD diagnosis (Mackinnon et al., 2023).

Owing to its preliminary nature, study hypotheses were broad. Hypotheses were:

- (i) IPV ratings would vary with perpetrator diagnostic status and gender identity;
and
- (ii) IPV discourses would vary with perpetrator diagnostic status and gender identity.

Method

Ethical Approval

The study received ethical approval from the University of Bath Psychology Research Ethics Panel (reference 21-257) (Appendix I).

Design

A between-groups, mixed methods design was used. All participants completed quantitative measures and half a qualitative exercise. Independent variables were perpetrator diagnostic status (PTSD or no PTSD) and gender identity (female, male or nonbinary). Dependent variables were IPV ratings and IPV discourses.

Participants

Participants were adults (18+ years) in the UK ($N = 265$) (Appendix J) recruited via social media and research participation panels (Appendix K). Age, ethnicity and sexual orientation were collected ($N = 265$). Partway through data collection, the participant gender question was reworded to reflect the author's position on gender identity and sex and align with the ONS Census 2021 language regarding sex and gender identity (see Appendix L). Therefore, gender data was collected for approximately half the participants ($n = 137$) and sex assigned at birth and gender identity data for the remaining participants ($n = 128$) (Table 3.1).

Table 3.1.

Demographic Data (N = 265)

Demographic category	<i>n (%)</i>
Age	
18–20	34 (12.8)
21–30	85 (32.1)
31–40	55 (20.8)
41–50	22 (8.3)
51–60	26 (9.8)
61–70	30 (11.3)
71–80	9 (3.4)
81–90	3 (1.1)
Prefer not to say	1 (.4)
Gender ($n = 137$)	
Female	101 (73.7)
Male	31 (22.6)
Nonbinary	2 (1.5)
Prefer not to say	3 (2.2)
Sex ($n = 128$)	
Female	85 (66.4)
Male	43 (33.6)
Prefer not to say	0 (0)
Gender identity ($n = 128$)	
Corresponds to sex	127 (99.2)
Does not correspond to sex	1 (.8)
Ethnicity	
Asian or Asian British – Indian	8 (3)
Asian or Asian British – Pakistani	2 (.8)
Asian or Asian British – Bangladeshi	1 (.4)
Asian or Asian British – Chinese	3 (1.1)
Asian or Asian British – Any other Asian background	1 (.4)
Black, African, Caribbean or Black British – African	1 (.4)

Black, African, Caribbean or Black British – Caribbean	1 (.4)
Mixed or multiple ethnic groups – White and Black Caribbean	3 (1.1)
Mixed or multiple ethnic groups – White and Black African	1 (.4)
Mixed or multiple ethnic groups – White and Asian	2 (.8)
Mixed or multiple ethnic groups – Any other mixed or multiple ethnic background	4 (1.5)
White – English/Welsh/Scottish/Northern Irish/British	212 (80)
White – Irish	8 (3)
White – Any other White background	14 (5.3)
Other ethnic group – Any other ethnic group	1 (.4)
Prefer not to say	3 (1.1)
Sexual orientation	
Heterosexual/straight	223 (84.2)
Gay/lesbian	13 (4.9)
Bisexual	17 (6.4)
Prefer to self-describe	7 (2.6)
Prefer not to say	5 (1.9)

Age ranged from 18 to 90 years old and was positively skewed. Ethnicity was somewhat representative (80% White British), as 74.4% of the population in England and Wales are White British (ONS, 2022). Women were overrepresented (70.2%), and three participants identified as gender nonbinary (2.3%). Of those asked ($n = 128$), most said their gender identity corresponds to their sex assigned at birth (99.2%). Reasonably well matched, gender identities of 93.5% of the population in England and Wales correspond to sex assigned at birth (0.5% do not; 6% missing) (ONS, 2023). Sexual orientation was reasonably well matched (84.2% heterosexual), as 89.4% of the population in England and Wales identify as heterosexual (ONS, 2023). Among participants who preferred to self-describe their sexual orientation (2.6%), responses were ‘queer’, ‘pansexual’ and/or ‘asexual’.

Participants were asked about relevant professional experience (working in a professional capacity with someone with experience), indirect personal experience (supporting someone in a personal capacity) and direct personal experience of IPV, PTSD diagnosis and nonbinary gender identity (Appendix M) (Table 3.2).

Table 3.2.

Participant Relevant Experience (N = 265)

		Experienced IPV <i>n (%)</i>	Perpetrated IPV <i>n (%)</i>	Received PTSD diagnosis <i>n (%)</i>	Partner received PTSD diagnosis <i>n (%)</i>	Identified as nonbinary <i>n (%)</i>
Professional experience	Yes	140 (52.8)	69 (26.0)	111 (41.9)	52 (19.6)	92 (34.7)
	No	86 (32.5)	124 (46.8)	104 (39.2)	158 (59.6)	149 (56.2)
	Not sure	38 (14.3)	70 (26.4)	49 (18.5)	54 (20.4)	23 (8.7)
	Prefer not to say	1 (.4)	2 (.8)	1 (.4)	1 (.4)	1 (.4)
Indirect personal experience	Yes	145 (54.7)	31 (11.7)	68 (25.7)	31 (11.7)	71 (26.8)
	No	108 (40.8)	215 (81.1)	168 (63.4)	201 (75.8)	186 (70.2)
	Not sure	10 (3.8)	19 (7.2)	29 (10.9)	32 (12.1)	8 (3.0)
	Prefer not to say	2 (.8)	0 (0)	0 (0)	1 (.4)	0 (0)

Direct personal experience	Yes	66 (24.9)	10 (3.8)	20 (7.5)	10 (3.8)	5 (1.9)
	No	183 (69.1)	245 (92.5)	242 (91.3)	239 (90.2)	258 (97.4)
	Not sure	12 (4.5)	9 (3.4)	3 (1.1)	16 (6.0)	2 (.8)
	Prefer not to say	4 (1.5)	1 (.4)	0 (0)	0 (0)	0 (0)

There were high rates of professional experience with IPV (52.8%) and PTSD diagnosis (41.9%) and indirect personal experience with IPV (54.7%). Rates of direct personal experience of IPV (24.9%) and PTSD diagnosis (7.5%) were elevated compared to UK prevalence rates for IPV (5%; ONS, 2022) and PTSD diagnosis (3.88%; PTSD UK, 2022).

Materials

Story

A story depicting IPV between two partners was adapted from Mackinnon et al. (2023) (Appendix N). In the story, Alex hid a phone belonging to Frances (control) then hit a wall and threw the phone towards Frances (physical threats; aggression). Frances told a friend, Nicky, and asked for advice. Stories were identical across conditions bar perpetrator diagnostic status (PTSD or no PTSD) and perpetrator gender identity (female, male or nonbinary). Names were chosen to be gender neutral.

Measures

Measures included the quantitative IPV Rating Scale (Mackinnon et al., 2023) and qualitative story completion (SC) task (Clarke et al., 2017) (Table 3.3).

Table 3.3.

Study Measures

Measure	Purpose	Description
Intimate Partner Violence (IPV) Rating Scale (Mackinnon et al., 2023)	To test the hypothesis that IPV ratings would vary with perpetrator diagnostic status and gender identity.	A scale from 0 (<i>definitely not abuse</i>) to 10 (<i>definitely is abuse</i>) measured participant appraisal of the behaviour in the story by the degree to which they thought the behaviour constituted IPV ¹ (see Appendix O).
Story Completion Task (Clarke et al., 2017)	To test the hypothesis that IPV discourses would vary with perpetrator diagnostic status and gender identity.	Participants were asked to complete the story stem. The prompt questions ' <i>What happens next?</i> ' and ' <i>What advice does Nicky give Frances?</i> ' were given to facilitate story completion.

Suitable for various theoretical positions, SC was analysed within a contextualist framework, which acknowledges that realities are mediated by socio-cultural meanings.

Procedure

¹ 'Domestic abuse' was used in the study text as this is a more commonly used phrase in lay terms.

The study was hosted online via Qualtrics. Participants were told the study aim was 'how we make sense of personal relationships' to reduce priming regarding IPV (Appendix P). Informed consent and demographic information were collected. Participants were randomly assigned via Qualtrics function to one of six groups: (i) Female-PTSD; (ii) Female-No PTSD; (iii) Male-PTSD; (iv) Male-No PTSD; (v) Nonbinary-PTSD; (vi) Nonbinary-No PTSD. The relevant story was provided, and participants rated the extent to which they thought the behaviour constituted IPV. Approximately half the participants were randomly allocated via Qualtrics function to the story completion exercise. Finally, participants were asked to specify their perception of the victim gender (Appendix Q). A debrief with information of relevant support organisations was provided to all participants on study completion (Appendix R).

Data Analysis

Quantitative Data

A G*Power analysis indicated that, based on Cohen's (1992) effect sizes and an alpha of .05, samples of 107 and 400 were needed for small and medium effect sizes, respectively. The study was, therefore, adequately powered to identify medium and small-medium effects.

Data pre- and post-participant demographic question change were analysed together. This decision was made because participant gender, gender identity and sex assigned at birth did not significantly affect IPV ratings, and the author's position is that gender is a construct, so separating the data based on different perceptions of this would be arbitrary.

Exploratory analysis identified three outliers in conditions three (Male-PTSD) and six (Nonbinary-No PTSD) and significant negative skew in condition six (Nonbinary-No PTSD). As the study was preliminary, all data including outliers were analysed, and the large sample size meant a normal distribution was not necessary (Field, 2013). A two-way ANOVA, therefore, measured main and interactive effects of perpetrator diagnostic status (PTSD or no PTSD) and gender identity (female, male or nonbinary) on IPV ratings. An ANCOVA measured effects of demographic and relevant experience variables on IPV ratings. Parameter estimates were based on 1000 bootstrapped samples to increase robustness (Field, 2013). Finally, victim gender check frequencies were calculated. As the study explored effects of perpetrator characteristics, the victim gender check was not an outcome measure, but captured broad narratives about who experiences IPV. Frequencies were, therefore, calculated for the whole sample.

Qualitative Data

Approximately half the participants in each condition were randomly assigned to the story completion task ($n = 130$). Data were uploaded to NVivo and analysed using reflexive thematic analysis (RTA) (Braun & Clarke, 2019) to explore themes in public sense-making of IPV. RTA was used within a contextualist framework and ‘reflexive’ acknowledges researcher subjectivity in theme identification. The author familiarised themselves with the data then generated codes to capture meaning in the data. Codes were semantic and captured explicit meaning in the data (where codes were latent this is clearly noted). Inter-rater reliability checks of codes were not used as inter-rater reliability is grounded in a positivist framework that presupposes a reality in the data. Codes were collated into themes and reflected upon and refined with the primary supervisor. Code frequency was explored to identify theme similarities and differences across conditions.

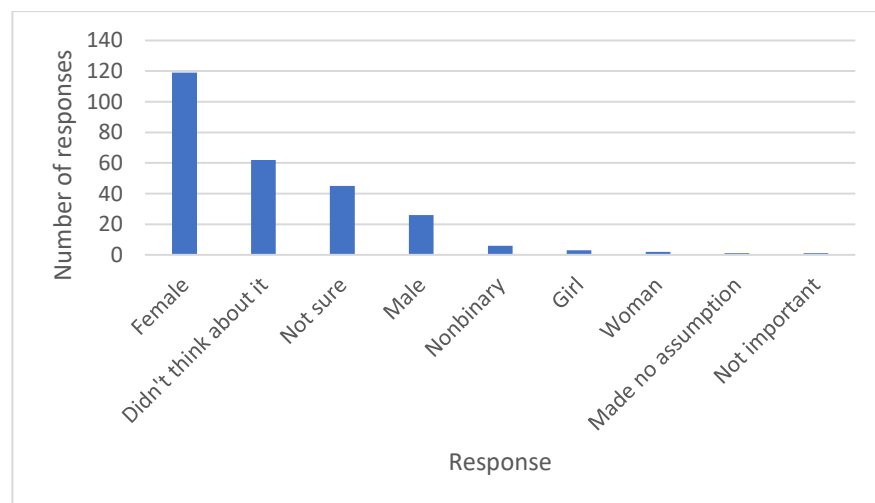
Results

Victim Gender Check

Participant perceptions of victim gender are shown below (Figure 3.1).

Figure 3.1.

Victim Gender Check Responses (N = 265)



Nearly half the participants ($n = 119$; 44.9%) responded ‘female’. Remaining responses were ‘did not think about it’ (62; 23.4%), ‘not sure’ (45; 17%), ‘male’ (26; 9.8%), ‘nonbinary’ (six; 2.2%), ‘girl’ (three; 1.1%), ‘woman’ (two; 0.8%), ‘made no assumption’ (one; 0.4%) and ‘not important’ (one; 0.4%).

