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TESIS DOCTORAL

TRASTORNO DE ESTRÉS POSTRAUMÁTICO COMPLEJO EN
MUJERES SUPERVIVIENTES DE VIOLENCIA DE GÉNERO

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RESUMEN/ SUMMARY

Resumen

La violencia de género es un problema muy grave de salud pública a nivel global debido al impacto que tiene en la salud física, psicológica y sexual de las que mujeres que la sufren y sobreviven a ella (WHO, 2012). A su vez, es una de las principales causas de muerte y discapacidad entre las mujeres de todo el mundo (WHO, 2013).

Las consecuencias son tan alarmantes en la salud que la investigación abarca el estudio de las secuelas físicas (García-Moreno et al., 2013), psicológicas (Dillon et al., 2013), neuropsicológicas (Stein et al., 2002) y cerebrales (Daugherty et al., 2022). En torno a estas tres últimas, destacan en número los estudios sobre estrés postraumático (TEPT) (Kastello et al., 2016; Twamley et al., 2009; Neumeister et al., 2018) debido a la gravedad del mismo y la alta prevalencia en la presente población. Sin embargo, la literatura no ha considerado a ningún nivel otro trastorno relacionado con el estrés traumático como el trastorno de estrés postraumático complejo (TEPTC), el cual ha sido definido en la CIE-11 por la Organización Mundial de la Salud (WHO, 2018).

Hasta el momento, este trastorno se ha estudiado a nivel psicológico como consecuencia de vivir un evento traumático o estresante que da lugar al conjunto de síntomas de reexperimentación en el aquí y el ahora, evitación, sensación actual de amenaza, desregulación emocional, autoconcepto negativo y alteraciones en las relaciones sociales. Desde su definición, numerosos estudios a nivel internacional han investigado su prevalencia, estructuras latentes, variables de riesgo y protección asociadas, instrumentos de evaluación, propiedades psicométricas de las medidas desarrolladas e incluso posibles tratamientos. Estos estudios se han llevado a cabo en numerosas poblaciones supervivientes de distintos eventos traumáticos como menores que han sufrido maltrato, menores soldados, supervivientes de trata, refugiados y prisioneros de guerra (Bertó et al., 2017; Ottisova et al., 2018; Murphy et al., 2018; Vallières et al., 2018; Zerach et al., 2019), y en diferentes países y culturas. Como observamos, especialmente se ha estudiado en poblaciones de supervivientes de traumas interpersonales, dado que son poblaciones que, por la violencia ejercida, la cronicidad y la dificultad para escapar (Hyland et al., 2018b) presentan mayor

prevalencia de TEPTC a diferencia del TEPT clásico (conformado por síntomas de reexperimentación, evitación y sensación actual de amenaza).

Sin embargo, en la población de mujeres supervivientes de violencia de género no se ha estudiado este trastorno. A pesar de que se trata de un tipo de violencia con las características comunes a otros tipos de traumas interpersonales y con la particularidad de que la violencia es deliberada por una persona con la que tienen un vínculo singular (Matheson et al., 2015; Pill et al., 2017; Santiago et al., 2013).

Al mismo tiempo, no se ha investigado si los instrumentos que se están utilizando en supervivientes de otros traumas tendrían óptimas propiedades psicométricas tal y como se ha reflejado en numerosos estudios en otras poblaciones a nivel internacional (Hansen et al., 2021; Hyland et al., 2017b; Karatzias et al., 2016; Kazlauskas et al., 2018). De este modo, contar con un instrumento validado en esta población permitiría evaluar el diagnóstico de TEPTC en mujeres supervivientes de este tipo de violencia, conocer cómo se presenta este diagnóstico, la relación entre sus síntomas, estudiar la fiabilidad y validez del mismo o las posibles variables que incrementan o disminuyen la presencia y severidad de los síntomas que lo componen.

Por consiguiente, el objetivo principal de la presente Tesis Doctoral es investigar el TEPTC en mujeres supervivientes de VG. Para llevar a cabo este objetivo, la tesis consta de nueve capítulos. En el Capítulo 1 se desarrolla el concepto de violencia interpersonal y violencia de género, estadísticas sobre prevalencia y secuelas en la salud de las mujeres que han sufrido este tipo de violencia. En el Capítulo 2 se define el TEPT y el TEPTC, se desarrolla la construcción del constructo de TEPTC, se indaga en ambos diagnósticos en poblaciones supervivientes de traumas distintos a VG y a la vez, específicamente en la población de mujeres supervivientes de VG y concretamente, las variables que pueden estar relacionadas con el TEPTC en esta población. En el Capítulo 3 se exploran las medidas para evaluar el TEPT y TEPTC y en el Capítulo 4, se presenta la justificación y objetivos de la presente Tesis. Del Capítulo 5 al 8 se exponen los cuatro estudios empíricos que componen la Tesis Doctoral. Para finalizar, el Capítulo 9 se centra en la discusión general del presente trabajo y el Capítulo 10, en la versión en inglés de la misma.

El primer estudio buscaba conocer las propiedades psicométricas de la prueba ITQ para medir el TEPT y TEPTC en la población de mujeres supervivientes de VG. Los resultados mostraron que dicha prueba es fiable y válida para medir ambos diagnósticos en la presente población de supervivientes (Capítulo 5). El segundo estudio consistió en conocer la prevalencia de TEPT y TEPTC a través de la prueba ITQ en esta población. Al mismo tiempo, en este estudio se investigan los factores relacionados con la presencia de cada uno de los síntomas de TEPTC y con el diagnóstico completo en relación al diagnóstico de TEPT. Los resultados indicaron que la prevalencia de TEPTC fue del doble en comparación a la de TEPT. A su vez, una baja resiliencia, altos niveles de miedo hacia el maltratador y un alto uso de estrategias de regulación emocional se relacionan con la presencia de diversos síntomas de TEPTC. Esta última variable también marcó la diferencia entre el diagnóstico de TEPT y TEPTC (Capítulo 6). El tercer estudio se centra en conocer si existe relación entre la severidad de la violencia y la severidad de los síntomas de TEPTC mediada por la resiliencia. Los resultados mostraron que existe relación entre resiliencia y los síntomas de TEPTC y también entre la severidad de la violencia y los síntomas de TEPTC. Sin embargo, entre la severidad de la violencia y la resiliencia no hubo relación. Por tanto, no se obtuvo una relación indirecta entre ambas variables mediada por la resiliencia (Capítulo 7). Por último, el cuarto estudio tuvo como objetivo, conocer las relaciones entre los síntomas de TEPTC y diferentes estrategias de regulación emocional. Al mismo tiempo, se profundiza en los síntomas de desregulación afectiva. De los resultados se obtiene que las estrategias de supresión de la expresión se relacionan más con los síntomas de TEPTC denominados alteraciones de la autoorganización (AAO) (desregulación afectiva, autoconcepto negativo y alteraciones en las relaciones sociales). Para finalizar, se obtuvo que, dentro de los síntomas de desregulación afectiva, la hipoactivación emocional tiene un papel protagonista en el conjunto de síntomas de TEPTC y en relación a la supresión de la expresión que presentan las mujeres supervivientes de VG (Capítulo 8).

En resumen, los presentes resultados muestran que un alto porcentaje de mujeres supervivientes de VG sufrirían TEPTC. De este modo, presentarían conjuntamente los síntomas clásicos de TEPT y los denominados síntomas de AAO. Al mismo tiempo, en este trabajo se obtiene que variables como la baja resiliencia, la supresión de la expresión, el miedo hacia el agresor y la severidad de la violencia sufrida

se relacionan con la severidad de los síntomas TEPTC o la presencia de los mismos. Por último, ante la ausencia de instrumentos específicos para evaluar este diagnóstico en mujeres supervivientes de VG, esta Tesis informa sobre la estructura latente de este trastorno en esta muestra y aporta que ITQ es fiable y válida para evaluar este diagnóstico en esta población.

Summary

Intimate partner violence (IPV) is a serious global public health problem having an important impact on the physical, psychological and sexual health of victims and survivors (WHO, 2012). Furthermore, it is a leading cause of death and disability among women (WHO, 2013).

The consequences are so alarming for women's health that research encompasses the study of physical (García-Moreno et al., 2013), psychological (Dillon et al., 2013), neuropsychological (Stein et al., 2002) and cerebral (Daugherty et al., 2022) sequelae. Regarding the latter three, studies on post-traumatic stress disorder (PTSD) stand out in number (Kastello et al., 2016; Twamley et al., 2009; Neumeister et al., 2018) due to the severity of PTSD and the high prevalence in the present population. However, previous studies have not considered the complex posttraumatic stress disorder (CPTSD) in this population, which has been defined in ICD-11 by the World Health Organization (WHO, 2018).

So far, this traumatic stress-related disorder has been studied as a consequence of experiencing a traumatic or stressful event that gives rise to a set of symptoms of re-experiencing in the here and now, avoidance, current sense of threat, emotional dysregulation, negative self-concept and alterations in relationships. Numerous international studies have already investigated its prevalence, latent structures, associated risk and protective variables, assessment instruments, psychometric properties of the measures developed, and even possible treatments. These studies have been conducted in numerous populations of survivors of different traumatic events such as abused children, child soldiers, trafficking survivors, refugees and prisoners of war (Bertó et al., 2017; Ottisova et al., 2018; Murphy et al., 2018; Vallières et al., 2018; Zerach et al., 2019), and in different countries and cultures. We notice that CPTSD has been studied especially in populations of survivors of interpersonal trauma where the violence perpetrated is chronic and difficult to escape (Hyland et al., 2018b), and there is higher prevalence of CPTSD with respect to classic PTSD (re-experiencing, avoidance, and current sense of threat).

However, CPTSD has not been studied in the population of women survivors of IPV, although it is a type of violence with characteristics common to other types of interpersonal trauma and with the particularity that the violence is deliberate by a person with whom they have a unique bond (Matheson et al., 2015; Pill et al., 2017; Santiago et al., 2013).

At the same time, it has not been investigated whether the instruments being used in other populations would have optimal psychometric properties as reflected in numerous studies in other populations internationally (Hansen et al., 2021; Hyland et al., 2017b; Karatzias et al., 2016; Kazlauskas et al., 2018). Thus, having a validated instrument in this population would allow us to assess the diagnosis of CPTSD in women survivors of this type of violence, know how this diagnosis is presented and the relationship between its symptoms, study its reliability and validity or the possible variables that increase or decrease the presence and severity of the symptoms that compose it.

Therefore, the main objective of the present Doctoral Thesis is to investigate CPTSD in female survivors of IPV. In order to carry out this objective, the thesis consists of nine chapters. Chapter 1 develops the concept of interpersonal violence and IPV, statistics on prevalence, and sequelae in the health of women who have suffered this type of violence. Chapter 2 defines PTSD and CPTSD, develops the construct of CPTSD, explores both diagnoses in populations of survivors of trauma other than IPV and in the population of women survivors of IPV, and the variables that may be related to CPTSD in this specific population. Chapter 3 explores measures for assessing PTSD and CPTSD, and Chapter 4 presents the rationale and objectives of this thesis. Chapters 5 to 8 present the four empirical studies that make up the Doctoral Thesis. Finally, Chapter 9 focuses on the general discussion of the present work, and Chapter 10 includes the English version of the discussion.

The first study sought to understand the psychometric properties of the ITQ test for measuring PTSD and CPTSD in a population of female IPV survivors. The results showed that the ITQ is reliable and valid for measuring both diagnoses in the present population of survivors (Chapter 5). The second study aimed to determine the prevalence of PTSD and CPTSD using the ITQ test in this population. At the same time,

this study investigated factors related to the presence of each of the CPTSD symptoms and to the full diagnosis in relation to the diagnosis of PTSD. The results indicated that the prevalence of CPTSD was twice as high as that of PTSD. In turn, low resilience, high levels of fear towards the perpetrator, and high use of emotional regulation strategies were related to the presence of several CPTSD symptoms. The latter variable also made a difference between a diagnosis of PTSD and CPTSD (Chapter 6). The third study investigated whether there is a relationship between the severity of violence and the severity of CPTSD symptoms mediated by resilience. The results showed that there is a relationship between resilience and CPTSD symptoms and also between severity of violence and CPTSD symptoms. However, there was no relationship between severity of violence and resilience. Therefore, there was no indirect relationship between the two variables mediated by resilience (Chapter 7). Finally, the fourth study aimed to find out the relationships between CPTSD symptoms and different emotional regulation strategies. At the same time, it delves into the symptoms of affective dysregulation. The results show that the strategies of suppression of expression are more closely related to the symptoms of DSO symptoms (affective dysregulation, negative self-concept and alterations relationships). Moreover, it was found that within the symptoms of affective dysregulation, emotional hypoactivation plays a leading role in the set of symptoms of CPTSD and in relation to the expressive suppression in female survivors of IPV (Chapter 8).

In summary, the present results show that a high percentage of female survivors of IPV would suffer from CPTSD. Thus, they would present both classic PTSD symptoms and the symptoms of DSO. At the same time, this study found that variables such as low resilience, suppression of expression, fear towards the perpetrator and the severity of the violence suffered were related to the severity or presence of CPTSD symptoms. Finally, in the absence of specific instruments to assess this diagnosis in female survivors of IPV, this thesis reports on the latent structure of this disorder and provides that the ITQ is reliable and valid for assessing this diagnosis in this population.

I. INTRODUCCIÓN TEÓRICA

Capítulo 1.
**Violencia de género y consecuencias
en la salud**

La violencia de género (VG) es una de las principales causas de reducción de la calidad de vida, daño y muerte en mujeres de todo el mundo (Breiding et al., 2015; WHO, 2013). Las mujeres que la sufren padecen multitud de consecuencias para su salud física, mental, así como secuelas neuropsicológicas y cerebrales. En esta línea, la presente tesis doctoral pretende estudiar en profundidad una posible secuela psicológica de la violencia sufrida, el trastorno de estrés postraumático complejo (TEPTC) (constructo que se desarrollará con detalle en el Capítulo 2). Sin embargo, tanto esta alteración psicológica como otras que sufren estas mujeres como consecuencia de la violencia, no aparecen de modo aislado. Por esta razón, y con el objetivo de tener una visión más amplia y completa de las alteraciones que se observan en las mujeres víctimas y supervivientes de VG, en este capítulo se profundizará en el término de VG, lo que implica, la epidemiología nacional e internacional, así como las alteraciones físicas, psicológicas, cerebrales y neuropsicológicas consecuentes a este tipo de violencia.

1.1. Introducción a la violencia de género

1. 1. 1. Violencia interpersonal y violencia de género

Alrededor de 1,3 millones de personas en todo el mundo pierden la vida cada año a consecuencia de las diferentes formas de violencia, y decenas de miles de personas son víctimas cada día de la violencia autoinfligida, interpersonal o colectiva (WHO, 2014). Esta categorización permite diferenciar entre la violencia que una persona se inflige a sí misma, la violencia causada por otro individuo o por un pequeño grupo de personas y la violencia llevada a cabo por grupos más grandes como estados, grupos políticos organizados, milicias u organizaciones terroristas. A su vez, la violencia interpersonal se divide en dos subcategorías: la violencia familiar y de pareja y, por otro lado, la violencia en la comunidad. La primera de ellas se refiere al maltrato infantil, la violencia dentro de la pareja y el maltrato a ancianos, todos ellos entre miembros de la familia, aunque no exclusivamente en el hogar. La segunda subcategoría incluye la violencia juvenil, los actos aleatorios de violencia, la violación o la violencia sexual por parte de extraños, y la violencia en instituciones como escuelas, lugares de trabajo, prisiones y residencias de ancianos (Krug et al. en WHO, 2002).

1. 1. 2. Definición de violencia de género

La violencia contra las mujeres (Violence Against Women, VAW) dentro de la pareja es una de las principales causas de muerte y discapacidad en todo el mundo. Por ello, la Organización Mundial de la Salud (WHO, 2013) destaca este tipo de violencia como un problema de salud internacional y una prioridad que ha de ser tratada.

Se utilizan diferentes términos para definir la violencia contra las mujeres (Violence Against Women, VAW) que difieren en sus matices según la nacionalidad, el contexto al que se refieren o la existencia o ausencia de relación con el agresor. "Violencia contra la mujer" (VAW) y "Violencia basada en el género" (Gender-Based Violence, GBV) se utilizan para referirse a toda la gama de violencias contra las mujeres reconocidos por la Declaración de las Naciones Unidas (ONU, 1993).

Otros términos comúnmente utilizados son "Violencia de pareja" (Intimate Partner Violence, IPV), "Maltrato hacia la esposa" (Wife Abuse) and "Violencia doméstica" (Domestic Violence) para referirse a diversos tipos de abusos sexuales, psicológicos y físicos contra las mujeres adultas y adolescentes por parte de sus parejas íntimas masculinas actuales o anteriores. Debido a la diversidad de términos utilizados, en este documento utilizaremos el término "Violencia de género" o VG (refiriéndonos en inglés a Intimate Partner Violence o IPV) para referirnos al tipo de violencia contra las mujeres por parte de sus parejas masculinas actuales o anteriores ya que, VG (IPV) se situaría en la superposición de los términos "Violencia basada en el género" (en inglés GBV) donde se incluyen otros tipos de violencia basada en el género en el que el vínculo con el agresor no tiene que ser necesariamente de pareja y "Violencia familiar" según la OMS (Ellsberg y Heise, 2005), el cual no excluye a las mujeres que no están casadas o que no comparten el hogar con sus agresores masculinos.

Por lo tanto, la definición de VG se refiere a cualquier comportamiento dentro de una relación íntima que cause daño físico, psicológico o sexual. A continuación, se enumeran ejemplos de tipos de comportamiento: actos de violencia física, como bofetadas, golpes, patadas y palizas; violencia sexual, incluidas las relaciones sexuales forzadas y otras formas de coerción; abuso emocional (psicológico), como insultos,

menosprecio, humillación constante, intimidación (por ejemplo, destruyendo cosas), amenazas de daño, amenazas de llevarse a los niños; control del comportamiento, incluyendo el aislamiento de la persona de la familia, de los amigos, la vigilancia de sus movimientos, la restricción del acceso a los recursos financieros, empleo, educación o atención sanitaria (WHO, 2012).

En nuestro país, la definición de VG afina aún más en cuanto a género se refiere. Así, se ha definido a través de la Ley de Medidas de Protección Integral contra la Violencia de Género (Ley Orgánica 1/2004, de 28 de diciembre), entendiéndose como la “manifestación de la discriminación, la situación de desigualdad y las relaciones de poder de los hombres sobre las mujeres, que se ejerce sobre éstas por parte de quienes sean o hayan sido sus cónyuges o de quienes estén o hayan estado ligados a ellas por relaciones similares de afectividad, aun sin convivencia, y comprende todo acto de violencia física y psicológica, incluidas las agresiones a la libertad sexual, las amenazas, las coacciones o la privación arbitraria de libertad”.

1. 2. Epidemiología de la violencia de género a nivel nacional e internacional

La consecuencia final más grave de la VG es que el 38% del total de homicidios de mujeres en todo el mundo se deben a este tipo de violencia. En nuestro país, el total de mujeres víctimas mortales de violencia de género a manos de sus parejas o ex parejas es de 1168, contando los datos recogidos desde 2003 hasta el 30 de noviembre de 2022 (Ministerio de Igualdad, 2021; Ministerio de Sanidad, Servicios Sociales e Igualdad, 2022).

A nivel internacional, una de cada tres mujeres en el mundo sufre violencia física y/o sexual por parte de una pareja íntima, y en algunas regiones, esta cifra puede llegar al 38% (WHO, 2013). Los datos europeos extraídos de 28 países a través de 42.000 entrevistas a mujeres, indican que el 43% de ellas ha sufrido alguna vez violencia psicológica y el 22% ha sufrido alguna vez violencia física y/o sexual, desde los 15 años y por su pareja o ex pareja (FRA, 2014).

En España, se recibieron 79.206 llamadas al 016 (Servicio telefónico de información y asesoramiento jurídico sobre VG) en 2020 y 946.792 desde 2007 hasta 2020. Durante el año 2020 se recibieron en los juzgados un total de 150.804

denuncias por violencia de género, se incorporaron 35.948 órdenes de protección y medidas, y en 2020 constan 32.605 casos activos de mujeres con protección policial (con nivel de riesgo apreciado). El mayor porcentaje se encuentra entre las mujeres con edades comprendidas entre los 31 y los 45 años de edad (Ministerio de Igualdad, 2020). A su vez, la macroencuesta sobre Violencia contra la Mujer (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2020), informa que del total de mujeres de 16 o más años residentes en España, el 14,2% (2.905.489 mujeres) ha sufrido violencia física y/o sexual de alguna pareja, actual o pasada, en algún momento de su vida desde que se recogen datos. También se obtuvieron los siguientes datos a partir de un total de 9568 mujeres entrevistadas en 2019, residentes en España y mayores de 16 años: el 11% de las mujeres había sufrido violencia física por parte de su pareja o expareja en algún momento de su vida. En el caso de las mujeres que han sufrido violencia física por parte de parejas pasadas, el 17,3% afirman que sucedió en una única ocasión mientras que el 82,5% afirman que ocurrió más de una vez.; El 8,9% ha sufrido violencia sexual de alguna pareja actual o pasada en algún momento de su vida. En el caso de las mujeres que han sufrido violencia sexual por parte de parejas pasadas, el 11,1% afirman que sucedió en una única ocasión mientras que el 88,8% afirman que ocurrió más de una vez.; Por último, el 27% de las mujeres ha sufrido violencia psicológica de control y el 23.2% ha sufrido violencia psicológica emocional, todas ellas por una pareja o ex pareja en algún momento de su vida. En el caso de las mujeres que han sufrido violencia emocional por parte de parejas pasadas, el 8,2% afirman que sucedió en una única ocasión mientras que el 91,3% que ocurrió más de una vez. Y, en el caso de la gravedad de la violencia de control, los comportamientos de control han sido sufridos de forma frecuente por el 52,9% de las mujeres que afirman haber sufrido esta violencia de alguna pareja pasada.

1. 3. Consecuencias físicas de la violencia de género en mujeres víctimas y supervivientes

Haber sufrido VG puede tener repercusiones en la salud de las víctimas y supervivientes, tanto físicas, psicológicas, neuropsicológicas y cerebrales. De hecho, la prevalencia de problemas de salud entre las mujeres supervivientes de violencia es el doble o el triple que entre las mujeres que no han experimentado ningún tipo de

violencia (García-Moreno et al., 2013). Por ello, la violencia de género se ha incluido como uno de los temas centrales dentro de los sistemas y políticas de salud internacional (UN, 2015).

Dentro de las secuelas y problemas físicos, podemos encontrar que el estrés relacionado con la exposición a la violencia se asocia con resultados adversos para la salud como afectaciones en el sistema inmunológico, respuestas neurales y neuroendocrinas (Olf, 1999; Stockman et al., 2011). Existe evidencia de que el estrés crónico induce una alteración de la sensibilidad de ciertos elementos del sistema inmunitario a los glucocorticoides (Miller et al., 2008; Rohleder, 2012). Los estudios sobre niveles de cortisol en mujeres supervivientes de VG indican de modo consistente que las mujeres que han sufrido este tipo de violencia, presentan alteraciones en los niveles de cortisol. Varios estudios han demostrado que existen elevados niveles de cortisol en mujeres supervivientes que desarrollan TEPT y/o depresión (Inslicht et al, 2006; Cordero et al., 2017; Pinna et al, 2014). También en mujeres embarazadas expuestas a VG durante los últimos 12 meses, se han observado niveles más altos de cortisol en el cabello en comparación con controles (Boeckel et al., 2017). Esto sugiere que el estrés crónico se refleja en una alta actividad HPA (Hipotalámico-Pituitario-Adrenal) general, y la sensibilidad alterada de los glucocorticoides después del estrés crónico podría afectar a otros sistemas biológicos (Goldberg et al., 2021).

Así, el sistema inmunitario, tras sufrir violencia de género, tiene mayores posibilidades de verse afectado. Unos pocos estudios han informado sobre las consecuencias de la VG en lo que respecta al sistema inmunitario, donde se han encontrado que en mujeres que han sufrido VG aparecen alteraciones en el número de algunos subconjuntos de células T, una reducción de las respuestas proliferativas y de la actividad de eliminación de células por parte de los linfocitos, así como una menor cantidad de inmunoglobulina A (IgA) salival y un aumento de las citocinas proinflamatorias en comparación con mujeres que no han sufrido VG (Constantino et al., 2000; Gill et al., 2005; Hoge et al., 2009; Woods et al., 2005). En cuanto a enfermedades víricas atañe, se ha determinado que la capacidad de la saliva para neutralizar herpes simple de tipo 1 (HSV-1) es más baja significativamente en mujeres

que sufren violencia física en comparación a mujeres que sufren violencia psicológica y mujeres que no sufren VG (García-Linares et al., 2004). En relación a ello, Sánchez-Lorente et al. (2010) indicaron que el cese de la VG de tipo física es el principal predictor de la recuperación de este tipo de herpes en mujeres que sufren VG. También en relación a la afectación del sistema inmune por la vivencia de VG, Pauwels et al. (2012) han demostrado que las mujeres que han sufrido este tipo de violencia tienen mayores posibilidades de sufrir cáncer. Algunos tipos de cáncer que se ha observado que pueden aparecer a largo plazo tras sufrir VG son de mama (Sawin et al., 2009; Sheikhezahad et al., 2022), pulmón (Nemeth et al., 2016) o cuello de útero (Coker et al., 2009; Loxton et al., 2006).

Además, experiencias como la violencia y el estrés están relacionadas con la aparición de problemas y enfermedades cardiovasculares (Chandan et al., 2020) como hipertensión (Mason et al., 2012), altos niveles de colesterol y presión sanguínea (Bosch et al., 2019), isquemia (Monahan et al. 2019) o accidente cerebrovascular (Thurston et al., 2019; Thurston et al., 2022). También aparecen problemas musculoesqueléticos como dolor crónico (Thurston et al., 2019), síndrome de fatiga crónica, fibromialgia (Chandan et al., 2021), artritis reumatoide (Coker et al., 2000) y lupus (Black y Breiding, 2008). Problemas respiratorios como asma (Wang et al., 2022), bronquitis o enfisema pulmonar (Loxton et al., 2006) y alergias (Woods et al., 2005). A la vez que problemas gastrointestinales (Stam, 1997) como indigestión frecuente, diarrea o estreñimiento (Coker et al., 2000). Por último, los estudios indican que la probabilidad del desarrollo de diabetes dependiente de insulina (Roberts 2015; Mead, 2005), anemia (Ackerson y Subramanian, 2008) y otros problemas que atañen a la salud física como migraña, tartamudeo, infecciones de transmisión sexual, úlceras estomacales y colon espástico (Coker et al., 2000), es mayor en mujeres que han sufrido VG.

1. 4. Consecuencias psicológicas de la violencia de género en mujeres víctimas y supervivientes

En la misma línea y en muchos casos relacionados con el desarrollo de las enfermedades físicas anteriormente expuestas, las mujeres supervivientes sufren trastornos y problemas mentales como consecuencia de vivir situaciones de violencia

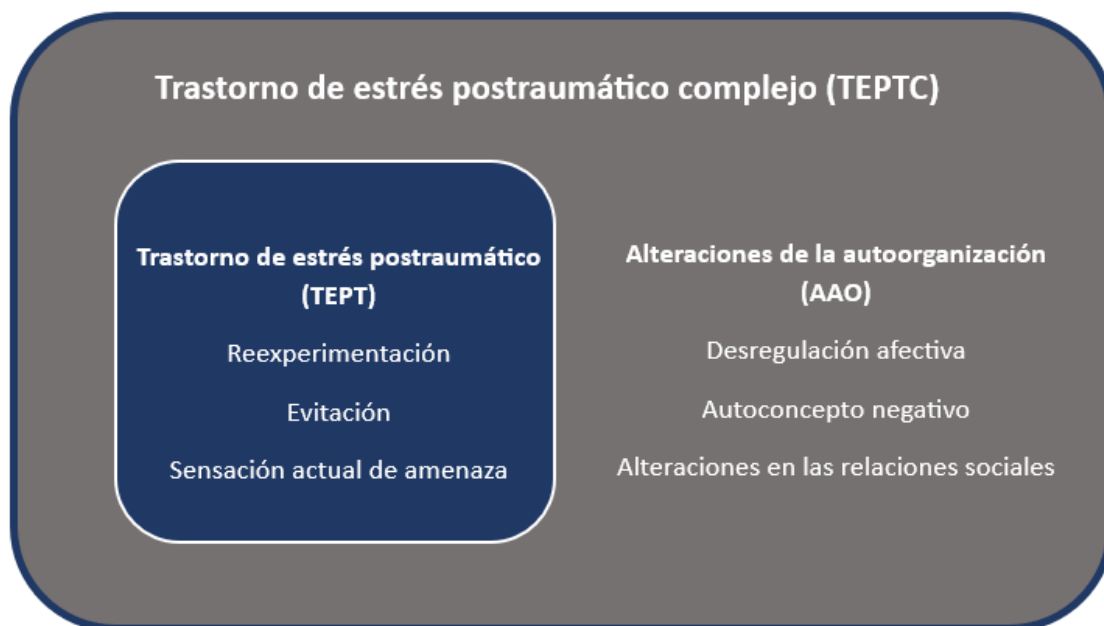
por parte de su pareja o ex pareja (Dillon, 2013). La prevalencia de alexitimia, dificultad en la identificación y expresión de emociones son problemas informados por las mujeres supervivientes de violencia de género que se relacionarían con una capacidad menor para manejar el estrés consecuente a la violencia (Craparo et al., 2014). Es por ello que surgen diferentes trastornos y problemas psicológicos que son más prevalentes en la presente población. Este es el caso del trastorno de estrés postraumático (TEPT), uno de los problemas mentales más comunes en esta población, con una estimación de prevalencia en un rango del 31% al 84,4% y una prevalencia media ponderada del 63,8% (Golding, 1999; Kastello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien y Schie, 2008; Pico-Alfonso et al., 2006). En los próximos capítulos detallaremos más en qué consiste este diagnóstico y también hablaremos del reciente diagnóstico definido de trastorno de estrés postraumático complejo (TEPTC). Diagnóstico que surge por la necesidad de definir un diagnóstico más grave o con más síntomas que el TEPT y que, aunque se diagnostica según los síntomas presentados, su estudio surge en torno a la gravedad de los síntomas derivados de traumas interpersonales (Kessler et al., 2017).

El TEPTC será el tema central de la presente tesis, dado que por los síntomas que las mujeres supervivientes informan en los centros a los que asisten tras sufrir la violencia (Lilly y Lim, 2012; Matheson et al., 2015; St. Vil et al., 2018), el vínculo que tienen con la fuente de violencia y la dificultad para escapar o salir de la situación traumática (Kazlauskas et al., 2018; Hyland et al., 2018), se podría considerar que una realidad derivada de dicha experiencia encajaría en el cuadro diagnóstico de TEPTC definido en la Clasificación Internacional de Enfermedades (CIE-11) de la Organización Mundial de la Salud (WHO, 2018). En la Figura 1 se pueden observar los síntomas de TEPT y TEPTC según la clasificación de la OMS.

Como hemos indicado, hasta el momento la literatura sólo ha considerado el TEPT, al que denominamos también clásico. Teniendo en cuenta ello, varios estudios indican que las mujeres con antecedentes de VG tienen entre 2 y 3 veces más probabilidades de desarrollar TEPT en comparación con las mujeres que nunca la han experimentado, controlando la etnia, el estado civil y los ingresos (Fedovskyi et al., 2008; Nerøien y Schei (2008); O'Campo et al., 2006). La gravedad de la VG se

correlaciona con la intensidad de los síntomas de TEPT, y el abuso psicológico es un fuerte predictor del TEPT (Pico-Alfonso 2005; Pico-Alfonso et al. 2006).

Figura 1. Síntomas de TEPT y TEPTC.



Por otro lado, la depresión es otro de los problemas psicológicos más prevalentes en la población de las mujeres supervivientes de VG. Los estudios afirman que la prevalencia de la depresión de las mujeres es del 47,6% (Golding, 1999; Hyde et al., 2008; Lövestad et al., 2017). Para el diagnóstico de depresión tiene que haber dos de los tres síntomas fundamentales de la depresión, que se consideran el humor depresivo, la pérdida de interés o de la capacidad de disfrutar en actividades que normalmente eran placenteras y disminución de la energía o aumento de la fatigabilidad (Rodríguez et al., 2021; WHO, 2018).

En relación a la VG, la depresión es el aspecto de la salud mental de las mujeres más investigado en relación con este tipo de violencia (Dillon et al., 2013). La literatura expone que el haber sido expuesta a diferentes tipos de violencia aumenta la probabilidad de sufrir depresión (Lagdon et al., 2014). así como la gravedad de esos síntomas (Chen et al., 2009; Eshelman y Levendovsky (2012); Houry et al., 2006; Pico-Alfonso et al., 2006).

En relación a ello, Pico-Alfonso et al. (2006) descubrieron que la violencia psicológica era tan perjudicial como la violencia física en términos de síntomas depresivos en su muestra de estudio de mujeres españolas que habían sufrido VG.

Wong et al. (2011) descubrieron que el maltrato psicológico es el factor predictivo más importante de niveles de depresión relacionados con la VG en su estudio de mujeres en China. Además, encontraron que cuanto más frecuente es el maltrato psicológico, mayor es el nivel de depresión.

Otro problema psicológico con alta prevalencia entre la población de mujeres supervivientes de VG es la ansiedad (Schafer et al., 2018). Concretamente, con un rango de prevalencia del 34% (Beck et al., 2014; Hurwitz et al., 2006) al 56,1% (Beck et al, 2015). Varios estudios informan de una asociación positiva entre experimentar VG y el aumento de los niveles de ansiedad en las mujeres que la sufren incluso teniendo en cuenta variables demográficas como edad, la educación y los ingresos (Fadardi y Ziaee, 2009; Savas y Agridag, 2011; Schneider et al., 2009). Pico-Alfonso et al. (2006) han observado una relación entre la gravedad de los síntomas de ansiedad y la comorbilidad con la depresión, observando que la gravedad de la ansiedad de estado es mayor en mujeres con síntomas depresivos. También se ha observado una mayor gravedad de los síntomas de ansiedad en las mujeres maltratadas cuando el abuso experimentado es más frecuente, más intenso o más grave (Ansara y Hidin 2011; Ludemir et al., 2008; Sato-DiLorenzo y Sharps, 2007).

Otros problemas psicológicos identificados en las mujeres supervivientes son abuso o dependencia del alcohol con una media ponderada de 18,5% (Golding, 1999; La Flair et al., 2012; Flanagan et al., 2016; Helfrich et al., 2008 o trastornos alimentarios con una prevalencia del 7,9% (Huston et al., 2019). Al mismo tiempo, uno de los problemas más preocupantes que pueden aparecer a consecuencia de la violencia en las mujeres que la sufren, es la ideación suicida. En un estudio llevado a cabo en la India, Vachher y Sharma (2010) informaron de que el 22,3% de las mujeres habían pensado alguna vez en el suicidio, el 12,0% el mes anterior, y el 3,4% de las mujeres había intentado suicidarse. Las tendencias suicidas eran considerablemente más comunes en las mujeres con antecedentes de VG, en comparación con las que no habían sufrido violencia. A su vez, en otro estudio llevado a cabo en Bangladesh encontraron que un aumento de formas de violencia experimentado por las mujeres, conduce a un aumento de la tasa de ideación suicida. Además, observaron que la violencia emocional y la violencia física severa eran los tipos de violencia más

relacionados con la ideación suicida entre una muestra de mujeres que habían sufrido VG (Naved y Akhtar, 2008). También, un estudio sobre las autolesiones en las víctimas de VG en China (Wong et al, 2011) reveló que las víctimas consideraban la autolesión como un método para canalizar las emociones dolorosas causadas por el maltrato como vía de escape cuando no veían otra opción o se sentían incapaces de soportar la violencia. Por último, todos los estudios sobre el sueño apoyan la conclusión de que la VG tiene la capacidad de afectar negativamente tanto a la calidad y la cantidad de sueño de las mujeres que han sufrido VG. Simultáneamente, las principales vías de mediación entre la VG y la falta de sueño son la depresión (Rauer et al., 2010; Walker et al., 2011] y el TEPT (Woods et al., 2010).