IPV Ratings

IPV rating statistics are shown in Table 3.4.

Table 3.4.*IPV Ratings (N = 265)*

		Condition 1 Female-PTSD (n = 45)		Condition 2 Female-No PTSD (n = 46)		Condition 3 Male-PTSD (n = 43)		Condition 4 Male-No PTSD (n = 43)		Condition 5 Nonbinary- PTSD (n = 44)		Condition 6 Nonbinary-No PTSD (n = 44)	
		Statistic	Std. Error	Statistic	Std. Error	Statistic	Std. Error	Statistic	Std. Error	Statistic	Std. Error	Statistic	Std. Error
Mean		7.733	.299	7.804	.319	7.534	.346	8.116	.279	8.204	.268	7.954	.360
95% Confidence Interval for Mean	Upper Bound	8.304		8.414		8.219		8.666		8.704		8.639	
	Lower Bound	7.127		7.125		6.866		7.525		7.674		7.189	
Std. deviation		2.082		2.156		2.281		1.734		1.719		2.322	
Variance		4.336		4.650		5.207		3.010		2.957		5.393	
Minimum		3.00		2.00		1.00*		3.00		3.00		1.00*	
Maximum		10.00		10.00		10.00		10.00		10.00		10.00	
Range		7.00		8.00		9.00		7.00		7.00		9.00	
Skewness		-.465	.354	-1.084	.350	-.917	.361	-.933	.361	-.879	.357	-1.273**	.357
Kurtosis		-.645	.695	.567	.688	.329	.709	.749	.709	.580	.702	1.182	.702

*Significant outliers identified by box plots.

**Significant skew (z-score -3.565; $p < .001$).

The highest mean rating was found in Nonbinary-PTSD ($M = 8.20$; $SD = 1.72$). Mean ratings were similar across conditions, with the maximum rating given in every condition and significant negative skew in Nonbinary-No PTSD (z -score -3.565 , $p < .001$). There were significant outliers in Male-PTSD and Nonbinary-No PTSD.

A two-way ANOVA found no significant interaction between diagnostic status and gender identity on IPV ratings ($F [2, 259] = .896$, $p = .410$, partial $\eta^2 = .007$). There was no significant main effect of diagnostic status ($F [1, 259] = .279$, $p = .598$, partial $\eta^2 = .001$) or gender identity ($F [2, 259] = .569$, $p = .567$, partial $\eta^2 = .004$) on IPV ratings. The model fit was weak ($r^2 = .012$), meaning most of the variance in IPV ratings is best explained by other factors.

Covariates

An ANCOVA found no significant effect of participant demographic or relevant experience variables on IPV ratings. Professional experience of experienced IPV (working in a professional capacity with someone who had experienced IPV) approached but did not reach significance ($F [1, 258] = 3.621$, $p = .058$, partial $\eta^2 = .014$).

IPV Discourses

RTA led to the identification of five themes: (i) characterise the behaviour; (ii) trajectory of IPV; (iii) show compassion towards victim of IPV; (iv) hold victim of IPV responsible; and (v) context influences decision-making (Tables 3.5 to 3.9). Most themes had subthemes. Themes and subthemes were identified in all conditions, but theme frequency varied.

Characterise the Behaviour

Participants consistently characterised Alex’s behaviour. Responses included descriptors and language that considered its frequency, duration and cause. Two subthemes were identified: (i) ‘what’; and (ii) ‘where, when, why and how’ (Table 3.5).

Table 3.5.

Data Extracts for ‘Characterise the Behaviour’ (n = 130)

Theme	Sub-theme	Example data extract
Characterise the behaviour	‘What’	“Nicky tells Frances that Alex’s behaviour is unacceptable” (PP109; Female-No PTSD)
		“Nicky suggests that Alex is being abusive” (PP169; Female-PTSD)
		“She points out that hiding someone’s phone is controlling and not normal or okay.” (PP45; Male-No PTSD)
		“God Frances, he’s so controlling! Why would he try to hide your phone from you? It’s scary. It’s not right.” (PP139; Male-PTSD)
		“...she considers this to be unacceptably violent...” (PP12; Nonbinary-No PTSD)

	“Nicky says it’s aggressive and controlling” (PP20; Nonbinary-PTSD)
‘Where, when, why and how’	“Nicky would ask how often this happened before to try and understand if this a common occurrence in their relationship.” (PP53; Female-No PTSD)
	“Nicky is aware of Alex’s mental health history and understands that some of her behaviours might be linked to this.” (PP154; Female-PTSD)
	“Nicky asks Frances if this has been going on for the entire five years of their relationship” (PP190; Male-No PTSD)
	“How long has this been going on for?” (PP190; Male-PTSD)
	“But what was that argument about/what triggered it” (PP38; Nonbinary-No PTSD)
	“What does Frances think could be the reason for this behavior. She also asks her if Frances has noticed any pattern or specific time or event which triggers this kind of behavior.” (PP198; Nonbinary-PTSD)

The behaviour was repeatedly described as aggressive, controlling, violent, abusive and unacceptable. ‘Abusive’ and ‘domestic violence’ were used more frequently in no PTSD than PTSD conditions regardless of gender identity, and most frequent in Nonbinary-PTSD. Responses across conditions linked the PTSD diagnosis to the behaviour but there was no theme regarding PTSD diagnosis as an excuse.

Trajectory of IPV

Language consistently referenced a trajectory of IPV. This trajectory organised immediate reactions and assumptions about the future. Three subthemes were identified: (i) once is a mistake; act if it happens twice; (ii) it will escalate; and (iii) it will become physical (Table 3.6).

Table 3.6.

Data Extracts for ‘Trajectory of IPV’ (n = 130)

Theme	Sub-theme	Example data extract
Trajectory of IPV	Once is a mistake; act if it happens twice	<p>“...as this has happened before, it is now time to calmly discuss this with Alex and to possibly seek some help.” (PP124; Female-No PTSD)</p> <p>“Nicky suggested that Frances sees how the conversation goes before making any rash decisions such as ending the relationship but also makes it clear to Alex that this will be a consequence if her behaviour continues.” (PP146; Female-PTSD)</p> <p>“Nicky would hopefully say to Frances to leave the relationship with Alex, particularly as it is a repetitive behaviour.” (PP247; Male-No PTSD)</p> <p>“However, they have talked about this behaviour before and Nicky can see it is not a one-off mistake.” (PP224; Male-PTSD)</p> <p>“If this was the first occurrence of them getting abusive during an argument then there could be some chance of reconciliation.” (PP221; Nonbinary-No PTSD)</p>

	<p>“Frances should consider reporting Alex’s behaviour to the police, especially since this was not a one off that could be explained away.” (PP240; Nonbinary-PTSD)</p>
It will escalate	<p>“It is likely to escalate and she is likely to physically abuse Frances eventually if they stay together.” (PP244; Female-No PTSD)</p> <p>“She feels things might continue this way, or even get worse which she tells Frances.” (PP132; Female-PTSD)</p> <p>“Nicky advises Frances to leave the relationship as she predicts things will only get worse and more violent in the future.” (PP89; Male-No PTSD)</p> <p>“Further, Nicky may warn Frances to be careful and use precautions (like staying with a friend) as abusive relationships like this often escalate even more after a breakup.” (PP257; Male-PTSD)</p> <p>“Nicky tells Frances that she does not deserve to be treated like that, and that it has happened before and will happen again, but perhaps worse” (PP64; Nonbinary-No PTSD)</p> <p>“Nicky suggests that Frances move out temporarily as they are worried about Alex’s behaviour escalating” (PP136; Nonbinary-PTSD)</p>
It will become physical	<p>“Frances should leave that relationship before physical harm has been inflicted.” (PP232; Female-No PTSD)</p> <p>“The relationship also sounds like it could potentially put Frances and Alex in physical danger which should immediately raise red flags.” (PP229; Female-PTSD)</p> <p>“...that behavior is unacceptable and can easily escalate to physically hurt Frances.” (PP207; Male-No PTSD)</p> <p>“ ‘ This time it was a phone that grazed your face, what happens next time when he doesn’t miss and hurts you badly. What then?’ ” (PP246; Male-PTSD)</p> <p>“Frances is in danger of getting physically hurt as next time the object may hit her.” (PP22; Nonbinary-No PTSD)</p> <p>“Nicky worries that Frances is being emotionally abused and at risk of physical abuse.” (PP61; Nonbinary-PTSD)</p>

Participants gave conditional advice organised by a premise that one-off IPV could be reconciled, but repetition warrants action. Predictions that things would inevitably escalate were more frequent in no PTSD than PTSD conditions, regardless of gender identity. ‘Escalate’ tended to equate to physical harm (typically inflicted on the victim).

Show Compassion Towards Victim of IPV

Language conveyed compassion towards the victim. Two sub-themes were identified: (i) sensitivity to suffering; and (ii) attempts to alleviate or prevent suffering (Table 3.7).

Table 3.7.**Data Extracts for 'Show Compassion Towards Victim of IPV' (n = 130)**

Theme	Sub-theme	Example data extract
Show compassion towards victim of IPV	Sensitivity to suffering	<p>"Nicky listens to Frances with a concerned look on her face." (PP137; Female-No PTSD)</p> <p>"Nicky is sad for Frances and angry that Alex treats Frances this way." (PP71; Female-PTSD)</p> <p>"...she would check in with Frances regularly to make sure things are okay." (PP207; Male-No PTSD)</p> <p>"Nicky tells Frances that they will be there for them regardless but that they have their best interests at heart and want them to be safe." (PP107; Male-PTSD)</p> <p>"Nicky tells Frances that she does not deserve to be treated like that" (PP64; Nonbinary-No PTSD)</p> <p>"Nicky expresses concern for her friend" (PP6; Nonbinary-PTSD)</p>
	Attempts to alleviate or prevent suffering	<p>"I believe Nicky would have told Frances that it's not right that she has to live in fear of Alex behaving in this way again. Nicky probably would have advised Frances that if she in genuine fear of her safety, then she has to leave the house/flat or Alex does. (PP182; Female-No PTSD)</p> <p>"Nicky offers advice to Frances around her and Alex being open, honest and upfront about their feelings to best ensure negative feelings don't get bottled up and result in an outburst." (PP71; Female-PTSD)</p> <p>"On Nicky's advice, Frances tells Alex to look into counselling to help deal with the medical issues and other stressful events that are resulting in this behaviour." (PP102; Male-No PTSD)</p> <p>"They spend some time talking about how Frances might be able to have a conversation with Alex when things have calmed down. They both feel that it is really important for Alex to get some extra support to manage their emotional experiences, as things have been slowly getting more difficult." (PP204; Male-PTSD)</p> <p>"If Frances & Alex want to continue the relationship, recommend they get some relationship counselling and Alex gets some support for anger management issues." (PP22; Nonbinary-No PTSD)</p> <p>"Nicky tells Frances that the best way to help their relationship is to go to a couple therapist and see what they can do about it." (PP158; Nonbinary-PTSD)</p>

Language expressed worry and concern for the safety of the undeserving victim (Frances). Anger on behalf of Frances was expressed in Female conditions only. Worry was expressed more frequently in Male and Nonbinary-No PTSD conditions. Attempts to alleviate or prevent suffering were conveyed across conditions via advice and recommendations.

Hold Victim of IPV Responsible

Language consistently held the victim responsible. Victim responsibility had two sub-themes: (i) responsible for the IPV; and (ii) responsible for fixing and/or supporting the perpetrator (Table 3.8).