1. 5. Consecuencias neuropsicológicas de la violencia de género en mujeres víctimas y supervivientes

Los siguientes apartados se centrarán en las consecuencias neuropsicológicas y cerebrales relacionadas con los diagnósticos de TEPT y TEPTC.

En relación al estrés traumático derivado de la VG, diversos estudios han demostrado que trastornos como el TEPT contribuyen a explicar alteraciones neuropsicológicas en mujeres que han sufrido VG por parte de sus parejas o exparejas (Clark, 2019; Dabkowska, 2007; Kennedy et al., 2001; Twamley et al., 2009). Concretamente, se ha observado un peor funcionamiento ejecutivo y de velocidad de procesamiento en dichas mujeres cuando los síntomas de TEPT son más graves (Chung et al., 2014; Stein et al., 2002; Twamley et al., 2009). La desregulación del eje HPAI y la alteración de los niveles de cortisol en las mujeres que sufren TEPT tras sufrir VG crónica descritos anteriormente, podría estar relacionada con dichas alteraciones neuropsicológicas (Pico-Alfonso et al., 2004; Pinto et al., 2016).

Por otro lado, hay que destacar las alteraciones neuropsicológicas percibidas por las mujeres supervivientes de VG. En los estudios realizados problemas cognitivos, las mujeres informan de un deterioro percibido en los dominios de concentración (Kennedy, 2001; Monahan y O'Leary, 1999; Sato-DiLorenzo y Sharps, 2008), atención (Daugherty et al., 2019), praxis, orientación (Kennedy et al., 2001), pensamiento abstracto (Monahan y O'Leary, 1999) y memoria (Kennedy et al., 2001; Monahan y

O'Leary, 1999; Sato-DiLorenzo y Sharps, 2008; Waite, 2018). Las alteraciones neuropsicológicas percibidas indicadas en dichos estudios se han relacionado con niveles más altos de VG de tipo psicológica (Straight et al. 2003), psicopatología y estrés traumático (Kennedy et al., 2001). Además, son un factor relevante para el bienestar de las mujeres supervivientes debido a su asociación con la calidad de vida y el funcionamiento social (Daugherty et al., 2020; Kennedy et al., 2001). Esta última afirmación, coincide con los hallazgos sobre el rendimiento en las pruebas neuropsicológicas objetivas, donde mayor nivel de psicopatología y mayor severidad del maltrato se relaciona con un peor rendimiento neuropsicológico (Twamley et al., 2009; Sato-DiLorenzo y Sharps, 2008; Valera y Berenbaum, 2003).

Por último, aún no se han hecho estudios sobre neuropsicología y TEPTC teniendo en cuenta la reciente definición TEPTC de la CIE-11 (WHO, 2018). Por tanto, sería interesante en futuros estudios investigar en mujeres supervivientes de VG, los síntomas de alteraciones en la autoorganización (AAO) del TEPTC y cómo influyen en el rendimiento de los distintos dominios neuropsicológicos.

1. 6. Consecuencias cerebrales de la violencia de género en mujeres víctimas y supervivientes

Existen diferentes estudios que han investigado las alteraciones cerebrales consecuentes a la psicopatología presentada en mujeres supervivientes de VG. La mayoría de estos estudios son estudios de neuroimagen funcional y en su mayoría, las participantes son seleccionadas en función de si cumplen criterios de TEPT, y no por haber sufrido este tipo de trauma sin un posterior diagnóstico (Fonzo et al., 2013; Neumeister et al., 2018). Dichos estudios, encontraron diferencias en la activación de diferentes zonas cerebrales en relación al trastorno mencionado cuando se presentaban estímulos con contenido emocional relacionado con el trauma o situaciones relacionadas (Aupperle et al., 2012; Fonzo et al., 2013; Invitto et al., 2018; Moser et al., 2013, 2015; y Neumeister et al., 2017, 2018; Schechter et al., 2012). Por ejemplo, estas zonas con actividad distinta fueron: la ínsula (Aupperle et al., 2012; Fonzo et al., 2013; Neumeister et al., 2018; Moser et al., 2013; Schechter et al., 2012), córtex prefrontal, córtex cingulado anterior (Aupperle et al., 2012; Invitto et al., 2018; Moser et al., 2015;

Neumeister et al., 2017, 2018; Moser et al., 2013; Schechter et al., 2012), amígdala (Aupperle et al., 2012; Neumeister et al., 2017, 2018; Schechter et al., 2012), hipocampo (Moser et al., 2015), tálamo, zona occipital y tallo cerebral (Neumeister et al., 2017, 2018). A nivel estructural, se han observado diferencias en 9 áreas del cerebro en mujeres que han sufrido VG (Daugherty et al., 2022) y concretamente, en el volumen del cuerpo calloso en mujeres que han sufrido VG y tienen TEPT (Flegar et al., 2011).

En el caso del TEPTC, dado que este diagnóstico se ha definido recientemente, hasta el momento los escasos estudios de neuroimagen que lo incluyen aún no están basados en los criterios definidos por CIE-11 (WHO, 2018), sino que se basan en el término previo al actual de TEPTC, el cual se asemeja más a la definición de DESNOS (Disorder of Extreme Stress Not Otherwise Specified o trastorno por estrés postraumático extremo no especificado) descrita por Herman (1992) (detallado en el Capítulo 2 de la presente tesis). A su vez, los únicos estudios de neuroimagen y TEPTC no incluyen a mujeres supervivientes de VG. Sin embargo, se centran en otros colectivos supervivientes de violencia interpersonal, como es el caso de adultos que han sufrido abusos sexuales en la infancia y cumplen los criterios para TEPTC (DESNOS; Herman, 1992), en comparación con adultos que no han sufrido abusos sexuales (Marinova y Maecker, 2015). En dichos estudios, los centrados en neuroimagen funcional indicaron que se producía un aumento en la activación de la circunvolución parahipocampal y el hipocampo izquierdo durante el recuerdo de palabras con connotaciones negativas (Thomaes et al., 2009), un aumento en la respuesta de la corteza cingulada anterior (CCA) ventral izquierda y dorsal hasta la corteza prefrontal dorsomedial durante la codificación de palabras negativas y una tendencia al aumento de la activación de la ínsula anterior izquierda y de la CCAA en la tarea de stroop (Thomaes et al., 2012). Por otro lado, un estudio de neuroimagen estructural, indicó que los volúmenes del hipocampo, la CCA y la corteza orbitofrontal derecha, son menores en los que han sufrido este tipo de abusos y presentan TEPTC (DESNOS) en comparación con los/as que no han sufrido este tipo de violencia (Thomaes et al., 2013). Por tanto, sería interesante investigar en futuros estudios a nivel de neuroimagen cuáles son las secuelas cerebrales que surgen en mujeres que sufren TEPTC, siguiendo criterios CIE-11, y si existen diferencias cerebrales en comparación con mujeres que no han sufrido VG o que

cumplen los criterios de TEPT según CIE-11, para conocer si los síntomas AAO están relacionados con secuelas cerebrales específicas a nivel funcional y estructural.

Capítulo 2.

Trastorno de estrés postraumático complejo en mujeres supervivientes de violencia de género por parte de sus exparejas

En el capítulo anterior, hemos mencionado las secuelas psicológicas más prevalentes en las mujeres que han sufrido violencia de género (VG) por parte de sus parejas o exparejas. En este capítulo, nos centraremos en el estrés postraumático en esta población. El diagnóstico de trastorno de estrés postraumático (TEPT) aparece en un alto porcentaje de la población objeto de estudio en investigaciones previas (Golding, 1999; Kastello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien y Schie, 2008; Pico-Alfonso et al., 2006). Sin embargo, en los últimos años, la Organización Mundial de la Salud ha redefinido y categorizado dicho trastorno en dos (WHO, 2018), clasificando por un lado el TEPT, y como diagnóstico separado de éste el trastorno de estrés postraumático complejo (TEPTC).

Para clarificar la diferencia y presencia de ambos diagnósticos, vamos a definir ambos diagnósticos por separado, comenzando con el TEPT y posteriormente con el TEPTC. También, comentaremos las distintas poblaciones en las que han sido estudiados, profundizaremos en los estudios focalizados en mujeres supervivientes de VG, el desarrollo de la definición de TEPTC y posibles variables relacionadas.

2. 1. Trastorno de estrés postraumático (TEPT)

2. 1. 1. Definición de TEPT

De manera clásica y hasta la penúltima versión del manual de diagnóstico y estadístico de la American Psychiatric Association (DSM-IV-TR; APA, 2000), los síntomas para diagnosticar el TEPT han sido reexperimentación persistente del trauma, evitación e hiperarousal tras haber sufrido un evento traumático. La definición más actual de TEPT según la APA añade algunos síntomas para el diagnóstico de este trastorno, englobando así, síntomas de intrusión y reexperimentación, evitación, alteraciones cognitivas y del estado de ánimo y sensación actual de amenaza tras una experiencia traumática. Según esta última clasificación, la duración de los síntomas mencionados debe ser superior a un mes y se considera agudo o crónico si dura menos o más de tres meses, respectivamente. Los síntomas pueden aparecer inmediatamente tras el trauma o pasados incluso seis meses, lo que se consideraría de inicio retardado. Además, pueden aparecer síntomas disociativos como despersonalización y desrealización, los síntomas no deben ser a

causa de sustancias u otra afección médica y causan malestar clínicamente significativo o deterioro en lo social, laboral u en otras áreas importantes del funcionamiento cotidiano (DSM 5; APA, 2013). Dichos síntomas son generados por la experiencia de un evento que causa un fuerte impacto, daño en la persona y altera su funcionamiento normal. De este modo, según la American Psychiatric Association (DSM 5; APA, 2013) un evento se considera potencialmente traumático si la persona ha estado expuesta a: muerte, amenaza de muerte, lesiones graves o amenaza para su propia integridad física de manera directa o como testigo presencial, si se enteró que un familiar o amigo fue expuesto a un evento violento o accidental, o por exponerse de manera indirecta y repetida producto de una actividad profesional. Así pues, según la clasificación de la APA (DSM 5, 2013) los eventos potencialmente traumáticos serían: catástrofe natural (inundación, huracán, tornado, terremoto), incendio o explosión, accidente de transporte (accidente de coche, accidente de barco, accidente de tren, accidente de avión), accidente grave en el trabajo, en casa o durante actividad recreativa, exposición a una sustancia tóxica (productos químicos peligrosos, radiación), agresión física (golpes, bofetadas, patadas, palizas), agresión con un arma (disparos, puñaladas, amenazas con un cuchillo, una pistola, bombas), agresión sexual (violación, intento de violación, obligar a realizar cualquier tipo de acto sexual por la fuerza o amenaza de daño), otra experiencia sexual no deseada o incómoda, combate o exposición a una zona de guerra (como militar o civil), cautividad (secuestro, rehenes, prisioneros de guerra), enfermedad o lesión que pone en peligro la vida, sufrimiento humano grave, muerte violenta repentina (por homicidio o suicidio), muerte accidental repentina, lesiones graves, daños o muerte que se haya causado a otra persona o cualquier otro acontecimiento o experiencia muy estresante (Weathers et al., 2013).

2. 1. 2. TEPT en poblaciones distintas a mujeres supervivientes de violencia de género

En un estudio llevado a cabo por la Organización Mundial de la Salud (Kessler et al, 2014) alrededor del mundo (Australia, Bélgica, Francia, Alemania, Israel, Italia, Japón, España, Países Bajos, Nueva Zelanda, Irlanda del Norte, Portugal, Estados Unidos, Brasil, Bulgaria, Líbano, México, Rumania, Sudáfrica, Ucrania, Colombia,

Nigeria, China y Perú) donde participaron llegaron a participar 47.466 personas, se indicó una prevalencia ponderada de TEPT del 4,0% en la muestra total que osciló entre el 0,1 y el 0,3% (desastres naturales y provocados por personas) y el 19% (violación).

Otros estudios comunitarios recientes muestran que la exposición al trauma es mayor en los países de bajos ingresos en comparación con los países de altos ingresos. A pesar de ello, las tasas de prevalencia de TEPT es en la mayoría de los tipos, similares en todos los países. Aunque las tasas más altas se encuentran en lugares donde ha habido previamente un conflicto (Atwoli et al., 2015). En el caso de España, según el estudio llevado a cabo por Olaya et al. (2015), el cual se estructuró de manera similar a estudios llevado a cabo por la World Mental Health (WMH) para demostrar diferencias sutiles en el riesgo condicional de TEPT y la exposición a eventos traumáticos en comparación con países europeos y no europeos, nuestro país tiene la tasa de prevalencia más baja de exposiciones traumáticas (54%) en comparación a países como Japón, Italia, Sudáfrica o Irlanda del Norte. En cuanto al riesgo condicional de TEPT, entendido como la prevalencia de sufrir TEPT entre las personas expuestas a eventos traumáticos (Atwoli et al., 2013), en España es similar a otros países (3,3%). A su vez, este estudio informa que el accidente de tráfico es el evento traumático más autoinformado (14,1%), la agresión sexual tiene el mayor riesgo condicional de TEPT (16,5%), los eventos traumáticos que más contribuyen a la carga social del TEPT son la muerte inesperada de un ser querido (36,4% de todos los casos) y la agresión sexual (17,2%). Por otro lado, tener un bajo nivel educativo se asocia con un bajo riesgo de exposición general a eventos traumáticos y, sin embargo, estar casado/a previamente se relaciona con un mayor riesgo. Por último, aunque ser mujer se asocia a un menor riesgo de exposición general a eventos traumáticos, se ha observado un patrón consistente de mayor riesgo de TEPT para las mujeres que para los hombres en los grupos de supervivientes civiles expuestos a eventos traumáticos en España y también en otros países (Atwoli et al., 2013; Brewin et al., 2000).

2. 1. 3. TEPT en mujeres supervivientes de violencia de género por parte de sus exparejas

Uno de los eventos traumáticos que las mujeres sufren más es la violencia por parte de su pareja/expareja o como denominaremos en el presente trabajo y previamente hemos comentado, violencia de género (VG) (Vogt, 2007). En el capítulo anterior, indicamos que una de cada tres mujeres en el mundo sufre violencia física y/o sexual por parte de su pareja, y en algunas regiones esta tasa puede alcanzar el 38% (WHO, 2013). En nuestro país, dicha prevalencia es del 32,4% de todas las mujeres residentes en España que han tenido previamente una pareja (de 16 años o más) (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2020). De las mujeres que experimentan este tipo de trauma, diferentes investigaciones han considerado el TEPT como el trastorno mental más común que desarrollan, con una prevalencia media ponderada del 63,8% (Golding, 1999; Kastello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien y Schie, 2008; Pico-Alfonso et al., 2006).

Independientemente del tipo de trauma o trauma experimentados por un/a superviviente u otro/a, los síntomas de estrés traumático necesarios para el diagnóstico de TEPT son los mismos (Kazlauskas et al., 2018). Sin embargo, existen ciertas características comunes relacionadas con síntomas de TEPT dentro de los/as supervivientes de un mismo tipo de trauma. Específicamente en la población de mujeres supervivientes de VG y a diferencia de otras poblaciones, la violencia se sufre de forma repetida, prolongada y deliberada por una pareja/ ex pareja con la que existe un vínculo. Estas características singulares pueden traer consigo una especial expresión de la sintomatología más próxima al recientemente denominado Trastorno de Estrés Postraumático Complejo (TEPTC), la cual incluye otros síntomas adicionales a los estudiados en los procesos clásicos de TEPT (Bailey et al., 2019) y en la que profundizaremos a continuación.

2. 2. Trastorno de estrés postraumático complejo (TEPTC)

2. 2. 1. Desarrollo del constructo de TEPTC y definición

Como hemos indicado anteriormente, la definición actual de TEPT engloba síntomas de intrusión y reexperimentación, evitación, alteración cognitiva y del estado de ánimo, y sensación actual de amenaza tras una experiencia traumática (DSM 5, 2013). Sin embargo, como decíamos, hay experiencias traumáticas que

pueden ser menos prevalentes, pero por el tipo de evento traumático, puede dar lugar más fácilmente a la posterior manifestación de los síntomas de TEPT y gravedad de este trastorno de una manera u otra. Por ejemplo, los tipos de experiencias traumáticas que están asociadas a un mayor riesgo de padecer dicho trastorno son las que tienen que ver con eventos traumáticos de carácter interpersonal. Es decir, cuando otra persona o personas abusan, violan o atacan deliberadamente a otra u otras. Dentro de este tipo de eventos podemos hablar de: violación, agresión sexual, la VG o violencia por parte de la pareja/ex pareja, secuestro y ser agredido/a sexualmente de forma distinta a la violación (Kessler et al., 2017). De esta manera y como hemos mencionado, la VG es una de las causas más frecuentes de trauma interpersonal que puede dar lugar a sufrir TEPT (Dutton et al., 2006).