Table 3.8.**Data Extracts for 'Hold Victim of IPV Responsible' (n = 130)**

Theme	Sub-theme	Example data extract
Hold victim of IPV responsible	Responsible for IPV	"Nicky asks, 'I mean, did you do anything to make her act that way?' Frances says 'I don't know, I was kind of being annoying.'" (PP134; Female-No PTSD)
		<p>"He recognises Frances may be minimising Alex's behaviour and blaming them self for what's happening. This is all too familiar to Nicky" (PP34; Female-PTSD)</p> <p>"Frances talks to Alex and he agrees that they need to work on their relationship, so agrees to therapy sessions - but he still blames Frances for not supporting him enough through his diabetes." (PP153; Male-No PTSD)</p> <p>"Frances – "Our fight was ugly, but I just kept poking him about this PTSD of his. And him hiding my phone only made me more irritated and made me say some hurtful stuff. He's going through a rough time."" (PP246; Male-PTSD)</p> <p>"I know alot of DV victims don't accept their partners behaviour isn't love or they blame themselves." (PP57; Nonbinary-No PTSD)</p>
	Responsible for fixing and/or supporting perpetrator of IPV	<p>"Nicky asks Frances how much she knows about diabetes. Very little. Nicky advises Frances to find out more so she can possibly support Alex with the diagnosis & evaluate how it maybe affecting her & her behaviour." (PP124; Female-No PTSD)</p> <p>"Frances believes they should be able to help Alex, but they find it hard when Alex is so volatile. Could we do more?" (PP34; Female-PTSD)</p> <p>"Frances agrees that she needs to discuss the events and possible triggers of these events and actions with Alex. Frances seeks the advice and guidance of a counselor in order to help her initiate these conversations with Alex." (PP190; Male-No PTSD)</p> <p>"They decide to go home and read up more on PTSD to think more about how they can support Alex and perhaps prevent this from happening again in the future." (PP107; Male-PTSD)</p> <p>"Frances broaches the subject by sharing how they feel whilst reminding Alex that they're there to support. Not judge or condemn." (PP76; Nonbinary-No PTSD)</p> <p>"Nicky does, however, change from suggesting Frances leave Alex to suggesting Frances help them receive support (i.e. therapy) in order to manage their emotions more calmly." (PP20; Nonbinary-PTSD)</p>

Victim responsibility for the IPV was expressed in all perspectives in the story: perpetrator (Alex), victim (Frances) and outsider (Nicky). Bar Nonbinary-PTSD, language directly held the victim responsible. Latent codes in Nonbinary-PTSD suggested a limiting of Alex's responsibility (e.g. "She assures Nicky that Alex didn't mean to try and hit Frances"; PP219). Victim responsibility to support the perpetrator was consistent but more frequent in PTSD than no PTSD conditions regardless of gender identity, and most frequent in Male-PTSD.

Context Influences Decision-Making

Language repeatedly told a story that context influences decision-making (Table 3.9).

Table 3.9.

Data Extracts for 'Context Influences Decision-Making' (n = 130)

Theme	Example data extract
Context influences decision-making	<p>"I think it is hard to complete the story based on the information provided ... The obvious response is that Frances should leave but this very much depends on when their relationship started to deteriorate and the degree to which Alex has become aggressive and controlling. Has it been for most of their time together or a recent development? Was there a specific event that triggered the deterioration of the relationship? Being controlling and aggressive is never acceptable of course but it may be that Alex is not entirely the one at fault." (PP24; Female-No PTSD)</p> <p>"From the limited introduction give here it's not possible to assess the depth of the differences between these two people, to obtain a balanced view of the relationship, or suggest the most constructive way ahead for either or both of them." (PP17; Female-PTSD)</p> <p>"Frances is torn and does not know what to do. She loves Alex and wants to believe that it will not happen again." (PP89; Male-No PTSD)</p> <p>"Nicky would also ask about how Frances feels about the whole incident. ... Nicky would also ask about how Alex responded after the argument. Did Alex apologise to Frances? Did they talk about what happened? Did they discuss how it made the other feel? Did they also think about how to stop the escalation of arguments before it gets to that point? Does it feel like it's something that can change or that they as a couple want to change? Do arguments feel one-sided or equal? Do they both become reactive and regret things. Nicky might give differing advice depending on the answers to these questions." (PP201; Male-PTSD)</p> <p>"I would ask for more context assess the existing dynamic and history leading up to it." (PP184; Nonbinary-No PTSD)</p> <p>"Frances was not sure about this as they have known Alex for over 5 years and feel conflicted about reporting them especially since they know that Alex does not need any more stress on their life. ... In the end Frances decides to stay at Nicky's house and consider the options further." (PP240; Nonbinary-PTSD)</p>

Context influences decision-making was a theme in both victim (Frances) and outsider (Nicky) positions. Nicky required more contextual information to enable decision-making, whereas the decision-making of Frances was influenced by the context already known.

Discussion

The study explored how people make sense of IPV in the context of perpetrator diagnostic status (PTSD or no PTSD) and gender identity (female, male or nonbinary) by exploring IPV ratings and IPV discourses. Hypotheses were that IPV ratings and IPV discourses would vary with perpetrator diagnostic status and gender identity. IPV discourses were consistent across conditions, but discourse frequency varied by condition. IPV ratings did not vary between conditions.

Victim Gender Check

Approximately half the participants thought the victim was female versus 10% male and 2.2% nonbinary. This suggests a narrative that IPV is rarely experienced by men or nonbinary individuals. Dominant discourses tend to position IPV victimisation as a woman's experience (Morgan & Wells, 2016), which may influence public sense-making of IPV. Some participants said 'Frances' is the spelling specific to women. Other participants may have agreed but not explicitly stated this, which may have influenced this narrative about who experiences IPV.

IPV Ratings

IPV ratings did not vary with perpetrator diagnostic status or gender identity. Participants tended to appraise Alex's behaviour as abuse: responses were consistently negatively skewed, and all mean responses corresponded to 'probably is abuse'. This is both interesting and inconsistent with the more nuanced responses in the story completion task.

That neither perpetrator PTSD diagnostic status nor gender identity altered IPV ratings is interesting in the context of research suggesting that the public may use these contextual details as legitimising or excusing factors (Carlson & Worden, 2005; Lelaurain et al., 2018; Mackinnon et al., 2023). This may reflect growing public knowledge around IPV. Indeed, Women's Aid and the National Domestic Violence Hotline have published resources regarding mental health diagnoses and IPV: both portray a clear message that the former does not excuse the latter. That such myth-challenging resources exist, however, suggests the appraisal process may be more ambiguous than the current findings imply. One may wonder what effect victim gender had on ratings, and whether specification of the gender would have affected these.

Neither personal nor professional participant IPV experience had a significant effect on ratings. This is inconsistent with previous findings that professional experience positively correlated with ratings (Carlson & Worden, 2005; Mackinnon et al., 2023). This may be due to the nature of the data overall, as ratings were consistently weighted towards abuse.

IPV Discourses

It should first be noted that the author and supervisors' positions are that the behaviour in the story was IPV. This inherently influences theme identification and interpretation, and it is not possible to analyse the data without also acknowledging this influence.

Characterise the Behaviour

Making sense of the behaviour's nature, details and course seemed necessary for participants to proceed. This aligns with theories that individuals name and categorise

experiences according to previous knowledges and experiences ('schemas') to make sense of the world (McVee et al., 2005). Participants told a story about the behaviour and drew on this for clues to other related stories (e.g. what happens next, what to think or feel, how to respond).

Interestingly, participants more frequently described Alex's behaviour as 'abusive' or 'domestic violence' in no PTSD than PTSD diagnosis conditions. This suggests a specific discourse regarding PTSD and IPV: a PTSD diagnosis somehow alters what the behaviour is and how it is described. It is a subtle difference, as IPV ratings were consistent and there was no theme that a PTSD diagnosis excuses IPV, but language suggests that 'abuse' and 'domestic violence' feature less in public sense-making when there is a known PTSD diagnosis. This supports previous findings that the public may use a PTSD diagnosis as a mitigating factor for IPV (Mackinnon et al., 2023), which may or may not be conscious.

Trajectory of IPV

The discourse about how IPV unfolds over time organised advice for the immediate future and predictions about what might happen longer term. IPV escalation predictions were more frequent in no PTSD than PTSD diagnosis conditions. This may relate to the finding above: described less frequently as 'abuse' and 'domestic violence' in PTSD conditions, it would figure that IPV trajectory discourses are referenced less in this context. Other themes may also be relevant here: a greater focus on support in PTSD diagnosis conditions may have overpowered the escalation narrative. Perhaps participants assumed that, with professional support, both the PTSD and IPV would improve. Such an assumption might suggest an inextricable PTSD-IPV link, where IPV is perhaps symptomatic of a PTSD diagnosis.

There was concern that physical harm was likely (especially for the victim). The narratives that once is a mistake and 'escalate' means becomes physical may presuppose that, currently, it is not so bad. Indeed, participants gave conditional advice, offering remedies or solutions *if* the behaviour persists. That physical abuse is necessarily 'worse' in public consciousness is a concern and supports previous findings that non-physical abuse is considered less abusive (Carlson & Worden, 2005; Cravens et al., 2015; Minto et al., 2020).

Show Compassion Towards Victim of IPV

Participants paradoxically showed compassion towards the victim and held the victim responsible. Sensitivity to suffering was expressed via worry and anger for the undeserving victim. Worry was greater in Male and Nonbinary-No PTSD conditions, and anger was expressed only in Female conditions. Such variation suggests IPV sense-making depends on who perpetrated the IPV: by men and nonbinary individuals

is seemingly anxiety-inducing, but by women is angering and unjust. Perhaps IPV perpetrated by women violates dominant discourses that victimisation, not perpetration, is a woman's experience (Morgan & Wells, 2016). Violation of such strong narratives may also feel angering and unjust.

Attempts to alleviate or prevent suffering were expressed via recommendations and advice (e.g. leave the relationship, talk about it, seek therapy). This finding may pertain specifically to narratives about IPV disclosures and their responses (i.e. do something about abusive behaviour), but may also be indicative of problem-solution narratives in general. For example, discourses may dictate that the 'correct' response to an identified problem is to offer a solution. This urge to solve others' problems has been named the righting reflex and is thought to involve listener intolerance of uncertainty (Easton, 2021). This finding may also reflect growing awareness of IPV and its risks. Either way, it is reassuring given the IPV ratings: the underlying message is that it cannot or should not continue without intervention.

Hold Victim of IPV Responsible

Victim responsibility had two subthemes: responsible for the IPV itself and responsible for fixing or supporting the perpetrator. Victim responsibility for the IPV was indirectly suggested in Nonbinary-PTSD and expressed directly and consistently in all other conditions in all perspectives in the story: perpetrator, victim and outsider. This is consistent with dominant victim-blaming IPV discourses (Lloyd & Ramon, 2016; Sprague et al., 2012; Waltermaurer, 2012), suggesting this narrative remains pervasive in public sense-making.

Theorised to underpin victim-blaming, the just-world bias (JWB) refers to beliefs that people get what they deserve, so individuals blame victims to defend their worldview (Strömwall et al., 2012). Victim-blaming reportedly increases with JWB, particularly in women who are thought to defend against the idea of their own victimisation (Kristiansen & Giulietti, 1990; Strömwall et al., 2012). Gender norms may also intersect with victim responsibility: for example, being 'a man' by taking responsibility for a partner's IPV (Entilli & Cipolletta, 2017), or being 'submissive' and meeting expectations of pervasive roles for women (Street & Dardis, 2018).

Responsibility for supporting the perpetrator was expressed more frequently in PTSD than no PTSD diagnosis conditions, and most frequently in Male-PTSD. This suggests that PTSD diagnoses, and especially men with PTSD diagnoses, alter discourses about helping responsibilities. Coupled with the victim gender check, these data may pertain to gender norms regarding help in general. Indeed, literature highlights pervasive gender roles regarding helping behaviour, as women are expected to provide caregiving or emotional support (Atkinson et al., 2023). These data may also

suggest that the burden of victim-blaming, and of helping responsibilities when IPV is perpetrated by men with PTSD diagnoses, falls on women. This finding may be contextualised by intersectionality theory, as these data together may reflect simultaneous gender identity-based oppression and privilege discourses. Caution must be exercised, however, given the earlier mentioned spelling of the name Frances, which may also have influenced these data.

Together with the compassion theme, this suggests a bind for IPV victims: they are suffering but are also both responsible for the IPV happening and, therefore, their suffering, and for providing a solution and support to the perpetrator.

Context Influences Decision-Making

Context influences decision-making was identified in both victim and outsider perspectives. In the outsider perspective, more contextual information was required before proceeding. Participants had many questions regarding the length of the relationship, the extent and duration of the behaviour, how both partners feel, respond and cope with conflict and what each partner wants from the relationship. The opposite was true in the victim perspective, where they were unsure what to do and whether to take advice because of all they knew about the relationship and the perpetrator. This might make sense given the expressed worry, an emotion strongly associated with uncertainty (Freeston et al., 2020). Individuals may cope with uncertainty via over-engagement to obtain certainty (e.g. repeated questioning), under-engagement to disengage (e.g. procrastination) or 'dither' behaviours (e.g. inaction) that lead to uncertainty paralysis (Freeston et al., 2020). This may help explain the influence of context on decision-making in both perspectives.

Interestingly, this theme accompanied behaviour characterisation, the IPV trajectory, victim responsibility and compassion towards the victim. Naming the IPV and referring to IPV discourses did not seem to enable satisfactory sense-making: despite these narratives, participants were unsure how, or reluctant, to proceed. Information seemed to strongly influence, even cloud, decision-making. Research reports similar findings: individuals were repeatedly more likely to engage in 'additive' problem-solving (adding more components to a problem situation) than the advantageous subtraction of components (Adams et al., 2021). Thought to have major implications for decision-making, this suggests individuals may problem-solve by adding unnecessary and complicating information (Adams et al., 2021).

Findings told a story about how people make sense of IPV. They tended to appraise it as abuse regardless of perpetrator diagnostic status or gender identity. They communicated narratives about behaviour characterisation, an IPV trajectory,

compassion towards the victim, victim responsibility and the influence of context on decision-making.

Limitations

Online data collection may have simultaneously facilitated and hindered accessibility. Although UK-wide participants were recruited, online collection privileges IT-literacy and internet accessibility. Second, women were overrepresented in the sample. Findings may not generalise to other gender identities. Third, story completion (SC) may privilege individuals with certain life experiences or education that enables experiences of storytelling and story-writing. SC may not have made sense without these experiences. SC also requires imagination and the ability to think creatively with minimal information and prompts, which may not be accessible for all. Finally, asking participants whether the behaviour was IPV may have produced framing effects and influenced ratings. One may wonder why a question is asked at all if it were not relevant in the first place.

Future Research

Further exploration that physical IPV is necessarily more damaging than other forms should be prioritised. As this suggests non-physical IPV is less serious or warrants less immediate action, research should explore the pervasiveness of this narrative and whether it also exists among helping services (e.g. healthcare, police and criminal justice systems).

Future research should also explore IPV discourses about victim gender. Figures suggest IPV disproportionately affects women and gender minority individuals (WHO, 2012). Indeed, victimisation has been positioned as a woman's experience in public discourses (Morgan & Wells, 2016), which may influence public sense-making of IPV. Is it still IPV if the victim is not a woman? Exploration of victim gender identity effects may provide further insight into discourses about who experiences IPV. Research should also explore victim and perpetrator gender identities together. Research highlights the roles of heterosexism and gender role socialisation in IPV sense-making in both same-gender couples and couples in which the perpetrator is a woman and the victim a man (Brown, 2008). This would be helpful for policy makers and the justice system to understand, as narratives may influence IPV disclosures and responses.

Discourses regarding IPV and PTSD diagnoses should also be explored. IPV was described less as abuse or domestic violence in the context of a PTSD diagnosis, suggesting a possible unconscious mitigating of IPV. Finally, it would be helpful to further explore experiences and discourses among men and gender nonbinary individuals.

Implications and Recommendations for Practice

Findings suggest further public information is needed regarding IPV and its different forms. Although ratings skewed towards abuse, escalation and physical harm narratives suggest public discourses may prioritise physical abuse. Given the UK Government definition was recently republished to include coercive control and financial abuse (Home Office, 2020a), it would be helpful to further publicise this to update public discourses.

Attention should also be paid to the narrative that context influences decision-making. In clinical practice this may look like awareness of risk or safeguarding issues, but uncertainty about how to proceed without first establishing further details, or because of the degree of detail already known. One would hope there are clear protocols to follow to protect safety that are less influenced by contextual factors. Further exploration, education and/or training may be useful in clinical practice. It may also be helpful to provide clinicians with training and/or resources to facilitate identification of IPV with clients and patients.

Finally, public information and professionals' training is needed regarding help-seeking responsibilities in IPV. Findings suggest IPV victims are suffering but responsible for the IPV and the solution, and the burden of this responsibility may fall on women when IPV is perpetrated by men with PTSD diagnoses. As IPV ratings did not vary with perpetrator gender identity, and the descriptors 'abusive' and 'domestic violence' were used more frequently in no PTSD conditions regardless of gender identity, it is not possible to make recommendations from the findings regarding violence and gender. However, training for professionals may be helpful regarding the potential gender bias in helping responsibilities and the importance of supporting victims to help themselves rather than feel responsible for supporting perpetrators. Public information on accountability and help-seeking in IPV is also needed to update public discourses and free victims from the bind in which such discourses place them.

Conclusions

The study explored how people make sense of IPV by looking at IPV ratings and IPV discourses in the context of perpetrator PTSD diagnostic status and gender identity. IPV ratings did not vary with PTSD diagnostic status or gender identity. Frequency of IPV discourses identified in all conditions did vary. Discourses suggest that context influences decision-making even when IPV is named; a PTSD diagnosis reduces the likelihood that IPV is described as abuse or domestic violence; escalation equates to physical harm and help is needed, but the responsibility falls on the victim. Public information campaigns are recommended to clarify the nature of IPV, who is responsible and who should seek help and how.

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Executive Summary

Systematic Literature Review

Complex post-traumatic stress disorder (CPTSD) is a relatively recent official diagnosis that encompasses trauma re-experiencing, avoidance of trauma reminders, persistent threat and three criteria related to disturbances in self-organisation (DSO): emotion dysregulation; negative self-concept; and relational difficulties (WHO, 2018). Research into this diagnosis is in its relative infancy. Existing literature on the less recent PTSD diagnostic classification suggests its presentation may vary with gender. We aimed to systematically review and synthesise relevant literature to establish whether gender and/or sex differences exist in CPTSD diagnosis rates and clinical presentation. Systematic database searches identified 16 papers. Papers spanned various countries and samples, although they were mostly White Western populations.

Four themes were identified across the 16 papers: the reporting of gender and/or sex; trauma type; CPTSD diagnosis rates; and CPTSD clinical presentation. Most papers adopted a binary approach to gender and sex, and many conflated the two constructs. Most found higher rates of sexual trauma among women and/or females. Most reported no gender and/or sex difference in overall CPTSD diagnosis rates, but some reported higher scores on specific groups of CPTSD criteria (negative thoughts and emotions) among women and/or females. Not all papers included data on all themes. Pervasive gender roles and norms may interact with these findings and shape the type of research that gets conducted, and the findings studies report. We recommend researchers and clinicians adopt gender- and sex-sensitive practices. We also encourage awareness of the intersect between gender (and other identity factors) and the experience and expression of complex trauma.

Service-Related Project

Client involvement is crucial to the planning, implementation and evaluation of services, research and policy (Millar et al., 2015). Client involvement positions clients and professionals more equally, promotes choice and shared decision-making and addresses power imbalances often experienced in therapeutic services. We aimed to evaluate a local NHS Trust's family therapy service to establish whether clients were receiving a service they would recommend. Existing processes for client feedback collection were unreliable. Clients and their family members who were in active therapy sessions were, therefore, contacted via telephone and asked a standardised service evaluation questionnaire. Four additional questions relating specifically to the family therapy service were asked. Additional questions were developed in separate consultations with service staff and a previous client of the service.

Findings were largely positive: average responses to 12 of the 16 questions were the most favourable response available. Responses to the remaining questions were mixed. We recommend the service incorporates routine client feedback collection into its practice to promote collaborative conversations with clients regarding therapy expectations and the therapy process and adapt practices accordingly. Not all clients felt they had adequate information about the help available at the service. We recommend the service investigates and develops service information that clients would find useful. Some clients were unclear about the purpose of the reflecting team. We recommend that conversations about the reflecting team are revisited to establish client understanding of this, as well as what is or is not working well.

Main Research Project

Intimate partner violence (IPV) is any behaviour by an intimate partner or ex-partner that causes physical, psychological or sexual harm (WHO, 2012). IPV has profound effects on victim physical and mental health and is a significant public health concern. Despite this, research suggests that public narratives about IPV and the way the public make sense of IPV may vary in different contexts. The use of 'conditional logics' has been reported, where individuals may use contextual details to excuse or legitimise IPV (Lelaurain et al., 2018). Perpetrator PTSD diagnostic status (Mackinnon et al., 2023) and gender (Carlson & Worden, 2005) may be conditional logics. IPV narratives may be held by IPV victims and their communities and may influence how disclosures are responded to and managed.

We aimed to explore how people make sense of IPV in different contexts when perpetrator PTSD diagnostic status and gender identity were deliberately changed. Two hundred and sixty-five (265) community participants completed an online study. They read a story containing IPV between two partners where only perpetrator details varied: perpetrators identified as either female, male or nonbinary, and either had or did not have a PTSD diagnosis, meaning there were six groups in total. Participants rated the degree to which they thought the behaviour in the story was IPV. Half the participants were randomly allocated to an additional exercise that asked them to complete the story. We analysed participant ratings with statistical analysis of variance and participant stories with thematic analysis.

We found that IPV ratings did not change based on perpetrator diagnostic status or gender identity. Themes from the story task suggested participants were less likely to describe the behaviour as 'abusive' or 'domestic violence' when there was a PTSD diagnosis. Participants predicted the IPV would worsen, although, again, this was less likely when there was a PTSD diagnosis. Physical IPV was considered necessarily worse in participants' responses. Participants showed both compassion towards the

victim and held the victim responsible for both the IPV and the solution. Focus on victim support for the perpetrator was greatest for men with PTSD diagnoses. We recommend further public information to help clarify the nature of IPV, who is responsible and who should seek help and how.

The main research project and systematic review findings relate. IPV is a form of complex trauma, and victims, and often perpetrators in the case of early life trauma, may receive CPTSD diagnoses. Experiences and expressions of complex trauma and certain CPTSD criteria may vary with gender, and public narratives about IPV may vary with gender and PTSD diagnostic status. Pervasive gender norms may shape how experiences and expressions of complex trauma, and narratives about IPV, are constructed. Both research and clinical practice should be mindful of this.

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A big thank you to Vuokko Wallace for your support over the past (nearly) three years. You continually created a space that enabled me to feel supported and heard. I am so grateful for your time and your role in my personal and professional development.

I feel fortunate to have been supervised by compassionate clinicians on my placements throughout training. The safe spaces they held in supervision enabled me to nurture my sense of curiosity, try new things and reflect, learn and develop my practice. I have learnt a lot from their approaches and practice, and I am grateful to have had the opportunity to learn from them. I am also grateful to cohort 2020 for being a supportive group of fellow trainees.

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Appendices

Appendix A

European Journal of Psychotraumatology Instructions for Authors

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Please note, the final word count includes the abstract and reference section at the end of the paper, but is excl. tables/figures.

In some cases, for longer articles, the word limit can be exceeded as we are an online journal, but in principle this should be avoided.