El interés en el estudio de eventos traumáticos interpersonales surge a partir de acontecimientos como la Segunda Guerra Mundial. Es por ello que, los expertos en trauma han considerado que los acontecimientos traumáticos de naturaleza interpersonal y continuados en el tiempo requieren de una especial atención. Del mismo modo, Terr (1991) hizo una distinción entre eventos traumáticos de tipo I y de tipo II. Los de tipo I se caracterizan por un único acontecimiento traumático mientras que los de tipo II se caracterizan por eventos y traumas prolongados y múltiples. Por tanto, mientras que los eventos de tipo I suponen un mayor riesgo para que la persona desarrolle los síntomas clásicos del TEPT (reexperimentación, evitación e hiperactivación), los eventos traumáticos de tipo II se asocian a una mayor variedad y complejidad de síntomas, además de los considerados como clásicos. En este caso, la violencia sexual, la violencia física, la violencia emocional, el abandono, el secuestro, la esclavitud, o situaciones de exilio o refugio, los síntomas clásicos de TEPT resultantes no suelen estar aislados de otros que afectan a la autoestima, el estado de ánimo, la regulación emocional o las relaciones sociales (Pill et al., 2017).

A su vez, Herman (1992; 2012) revisa y defiende la evidencia de la existencia de una forma compleja de trastorno postraumático en supervivientes de trauma repetido y prolongado. Propuso el nombre de DESNOS (Disorder of Extreme Stress Not Otherwise Specified o trastorno por estrés postraumático extremo no especificado) para este conjunto de síntomas provocados por la experimentación de

un trauma con dichas características, comenzando a utilizar este término para definir los síntomas consecuentes a abusos sexuales en la infancia. La propuesta de DESNOS surgió porque la formulación diagnóstica del TEPT derivaba principalmente de observaciones de supervivientes de eventos traumáticos relativamente circunscritos o aislados. Por tanto, esta formulación no capturaba la complejidad del trauma prolongado y repetido. A diferencia de la vivencia de un evento traumático aislado, el trauma prolongado y repetido solo puede ocurrir cuando la víctima está en un estado de cautiverio o bajo el control del perpetrador. Es por ello, que se consideró que el impacto psicológico de los eventos basados en la subordinación y control coercitivo interpersonal podría tener muchas características comunes. Esta posición respecto a la diferencia entre TEPT y otro tipo de estrés postraumático es apoyada posteriormente por Ford et al. (2014), basándose en el estudio del trauma infantil y prolongado. Consolidando así, la idea de la existencia de que DESNOS es una construcción separada del TEPT clásico y con cada vez más pruebas de que está altamente asociada a la desregulación afectiva, la disociación y el deterioro relacional o apego en la infancia.

Sin embargo, a día de hoy, DESNOS se trata de una realidad psicológica que aún no se recoge en el DSM-5 (APA, 2013). Por el contrario, a partir de los estudios llevados a cabo por Cloitre et al. (2013) y Hyland et al. (2017a) donde se respalda la existencia de dos trastornos distintos tras sufrir una experiencia traumática, la Organización Mundial de la Salud en la Clasificación Internacional de Enfermedades (CIE-11) (WHO, 2018) asume que el estrés postraumático evidencia diferentes grados y uno de ellos está compuesto por más síntomas que lo convertirían en un trastorno más extremo o grave.

Por este motivo, la CIE-11 (WHO, 2018) es la primera que propone distinguir entre el TEPT y el trastorno de estrés postraumático complejo (TEPTC). Aunque en un inicio, la diferencia de ambos diagnósticos es propuesta en función de la experiencia traumática sufrida, finalmente se definen por los síntomas manifestados. Para llevar a cabo esta distinción, el grupo de trabajo sobre TEPT de la OMS este tema en la CIE-11 tuvo como cometido revisar evidencia científica y otra información sobre el uso, la utilidad clínica y la experiencia con diagnósticos relevantes de la versión anterior

(CIE-10; WHO, 1992) en diversos centros de atención médica. Y a su vez, revisar las propuestas del DSM-5 (APA, 2013) considerando cómo éstas podrían ser adecuadas o útiles para aplicaciones globales, reunir las propuestas para CIE-11 y centrándose en mejorar la utilidad clínica.

Por consiguiente, en la CIE-11 se han propuesto las siguientes modificaciones respecto a su versión anterior (CIE-10; WHO, 1992): una agrupación separada para los trastornos específicamente asociados con el estrés, requisitos más estrictos para los síntomas de TEPT, la adición del TEPTC y el trastorno por duelo prolongado. La descripción del trastorno de adaptación en términos de síntomas específicos y la reacción de estrés aguda se clasifica como una respuesta no patológica a un factor estresante excepcional que puede requerir de intervención terapéutica. Finalmente, existen importantes diferencias entre la CIE-11 y el DSM-5, derivadas del énfasis de la OMS en la utilidad clínica. En el DSM-5, el TEPT se operacionaliza por medio de 20 síntomas agrupados en cuatro grupos, dando lugar a más de 10.000 combinaciones de síntomas por los cuales una persona puede cumplir los criterios mínimos para el TEPT. En cambio, como veremos más adelante, la propuesta para diagnóstico de TEPT de la CIE-11 es más sencilla. Por otro lado, la CIE-11 distingue el TEPTC del TEPT que suele derivarse de eventos prolongados o múltiples. Sin embargo, en el DSM-5 ha decidido no incluir un diagnóstico independiente de TEPT y en lugar de ello, se ha ampliado el TEPT para incluir aspectos adicionales de emocionalidad y conducta alterada. Por tanto, la clasificación CIE-11 respecto al estrés postraumático es mucho más sencilla, más fácil de usar para los clínicos y más factible en situaciones humanitarias y de bajos recursos (Maercker et al., 2013).

Por consiguiente, el TEPTC en la CIE-11 es un diagnóstico más amplio que incluye los tres síntomas principales o clásico del TEPT (reexperimentación del trauma, evitación de los recuerdos traumáticos y una sensación persistente de amenaza que se manifiesta por un shock exagerado e hipervigilancia) tras experimentar un evento traumático, así como, un conjunto adicional de síntomas denominados síntomas de alteraciones de la autoorganización (AAO), que a su vez se componen de la desregulación afectiva, el autoconcepto negativo y las alteraciones en las relaciones. Por tanto, dada la composición de sus síntomas, el TEPT se

conceptualiza como un trastorno basado en el miedo, mientras que el TEPTC se conceptualiza como un trastorno clínico más amplio que caracteriza el impacto del trauma en la regulación emocional, la identidad y los dominios interpersonales (Hyland et al., 2017b). Al mismo tiempo, es de relevancia clínica que el grado de afectación en la vida de los/as supervivientes es mayor a causa de las AAO que por los síntomas centrales o clásicos del TEPT (Villalta et al., 2020). En relación a ello, los datos empíricos sugieren que pacientes con síntomas de TEPTC tienen mayor deterioro funcional que aquellos que presentan síntomas de TEPT solo (Brewin et al., 2017; Cloitre et al., 2013; Karatzias et al., 2017a; Zerach, et al., 2019), y la desregulación emocional destaca como el contribuyente más significativo al deterioro de los/as supervivientes (Cloitre et al., 2005; Cloitre et al., 2011).

Los síntomas de desregulación emocional u afectiva implican dificultades con la regulación de las emociones, que se manifiestan en términos de hiperactivación (p. ej., mayor reactividad emocional y arrebatos de ira) o hipoactivación (p. ej., sentirse emocionalmente entumecido o disociado) de los estados emocionales (Karatzias et al., 2018a). Por tanto, la desregulación emocional implica un acceso limitado o incapacidad para implementar estrategias de reducción de estados afectivos intensos, dificultad para el manejo de impulsos y comportamiento dirigido a objetivos, no aceptación y conciencia limitada o claridad de las emociones experimentadas. De este modo, la ira puede convertirse en ansiedad y ésta en un estado de terror incontrolable, pueden aparecer estados de profundo vacío o desapego emocional (van Dijke et al., 2018), arrebatos violentos, comportamiento imprudente o autodestructivo, tendencia a la disociación bajo periodos prolongados de estrés y falta de capacidad para experimentar placer o emociones positivas (Ford et al., 2014).

Otro de los síntomas característicos de las AAO en el TEPTC descrito en la CIE-11 es el autoconcepto negativo. Este síntoma da lugar a auto perturbaciones que se basan en creencias persistentes acerca de uno mismo como inferior (Ford et al., 2014) y alteraciones en la identidad que implican problemas para mantener un sentido coherente del yo (van Dijke et al., 2018). A diferencia de otros diagnósticos como el Trastorno Límite de la Personalidad (TLP), el autoconcepto en este último se

caracteriza por vacilaciones muy positivas y negativas de sí mismos y de los demás, mientras que en el TEPTC el autoconcepto está marcado por percepciones estables profundamente negativas en los dominios del yo y de las relaciones (Frost et al., 2018). De este modo, el autoconcepto negativo según la clasificación CIE-11 se traduce en sentimientos de culpa e inutilidad que implican sentimientos de fracaso y de inutilidad (Cloitre et al., 2018).

Por último, los síntomas de AAO de alteraciones en las relaciones sociales consecuencia del trauma provocan que las personas que sufren este diagnóstico se puedan sentir distantes o aisladas del resto, o les puede resultar difícil estar emocionalmente cercanas respecto a los/as demás. A raíz de ello, el funcionamiento cotidiano en sus relaciones, su vida social, su capacidad para trabajar u otros aspectos importantes que implican interacción, pueden verse afectados. Por ejemplo, la crianza de hijos o hijas, el trabajo, el rendimiento académico u otras actividades importantes (Cloitre et al., 2018).

En la misma línea, Simon et al. (2019) concluyen que las personas que sufren TEPTC tienden a mostrar niveles más bajos de apoyo social percibido en comparación con personas que no presentan dicho trastorno, y en menor medida, en comparación con personas que sufren TEPT. Y, a su vez, afirman que las personas con niveles más bajos de apoyo social percibido informan significativamente de un mayor número de alteraciones en las relaciones.

2. 2. 2. TEPTC en diferentes poblaciones expuestas a trauma y en mujeres supervivientes de VG

2. 2. 2. 1. TEPTC en diferentes poblaciones expuestas a trauma

Como hemos indicado previamente, aunque el riesgo de sufrir TEPTC aumenta más tras la exposición a eventos traumáticos de carácter interpersonal y de los que es difícil o imposible escapar (Hyland et al, 2018b), el diagnóstico está determinado en última instancia no por los antecedentes, sino por el perfil de los síntomas que se manifiestan (Kazlauskas et al, 2018). Es por ello que a partir de la distinción de ambos diagnósticos (TEPT y TEPTC) por parte de la Organización Mundial de la Salud (WHO, 2018), investigadores e investigadoras de todo el mundo

han considerado los criterios diagnósticos de ambos trastornos en sus estudios con diferentes poblaciones de supervivientes de distintos eventos traumáticos.

Hasta ahora, los estudios sobre el TEPTC se han realizado con muestras clínicas de adultos (Stadtman et al., 2018; van Dijke et al., 2018; Karatzias et al., 2016; Hyland et al., 2017b; Kazlauskas et al., 2018; Simon et al., 2019; Cloitre et al., 2018), muestras comunitarias no clínicas (Karatzias et al., 2018a; Murphy et al., 2018), niños/as y adolescentes víctimas de maltrato (Bertó et al., 2017), niños/as víctimas de la trata (Ottisova et al., 2018), niños ex-soldados (Murphy et al., 2018), muestras clínicas de mujeres (Hyland et al., 2018b; Cloitre et al., 2014), maltratadores (Gilbar et al., 2018), refugiados (Vallières et al., 2018) y prisioneros de guerra (Zerach et al., 2019). Además, algunos de estos estudios compararon las prevalencias de TEPT y TEPTC en distintas poblaciones (Cloitre et al., 2014, 2018; Gilbar et al., 2018; Hyland et al., 2017b, 2018; Karatzias et al., 2016; Murphy et al., 2018; Simon et al., 2019; Vallières et al., 2018). En los estudios que se centraron en supervivientes de traumas interpersonales observaron importantes prevalencias de TEPTC. Por ejemplo, Cloitre et al. (2014) encontraron que la prevalencia de TEPT y TEPTC en mujeres adultas de Estados Unidos que habían sufrido abusos sexuales en la infancia era del 53,9 % y el 38,2 %, respectivamente. Los porcentajes de estos diagnósticos en adultos daneses que en su mayoría eran supervivientes soldados veteranos, fueron de 10,9 % para TEPT y 53,6% para TEPTC (Hyland et al., 2017b). En adultos de Escocia, en los cuales los traumas más frecuentes sufridos fueron agresiones físicas y sexuales, presentaban una prevalencia de TEPT y de TEPTC del 37% y del 53,1% respectivamente (Karatzias et al., 2016). En el estudio de Simon et al. (2019) con muestra de adultos derivados del servicio nacional de salud mental de Gales (NCMH) que habían sufrido diferentes tipos de traumas, los porcentajes eran de 15,51% (TEPT) y 50,3% (TEPTC). Vallières et al. (2018) observaron que el TEPTC (36,1%) fue más común que el TEPT (25,2%) en refugiados sirios. Por último, Møller et al., (2020) vieron que en pacientes clínicos daneses que habían sufrido un evento traumático en la infancia o adolescencia, las prevalencias de TEPT y TEPTC eran 8% y 36%, respectivamente.

Al igual que en estudios en los que previamente se ha hablado de las diferencias de sexo en cuanto al porcentaje de TEPT (Christiansen y Elklit, 2012; Palic

et al., 2016), en los estudios que ya contemplan el TEPTC según CIE-11 se ha observado que las mujeres son más significativamente propensas a ser diagnosticadas de TEPT y TEPTC que los hombres. De hecho, en muestras clínicas y comunitarias se ha indicado que las mujeres tienen aproximadamente el doble de probabilidades de cumplir con los diagnósticos TEPT y TEPTC que en el caso de los hombres (Hyland et al., 2017a; Karatzias et al., 2016; Karatzias et al., 2017b).

2. 2. 2. 2. TEPTC en mujeres supervivientes de VG

En el caso de la VG en relación al TEPTC, a pesar de que es un tipo de violencia interpersonal de la que es difícil escapar por su particular vínculo entre la víctima y el agresor, y a pesar de sus posibles consecuencias, como la baja autoestima y la deconstrucción de la identidad (Hyland et al., 2018b; Matheson et al., 2015; Pill et al., 2017), la investigación sobre el TEPTC en mujeres supervivientes de VG es escasa. Hasta ahora solo hay un estudio que ha analizado la presencia de TEPTC en esta población (Dokkedahl et al., 2021), que encontró una prevalencia de TEPT del 56,5% y de TEPTC del 21,1% en una muestra danesa reclutada en cuatro centros de acogida. Sin embargo, aunque este estudio habla de la presencia de TEPTC en dicha población, utiliza unos criterios diagnósticos distintos a los finalmente publicados en la CIE-11 (Cloitre et al., 2013 en Dokkedahl et al., 2021). El Capítulo 6 de la presente Tesis, se lleva a cabo el primer estudio de prevalencia de TEPT y TEPTC en mujeres supervivientes de VG siguiendo los criterios CIE-11. En este estudio, se obtuvo una mayor prevalencia de TEPTC (39,50%), en comparación con el TEPT (17,90%).

En cuanto a los síntomas de AAO, la literatura es escasa en cuanto a que, a pesar de que son síntomas que tanto profesionales como las propias supervivientes informan, no han sido considerados como objeto de estudio dentro del TEPTC. Muñoz et al. (2021) han observado que las mujeres que han sufrido varios episodios de VG, presentan un patrón de regulación emocional diferencial respecto al resto de víctimas y supervivientes de este tipo de violencia que está relacionado una mayor psicopatología como el TEPT. Concretamente, con un perfil de abrumamiento emocional caracterizado por alta puntuación en supresión, signos de emociones no procesadas, emociones no reguladas y empobrecimiento emocional. Respecto a dicho embotamiento afectivo o supresión emocional, Signorelli et al., 2020,

observaron que en las mujeres supervivientes de violencia de género aparecen síntomas similares definidos como alexitimia. Entendiendo la alexitimia como la incapacidad de comprender, procesar o describir las emociones (Bressi et al., 1996). Estos hallazgos son coherentes con estudios previos sobre TEPT que identifican la supresión, evitación y rumiación como elementos desadaptativos de la desregulación emocional en dicho trastorno (Aldao y Nolen-Hoeksema, 2012; Dixon-Gordon et al., 2014; Seligowski et al., 2015). A su vez, estos resultados también serían coherentes con los síntomas clásicos de evitación de TEPT (Rachman et al., 2001). Y aunque en dicho estudio no se haya tenido en cuenta aún la asociación directa con los síntomas AAO de TEPTC, actualmente podríamos ver la similitud con síntomas de la desregulación afectiva descrita del TEPTC como embotamiento afectivo (Cloitre et al., 2018). Por tanto, estos hallazgos confirman que la desregulación emocional es un síntoma informado y aún no considerado en el estudio de la VG y el TEPTC, tratándose así de una vía crítica para la disminución de la salud entre las víctimas y supervivientes de VG. Por otro lado, Simpson et al. (2021) hacen hincapié en la importancia de investigar también la desregulación emocional de las emociones positivas que informan las mujeres que han sufrido VG. Estos autores encontraron que tanto la VG física, sexual y psicológica se asociaron positivamente de forma significativa con la desregulación de las emociones negativas y positivas, así como con la gravedad de los síntomas del TEPT definidos en DSM-5 (APA, 2013). Sin embargo, como previamente indicamos, aunque se trata de síntomas claramente presentes en mujeres supervivientes de VG, estos hallazgos aún no se han estudiado en relación a los síntomas AAO de TEPTC descritos en CIE-11 (WHO, 2018).