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Appendix B

Excluded Papers with Reasons

Study excluded	Reason for exclusion
Barnett, S. D., Hickling, E. J., & Sheppard, S. (2018). The impact of gender on the factor structure of PTSD symptoms among active-duty United States military personnel. <i>European Journal of Trauma & Dissociation</i> , 2, 117–124. https://doi.org/10.1016/j.ejtd.2018.01.002	No use of accepted measure
Carthy, N., Best, D., Heckels, V., Weber, L., & Eberhardt, J. (2023). Complex posttraumatic stress disorder symptoms among midlife to older female survivors of intimate partner violence. <i>Psychological Trauma: Theory, Research, Practice and Policy</i> , 15(2), 331–339. https://doi.org/10.1037/tra0001238	No diagnosis of CPTSD, DESNOS or DSM-5 PTSD
Carmassi, C., Corsi, M., Bertelloni, A., Carpita, B., Gesi, C., Pedrinelli, V., Massimetti, G., Peroni, D. G., Bonuccelli, A., Orsini, A., & Dell’Osso, L. (2018). Mothers and fathers of children with epilepsy: gender differences in post-traumatic stress symptoms and correlations with mood spectrum symptoms. <i>Neuropsychiatric Disease and Treatment</i> , 1371–1379. https://doi.org/10.2147/NDT.S158249	No use of accepted measure
Chaplo, S. D., Kerig, P. K., Modrowski, C. A., & Bennett, D. C. (2017). Gender differences in the associations among sexual abuse, posttraumatic stress symptoms and delinquent behaviours in a sample of detained adolescents. <i>Journal of Child & Adolescent Trauma</i> , 10, 29–39. https://doi.org/10.1007/s40653-016-0122-z	No use of accepted measure
Craig, C. D., & Sprang, G. (2014). Gender differences in trauma treatment: do boys and girls respond to evidence-based interventions in the same way? <i>Violence and Victims</i> , 29(6), 927–939. https://doi.org/10.1891/0886-6708.VV-D-13-00016	No use of accepted measure
Cyr, G., Godbout, N., Cloitre, M., & Bélanger, C. (2022). Distinguishing among symptoms of posttraumatic stress disorder, complex posttraumatic stress disorder and borderline personality disorder in a community sample of women. <i>Journal of Traumatic Stress</i> , 35, 186–196. https://doi.org/10.1002/jts.22719	CPTSD presentation not specifically and clearly discussed
Eidhof, M. B., Djelantik, M. J., Klaassens, E. R., Kantor, V., Rittmansberger, D., Sleijpen, M., Steenbakkens, A., Weindl, D., & ter Heide, F. J. J. (2019). Complex posttraumatic stress disorder in patients exposed to emotional neglect and traumatic events: latent class analysis. <i>Journal of Traumatic Stress</i> , 32, 23–31. https://doi.org/10.1002/jts.22363	No use of accepted measure
Ford, J. D., Schneeberger, A. R., Komarovskaya, I., Muenzenmaier, K., Castille, D., Opler, L. A., & Link, B. (2017). The Symptoms of Trauma Scale (SOTS): Psychometric evaluation and gender differences with adults diagnosed with serious mental illness. <i>Journal of Trauma & Dissociation</i> , 18(4), 559–574. https://doi.org/10.1080/15299732.2016.1241850	No use of accepted measure
Fox, R. (2020). <i>An evaluation of the structure, comorbidity and correlates of posttraumatic stress responses in older adults across multiple national samples</i> . PhD thesis, National University of Ireland.	No use of accepted measure
Gasior, K., & Chodkiewicz, J. (2020). Adverse childhood experiences in women with externalisation and internalisation disorders. <i>Current Issues in Personality Psychology</i> , 8(2), 119–130. https://doi.org/10.5114/CIPP.2020.96087	No use of accepted measure
Herbert, M., Paradis, A., & Fortin, A. (2021). Symptom patterns of sexually abused teenage girls seeking services. <i>American Journal of Orthopsychiatry</i> , 91(4), 464–476. https://doi.org/10.1037/ort0000548	No use of accepted measure
Hopper, E. K., & Gonzalez, L. D. (2018). A comparison of psychological symptoms in survivors of sex and labor trafficking. <i>Behavioral Medicine</i> , 44(3), 177–188. https://doi.org/10.1080/08964289.2018.1432551	No use of accepted measure

Knefel, M., & Leuger-Schuster, B. (2013). An evaluation of ICD-11 PTSD and complex PTSD criteria in a sample of adult survivors of childhood institutional abuse. <i>European Journal of Psychotraumatology</i> , 4(1). https://doi.org/10.3402/ejpt.v4i0.22608	No use of accepted measure
Matthews, K. M. (2020). <i>Exploring the lived experiences of female trauma survivors with comorbid substance use disorder</i> . PhD thesis, University of Mississippi.	No diagnosis of CPTSD, DESNOS or DSM-5 PTSD
McGinty, G., Fox, R., & Hyland, P. (2023). Assessing prevalence, validity and correlates of ICD-11 posttraumatic stress disorder and complex posttraumatic stress disorder in Ireland. <i>Psychological Trauma: Theory, Research, Practice and Policy</i> . https://doi.org/10.1037/tra0001472	CPTSD not separated by gender
Milne, L., Collin-Vézina, D., & Wekerle, C. (2021). Diverse trauma profiles of youth in group care settings: A cluster analysis. <i>Child Abuse & Neglect</i> , 120. https://doi.org/10.1016/j.chiabu.2021.105221	No use of accepted measure
Nutskova, E. V. (2016). Phenomenology of the psychological consequences of sexual abuse in children and adolescents depending on the action of various factors. <i>Psychology and Law</i> , 6(1), 73–90. https://doi.org/10.17759/psylaw.2016060107	No use of accepted measure
Martínez Pajuelo, A. R., Irrazabal Ramos, J. E., & Lazo-Porras, M. (2022). Anxiety, depression and post-traumatic stress disorder (PTSD) symptomatology according to gender in health-care workers during the COVID-19 pandemic in Peru. <i>International Journal of Environmental Research and Public Health</i> , 19. https://doi.org/10.3390/ijerph191911957	DSM-5 PTSD does not specify CPTSD component
Polusny, M. A., Kumpula, M. J., Meis, L. A., Erbes, C. R., Arbisi, P. A., Murdoch, M., Thuras, P., Kehle-Forbes, S. M., & Johnson, A. K. (2014). Gender differences in the effects of deployment-related stressors and pre-deployment risk factors on the development of PTSD symptoms in National Guard soldiers deployed to Iraq and Afghanistan. <i>Journal of Psychiatric Research</i> , 49, 1–9. https://doi.org/10.1016/j.jpsychires.2013.09.016	No use of accepted measure
Post, M., Hanten, G., Li, X., Schmidt, A. T., Avci, G., Wilde, E. A., & McCauley, S. R. (2014). Dimensions of trauma and specific symptoms of complex posttraumatic stress disorder in inner-city youth: a preliminary study. <i>Violence and Victims</i> , 29(2), 262–279. https://doi.org/10.1891/0886-6708.VV-D-12-00097R1	No use of accepted measure
Powers, A., Fani, N., Carter, S., Cross, D., Cloitre, M., & Bradley, B. (2017). Differential predictors of DSM-5 PTSD and ICD-11 complex PTSD among African American women. <i>European Journal of Psychotraumatology</i> , 8(1). https://doi.org/10.1080/20008198.2017.1338914	CPTSD presentation not specifically and clearly discussed
Sigurdardottir, S., Halldorsdottir, S., & Bender, S. S. (2014). Consequences of childhood sexual abuse for health and well-being: Gender similarities and differences. <i>Scandinavian Journal of Public Health</i> , 42, 278–286. https://doi.org/10.1177/1403494813514645	No diagnosis of CPTSD, DESNOS or DSM-5 PTSD
Smith, J. A., Zhang, J., Urusov, A., Colucci, L., Sloss, I., Eckert, L., Price-Cameron, M., & Browne, D. T. (2023). <i>Exploring gender differences in complex developmental trauma symptomatology among children and adolescents involved in child welfare</i> . https://doi.org/10.31234/osf.io/5qtu6	No use of accepted measure
Taha, P. H., & Sijbrandij, M. (2021). Gender differences in traumatic experiences, PTSD and relevant symptoms among the Iraqi internally displaced persons. <i>International Journal of Environmental Research and Public Health</i> , 18. https://doi.org/10.3390/ijerph18189779	No use of accepted measure
Wamser-Nanney, R., & Cherry, K. E. (2018). Children’s trauma-related symptoms following complex trauma exposure: Evidence of gender differences. <i>Child Abuse & Neglect</i> , 77, 188–197. https://doi.org/10.1016/j.chiabu.2018.01.009	No use of accepted measure

Appendix C

MMAT Quality Assessment Descriptive Summary

Study	Criterion				
	4.1. Sampling strategy relevant to research question?	4.2. Sample representative of target population?	4.3. Appropriate measurements?	4.4. Low risk of nonresponse bias?	4.5. Appropriate statistical analysis to answer research question?
Bramblett (2017)	Health care practitioners and social media. Appropriate for research question and scope of research. 1	Very small sample. No clear indication of population attempting to represent. 0	PCL-5. Appropriate, valid, reliable. 1	All Ps recruited participated. Study reports 100% completion. 1	No statistical analysis. "Due to the limited number of participants, statistical analysis could not be completed due to insufficient power". 0
Charak et al. (2023)	Social media and LGBTQ+ associations and influencers contacted to recruit LGBTQ+ Ps. Relevant and appropriate for research question. 1	Target population seems to be Spain. No reference to sample representativeness. 0	LEC; ITQ Spanish version. Valid and reliable. 1	No reference to non-response rate. 0	Statistics described and appropriate. 1
Cloitre et al. (2019)	Probability sampling (from nationally representative community sample) to randomly recruit Ps with experience of 1+ traumatic event. 1	National representative online community sample + statistics to ensure representative of adult US population aged 18-70. 1	ITQ; LEC. Appropriate, valid, reliable. 1	Participation rate 46.3%. No reference to reasons for nonresponse or statistical corrections. 0	Statistics for each hypothesis described and appropriate. 1
de Vries et al. (2018)	Non-random sampling – Ps were recruited in homeless shelters. Appropriate for target population. 1	Target population not clear and no reference to sample representativeness. 0	SIDES; Trauma Centre PTSD Scale. Both valid and reliable. 1	No reference to non-response rate. 0	Statistics reported in results, but no reference in methods section to statistical analysis used. 0

Farhood et al. (2018)	Secondary data analysis. Randomly selected community sample. 1	Geographically diverse villages from South Lebanon. No reference to target population or whether sample is representative. 0	HTQ to measure DSM-5 PTSD – Arabic version. Validated for Arabic-speaking populations. 1	All randomly selected Ps participated. 1	Statistical analyses described and appropriate. 1
Fernandez-Fillol et al. (2021)	Non-random sampling – Ps who had experienced IPV recruited in associations and women’s centres. Appropriate for target population. 1	Assumed target population women who had experienced IPV across Spain, but not explicitly stated. 0	ITQ Spanish version validated for use with this population. 1	All except one P approached participated. Reason for non-participation stated. 1	Statistical analyses described and appropriate. 1
Giarratano et al. (2020)	Random sampling of all new admissions to all relevant prisons across state. Sample relevant to target population. 1	Target population stated (incarcerated adults) and reference to sample representativeness. 1	SIDES; SCID; TEI. All appropriate, valid, reliable. 1	Proportion of nonresponses stated and relatively low (7%), and reasons stated (refusal). 1	Statistical analyses described and appropriate. 1
Gilbar et al. (2018)	Random sampling from target population. 1	Target population stated (Israeli male perpetrators of IPV) but no reference to sample representativeness. 0	ITQ; LEC-5. No reference to versions used or psychometrics among Israeli individuals. 0	Proportion of nonresponses inferred (70% completion). No reasons given or reference to statistical compensation. 0	Statistical analyses described and appropriate. 1
Guina et al. (2019)	Non-random, opportunity sampling in one military medical centre (unclear if this is target population). 0	No reference to target population or sample representativeness. 0	PCL-5. Appropriate, valid and reliable for use with American Ps, but Ps assumed not explicitly stated. 0	Proportion of nonresponses inferred (77.5% completion), but no reasons given or reference to statistical compensation. 0	Statistical analyses described and appropriate. 1
Hecker et al. (2018)	Non-random sampling of refugees and asylum seekers in counselling and information centres. Appropriate strategy for, and sample relevant to, target population. 1	Target population stated (asylum seekers and refugees resettled in Switzerland) and reference to sample representativeness. 1	HTQ; ITQ. Both valid and reliable. Translated from English and back translated to English by trained translators. 1	Low proportion of nonresponses (4.1%) and reasons stated. 1	Statistical analyses described and appropriate. 1

Ho et al. (2021)	Non-random sample from existing internet research panels to generate nationally representative sample of Irish adults. Appropriate for research question. 1	Target population stated (Ireland) and reference to sample representativeness. 1	ITEM; ITQ. Validated in target population and appropriate. 1	No reference to nonresponse rate. 0	Statistical analyses described and appropriate. 1
Hyland et al. (2018)	Non-random sampling of treatment-seeking Syrian refugees living in Lebanon – appropriate to target population. 1	Target population stated (treatment-seeking Syrian refugees living in Lebanon) but no reference to sample representativeness. 0	ITQ-Arabic version. Validated for use with Arabic-speaking individuals. Appropriate. 1	No reference to nonresponse rate. 0	Statistical analyses described and appropriate. 1
Karatzias et al. (2019)	Random sampling of trauma-exposed adults from existing online research panel representative of UK population. Appropriate for research question. 1	Target population stated (UK adults) and reference to sample representativeness. 1	LEC-5; ITQ. Appropriate, valid, reliable. 1	All randomly selected Ps who met inclusion criteria participated. 1	Statistical analyses described and appropriate. 1
Liu et al. (2020)	Survey sent to residents in Wuhan, China. No reference to method of sampling. 0	Assumed target population (residents of Wuhan) but not stated and no reference to sample representativeness. 0	PCL-5 Chinese version. Appropriate, valid, reliable. 1	15 Ps did not participate. No reasons stated. 0	Statistical analyses described but not all appropriate. 0
McGinty et al. (2021)	Four samples (UK, USA, Ireland, Israel) – data non-randomly selected from nationally representative (bar UK) samples of pre-existing data. Appropriate for research question. 1	Target populations stated and reference to sample representativeness. 1	LEC-5 for UK, USA, Israel samples; ITEM for Irish sample; ITQ. No reference to version of ITQ used. 0	No reference to nonresponse rate. 0	Statistical analyses described and appropriate. 1
Powers et al. (2017)	Non-random sampling of Ps from waiting rooms in clinics in publicly funded hospital and A&E departments in one city in one American state. Possibly appropriate but no reference to why this strategy was used. 0	Target population not clear and no reference to sample representativeness. 0	CAPS-5; ICD-TI; CTQ; TWI. All appropriate, valid, reliable. 1	No reference to nonresponse rate. 0	Statistical analyses described and appropriate. 1

Soegaard et al. (2021)	Non-random sample of severely traumatised individuals attending outpatient clinic. Appropriate for research question. 1	Target population not clear and no reference to sample representativeness. 0	LEC; SCI-1-PTSD; SIDES. No reference to psychometrics among Norwegian individuals. 0	Relatively low nonresponse (nine out of 119; 7.6%) due to consent withdrawal. 1	Statistical analyses described and appropriate. 1
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Appendix D

Journal of Family Therapy Author Guidelines

Author Guidelines

Manuscript Format - Free format submission

The *Journal of Family Therapy* now offers free format submission for a simplified and streamlined submission process.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) format.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including statements relating to our ethics and integrity policies:
 - funding statement (if applicable)
 - conflict of interest disclosure
 - ethics approval statement
 - permission to reproduce material from other sources

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details.