Otro de los síntomas de AAO que la reciente literatura sobre TEPTC no ha explorado aún en la población de mujeres supervivientes de VG es el autoconcepto negativo. A su vez, tradicionalmente la literatura sobre salud mental y VG se ha centrado principalmente en la depresión, el uso de sustancias, la ansiedad y el TEPT con exclusión de los problemas asociados de baja autoestima y pérdida o reformulación de la identidad propia consecuente a este tipo de violencia (Smith et al., 1995). Sin embargo, recientemente están apareciendo los primeros estudios en la exploración de estos temas donde se informa que el autoconcepto se ve afectado tras sufrir VG. Por ejemplo, en el estudio de Matheson et al. (2015) en el que

participaron mujeres supervivientes que habían sufrido distintos tipos de VG (física, sexual, emocional, psicológica, aislamiento social y comportamientos de control), observaron que en mujeres que informaban de violencia psicológica tenían daños más persistentes en la autoestima y la propia identidad. Concretamente, en la revisión sistemática llevada a cabo por Childress (2013) las mujeres describieron sus experiencias con la violencia como devastadoras para su autoestima e identidad. Manifestando sentimientos de tristeza, aislamiento, degradación y desesperación tras tal tipo de trauma. Por tanto, durante y después de haber sufrido VG, el autoconcepto se ve afectado y alterado. Generalmente produciendo una deconstrucción de la identidad que para que se reconstruya, requiere de un proceso muy largo de cambio destinado a restaurar la autoestima, el bienestar mental, la autoeficacia y en última instancia, la identidad propia (Matheson et al., 2015). Si profundizamos en qué aspectos concretos del autoconcepto se ven afectados por la VG, encontramos que la autoeficacia está completamente alterada (Fishman et al., 2010; Kang y Kim, 2011), refiriéndose a esta como la creencia en la propia capacidad para tener éxito en una situación determinada (Bandura, 1977). Por otro lado, otro aspecto alterado es que se produce una tendencia a culparse a sí mismas por haber sufrido VG y esto daña aún más la autoestima (González-Guarda et al., 2011; González-Guarda et al., 2013). Estos últimos hallazgos coinciden con los sentimientos de fracaso e inutilidad que definen el síntoma de autoconcepto negativo del TEPTC en la CIE-11 (Cloitre et al., 2018; WHO, 2018) que aún no se han explorado en la población de mujeres supervivientes de VG.

Por último, otro de los síntomas de AAO que no ha sido investigado en mujeres que han sufrido VG, son las alteraciones en las relaciones sociales. A pesar de que, previos estudios han indicado que las mujeres supervivientes de la violencia de género suelen acudir a los servicios para víctimas y supervivientes para hacer frente a los problemas relacionados con las relaciones interpersonales (St. Vil et al., 2018). Las dificultades para crear o mantener relaciones sociales pueden aparecer tras la violencia por el miedo a la repetición del abuso por parte de otras personas (Flasch et al., 2015; St. Vil et al., 2018). También la tendencia supresora de la que previamente hemos hablado se presenta en el ámbito social y podría explicarse porque como otros/as supervivientes de trauma interpersonal, pueden tender o

preferir no expresar o evitar los juicios de otras personas durante interacciones, reservar su intimidad, o pueden sentirse vulnerables y buscar protegerse de los demás (Cloitre et al., 2020).

Por tanto, a pesar de que las mujeres que sufren VG manifiestan soledad emocional, desesperación, culpa, confusión, miedo, baja autoestima e identidad disminuidas (Lammers et al., 2005), los cuales son problemas que caracterizan a los síntomas de AAO del TEPTC, aún no se han llevado a cabo estudios que contemplen este diagnóstico definido según la CIE-11 en la población de mujeres supervivientes de VG como sí se han llevado a cabo en otras poblaciones supervivientes de traumas interpersonales.

2. 2. 3. Posibles variables relacionadas con el TEPTC tras sufrir VG

En este punto, nos vamos a centrar en factores o variables que podrían estar relacionados con la manifestación más o menos grave de los síntomas que componen el TEPTC según se define en CIE-11. Ya que, se tratan de variables que se han visto previamente relacionadas con las previas definiciones de TEPT, porque han sido variables significativas en otras poblaciones en las que se ha investigado sobre TEPTC o porque podrían estar relacionadas con la presente población objeto de estudio. Para ello, hablaremos de variables objetivas como la gravedad de la VG o la duración, otras variables más subjetivas relacionadas con la experiencia como el miedo sentido hacia el agresor, y variables de carácter más personal como la resiliencia o la regulación emocional.

La gravedad de la violencia experimentada es un factor que puede facilitar la aparición o el agravamiento de los síntomas clásicos de TEPT (Lagdon et al., 2014). En el caso de mujeres que han sufrido VG, hay un estudio que indica que tres cuartas partes de las participantes habían experimentado altos niveles de VG reciente, mostraron puntuaciones de TEPT por encima del umbral clínico (Ferrari et al., 2016). Estos resultados son acordes con la idea de que el riesgo de estrés traumático es mayor que el de otro problema de salud mental experimentado por supervivientes de VG (Howarth y Feder, 2013). Además, el tiempo transcurrido desde el evento estresante o traumático puede influir en la manifestación actual de los síntomas del

TEPT (Badour et al., 2017). Al mismo tiempo, se ha observado que el tiempo medio de remisión de los síntomas del TEPT es más largo en las personas que han experimentado un trauma interpersonal, en comparación con aquellas que han experimentado un trauma no interpersonal (Chapman et al., 2012; Kessler et al., 1995).

Por otro lado, se ha demostrado una asociación positiva entre el nivel de miedo experimentado y la gravedad de los síntomas de TEPT (Hebenstreit et al., 2015), así como con el número de síntomas presentados (Amstadter et al., 2009; Mahan y Ressler, 2012; Milad et al., 2008). Esta asociación con el TEPT tiene sentido, ya que el TEPT se conceptualiza como un trastorno basado en el miedo. Sin embargo, aún no se ha relacionado con los síntomas de AAO, quizás porque en este caso se conceptualiza como un trastorno clínico más amplio que abarca más dominios (Hyland et al., 2017a).

Una variable protectora ante eventos estresantes y traumáticos es la resiliencia (Horn y Feder, 2018). La cual se define como las cualidades personales que permiten prosperar frente a la adversidad y que está constituida por tenacidad, presión y control, adaptabilidad y apoyo, control y propósito, y espiritualidad (Connor y Davidson, 2003). Así, la resiliencia entendida como estrategias de afrontamiento activo se ha relacionado negativamente con el desarrollo de síntomas de TEPT, a diferencia de un afrontamiento negativo (Thompson et al., 2018). En el caso de las mujeres supervivientes de VG, se ha observado que cuanto menor es el uso de estrategias de afrontamiento efectiva, mayor número de síntomas de TEPT (Sullivan et al., 2018). Jose y Novaco (2016) obtuvieron en un estudio que una mayor resiliencia se asocia con síntomas de ánimo más bajos y menor estrés percibido, controlando el historial de abuso, la demografía y el apoyo social de mujeres supervivientes de VG.

Finalmente, las estrategias de regulación emocional se definen como un intento, ya sea implícito o explícito, de modificar la propia respuesta emocional (Werner y Gross, 2010). Diferentes estudios han demostrado que las personas que presentan mayores dificultades de regulación emocional y estrategias desadaptativas se relacionan con una mayor gravedad del TEPT (Chang et al., 2018; Moore et al., 2008; Short et al., 2018; Weiss et al., 2012). Del mismo modo, se ha observado esta

relación en mujeres supervivientes de VG (Lilly y Lim, 2012). En el estudio llevado a cabo por McMullen et al. (2014), se observó que la interacción de las expectativas de regulación del estado de ánimo negativo y el abuso psicológico en mujeres supervivientes de VG predecían un incremento de conductas de afrontamiento evitativo. A su vez, en cuanto a la importancia de la regulación de emociones positivas en mujeres supervivientes de VG, en la investigación llevada a cabo por Weiss et al. (2019) afirman que las dificultades para regular las emociones positivas muestran una relación incremental con la gravedad de los síntomas del TEPT más allá de la variación explicada por las dificultades para regular las emociones negativas. Por último, en el caso de las estrategias de regulación emocional y TEPTC, (Karatzias et al., 2018b) indican que las estrategias desadaptativas de regulación emocional se relacionaron significativamente con recibir este diagnóstico.

Sin embargo, hemos de destacar que los factores previamente descritos no se han estudiado en relación al TEPTC en la población de mujeres supervivientes de VG. Por consiguiente, en el presente trabajo planteamos la necesidad de conocer si el TEPTC se presenta en la población de mujeres supervivientes de VG tal como se presenta en otras poblaciones de traumas interpersonales. Al mismo tiempo, sugerimos el estudio de la relación de las posibles variables relacionadas con los síntomas de TEPTC que podrían presentar las mujeres que han sufrido este tipo de violencia.

Capítulo 3.
Evaluación y diagnóstico del TEPT y
TEPTC

Como hemos indicado en el Capítulo 2, el TEPTC se define en función de los criterios diagnósticos específicos según la OMS (WHO, 2018). Es por ello que, la literatura más contemporánea respecto al TEPTC se ha centrado en la elaboración de instrumentos específicos para dicho diagnóstico. A continuación, nos focalizamos en los instrumentos para TEPT y TEPTC según las clasificaciones diagnósticas más recientes.

3. 1. Evaluación y diagnóstico de TEPT y TEPTC

De acuerdo con toda la literatura revisada, actualmente existen instrumentos que siguen los criterios TEPT según DSM-5 e instrumentos que tienen en cuenta la existencia de la sintomatología que acompaña y agrava los síntomas clásicos del TEPT definidos por la OMS (CIE-11) cuando una persona ha sufrido violencia interpersonal. A continuación, veremos una descripción detallada de cada uno de ellos y comentaremos algunas diferencias con los propuestos por otras clasificaciones coetáneas.

3. 1. 1. Evaluación y diagnóstico de TEPT

Para obtener información en cuanto el tipo de evento u eventos traumáticos sufridos, en el apartado "2.1.1. Definición de TEPT" del Capítulo 2, especificamos los eventos vitales considerados traumáticos según el DSM-5 (APA, 2013), los cuales recogen en el Listado de Eventos para el DSM-5 (Life Events Checklist for DSM-5, LEC-5; Weathers et al., 2013).

En cuanto a la evaluación de TEPT según los criterios DSM-5, encontramos el Listado de Verificación para el TEPT según DSM-5 (PTSD Checklist for DSM-5 PCL-5; Weathers et al., 2013). El cuestionario PCL-5 es una medida de autoinforme de 20 ítems, que corresponde a los criterios sintomáticos del DSM-5 para el TEPT. La escala de calificación de autoinforme es de 0 a 4 para cada síntoma y los descriptores de la escala de valoración son: "En absoluto", "Un poco", "Moderadamente", "Bastante" y "Extremadamente". La interpretación de la PCL-5 debe ser realizada por un clínico. La prueba PCL-5 se puede puntuar de diferentes maneras: se puede obtener una puntuación total de gravedad de los síntomas (rango 0-80) sumando las puntuaciones de cada uno de los 20 ítems. Las puntuaciones de gravedad de los grupos de síntomas del DSM-5 pueden obtenerse sumando las puntuaciones de los ítems de un grupo

determinado, es decir, el grupo B (ítems 1-5), el grupo C (ítems 6-7), el grupo D (ítems 8-14) y el grupo E (ítems 15-20). También, se puede hacer un diagnóstico provisional de TEPT tratando cada ítem calificado como 2 = "Moderadamente" o superior, y luego siguiendo la regla diagnóstica del DSM-5 que requiere al menos: 1 ítem B (preguntas 1-5), 1 ítem C (preguntas 6-7), 2 ítems D (preguntas 8-14), 2 ítems E (preguntas 15-20). La investigación inicial sugiere que una puntuación de corte de la PCL-5 entre 31-33 es indicativa de un probable TEPT en todas las muestras. Sin embargo, se necesita más investigación debido a que la población y el propósito del cribado pueden justificar diferentes puntuaciones de corte. Las propiedades psicométricas del PCL-5 se examinaron en estudiantes universitarios expuestos a traumas y las puntuaciones exhibieron una fuerte consistencia interna ($\alpha = .94$) (Blevins et al., 2015). Los estudios llevados a cabo en veteranos de guerra también demostraron una buena consistencia interna ($\alpha = .96$) (Bovin et al., 2016) y en militares ($\alpha = .95$) (Wortmann et al., 2016).

Actualmente, no hay estudios que aborden las propiedades de PCL-5 en muestras de diferentes poblaciones en nuestro país. Sin embargo, existe una escala que sigue los criterios diagnósticos DSM-5 que ha sido validada en mujeres supervivientes de agresiones sexuales y violencia familiar en España. Se trata de la Escala de gravedad de los síntomas del trastorno de estrés postraumático revisada (EGS-R; Echeburua et al., 2016). Consta de 21 ítems, basada en los criterios diagnósticos del DSM-5, y sirve para evaluar la gravedad de los síntomas del TEPT. Dispone de propiedades psicométricas adecuadas, mostrando una alta consistencia interna ($\alpha = .91$) y apoya la práctica profesional y la investigación clínica.

En cuanto a criterios DSM-5, se ha desarrollado un cuestionario para el diagnóstico de TEPT en niños/niñas y adolescentes. El Cuestionario de Trauma en Niños y Adolescentes (Child and Adolescent Trauma Screen, CATS; Sachser et al., 2017) está compuesto por 20 ítems, el CATS evalúa los síntomas de intrusiones, evitación, alteraciones negativas en la cognición y el estado de ánimo e hiperactividad. Los participantes indican cuánto les ha molestado cada síntoma en las últimas dos semanas. La fiabilidad interna de las puntuaciones totales del CATS es muy buena ($\alpha = .90$).

Por último, hay varias entrevistas que siguen los criterios diagnósticos para TEPT del DSM-5. Encontramos la Escala de TEPT administrada por el clínico para el DSM-5 (Clinician-Administered PTSD Scale for DSM-5, CAPS-5; Weathers et al., 2013) y la Entrevista de la Escala de Síntomas del TEPT (PTSD Symptom Scale Interview, PSS-I-5; Foa y Capaldi, 2013; Foa et al., 2018).

3. 1. 2. Evaluación y diagnóstico de TEPTC

Actualmente, también se han desarrollado instrumentos de listado de eventos, cuestionarios de autoinforme y entrevista acordes con la clasificación CIE-11 (WHO, 2018) para el diagnóstico de TEPT y TEPTC.

En primer lugar, la Medida Internacional de Exposición al Trauma (International Trauma Exposure Measure, ITEM; Hyland et al., 2019) es una reciente lista de verificación desarrollada para recopilar eventos traumáticos de la vida y sus características asociadas, de manera consistente con la descripción de un trauma en la CIE-11. Por tanto, ITEM mide la exposición a diferentes eventos traumáticos a lo largo de diferentes períodos de la vida (infancia, adolescencia, adultez y vida), la frecuencia de exposición al evento traumático más angustioso, y la emoción principal asociada con el evento traumático más angustioso. Además, ITEM está disponible gratuitamente para las comunidades clínicas y de investigación.

Los eventos traumáticos recopilados en ITEM son: diagnóstico de una enfermedad que amenaza la vida o es potencialmente mortal; muerte terrible de alguien cercano; ser agredido/a físicamente por un progenitor, cuidador u otra persona (golpeado/a, pateado/a, abofeteado/a, asaltado/a, o robado/a, etc.); ser agredido/a sexualmente por un progenitor, cuidador u otra persona (penetración anal, vaginal, u oral, o cualquier contacto en y con zonas sexuales); ser acosado/a sexualmente (comentarios o conductas sexuales no deseadas); estar expuesto/a a la guerra o combate (como un soldado o como un civil); estar en cautiverio y/o ser torturado/a; causar sufrimiento extremo o la muerte a otra persona; ser testigo de cómo otra persona experimentaba sufrimiento extremo o muerte; estar involucrado/a en un accidente (ej., transporte, trabajo, hogar, ocio) donde su vida estuvo en peligro; estar expuesto/a un desastre natural (ej., huracán, tsunami, terremoto) donde su vida estuvo en peligro;

estar expuesto/a a un desastre causado por una persona (ej., ataque terrorista, derrame químico, tiroteo público) donde su vida estuvo en peligro; otra persona lo/a acosó; ser intimidado/a (bullying) repetidamente (online o fuera de línea); ser humillado/a, menospreciado/a, o insultado/a por otra persona; sentirse no amado/a, indeseable/a, o desvalorizado/a por otras personas; otras personas lo descuidaron, ignoraron, rechazaron, o aislaron; otro evento no mencionado.

En comparación a la propuesta en ITEM (Hyland et al., 2019), existen ciertas diferencias referidas a los tipos de eventos considerados según el Criterio A del DSM-5 en la prueba Listado de Eventos para el DSM-5 (Life Events Checklist for DSM-5, LEC-5; Weathers et al., 2013) previamente mencionada en el apartado anterior y en cuanto a la definición de evento traumático. Estas diferencias son muy importantes porque la forma en la que se define la exposición traumática, tiene implicaciones para determinar la epidemiología del TEPT y el TEPTC, identificar factores de riesgo y protección, proporcionar acceso a los servicios de salud mental y seguros, y planificar y evaluar las intervenciones de tratamiento (Hyland et al., 2021).

Además, Frewen et al. (2019) encontraron que experiencias adversas en la infancia como negligencia y abuso emocional no se clasifican convencionalmente como traumáticos según el DSM-5, aun siendo más predictivos de TEPT que otros eventos definidos como traumáticos. Por tanto, estos hallazgos cuestionan la validez predictiva del conjunto de eventos “traumáticos” en relación con el conjunto de eventos denominados como “estresantes”, indicando que puede haber eventos traumáticos importantes que actualmente no se ajustan a la definición del Criterio A en el DSM-5. A su vez, otros eventos como el acoso o la intimidación, no cumplen con la definición del Criterio A en el DSM-5. En relación a ello, dichos eventos y también otros como el abuso emocional o la negligencia pueden causar TEPT y TEPTC, y pueden ser experimentados como amenazantes para la supervivencia, así como ocurre con los eventos que suponen una amenaza más obvia para la vida, la seguridad física o sexual (Cloitre et al., 2019; Frewen et al., 2019). De este modo, los profesionales pertenecientes al ámbito clínico y de investigación consideran que puede haber personas que no son diagnosticadas de TEPT porque el evento estresante al que han sido expuestos no se ajusta a la definición actual del Criterio A del DSM-5 (Hyland et al., 2021).