(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)

- Your co-author details, including affiliation and email address. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)*
- An ORCID ID, freely available at <https://orcid.org>. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at <https://wiley.atyponrex.com/journal/JOFT> and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must not** contain author names or any identifiable data.
2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:

- **Title Page:** to contain the title of the paper, word count, suggested running head (short title for your paper), key words, author names, affiliations and contact details for the corresponding author.
- **Abstract:** on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present. *For tips on optimizing your abstract for search engines please click [here](#).*
- **Practitioner Points:** two to six bullet points of no more than 180 characters each (including spaces), up to a total of 480 characters.
- **References:** References in published papers are formatted according to the Publication Manual of the American Psychological Association (6th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

3. The word limit, excluding abstract and practitioner points will vary depending on the type of paper you are submitting. Please refer to the 'Advice to Authors' section below.

4. Style: Whilst Journal style is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Your manuscript will be returned to you if you fail to conform to these requirements.

Power, Difference and Inequality

Authors should ensure that they demonstrate an awareness of and sensitivity to issues of power, difference and inequality, and describe how these were reflexively considered and responded to in the work in their submissions. Authors' own position and intersecting identities may influence how they respond to, and be influential in how they are received and responded to, by their research subjects, clients, consultees or trainees, as well as how they are making sense of their findings. The race, gender and class of the researcher, therapist or teacher and of the research subjects, clients and trainees referred to in submissions may also be influential in findings in a research study, or outcomes of a case study or teaching and learning submission.

Case material and Confidentiality

Journal of Family Therapy readers particularly welcome papers which link theory and practice, and such papers are often enhanced by case material. The Author takes responsibility for de-identifying material in order to protect client confidentiality. While recognising that it is often details and contextual features which give an account its richness, these need to be de-identified as much as possible without jeopardising their integrity (i.e., being adequate to support the author's claims). All possible identifying information must be altered. Another way of protecting confidentiality is by presenting composite case material, made up of different aspects from a number of similar cases.

Signed consent must always be sought to include accounts of clinical material, even

though de-identified. When children and young people are included in the material described, their consent too will need to be sought, according to their level of understanding.

Every paper that contains case material must be accompanied by:-

- A statement in the letter to the Editor from the Author(s) specifying whether the material presented is disguised/generic/composite; or
- A statement in the letter to the Editor that the Author has gained signed consent from patients/clients or teachers/students authorizing publication of the material. Please note that upon signing the Author Agreement the Author becomes liable for any third party information collated and takes complete responsibility for preparing the work and gaining the relevant permissions and consent.

Advice to Authors

Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important both for the development of our chosen field and for the development of the individual practitioner. We intellectually sustain ourselves by creating a healthy and vibrant literature. Family therapy needs to develop authors and *The Journal of Family Therapy* wants to hear from you.

These are the types of papers that are regularly submitted to the *Journal of Family Therapy*:

(The word count for all these papers does not include tables and figures.)

Research Article (3,000-6,000 words)

It is considered good practice (as recommended for example by the UK National Institute For Health Research) for researchers to include participants throughout the process of studies, from design to interpretation to dissemination.

A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study
- Previous work
- Description of methodology including participants
- Results/Findings
- Discussion of results, including implications for future research and practice

Additional Notes to Authors:

- JFT has an international readership, so spell out details that might be unfamiliar to the non UK field.
- JFT welcomes the linking of previous literature in a substantive, explanatory sense and therefore advises authors to reference other papers where possible.

PAPERS EXCEEDING THE SPECIFIED WORD LIMITS (including references) WILL BE RETURNED TO THE AUTHOR

Appendix E

AWP Letter of Approval



Carla Carter
Quality Improvement &
Clinical Audit Manager

AWP NHS Trust
Victoria Centre
53 Downs Way
Swindon SN3 6BW

T: [redacted]
Or dial

reception on: [redacted] Date: 15.03.2021

Dear Ella

Re: “Are clients of the AWP North Somerset Family Service receiving a service that they would recommend to others?”

I am pleased to confirm approval of your Service Evaluation by AWP NHS Trust.

Please note that this approval has come from AWP’s Quality Team and not AWP’s Research and Development Team. However, we do expect a good level of governance will be achieved from the ethical scrutiny by your University as well as adherence to general ethical principles for the protection of patients. The specific ethical principles and patient protection laws to be followed are:

- Consent – It is important that potential participants are not coerced to take part in the project. They have the right to refuse to take part and to withdraw at any point and this is explained via an information sheet provided prior to any engagement or data gathering such as surveys or interviews. This information sheet will often lead to the signing of a consent form by participants agreeing to take part in your Project.
- Anonymity – Participants need to know whether their anonymity will be protected and if so how this will be carried out. This will also be documented within your participants’ information sheet/consent form.
- Data protection and privacy – You need to consider how you are going to ensure that your data is stored safely and that participant privacy is protected. Again this should be

stipulated within your participants' information sheet/consent form. You will need to adhere to the Data Protection Act (2018) and the General Data Protection Regulation (GDPR).

Chair
Charlotte Hitchings
Hardisty

Trust Headquarters
Bath NHS House, Newbridge Hill, Bath BA1 3QE

Chief Executive
Dominic

'We are a teaching, learning and research Trust; we aim to inform you about relevant opportunities, unless you tell us otherwise.'

- Information sharing and data transfer – If you have securely transferred data between an AWP and University device, the data cannot then be analysed or transferred onto a personal device. This would not be secure and therefore considered a data breach. Using Citrix on a personal laptop is considered secure. You cannot email data to your personal email address.

Bethany Duckworth [email redacted] has been assigned as your allocated AWP Quality Team Facilitator. Please contact this Facilitator if you have any queries or require further support or information during your project. They will email you at regular intervals for updates, so that progress of your project can be updated on our central project database, and fed into Trust committees. You will be assigned an AWP Project Reference Number by your Facilitator once we have confirmation that data collection has commenced and the project has actually started.

The importance of dissemination of all Service Evaluation or Quality Improvement work cannot be over emphasised. For this reason, the findings of all Projects should be shared with the Quality Team so that we can make judgements regarding risk and champion and disseminate the results across the rest of the Trust so that good practice can be shared and replication kept to a minimum. Reports may require approval by Locality Governance Groups if specific actions or improvements are required following your findings or particularly, if you wish to gain external publication, you will require AWP approval of your final report before doing so. Therefore, please share draft copies of your report with your Facilitator so that presentation and approval at Governance Groups can be arranged. Once you have an approved final version of your report, please ensure you send a copy to your allocated Facilitator.

If you do need any further support or information, please contact your Facilitator or myself, quoting the title of your project.

Yours sincerely


Carla Carter
Quality Improvement and Clinical Audit Manager

Appendix F

Experience of Service Questionnaire



EXPERIENCE OF SERVICE QUESTIONNAIRE

Please think about the appointments you have had at this service or clinic.

For each item, please tick the box that best describes what you think or feel (e.g.)

	Certainly True	Partly True	Not True	Don't know	
I feel that the people who saw me listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
It was easy to talk to the people who saw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
I was treated well by the people who saw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
My views and worries were taken seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
I feel the people here know how to help me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
I have been given enough explanation about the help available here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
I feel that the people who have seen me are working together to help me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
The facilities here are comfortable (e.g. waiting area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8
My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
It is quite easy to get to the place where I have my appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
If a friend needed this sort of help, I would suggest to them to come here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
Overall, the help I have received here is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12

PLEASE TURN OVER...

What was really good about your care?

13

Was there anything you didn't like or anything that needs improving?

14

Is there anything else you want to tell us about the service you received?

15

THANK YOU FOR YOUR HELP

Appendix G

Solution Focused Family Service Questionnaire (SFFSQ)

ID number: _____

Are you the 'index' client (*by this, we mean the person who is receiving services from the recovery team*)?

Yes No

If 'no', what relation to the 'index' client are you? _____

I'll read a series of statements about your care at the Family Service. For each one please indicate whether you feel this is certainly true, partly true, not true or you don't know.

	Certainly true	Partly true	Not true	Don't know
Q1. I feel that the people who saw me listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q2. It was easy to talk to the people who saw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3. I was treated well by the people who saw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q4. My views and worries were taken seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q5. I feel the people here know how to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q6. I have been given enough explanation about the help available here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q7. I feel that the people who have seen me are working together to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q8. The team's approach was a good fit for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q9. We worked on and talked about what I wanted to work on and talk about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q10. The comments from the reflecting team were useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q11. The purpose of the reflecting team was clear to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q12. The facilities here are comfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q13. My appointments are usually at a convenient time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q14. It is quite easy to get to the place where I have my appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q15. If a friend needed this sort of help, I would suggest to them to come here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q16. Overall, the help I have received here is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix H

Journal of Interpersonal Violence Submission Guidelines

Manuscript Submission Guidelines:

JIV only publishes reports on individual studies in which the scientific method is applied to the study of some aspect of interpersonal violence. Research may use qualitative or quantitative methods. *JIV* does not publish reviews of research, individual case studies, or the conceptual analysis of some aspect of interpersonal violence.

Each manuscript must:

- be prepared using APA style, and be **no longer than 30 double-spaced pages**, including references, tables, and figures;
- include an abstract of 250-300 words that clearly and concisely summarizes the study questions, subjects, methods, findings and major implications;
- include a discussion of diversity as it applies to the reviewed research.*

* Journal policy on addressing diversity in manuscripts:

JIV requires all submissions to include a discussion of diversity as it applies to the reviewed research (e.g., nature of the sample, limitations of the measurement). The discussion should address the body of knowledge reviewed as it addresses or fails to address issues of diversity. Diversity concerns are not criteria for publication but must be addressed. The nature of the discussion and amount of space devoted to the discussion is the responsibility of the author(s).

JIV understands diversity to include all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, ability, age, and culture.

Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for expanding knowledge and practice with all human beings. While science seeks knowledge that can be generalized, it must appreciate that specific findings, while important in understanding the unique experiences of individuals or groups, are not necessarily applicable to all.

All manuscripts are peer reviewed and should be submitted with a letter indicating that the material has not been published elsewhere and is not under review at another publication. **Manuscripts should be submitted electronically to <http://mc.manuscriptcentral.com/jiv>** where authors will be required to set up an online account on the SageTrack system powered by ScholarOne. Inquiries may be made by email at JIV@u.washington.edu.

Please be aware that SAGE has no affiliation with these companies and makes no endorsement of them. An author's use of these services in no way guarantees that his or her submission will ultimately be accepted. Any arrangement an author enters into will be exclusively between the author and the particular company, and any costs incurred are the sole responsibility of the author.

Manuscript Preparation

Manuscripts should be prepared using the APA Style Guide, and should be **no longer than 30 double-spaced pages, including references, tables, and figures**. (Brief Notes should be no longer than 12 double-spaced pages, inclusive.) Text must be in 12-point Times New Roman font. Block quotes may be single-spaced. Manuscripts must include margins of 1 inch on all sides and pages must be numbered sequentially. All files should be in Word (.docx or .doc).

The manuscript should include five major sections (in this order): Title Page, Abstract, Main Body (anonymized, with all author names and identifying information removed for peer review), References, and Author Biographies.

Sections in a manuscript may include the following (in this order): (1) Title page, (2) Abstract, (3) Keywords, (4) Text, (5) Notes, (6) References, (7) Tables, (8) Figures, (9) Appendices, and (10) Author Biographies.