Por el contrario, la CIE-11 no contiene un criterio definido como el criterio A del DSM-5, sino que proporciona una orientación clínica según la cual el TEPT y TEPTC “pueden desarrollarse tras la exposición a un acontecimiento o una serie de acontecimientos extremadamente amenazantes y horrorosos”. Por tanto, esta perspectiva operacionaliza el trauma resaltando la saliencia de la amenaza y el horror y asegura que el diagnóstico depende principalmente de la presentación de los síntomas o problemas consecuentes (Brewin et al., 2009).

A su vez, en el estudio llevado a cabo por Hyland et al. (2021) donde se compararon ambas definiciones de evento traumático y sus consecuentes tasas de diagnóstico, se observó que la diferencia entre las tasas de prevalencia siguiendo ambas clasificaciones era del 1,0% y la definición de exposición traumática del Criterio A del DSM-5 obtuvo una validez predictiva mínima. Además, dichos resultados son consistentes con estudios previos (Franklin et al., 2019; Larsen y Berenbaum, 2017). Por tanto, Hyland et al. (2021) consideran que tener una adhesión estricta al Criterio A puede obstaculizar el reconocimiento y tratamiento del TEPT y TEPTC. Y a su vez, no considerar eventos psicológicamente amenazantes como la intimidación o el acoso, los cuales están asociados a un mayor riesgo de cumplir los criterios diagnósticos para el TEPT y TEPTC. Este punto es especialmente importante en VG ya que, como hemos visto en el Capítulo 1, la violencia psicológica puede aparecer no acompañada de otros tipos de violencia (física o sexual). En conclusión, Hyland et al. (2021) plantean un punto intermedio en el que el DSM-5 podría adoptar una definición menos específica que proporcione un contexto para el TEPT pero que no tenga el estatus de criterio diagnóstico formal.

Por otro lado, encontramos dos cuestionarios de autoinforme que permiten diagnosticar TEPT y TEPTC según los criterios diagnósticos descritos en CIE-11. En primer lugar, encontramos el Cuestionario Internacional de Trauma (International Trauma Questionnaire, ITQ; Cloitre et al., 2018). Se trata de una medida breve del TEPT y TEPTC (de libre acceso) desarrollada a nivel internacional según los criterios de la CIE-11 (OMS, 2018). Incluye 18 ítems: seis de síntomas de TEPT, seis de AAO y seis ítems relacionados con el deterioro funcional de los síntomas de TEPT y el deterioro funcional de los síntomas de AAO. El diagnóstico de TEPT requiere la aprobación de uno de los dos síntomas (puntuaciones superiores a 2) de cada grupo de síntomas de TEPT

(reexperimentación, evitación y sensación actual de amenaza), más el cumplimiento del criterio del deterioro funcional asociado a estos síntomas. El diagnóstico de TEPTC requiere la aprobación de uno de los dos síntomas de cada uno de los tres grupos de TEPT y uno de dos síntomas de cada uno de los tres grupos de AAO (desregulación afectiva, autoconcepto negativo y alteraciones en las relaciones), más el cumplimiento del deterioro funcional asociado a estos síntomas. De acuerdo con la estructura taxonómica de la CIE-11, el ITQ sólo permite un diagnóstico de TEPT o de TEPTC, pero no ambos. La fiabilidad es satisfactoria, con un α de Cronbach $\geq .79$ (Cloitre et al., 2018).

Al mismo tiempo, encontramos el Inventario de Trauma Complejo (CTI; Litvin et al., 2017). El cual, es un instrumento que, aunque sigue criterios CIE-11 todavía tiene poco apoyo empírico. Dado que sólo hay un estudio que apoya sus propiedades psicométricas (Litvin et al., 2017). A diferencia del CTI, el Cuestionario Internacional de Trauma (ITQ; Cloitre et al., 2018) está utilizándose a nivel global con los objetivos de recopilar datos sistemáticos de todo el mundo sobre la prevalencia del trauma y el malestar relacionado con el trauma identificar importantes factores de riesgo y protección en diversos contextos culturales, para desarrollar estrategias preventivas para minimizar el impacto de los traumas a lo largo de la vida y en todas las culturas, para desarrollar tratamientos eficaces y rentables para el TEPTC que sean pertinentes a lo largo de la vida y en diversos contextos culturales, y difundir y comunicar los resultados a la comunidad científica y al público en general. Hasta el momento, las versiones en inglés de este cuestionario han demostrado tener buenas propiedades psicométricas proporcionando apoyo empírico a la fiabilidad y validez del ITQ (Hyland et al., 2017b; Karatzias et al., 2016). Dado que los diagnósticos de TEPT y TEPTC pretenden ser aplicables en diferentes culturas, es importante que este constructo y su medición sean evaluados en diversas poblaciones e idiomas (Karatzias et al., 2017a; Kazlauskas et al., 2018). Así, el cuestionario está traducido y adaptado al inglés (Cloitre et al., 2018), árabe (Vallières et al., 2017), chino (Ho, 2017), croata (Letica-Crepulja, 2017), dari (Hosainy, 2017), francés, alemán (Lueger-Schuster et al., 2018), hebreo (Ben-Ezra, 2018), japonés (Inoue, 2017), noruego (Bækkelund et al., 2019), polaco (Cechowski et al., 2019), español (Fernández-Fillol et al., 2020), sueco (Bondjers et al., 2017), portugués (Donat et al., 2019) e italiano (Somma et al., 2019). La validación del cuestionario también se ha

publicado con poblaciones de China (Ho et al., 2019), Líbano (Vallières et al., 2018), Israel (Ben-Ezra et al., 2018), Alemania (Maecker et al., 2018), Lituania (Kazlauskas et al., 2018), Brasil (Donat et al., 2019) e Italia (Somma et al., 2019).

Actualmente también se ha desarrollado el Cuestionario Internacional de Trauma Versión para Niños/as y Adolescentes (International Trauma Questionnaire Child and Adolescent Version, ITQ-CA; Cloitre et al., 2018), el cual es una medida breve y sencilla de los síntomas del TEPT y TEPTC para usar con menores entre 7 a 17 años. Consta de 22 ítems para evaluar los síntomas de TEPT, AAO y para medir el deterioro funcional tanto para la sintomatología del TEPT como para la del AAO, evaluando el deterioro en las áreas de amigos, familia, escuela, otras áreas importantes y felicidad general. Los ítems de deterioro funcional se responden en una escala binaria (sí/no). Actualmente solo un estudio ha investigado las propiedades psicométricas de dicha escala. Sin embargo, los resultados han sido satisfactorios ya que la ITQ-CA en alemán mostró altas cargas factoriales y excelentes niveles de fiabilidad interna en las escalas de TEPT y AAO, demostrando su aplicabilidad por primera vez (Haselgruber et al., 2020a).

Recientemente se ha publicado una versión nueva del CATS (Sachser et al., 2017) previamente mencionado, el CATS 7-17 versión 2.0 (Sachser et al., 2022). El cual evalúa TEPT y TEPTC según criterios DSM 5 y CIE 11 en niños /as y adolescentes de 7 a 17 años. Sin embargo, aún no está adaptado ni validado en español.

Por último, en cuanto a entrevistas, recientemente se ha publicado la Entrevista Internacional de Trauma (International Trauma Interview, ITI; Roberts et al., 2018), siguiendo los criterios del TEPT y TEPTC de la CIE-11. Los resultados afirman que la consistencia interna fue satisfactoria ($\alpha = .76$), y el análisis factorial confirmatorio indicó que un modelo de segundo orden de dos factores consistente con el modelo de la CIE-11 del TEPT/TEPTC proporcionó un ajuste aceptable a los datos. El análisis de fiabilidad compuesta demostró que el ITI posee una fiabilidad interna aceptable, y las asociaciones con medidas de otros trastornos psiquiátricos, insomnio, discapacidad funcional y QoL apoyaron la validez concurrente del ITI en la población sueca que fue evaluada (Bondjers

et al., 2019). Resultados similares en cuanto a consistencia interna se obtuvieron recientemente en una muestra de Lituania (Gelezelyte et al., 2022).

En resumen, como hemos indicado en el presente capítulo, la investigación sobre pruebas que evalúen el TEPT y TEPTC es muy reciente y poco a poco se van desarrollando, validando y adaptando culturalmente medidas en función de las clasificaciones diagnósticas más recientes. En cuanto a la evaluación del TEPTC en mujeres supervivientes de VG, no hay literatura acorde con los presentes síntomas descritos en CIE-11 en los que se hayan utilizado las pruebas con más apoyo psicométrico internacional, como es el caso del Cuestionario Internacional sobre el Trauma (ITQ). Sin embargo, y tal y como hemos señalado anteriormente, la VG es un evento que se considera estresante o traumático, que se ha evidenciado que puede dar lugar a TEPT en numerosos estudios, y sus síntomas de AAO son informados tanto por profesionales clínicos, del campo de la investigación y las propias mujeres supervivientes. Por consiguiente, consideramos que una buena manera de comenzar a investigar los síntomas de TEPTC en esta población es contando con un instrumento de diagnóstico específico como ITQ y conocer las propiedades psicométricas de dicha medida en la presente población, nos indicaría si sería óptimo utilizarlo en mujeres supervivientes de VG.

II. JUSTIFICACIÓN, OBJETIVOS E HIPÓTESIS

Capítulo 4.

Justificación, objetivos e hipótesis

4. 1. Justificación y objetivo general.

Como hemos visto en el Capítulo 1, sufrir violencia de género tiene efectos en la salud de las mujeres supervivientes a nivel físico, psicológico, neuropsicológico o cerebral. Una de las secuelas en la salud mental más prevalentes y alarmantes en porcentaje es el trastorno de estrés postraumático (TEPT), el cual se presenta con un rango de prevalencia estimada de entre el 31% al 84.4% y con una prevalencia media ponderada del 63.8% (Golding, 1999; Castello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien y Schie, 2008; Pico-Alfonso et al., 2006). Estos resultados son coherentes dado que, en los eventos violentos aspectos como la gravedad, la duración, la distancia del contexto de violencia o la distancia física y la relación con fuente de violencia, hacen que la probabilidad de sufrir TEPT sea mayor (Jonhson et al., 2008; Hecker et al., 2017). Por tanto, por las características de la VG, las mujeres supervivientes de este tipo de violencia se convierten en una población de alto riesgo de sufrir TEPT tras ser víctimas de sus parejas o ex parejas (Nathanson et al., 2012; Kessler et al., 2017).

Sin embargo, desde los estudios de Terr (1991) o Herman (1992) hasta estudios más recientes han comprobado que ciertos tipos de eventos traumáticos aumentan el riesgo de sufrir TEPT o de presentarse en forma de un estrés postraumático con sintomatología más severa o con más síntomas de los hasta ahora considerados. Eventos traumáticos como la violencia sexual, la violencia física, la violencia emocional, el abandono, el secuestro, esclavitud o situaciones de refugio dan lugar a los síntomas clásicos de TEPT que se manifiestan junto a otros que afectan a la autoestima, el estado de ánimo, la regulación emocional o las relaciones sociales (Pill et al., 2017). Por este motivo, la Organización Mundial de la Salud propone distinguir entre el TEPT y TEPTC en función de los síntomas manifestados (WHO, 2018).

Los estudios pioneros que consideran el TEPTC informan que el riesgo de sufrir un TEPTC aumenta tras la exposición a eventos traumáticos de carácter interpersonal y de los que es difícil o imposible escapar (Hyland et al, 2018b); y el diagnóstico está determinado, en última instancia, no por los antecedentes, sino por el perfil de los síntomas que se manifiestan (Kazlauskas et al, 2018).

Hasta el momento, como hemos indicado en el Capítulo 2, se ha estudiado dicho diagnóstico en poblaciones que han sufrido diferentes tipos de traumas (niños/as y adolescentes supervivientes de maltrato, refugiados, prisioneros de guerra, etc.). Sin embargo, como también hemos visto en el Capítulo 3, actualmente y hasta donde sabemos, no se ha considerado el diagnóstico de trastorno de estrés postraumático complejo (TEPTC) en la población de mujeres supervivientes de violencia de género. A pesar de que, por las características de la violencia, el vínculo específico con el agresor o la dificultad para salir de la situación de violencia, podrían presentar los denominados síntomas clásicos de TEPT y también los síntomas de alteraciones en la desorganización (AAO) que conforman el TEPTC.

Esta falta de investigación sobre el TEPTC en mujeres supervivientes de VG es la principal justificación para desarrollar la presente Tesis doctoral. Sin embargo, junto a la falta de estudios sobre la presencia y prevalencia del TEPTC en esta población, nos encontramos con la ausencia de un instrumento específico para su diagnóstico en población española. Es por ello que previamente al inicio de la tesis se llevó a cabo la traducción y adaptación cultural de la prueba del International Trauma Questionnaire (ITQ; Cloitre et al, 2018; Fernández-Fillol et al., 2020) al español de España. Como hemos expuesto en el Capítulo 3, ITQ es un instrumento con mejor aval científico para el diagnóstico del TEPTC ya que, este cuestionario, ha demostrado tener buenas propiedades psicométricas (Hyland et al., 2017a; Karatzias et al., 2016). Además, está utilizándose a nivel internacional para recopilar datos sobre prevalencia, factores de riesgo y protección en diferentes contextos culturales con el objetivo de desarrollar estrategias preventivas para minimizar el impacto del trauma en diferentes etapas de la vida y en todas las culturas. Es por ello que se utilizará este instrumento en la presente tesis para investigar el TEPTC en una muestra española.

A su vez, junto a la necesidad de utilizar un instrumento adecuado a nivel internacional, debíamos saber si este instrumento era adecuado para usarlo en nuestra población. Es por ello que surge la necesidad de conocer las propiedades psicométricas de dicha prueba en la población objeto de estudio de la presente tesis, esto es, mujeres supervivientes de VG. Al mismo tiempo, unida al interés de conocer la prevalencia del TEPTC en mujeres supervivientes, surge la necesidad de conocer cuáles son los factores

relacionados con los síntomas AAO en mujeres supervivientes. Factores como el miedo, la gravedad de la violencia, la resiliencia o las estrategias de regulación emocional se han observado como variables importantes que estarían relacionadas con la severidad de los síntomas de TEPT y TEPTC (Hebenstreit et al., 2015; Horn y Feder, 2018; Langdon et al., 2014, Lilly y Lim, 2012). Sin embargo, hasta el momento no se ha investigado esta relación con los posibles síntomas de TEPTC que las mujeres supervivientes de VG podrían presentar. Es por ello, que, en la presente tesis, se llevarán a cabo diferentes estudios relacionados con la investigación de dichas variables en relación a los síntomas de TEPTC en esta población.

Por todo ello, el objetivo general de esta Tesis doctoral será investigar el TEPTC en mujeres supervivientes de violencia de género. Este objetivo se abordará siguiendo los objetivos específicos detallados en el siguiente apartado.

4. 2. Objetivos específicos e hipótesis.

Objetivo 1. Conocer las propiedades psicométricas de la prueba ITQ en la población de mujeres supervivientes de VG (fiabilidad, validez de constructo y validez concurrente).

Para desarrollar este objetivo se realizó el Estudio 1 (ver Capítulo 5).

Objetivo 2. Estudiar la prevalencia del TEPTC en comparación con el TEPT en mujeres supervivientes de VG.

Para desarrollar este objetivo se realizó el Estudio 2 (ver Capítulo 6) publicado en:

Fernández-Fillol, C., Pitsiakou, C., Perez-Garcia, M., Teva, I., & Hidalgo-Ruzzante, N. (2021). Complex PTSD in survivors of intimate partner violence: risk factors related to symptoms and diagnoses. *European journal of psychotraumatology*, 12(1), 2003616.

Objetivo 3. Estudiar las variables relacionadas con la sintomatología del TEPTC en mujeres supervivientes de VG.

Objetivo 3. 1. Estudiar los factores de riesgo relacionados con la presencia de síntomas de TEPTC y factores que marcan la diferencia entre TEPT y TEPTC.

Para desarrollar este objetivo se realizó el Estudio 2 (ver Capítulo 6) publicado en:

Fernández-Fillol, C., Pitsiakou, C., Perez-Garcia, M., Teva, I., & Hidalgo-Ruzzante, N. (2021). Complex PTSD in survivors of intimate partner violence: risk factors related to symptoms and diagnoses. *European journal of psychotraumatology*, 12(1), 2003616.

Objetivo 3. 2. Estudio de la resiliencia como mediador entre la severidad de la VG y la severidad de los síntomas de TEPTC.

Para desarrollar este objetivo se realizó el Estudio 3 (ver Capítulo 7).

Objetivo 3. 3. Estudio de la relación entre los síntomas de TEPTC y estrategias de regulación emocional.

Para desarrollar este objetivo se realizó el Estudio 4 (ver Capítulo 8).

De estos objetivos específicos se derivan las siguientes hipótesis:

Hipótesis para el Objetivo 1: Se hipotetizó que el ITQ demostraría una óptima fiabilidad. En cuanto a la validez concurrente, ITQ estaría correlacionado con una prueba validada previamente para medir TEPT. Por último, se hipotetizó que la estructura latente del ITQ se explicaría mejor por uno de los dos modelos consistentemente apoyados en la literatura del ITQ para otras poblaciones de supervivientes. Es decir, por un modelo correlacionado de seis factores o un modelo de dos factores de orden superior, los cuales ambos capturan la distinción entre los síntomas del TEPT y del AAO.