1. Title page must be uploaded as a separate file. Please include the following:

- Full article title
- Acknowledgments and credits
- Each author's complete name and institutional affiliation(s)
- Grant numbers and/or funding information
- Conflict of interests, if any
- Corresponding author (name, address, phone/fax, e-mail)

2. Abstract. Copy and paste the abstract (250 to 300 words) into the space provided, headed by the full article title. Omit author names. Abstract must clearly and concisely summarize the study questions, subjects, methods, findings, and major implications.

3. Keywords. 5-7 keywords must be included in the manuscript.

4. Text. Begin text headed by the full article title. Text must be anonymized, with all author names and other identifying information removed, for peer review.

a. Headings and subheadings. Subheadings should indicate the organization of the content of the manuscript. Generally, three heading levels are sufficient to organize text.

Level 1: centered, boldface, upper & lowercase

Level 2: flush left, boldface, upper & lowercase

Level 3: indented, boldface, lowercase paragraph heading ending with a period

Level 4: indented, boldface, italicized, lowercase paragraph heading ending with a period

Level 5: indented, italicized, lowercase paragraph heading ending with a period

b. Citations. For each text citation there must be a corresponding citation in the reference list and for each reference list citation there must be a corresponding text citation. Each corresponding citation must have identical spelling and year. Each text citation must include at least two pieces of information: author(s) and year of publication. Following are some examples of text citations:

(i) Unknown Author: To cite works that do not have an author, cite the source by its title in the signal phrase or use the first word or two in the parentheses. For example, "The findings are based on the study of students learning to format research papers"

("Using XXX," 2001)

(ii) Authors with the Same Last Name: Use first initials with the last names to prevent confusion. For example, "L. Hughes, 2001; P. Hughes, 1998."

(iii) Two or More Works by the Same Author in the Same Year: For two sources by the same author in the same year, use lowercase letters (a, b, c) with the year to order the entries in the reference list. The lower-case letters should follow the year in the in-text citation. For example, "Research by Freud (1981a) illustrated that..."

(iv) Personal Communication: For letters, e-mails, interviews, and other person-to-person communication, citation should include the communicator's name, the fact that it was personal communication, and the date of the communication. For example, E. Clark, personal communication, January 4, 2009. Do not include personal communication in the reference list.

(v) Unknown Author and Unknown Date: For citations with no author or date, use the title in the signal phrase or the first word or two of the title in the parentheses and use the abbreviation "n.d." (for "no date"). For example, "The study conducted by the students and research division discovered that students succeeded with tutoring" (Tutoring and APA, n.d.).

5. Notes. If explanatory notes are required for your manuscript, insert a number formatted in superscript following almost any punctuation mark. Footnote numbers should not follow dashes (—), and if they appear in a sentence in parentheses, the footnote number should be inserted within the parentheses. The footnotes should be added at the bottom of the page after the references. The word "Footnotes" should be centered at the top of the page.

6. References. Basic rules for the reference list:

- The reference list should be arranged in alphabetical order according to the authors' last names.
- If there is more than one work by the same author, order them according to their publication date – oldest to newest (therefore a 2008 publication would appear before a 2009 publication).
- When listing multiple authors of a source use "&" instead of "and."
- Capitalize only the first word of the title and of the subtitle, if there is one, and any proper names – i.e., only those words that are normally capitalized.
- Italicize the title of the book, the title of the journal/serial and the title of the web document.
- Manuscripts submitted to JIV should strictly follow the current APA style guide.
- Every citation in text must have the detailed reference in the Reference section.
- Every reference listed in the Reference section must be cited in text.
- Do not use "et al." in the Reference list at the end; names of all authors of a publication should be listed there.

IMPORTANT NOTE: To encourage a faster production process of your article, you are requested to closely adhere to the points above for references. Otherwise, it will entail a long process of solving copyeditor's queries and may directly affect the publication time of your article. In case of any question, please contact the journal editor at JIV@u.washington.edu.

7. Tables. They should be structured properly. Each table must have a clear and concise title. When appropriate, use the title to explain an abbreviation parenthetically, for example, Comparison of Median Income of Adopted Children (AC) v. Foster Children (FC).

8. Figures. They should be numbered consecutively in the order in which they appear in the text and must include figure captions. Figures will appear in the published article in the order in which they are numbered initially. The figure resolution should be at least 300dpi at the time of submission.

IMPORTANT: PERMISSION - The author(s) are responsible for securing permission to reproduce all copyrighted figures or materials before they are published in *JIV*. A copy of the written permission must be included with the manuscript submission.

9. Appendices. They should be lettered to distinguish from numbered tables and figures. Include a descriptive title for each appendix (e.g., "Appendix A. Variable Names and Definitions"). Cross-check text for accuracy against appendices.

10. Author Biographies. Author(s) are required to send a 40-60 word biography for publication at the end of the article. A sample biography is given below:

Appendix I

Confirmation of Ethical Approval

From: psychology-ethics <psychology-ethics@bath.ac.uk>
Sent: 20 December 2021 16:01
To: Ella Lonnen <(redacted)>
Cc: (Redacted)
Subject: 21-257

Hi Ella,

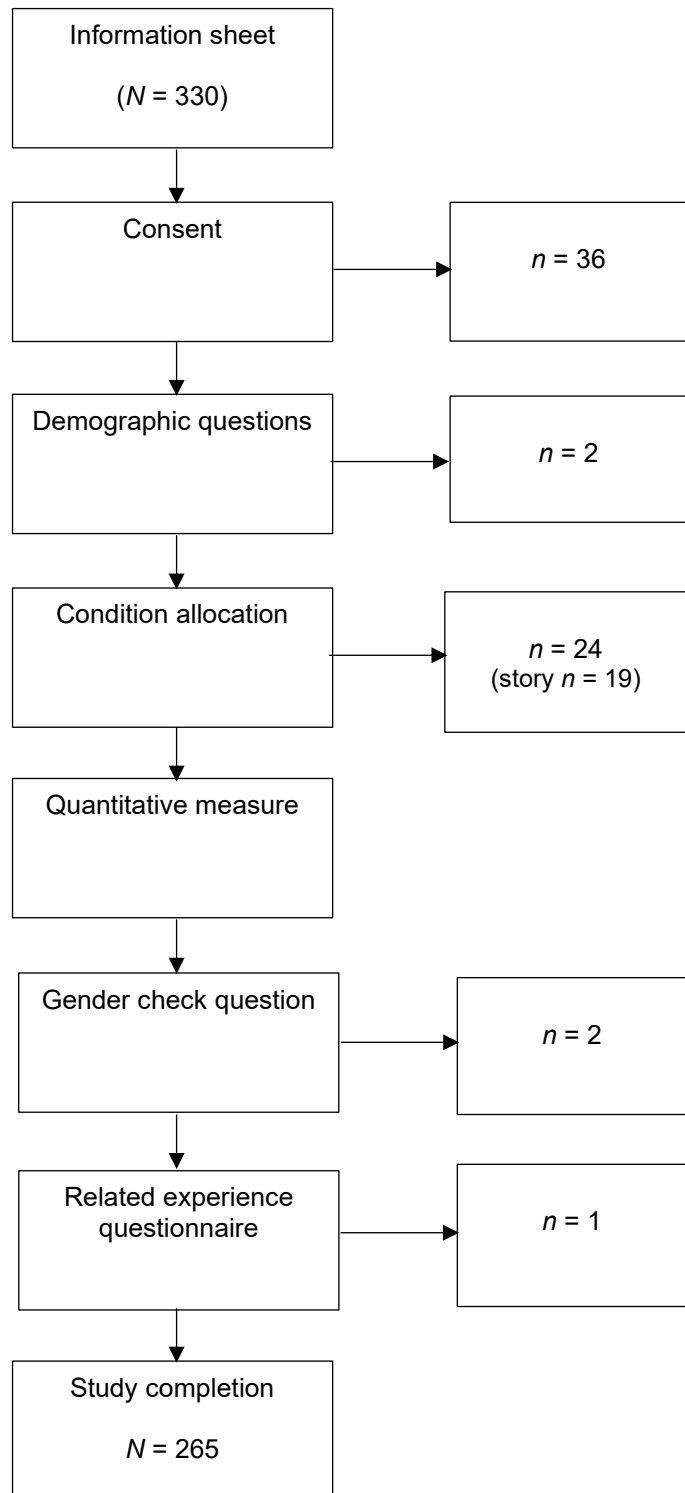
Full title of study: How Do We Make Sense of Intimate Partner Violence (IPV) in the Context of PTSD Diagnostic Status and Gender Identity?
PREC reference number: 21-257

I am taking Chairs Action to approve your application. Good luck with the research.

Best wishes,
(Redacted)
Chair of PREC

Appendix J

Participant Completion Progress



Research participants wanted

We are interested in how people make sense of personal relationships.

You will be asked to read a short story and answer some questions online. It is anonymous and takes around 20 minutes.

Who can take part?

Anyone aged 18+ in the UK can take part.

Who is conducting this research?

My name is Ella Lonnen. I am a trainee clinical psychologist at the University of Bath.

The research is supervised by Dr Rachel Paskell ().



To participate scan the QR code or follow the link to find out more

https://bathpsychology.eu.qualtrics.com/jfe/form/SV_6x8lgYCPRJsNkTI



Any questions? Please contact me:

ETHICS CODE: 21-257

Appendix L

Pre- and Post-Change Information

Pre-change N = 137

Post-change N = 128

Change Information

(N for each response option pre- and post-change included in brackets)

Where?	What?	Why?
Participant gender question	<p>Removed the transgender option and split original question into two different questions – one about sex assigned at birth and one about gender. Retained the <i>prefer not to say</i> and free text/self-describe options.</p> <p>From:</p> <p><i>How would you describe your gender identity?</i></p> <ul style="list-style-type: none"> ○ <i>Female</i> (101) ○ <i>Male</i> (31) ○ <i>Transgender</i> (0) ○ <i>Nonbinary</i> (2) ○ <i>Prefer to self-describe _____</i> (0) ○ <i>Prefer not to say</i> (3) <p>to:</p> <p><i>What sex were you assigned at birth?</i></p> <ul style="list-style-type: none"> ○ <i>Female</i> (85) ○ <i>Male</i> (43) ○ <i>Prefer not to say</i> (0) <p><i>Does the gender you identify with correspond to the sex you were assigned at birth?</i></p> <ul style="list-style-type: none"> ○ <i>Yes</i> (127) ○ <i>No – please enter your gender identity _____</i> (1 – “nonbinary”) ○ <i>Prefer not to say</i> (0) 	<p>To amend the language to accurately reflect our position that:</p> <p>(i) sex and gender are two separate constructs; and</p> <p>(ii) sex is typically assigned at birth, whereas gender is a deeply personal and self-defined identity or internal sense of self.</p> <p>To fall in line with the Office for National Statistics’ phrasing re: sex and gender in the 2021 Census.</p>

<p>Question to check what gender participants thought the victim in the story was</p>	<p>Changed pre-determined choice options to free text box to allow participants to describe in their own words (importantly, this also allowed us to remove the transgender option).</p> <p>From:</p> <p><i>In the story, Alex threw Frances’s phone. What did you think Frances’s gender was?</i></p> <ul style="list-style-type: none"> ○ Female (69) ○ Male (14) ○ Transgender (0) ○ Nonbinary (6) ○ Other (please describe) _____ (5) ○ I didn’t think about Frances’s gender (25) ○ I’m not sure (18) <p>to:</p> <p><i>In the story, Alex threw Frances’s phone. What do you think the gender of Frances is?</i></p> <ul style="list-style-type: none"> ○ I think Frances’s gender is _____ (65)* ○ I didn’t think about Frances’s gender (37) ○ I’m not sure (26) *"female" (46) "male" (12) "woman" (2) "girl" (3) 'not sure – wondered about female' (2) 	<p>To allow participants to describe in their own language.</p>

Appendix M

Participant Relevant Experience Questionnaire

Please complete the questions below. This will help us to learn whether personal and/or professional experiences affect the way people answer questions and the responses they give. *The answers you give will never be linked to your individual responses to other questions and cannot be used to identify you.*

1. In a professional capacity, have you ever worked with individuals (not as colleagues) who have:
 - a. Experienced domestic abuse? Yes / No / Prefer not to say
 - b. Perpetrated domestic abuse? Yes / No / Prefer not to say
 - c. A diagnosis of PTSD? Yes / No / Prefer not to say
 - d. Been the partner of someone with a diagnosis of PTSD? Yes / No / Prefer not to say
 - e. Identified as gender nonbinary or used the pronouns they/them? Yes / No / Prefer not to say

2. In a personal capacity, have you ever supported someone who has:
 - a. Experienced domestic abuse? Yes / No / Prefer not to say
 - b. Perpetrated domestic abuse? Yes / No / Prefer not to say
 - c. A diagnosis of PTSD? Yes / No / Prefer not to say
 - d. Been the partner of someone with a diagnosis of PTSD? Yes / No / Prefer not to say
 - e. Identified as gender nonbinary or used the pronouns they/them? Yes / No / Prefer not to say

3. Have you ever:
 - a. Experienced domestic abuse? Yes / No / Prefer not to say
 - b. Perpetrated domestic abuse? Yes / No / Prefer not to say
 - c. Had a diagnosis of PTSD? Yes / No / Prefer not to say
 - d. Been the partner of someone with a diagnosis of PTSD? Yes / No / Prefer not to say
 - e. Identified as gender nonbinary or used the pronouns they/them? Yes / No / Prefer not to say

Appendix N

Story Conditions with Story Completion Task

Below is a short story. Please read the story and then complete it with the following prompt questions in mind: 'What happens next?' and 'What advice does Nicky give Frances?'.