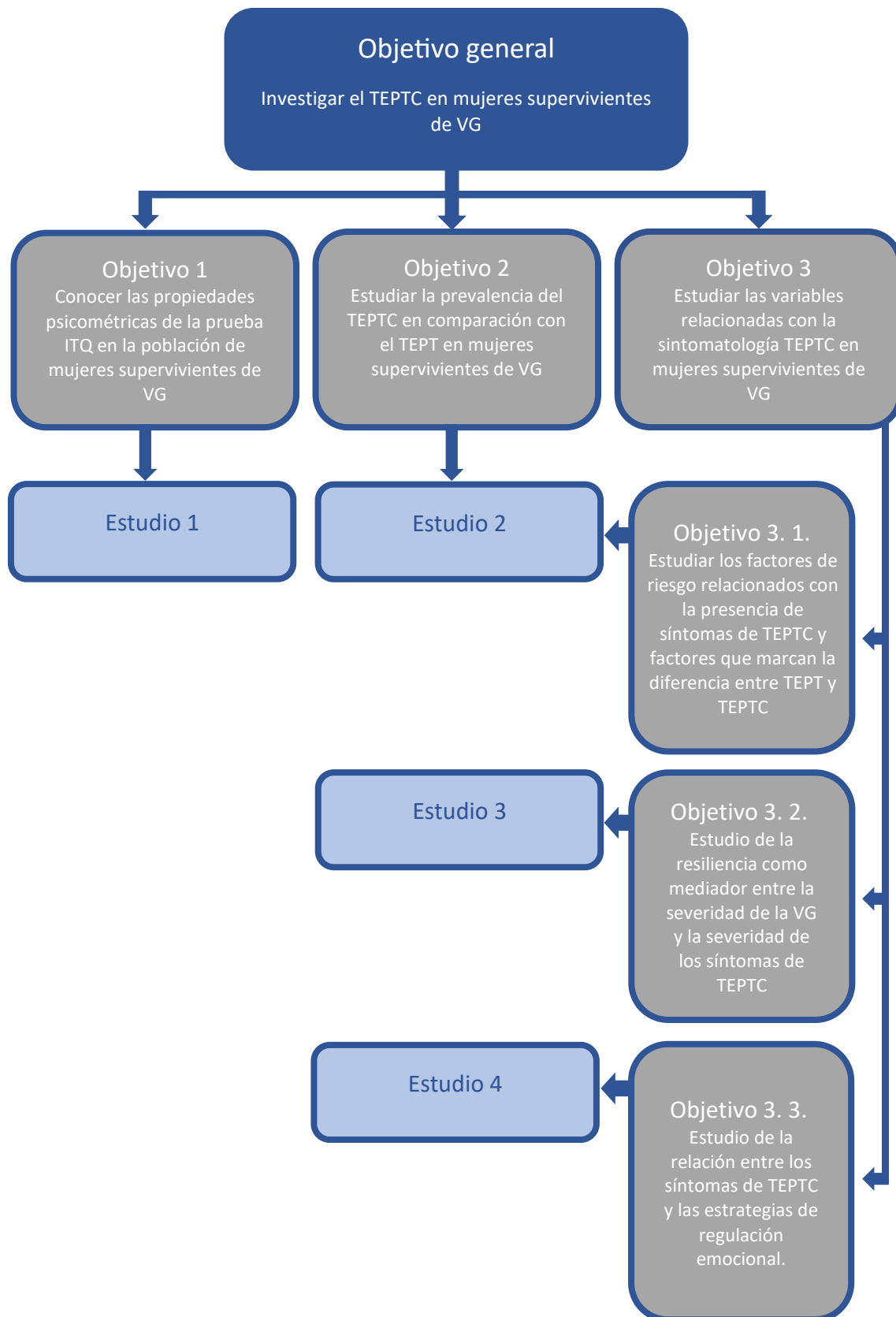
Hipótesis para el Objetivo 2: Se planteó la hipótesis de que la presencia de TEPTC sería mayor que la de TEPT debido a las características de la violencia sufrida por estas mujeres. Ya que la VG, es un trauma repetido que implica una dificultad para escapar de la situación y es perpetrada en el contexto de una relación íntima. Esta alta prevalencia de TEPTC también se observó en otras poblaciones de supervivientes y víctimas de otro tipo de violencia interpersonal (Cloitre et al., 2014 , 2018; Hyland et al., 2017b , 2018b; Karatzias et al., 2016; Murphy et al., 2018; Simon et al.,2019; Vallières et al., 2018).

Hipótesis para el Objetivo 3. 1.: Planteamos la hipótesis de que las mujeres que sufren violencia más severa, mostraran mayor nivel de miedo hacia el agresor,

estrategias disfuncionales de regulación emocional y un bajo nivel de resiliencia, presentarían un mayor nivel de síntomas de TEPTC. A su vez, planteamos la hipótesis de que las estrategias de regulación emocional desadaptativas podrían considerarse factores de riesgo que estarían asociados con los síntomas del TEPTC.

Hipótesis para el objetivo 3. 2.: Hipotetizamos que la severidad de la violencia se relacionaría positivamente con la severidad del TEPTC y negativamente con los niveles de resiliencia, mientras que la resiliencia se relacionaría negativamente con la severidad del TEPTC (Ferrari et al., 2016; Lagdon et al., 2014). Dado que en presencia de un trauma interpersonal violento la severidad de la violencia está altamente relacionada con la baja resiliencia (Klasen et al., 2010; Margolin & Gordis, 2004; Nishimi et al., 2020; Portnoy et al., 2018), hipotetizamos que la baja resiliencia mediaría la asociación entre la severidad de la violencia y la severidad del TEPTC.

Hipótesis para el objetivo 3. 3.: Consideramos que los síntomas de AAO se relacionarán positivamente con las estrategias desadaptativas de supresión de la expresión y negativamente con las estrategias de reevaluación cognitiva, teniendo en cuenta que la literatura ha relacionado la estrategia de supresión de la expresión con la presencia de psicopatología (McRae y Gross, 2020) y el uso de esta estrategia marca la diferencia entre el TEPT y el TEPTC en mujeres supervivientes de VG (Fernández-Fillol et al., 2021). En el caso de los síntomas de desregulación afectiva, consideramos que la hipoactivación tendría un papel más central en las relaciones estudiadas que la hiperactivación. Por lo tanto, consideraríamos un predominio de los problemas de hipoactivación emocional en el caso de las mujeres supervivientes de VG.



III. MEMORIA DE TRABAJOS

Capítulo 5.

Psychometric properties of the ITQ for measuring ICD-11 CPTSD in a Spanish sample of female survivors of IPV

Este estudio se encuentra en preparación para ser enviado y publicado como:

Fernández-Fillol, C., Perez-Garcia, M., & Hidalgo-Ruzzante, N. (2022).
Psychometric properties of the ITQ for measuring ICD-11 CPTSD in a Spanish
sample of female survivors of IPV.

5. 1. Introduction

The World Health Organisation has recently proposed the International Classification of Diseases (ICD-11) where Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (CPTSD) are included under the new cluster of "Disorders specifically associated with stress" (WHO, 2018). This new classification would allow for a singular and more specific diagnosis for either PTSD or CPTSD. The need to define CPTSD arose because additional symptoms and/or more severe symptoms appeared than in populations experiencing interpersonal trauma, people deliberately abuse, violate, or attack another (Kessler et al., 2017). However, the ICD-11 classification indicates that the diagnosis of CPTSD is not determined by the history of trauma, but by the presenting symptoms (Kazlauskas et al., 2018).

According to ICD-11, CPTSD is composed of symptoms resulting from trauma exposure such as (1) re-experiencing the trauma in the here and now (Re), (2) avoidance of traumatic reminders (Av), and (3) a persistent sense of current threat manifested by arousal and hypervigilance (Th). In addition to these core symptoms of PTSD, ICD-11 proposes additional symptoms reflecting "disturbances of self-organisation" (DSO) in its diagnostic formulation for CPTSD. DSO symptoms are represented by three symptom clusters: (1) affective dysregulation (AD), (2) negative self-concept (NSC), and (3) disturbances in relationships (DR). On the basis of the symptoms presented, studies comparing prevalence of both diagnoses in interpersonal trauma survivor populations found a higher prevalence of CPTSD over PTSD in adults who experienced childhood sexual abuse (Cloitre et al., 2014; Hyland et al., 2017b), physical assault (Karatzias et al., 2016), and violence in armed conflict (Vallières et al. 2018).

In order to carry out the assessment of both ICD-11 based diagnoses, research on CPTSD measurement instruments has become prominent in the field of traumatic stress in recent years. The International Trauma Questionnaire (ITQ; Cloitre et al., 2018) has been the main instrument for measuring the CPTSD symptoms as well as for providing a diagnosis. The most recent version of the ITQ includes 12 items (six for PTSD and six for DSO symptoms) and in addition, a total of six functional impairment items to measure the symptom impairment of each cluster. Moreover, this instrument has been

validated internationally and has shown very optimal psychometric properties. Numerous studies have examined its factor structure and have found a structure of six first-order correlated factors (Armour et al., 2021; Ho et al., 2019; Kazlauskas et al., 2020; Li et al., 2021; Vang et al., 2021). Another well-established structure in the literature is the two-factor second-order model with six first-order factors (Cyr et al., 2022; Haselgruber et al., 2020b; Hyland et al., 2017b; Li et al., 2021; Owczarek et al., 2019). Concretely, the six-factor model is a first-order model where symptoms of re-experiencing, avoidance, current sense of threat, affective dysregulation, negative self-concept, and disturbances in relationships correlate with one another. In the case of the two-factor second-order model, the principal factors would be PTSD and DSO, where PTSD is made up of the symptoms re-experiencing, avoidance, and current sense of threat, while the DSO factor is made up of affective dysregulation, negative self-concept, and disturbances in relationships symptoms. Ho et al. (2020) argue that the six-factor correlated structure is more common in community samples and the two-factor second-order structure is a better fit for clinical samples. However, in a study by Vang et al. (2021), the six-factor correlated structure was obtained in clinical samples and they argue that this structure may appear in clinical samples when the samples are heterogeneous.

At the same time, the ITQ reliability has been demonstrated in different populations exposed to different types of trauma (Hansen et al., 2021; Hyland et al., 2017b; Karatzias et al., 2016; Kazlauskas et al., 2018) and in community samples (Ho et al., 2019). In terms of concurrent validity, the ITQ total score correlated strongly and positively with previously validated measures of posttraumatic stress (Hansen et al., 2021). This concordance with other previously validated tests has also been demonstrated with tools used to diagnose PTSD and CPTSD (Hansen et al., 2022; Rzeszutek et al., 2021) and for detecting therapeutic change after treatment (Cloitre et al., 2021; Voorendonk et al., 2020).

Nevertheless, the literature on CPTSD in women survivors of IPV is scarce and the psychometric properties of the ITQ have not been studied neither in this population nor in the Spanish population. Recently, Fernández-Fillol et al. (2021) have shown that the prevalence of CPTSD (39.5%) is double that of PTSD (17.9%) according to ICD-11 in a

sample of women suffering IPV. This is consistent with the characteristics of violence in this population including interpersonal violence, the impossibility of escaping and the bond with the perpetrator (Hyland et al., 2018b; Pill et al., 2017). However, we should not assume the same psychometric properties for this population based on studies of other traumatised populations since the present population differs from those studied previously (e.g., veterans, community samples or survivors of sexual abuse). Women IPV survivors are exposed to interpersonal and intentional violence in which the bond with the aggressor together with a continuous cycle of different phases of violence gradually work to erode the mental health of women survivors (Santiago et al., 2013; Walker et al., 2016). Furthermore, this population has the peculiarity that it is not homogeneous. IPV survivors face different types of IPV (psychological, physical and/or sexual violence), which varies in duration and/or severity, and some may still be in contact with the perpetrators for legal issues (e.g., child custody; Potter et al., 2021).

5. 1. 1. Objectives and hypotheses

The aim of this study is to examine the reliability, construct validity, and concurrent validity of the ITQ in female survivors of IPV. We hypothesised that the ITQ would demonstrate strong internal consistency (Hansen et al., 2021; Hyland et al., 2017b; Karatzias et al., 2016; Kazlauskas et al., 2018). In terms of concurrent validity, we hypothesised that the ITQ would be correlated with a previously validated test for measuring PTSD (Hansen et al., 2021). Finally, in terms of construct validity, it was hypothesised that the latent structure of the ITQ would be best explained by one of two models consistently supported in the ITQ literature for other survivor populations (Armour et al., 2021; Cyr et al., 2022; Ho et al., 2019; Haselgruber et al., 2020b; Hyland et al., 2017b; Kazlauskas et al., 2020; Li et al., 2021; Owczarek et al., 2019; Vang et al., 2021): a six-factor correlated model or a higher-order two-factor model, both of which capture the distinction between PTSD and DSO symptoms.

5. 2. Method

5. 2. 1. Participants and procedures

Participants were 340 women survivors of IPV (physical, sexual, and/or psychological) perpetrated by former partners. None of them were still in a relationship or lived with the perpetrator. Users were recruited from regional government women's centres and non-governmental women's survivors' associations from ten different regions of Spain (Andalucía, Asturias, Aragón, Cantabria, Castilla la Mancha, Castilla y León, Comunidad de Madrid, Comunidad Valenciana, Extremadura, and Islas Baleares), they were over 18 years old ($M = 42.67$ years old; $SD = 10.96$; age range: 19-75) and they spoke and wrote fluent Spanish. They had a $M = 14.91$ years in education ($SD = 6.46$) and 71.8% shared children with their violent ex-partners. Women who have not suffered IPV from their partner/ex-partner, being under 18 years old, and not being able to read or understand and write in Spanish, could not participate in this study. The sample was composed entirely of women residents in Spain (Table 1 shows other socio-demographic and violence-related information).

The study was approved by the Ethics Committee of the University of Granada (933/CEIH/2019. Ethics Committee on Human Research, CEIH) and the data were collected after agreeing on a collaboration with the centres and associations where women attended. First, information about the study was given and collaboration was proposed. In the case of non-governmental associations, permission was given by the associations themselves. Centres dependent on regional or local governments needed permission from the authorities in order to be able to participate. From the different centres that were contacted, the professionals informed us of their acceptance to participate in the study and they referred the women to us for evaluation. The professionals of the governmental women's centres and associations made the first contact and the women who agreed to know about the study were informed in detail by members of our research team. Our team directly requested the women's permission to participate by means of informed consent, previously approved by the ethics committee. Participants were invited to collaborate in the study on a voluntary and anonymous basis and they had the right to withdraw from the study at any time.

Assessment consisted of completing a brief interview and self-reporting questionnaires and participants were assessed by at least one psychologist. That is, at the time of the assessment participants were always supported by a psychologist in

person or via video call in cases where participants lived further away. All questionnaires were completed in individual sessions previously arranged with each participant and lasted approximately 90 minutes. The majority was done via an electronic device (either face-to-face or remotely) but as some participants had resource problems to have a device or were not comfortable with the technology, some of them were given the possibility to do it in paper format. In the online format there was no loss of data due to the mandatory nature of the questions. However, among those who completed the paper version, 9 participants were excluded because they had not fully completed some of the tests and only one participant was unable to take part in the assessment due to severe symptoms of disorientation and memory loss. Therefore, of the initial 350 participants, data from 340 were considered in our analysis.

The data collection period was from November 2019 to September 2022. Participants did not receive incentives or payments for their participation. Confidentiality was kept and guaranteed according to the Spanish legislation on personal data protection (Organic Law 3/2018, December 5).

Table 1. Socio-demographic and violence data.

	% (N = 340)
University studies	20.1 %
No university studies	79,9%
Currently studying	38.2 %
Intimate partner violence	100 %
Psychological violence	99.1 %
Physical violence	68.8 %
Sexual violence	39.3 %
Other traumatic event	44.5 %
Other interpersonal trauma	19.4 %
Children witness of IPV	45.3 %
Current legal proceeding with perpetrator	60.4 %
Current perpetrator restraining order	37 %

Perpetrator currently in prison	3.5 %
Contact by children of legal age	71.4 %

5. 2. 2. Measures

Socio-demographic and violence-related interview

A self-reported structured interview developed for the purposes of this research. It was completed by the participants themselves but always in the presence of at least one psychologist, the survey was never distributed outside the previously scheduled sessions. In this interview, socio-demographic (date of birth, information about children, school attendance, level of education, current education) and violent relationship data were collected. For instance, types of violence suffered, duration of the violence, previous trauma and its type, current relationship status and contact with perpetrator due to legal issues such as parenting custodies, restraining order or prison

ICD-11 CPTSD and PTSD

The International Trauma Questionnaire (ITQ: Cloitre et al., 2018) is a brief measure of CPTSD developed according to ICD-11 (WHO) criteria. The ITQ was used to measure PTSD and CPTSD and as the original version includes 18 items. Symptom severity is measured on a scale of 0 to 4 where 0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quit a bit and 4 = Extremely. In turn, this test allows for the diagnosis of PTSD and CPTSD. PTSD diagnosis requires the endorsement of one of two symptoms (scores ≥ 2) from each PTSD cluster, plus endorsement of functional impairment associated with these symptoms. Diagnosis of CPTSD requires the endorsement of all the six PTSD and DSO clusters, plus endorsement of functional impairment associated with these symptoms. According to the ICD-11 taxonomic structure, ITQ only allows one diagnosis of PTSD or CPTSD, but not both. The internal reliability for both scales is satisfactory, with Cronbach's $\alpha \geq .79$.