Condition 1: Female–PTSD

Alex and Frances have been together for five years and live together with their pet cat. Alex identifies as female and uses the pronouns she/her. Alex has been given a diagnosis of post-traumatic stress disorder by her doctor. Last Friday, Alex and Frances had an argument as a result of a number of stressful events. Alex became increasingly upset and would not stop shouting at Frances. She punched the wall and threw Frances's phone, which she had previously hidden. It narrowly missed Frances's face. This is not the first time the couple have argued and something like this has happened. A couple of days later, Frances talks to a friend, Nicky, about what happened and asks Nicky what to do.

Condition 2: Female–no PTSD

Alex and Frances have been together for five years and live together with their pet cat. Alex identifies as female and uses the pronouns she/her. Alex has been given a diagnosis of diabetes by her doctor. Last Friday, Alex and Frances had an argument as a result of a number of stressful events. Alex became increasingly upset and would not stop shouting at Frances. She punched the wall and threw Frances's phone, which she had previously hidden. It narrowly missed Frances's face. This is not the first time the couple have argued and something like this has happened. A couple of days later, Frances talks to a friend, Nicky, about what happened and asks Nicky what to do.

Condition 3: Male–PTSD

Alex and Frances have been together for five years and live together with their pet cat. Alex identifies as male and uses the pronouns he/him. Alex has been given a diagnosis of post-traumatic stress disorder by his doctor. Last Friday, Alex and Frances had an argument as a result of a number of stressful events. Alex became increasingly upset and would not stop shouting at Frances. He punched the wall and threw Frances's phone, which he had previously hidden. It narrowly missed Frances's face. This is not the first time the couple have argued and something like this has happened. A couple of days later, Frances talks to a friend, Nicky, about what happened and asks Nicky what to do.

Condition 4: Male–no PTSD

Alex and Frances have been together for five years and live together with their pet cat. Alex identifies as male and uses the pronouns he/him. Alex has been given a diagnosis of diabetes by his doctor. Last Friday, Alex and Frances had an argument as a result of a number of stressful events. Alex became increasingly upset and would not stop

shouting at Frances. He punched the wall and threw Frances's phone, which he had previously hidden. It narrowly missed Frances's face. This is not the first time the couple have argued and something like this has happened. A couple of days later, Frances talks to a friend, Nicky, about what happened and asks Nicky what to do.

Condition 5: Nonbinary--PTSD

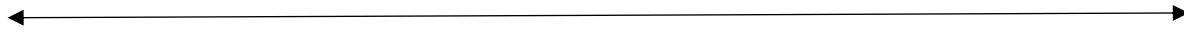
Alex and Frances have been together for five years and live together with their pet cat. Alex identifies as gender nonbinary and uses the pronouns they/them. Alex has been given a diagnosis of post-traumatic stress disorder by their doctor. Last Friday, Alex and Frances had an argument as a result of a number of stressful events. Alex became increasingly upset and would not stop shouting at Frances. They punched the wall and threw Frances's phone, which they had previously hidden. It narrowly missed Frances's face. This is not the first time the couple have argued and something like this has happened. A couple of days later, Frances talks to a friend, Nicky, about what happened and asks Nicky what to do.

Condition 6: Nonbinary--no PTSD

Alex and Frances have been together for five years and live together with their pet cat. Alex identifies as gender nonbinary and uses the pronouns they/them. Alex has been given a diagnosis of diabetes by their doctor. Last Friday, Alex and Frances had an argument as a result of a number of stressful events. Alex became increasingly upset and would not stop shouting at Frances. They punched the wall and threw Frances's phone, which they had previously hidden. It narrowly missed Frances's face. This is not the first time the couple have argued and something like this has happened. A couple of days later, Frances talks to a friend, Nicky, about what happened and asks Nicky what to do.

Appendix O
IPV Rating Scale

On a scale from 0 to 10, what extent do you think Alex's behaviour is domestic abuse?



0 1 2 3 4 5 6 7 8 9 10

Definitely
not abuse

Probably
not abuse

Not sure if
it is abuse

Probably
is abuse

Definitely
is abuse

Appendix P

Participant Information Sheet

How We Make Sense of Personal Relationships - Study Information Sheet

Before deciding whether to take part in this study, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Who is conducting the study?

My name is Ella Lonnen, and I am a trainee clinical psychologist at the Department of Psychology, University of Bath. I am carrying out this research with clinical psychologists Dr Rachel Paskell (University of Bath; NHS) and Dr Jess Mackinnon (NHS).

Who can take part in the study?

Anyone who is over the age of 18 and living in the UK can take part in the study.

What is the study about?

I am interested in the way we understand and make sense of personal relationships. We all make sense of the world around us in different ways, and this process is often shaped by our experiences and wider influences such as social, contextual and cultural factors. The way we understand and make sense of the world can influence how we interact with it. Exploring these factors can help us to learn more about this process for different people.

What is involved if I take part?

Taking part in this study is anonymous. This means that it will not be possible to identify you from your responses.

The study will take around 20 minutes to complete. You will first be asked to provide demographic information (age, gender identity, ethnicity, sexual orientation). This is to help us know about the groups of people who are taking part in the study. It will not be possible to identify you based on this information. If you would prefer not to provide this information, there will be a 'prefer not to say' option for each question.

You will then be asked to read a short story about an interaction between a couple in which one partner becomes very angry. Some people may experience this as distressing, so please bear this in mind when you are deciding whether to take part. You will be asked some questions about the story.

You may also be randomly selected to complete a task that will ask you to complete the story. There will be a prompt question for this task, but you may complete the story how you wish. Spelling and grammar are not important and there are no right or wrong answers for this - we are interested in what sense you make of the story. You will be asked to write ten lines to help me to get a sense of how you have responded to the story.

Are there any benefits to taking part?

The study is voluntary. There is no payment for taking part, but your participation is valuable and will help us better understand how people make sense of personal relationships.

What if I want to withdraw?

Taking part is completely voluntary. You can withdraw from the study at any point before completion simply by closing your web browser. You do not need to give a reason for this. Once you reach the end of the study, your responses will be submitted. As the study is anonymous, you will not be able to withdraw after this point as I will not be able to link you to your responses.

What will happen to my responses?

Once you submit your responses, they will be stored in a secure file with all the other responses. Only the researchers will have access to this file. The responses will be analysed to identify themes in the way that people respond. Your data will be securely stored by the University of Bath for ten years after study completion, in line with research requirements.

What will happen to the results of the study?

The results of the study may help us better understand how people make sense of personal relationships. The results will be written up as part of my Doctorate in Clinical Psychology and may be published in an academic journal. This is to contribute to public dialogue and to help other people learn from the research and the findings. A summary of the study findings can be shared with you if you wish to receive this. As the study is anonymous, I will not be able to contact you about this but if you email me at (redacted) stating that you wish to receive this, I will be happy to send a summary when the study is complete.

University of Bath privacy notice

The University of Bath privacy notice can be found here

<https://www.bath.ac.uk/corporate-information/university-of-bath-privacy-notice-for-research-participants/>

What if I have questions?

You are welcome to contact either my supervisor, Dr Rachel Paskell, at (redacted) or me, Ella Lonnen, at (redacted) if you have any questions about the study.

If you have any concerns related to your participation in this study, please direct them to the chair of the Department of Psychology Research Ethics Committee email: psychology-ethics@bath.ac.uk.

Our address is: Department of Psychology, University of Bath, Claverton Down, Bath BA2 7AY

Thank you for taking the time to read this.

Appendix Q

Victim Gender Check Question

In the story, Alex threw Frances's phone. What do you think the gender of Frances is?

- I think Frances's gender is: _____
- I didn't think about Frances's gender
- I'm not sure

Appendix R

Study Debrief

How We Make Sense of Personal Relationships - Debrief and Support Information

Thank you for taking the time to complete this study exploring the way the public make sense of personal relationships. The study focused on gender identity, the mental health diagnosis post-traumatic stress disorder (PTSD) and domestic abuse. Some research suggests that we may make sense of domestic abuse in different ways depending on contextual factors (e.g. the mental health status or gender identity of the perpetrator). No studies have explored this process in the context of gender identities outside of the binary female and male.

We are interested in whether gender identity and mental health status (specifically the diagnostic label PTSD) affect how we make sense of violent behaviour.

You were randomly allocated to one of six groups and asked to read a short story that contained violent behaviour. Some of the details of this story varied depending on the group to which you were allocated. We anticipate that these details may play a role in the way that people make sense of domestic abuse. Understanding this process will help us to know more about what influences disclosures of abuse and how they are responded to, and about how to develop public campaigns to support this process for people.

Please do not speak about the aims of this project with anyone else who may be taking part, as this may affect the responses they give.

Thank you again for taking part – your participation is greatly appreciated. If you would like to know more or you have any questions, please feel free to contact me, Ella Lonnen, on (redacted) or my supervisor, Dr Rachel Paskell, on (redacted).

If you would like more information or to access support about any of the themes in this study:

If you or someone else are in immediate danger, please call 999

Mental health

GP: If you are experiencing mental health difficulties, you may wish to contact your GP who will be able to signpost you to services in your area.

Mind: Mind provide advice and support to anyone experiencing a mental health problem.

Website: www.mind.org.uk

Infoline: 0300 123 3393

Email: info@mind.org.uk

Samaritans: Samaritans provide a 24-hour, 365-day a year service if you need someone to speak to.

Website: www.samaritans.org

Phone: 116 123

Email: jo@samaritans.org

PTSD UK: PTSD UK provide information and resources specifically related to post-traumatic stress disorder.

Website: www.ptsduk.org

Domestic abuse

Galop: provide information, advice and support to members of LGBT+ communities experiencing, or who have experienced, domestic abuse and violence. Galop run the **National LGBT+ Domestic Abuse Helpline**, which is open Monday to Friday, 10am – 5pm (Wednesday and Thursday until 8pm).

Website: www.galop.org.uk

National LGBT+ Domestic Abuse Helpline: 0800 999 5428

Email: help@galop.org.uk

Stonewall: campaign and advocate for the rights and equality of LGBTQ+ communities. They have information, support and helpline details specifically for LGBTQ+ individuals experiencing domestic abuse at the website below.

Website: www.stonewall.org.uk/domestic-violence-and-abuse-resources-lgbt-people

National Domestic Abuse Helpline: a 24-hour, 365-day a year helpline run in partnership between **Women's Aid** and **Refuge** for women. They listen, help women to understand their options and increase their safety, and can help locate places of refuge and other support services.

Website: www.nationaldahelpline.org.uk

Phone: 0808 2000 247

Refuge: provide information and support to women and children experiencing, or who have experienced, domestic abuse. Refuge run a live online chat service which is open Monday to Friday, 3pm – 10pm.

Website: www.refuge.org.uk

Live chat: www.nationaldahelpline.org.uk/en/chat-to-us-online

Women's Aid: provide information and support for women and children experiencing, or who have experienced, domestic abuse. They also provide a live, online chat service which is open Monday to Sunday, 10am – 6pm.

Website: www.womensaid.org.uk

Live chat: www.chat.womensaid.org.uk

Email: helpline@womensaid.org.uk

Respect Men's Advice Line: provide support, practical advice and information to men experiencing domestic abuse. They also offer webchat support.

Helpline: 0808 8010327

Email: info@mensadviceline.org.uk