DSM-5 PTSD

Escala de Gravedad de Síntomas del Trastorno de Estrés Postraumático (EGS-R; Echeburúa et al., 2016). It is a hetero-applied scale that is structured in a Likert-type

format from 0 to 3 according to the frequency and intensity of symptoms. It consists of 21 items in correspondence with the DSM-5 diagnostic criteria (APA, 2013): 5 refer to re-experiencing symptoms (range 0 to 15 points), 3 to behavioural/cognitive avoidance symptoms (range 0 to 9 points), 7 to cognitive disturbances and negative mood (range 0 to 21 points) and 6 to symptoms of increased activation and psychophysiological reactivity (range 0 to 18 points). The global scale ranges from 0 to 63 points. In addition to the core symptoms of PTSD, four items have been added to assess the presence of dissociative symptoms in a complementary way due to the importance given to these symptoms in the DSM-5 and six items to assess the degree of impairment or dysfunctionality related to the traumatic event. This core part (EGS-R) has shown adequate psychometric properties in the Spanish population: a satisfactory internal consistency for the total score of 21 items ($\alpha = .91$), as well as for the four PTSD specific symptom cores (values between .72 and .79) (Echeburúa et al., 2016). In our sample the Cronbach's $\alpha = .92$.

5. 2. 3. Statistical analysis

Reliability was calculated using the split-half method for the PTSD cluster (first half: Re1, Av1 and Th1; second half: Re2, Av2 and Th2), for the DSO cluster (first half: AD1, NSc1 and DR1; second half: AD2, NSc2 and DR2) and the whole ITQ (first half: Re1, Av1, Th1, AD1, NSc1 and DR1; second half: Re2, Av2, Th2, AD2, NSc2 and DR2). Also, Internal consistency analyses were conducted via Cronbach's alpha. Concurrent validity analyses were conducted using Pearson correlation between ITQ and EGS-R. These analyses were conducted using Statistical Package for the Social Sciences, version 26.0 (SPSS; IBM Corp., 2019).

The latent structure of the ITQ was tested using a confirmatory factor analysis (CFA) based on responses to the 12 core symptom items using data from participants who had experienced IPV by an ex-partner. The models are depicted in Figure 1.

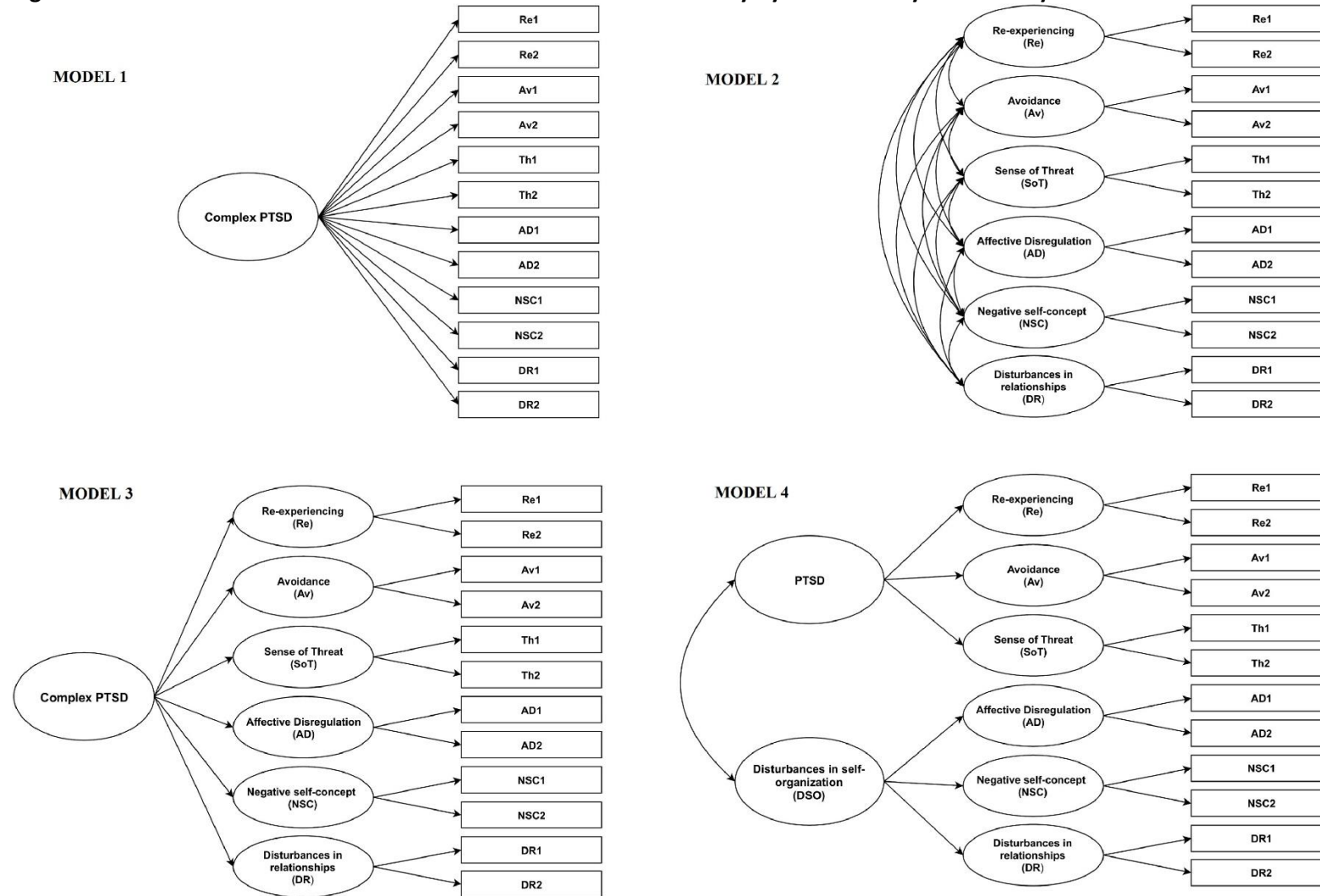
Twelve items from the ITQ were used in the estimation of the models; six PTSD items and six DSO items. The models that have been chosen are the most replicated based on previous literature on the factor structure of the ITQ and those that separate emotional hyperarousal and hypoarousal have been discarded, as they have been

shown to be part of the same domain of affective dysregulation (Ben-Ezra et al., 2018). Therefore, we included model 1 which is a one-factor model in which all symptoms load on a single latent variable representing CPTSD; model 2 is a six-factor correlated model; model 3 replaces the factorial correlations of model 2 with a single second-order factor representing CPTSD; and finally, model 4 specified two correlated second-order factors (PTSD and DSO), each measured by three first-order factors (see Figure 1).

Each model was estimated using weighted least square mean and variance adjusted (WLSMV) estimation as used as it provides accurate parameter estimates, standard errors, and test-statistics for ordinal indicators (Flora & Curran, 2004) using R-package lavaan (Rosseel, 2012), in statistical environment R (R Development Core Team, 2021). Lavaan is a package to provide a collection of tools that can be used to explore, estimate, and understand a wide family of latent variable models, including factor analysis, structural equation, longitudinal, multilevel, latent class, item response, and missing data models. The WLSMV is a robust estimator which does not assume normally distributed variables and provides the best option for modelling categorical or ordered data (Brown, 2006).

Model fit was assessed using standard procedures: a non-significant chi-square (χ^2) test; Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) values greater than 0.90; Root Mean Square Error of Approximation value between .06–.08 with 90% confidence intervals (RMSEA 90% CI) indicate excellent model fit (Browne & Cudeck, 2016; Hu & Bentler, 1999); and a Standardised Root Mean Square Residual (SRMR) of 0 indicates perfect fit but it must be noted that SRMR will be lower when there is a high number of parameters in the model and in models based on large sample sizes. However, values as high as .08 are deemed acceptable (Hu and Bentler, 1999; Hooper et al., 2008).

Figure 1. Factor models of ICD-11 PTSD and CPTSD assessed in the study by confirmatory factor analysis.



(Figure obtained from Kazlauskas et al., 2020).

5. 3. Results

340 female survivors of IPV completed the ITQ. The symptoms with the highest scores were “avoiding external reminders of the experience” (Av2), “Being super-alert, watchful, or on guard” (Th1), “avoiding internal reminders of the experience” (Av1), “Feeling jumpy or easily startled” (Th2) and “I feel numb or emotionally shut down” (AD2). Table 2 shows the mean scores and standard deviations for each of the ITQ items.

Table 2. Mean scores and standard deviations for each of the ITQ items.

ITQ subscales	Item	Mean	SD
ITQ - Re-experiencing (Re)	Re1 = distressing dreams	1.94	1.366
	Re2 = intrusive recollections	2.22	1.240
ITQ - Avoidance (Av)	Av1 = internal avoidance	2.56	1.116
	Av2 = external avoidance	2.63	1.243
ITQ - Current sense of threat (Th)	Th1 = hypervigilance	2.60	1.360
	Th2 = exaggerated startle response	2.56	1.294
ITQ - Affective dysregulation (AD)	AD1 = long time to be able to stay in calm	2.09	1.015
	AD2 = emotional numbing	2.53	1.196
ITQ - Negative self-concept (NSc)	NSC1 = feelings of failure	2.10	1.387
	NSC2 = feelings of worthlessness	1.67	1.405
ITQ - Disturbances in relationships (DR)	DR1 = feeling distant or cut off from others	2.02	1.309
	DR2 = difficulties feeling close to others	1.97	1.343

Reliability analyses

In our sample, split-half reliability for the PTSD cluster was .920, for the DSO cluster was .924, and for the whole ITQ was .958. The internal consistency (Cronbach's test) of the PTSD cluster was .86, for the DSO cluster was .88 and for the whole ITQ was .90. This indicates a good reliability for the ITQ.

Concurrent validity

The individual symptom scores and the summed ITQ and DSO cluster scores were all positively and significantly correlated with all EGS-R subscales and with the total score. The ITQ re-experiencing was more the most correlated symptom with EGS-R intrusion ($r = .702$). Table 6 shows correlations between ITQ and EGS-R measures.

Table 3. Correlations between CPTSD symptom clusters measured with ITQ and PTSD symptom clusters measured with EGS-R.

Symptoms	Intrusion (EGS-R)	Avoidance (EGS-R)	Cognitive disturbances and negative moods (EGS-R)	Hyperactivation (EGS-R)	Dissociation (EGS-R)	PTSD (EGS-R)
Re (ITQ)	.702	.422	.518	.585	.470	.677
Av (ITQ)	.488	.594	.442	.451	.357	.564
Th (ITQ)	.605	.478	.460	.673	.463	.664
AD (ITQ)	.455	.294	.608	.600	.508	.638
NSc (ITQ)	.465	.303	.665	.546	.575	.661
DR (ITQ)	.421	.398	.671	.544	.502	.651
PTSD (ITQ)	.710	.585	.560	.679	.511	.753
DSO (ITQ)	.505	.378	.738	.633	.601	.737
CPTSD (ITQ)	.690	.546	.742	.747	.635	.849

All correlations significant ($p < .001$).

Construct validity

Model 1 has a poor fit and thus it is rejected. Model 3 had an acceptable fit based on the CFI and TLI values, but it has higher RMSEA and SRMR values, so it is also rejected. Models 2 and 4 show acceptable fit based on RMSEA, SRMR, CFI and TLI values. Although the chi-square statistic was statistically significant, this should not lead to the rejection of the CFA model in our study, as the power of the chi-square is positively related to sample size and tends to reject models based on large sample sizes (Tanaka, 1987). Model 2 (the six-factor correlated model) has the lowest RMSEA and SRMR values, and the highest CFI and TLI values. The RMSEA value from model 2 to model 4 is lower and based on the slightly higher fit statistics and theoretical consistency, model 2 is considered to be the best fit. Table 4 shows model fit statistics for alternative models of ICD-11 CPTSD (CFA).

The factor loadings for the selected model are presented in Table 4. All of them were positive and statistically significant ($p < .001$) and were high ($> .60$), with the exception of one affective dysregulation item "When I am upset, it takes me a long time

to calm down" (.539). In turn, inter-factor correlations (Table 6) were also significant, ranging from .323 to .692.

Table 4. Model fit statistics for alternative models of ICD-11 CPTSD.

Model	CFI	TLI	RMSEA (90% CI)	SRMR	χ^2 (df), <i>p</i>
Model 1	.854	.822	.224 (.212-.236)	.133	972.104 (54), <.001
Model 2	.996	.993	.044 (.024-.063)	.025	64.612 (39), <i>p</i> = .006
Model 3	.931	.914	.155 (.143-.168)	.112	487.157 (53), <.001
Model 4	.975	.968	.096 (.096-.109)	.068	208.727 (51), <.001

Table 5. Standardised Factor Loadings for Model 2 of PTSD and CPTSD Symptoms.

Item	Re	Av	Th	AD	NSc	DR
Re1	.734					
Re2	.884					
Av1		.790				
Av2		.884				
Th1			.865			
Th2			.931			
AD1				.539		
AD2				.908		
NSc1					.947	
NSc2					.920	
DR1						.903
DR2						.847

All factor loadings are statistically significant ($p < .001$). Re1 to Th2 are the PTSD items and AD1 to DR2 are the DSO items.

Table 6. Factor Correlations for Model 2 of ITQ Symptom Clusters.

	Re	Av	Th	AD	NSc
Av	.526				
Th	.625	.562			
AD	.425	.323	.397		
NSc	.441	.362	.392	.663	

DR	.417	.448	.437	.638	.692
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All correlations significant ($p < .001$).

5. 4. Discussion

The present study aims to evaluate the psychometric properties of ITQ scores in a Spanish sample of female survivors of IPV. Overall, the results showed that the Spanish ITQ has strong reliability and optimal concurrent and construct validity in the present population of women survivors of IPV.

The first principal finding was that the ITQ demonstrated optimal reliability in women survivors of IPV, according to reference studies indicating that acceptable alpha values range between .70 and .95 (Bland et al., 1997; Cronbach, 1951; DeVellis, 2003; Nunnally et al., 1994). Our results are similar to others studies that likewise report adequate reliability scores in other clinical (Hansen et al., 2021; Hyland et al., 2017b; Karatzias et al., 2016; Kazlauskas et al., 2018) and in community samples (Ho et al., 2019).

With regard to concurrent validity, we observed that symptoms, subscales, and total scores of both scales correlated significantly with one another. These results support our hypothesis that the ITQ would be related to the results of a previously validated test for PTSD. We observed that ITQ PTSD cluster symptoms are related to EGS-R symptoms measuring the same domains. These results are similar to those showing that the ITQ total score correlated strongly and positively with previously validated measures of posttraumatic stress (Hansen et al., 2021). This concordance with other previously validated tests has also been observed when the ITQ found to be a valid test for diagnosing PTSD and CPTSD (Hansen et al., 2022; Rzeszutek et al., 2021).

Consistent with previous factor analytic studies of CPTSD (Armour et al., 2021; Cyr et al., 2022; Haselgruber et al., 2020b; Ho et al., 2019; Hyland et al., 2017b; Kazlauskas et al., 2020; Li et al., 2021; Owczarek et al., 2019; Vang et al., 2021), we hypothesised that, of our 4 models, the first-order model with six correlated factors (Model 2) or the second-order model of two factors with six first-order factors (Model 4) would provide the best fit to our data. In this regard, our hypothesis was confirmed as the first order model of six correlated factors (Model 2) provided the best fit to our

data. The second best fitting model was the second-order two-factor model with six first-order factors (Model 4). These results are in line with studies that accept both models (Li et al., 2021) but they especially support the results found by with Armour et al., (2021), Ho et al., (2019), Kazlauskas et al., (2020) and Vang et al., (2021) where the correlated six-factor model provides a slightly better fit.

In terms of correlations between symptoms, our results indicate that the PTSD cluster symptoms (re-experiencing, avoidance, and current sense of threat) are more highly correlated with each other than with the DSO cluster symptoms (negative self-concept, affective dysregulation, and disturbances in relationships). These results indicate that although the best-fitting model is the six correlated symptoms, we also observe a tendency for symptoms to be more correlated within their cluster. As such, this would suggest a potentially adequate fit for the two-factor second-order model of PTSD and DSO (Model 4). Thus, findings from the internal structure analysis indicate that the ICD-11 formulation is an adequate representation of the latent structure of the Spanish version of the ITQ, although the best fitting model was the six first-order correlated factors followed by the second-order two-factor model with six first-order factors.

In other populations that have obtained Model 2 as the best-fitting model, it was considered that the first-order model better describes the structure of ICD-11 trauma-related disorders in community samples, whereas the second-order model is a more appropriate description of the data in clinical and highly trauma-exposed samples (Ho et al., 2020). However, findings from a more recent study partly contradict this proposition, as the first-order model showed an equal and sometimes superior fit to clinical samples, especially in heterogeneous clinical samples (Vang et al., 2021).

Notably, all items representing the PTSD and DSO constructs were excellent representations of their corresponding factors due to their high standardised factor loadings (Table 5). The highest standardised factor loadings were found for the item, "I feel like a failure," from the DSO's negative self-concept factor (.947). Therefore, this item would be considered the best representative for the CPTSD construct in a sample of female IPV survivors. This finding is not surprising, given that perpetrators of IPV often attack their partner's self-esteem as a tactic in the victimisation process (Gonzalez-

Guarda et al., 2013). As a result, many women survivors describe their IPV experiences as devastating to their self-esteem, self-identity, and self-efficacy and there is an increased belief in one's own inability to succeed in a given situation (Childress, 2013; Kang and Kim, 2011; Lammers et al., 2005). In fact, this alteration in negative self-concept has been reported after violence on women survivors from different countries and cultures (Bradley et al., 2005; Matheson et al., 2015; Costa and Canossa, 2018).

As for the correlations between factors in the best-fitting model (Model 2), all were positive and significant ($p < .001$). The PTSD factors demonstrated a correlation coefficient between .526 and .625, the DSO factors between .638 and .692, and the cross-construct factors between .323 and .448. Overall correlation coefficients ranged from the lowest of .323 (affective dysregulation with avoidance) to the highest of .692 (affective dysregulation with relationship disturbances). This high correlation is similar to those found in a population of veterans (Armour et al., 2021) and adolescents exposed to different types of trauma (Kazlauskas et al., 2020). In the case of women survivors, there is a breakdown in emotional wellbeing, resulting in a violation of trust (Freyd et al., 2005; St. Vil et al., 2018). This results in some women survivors deliberately believing that building emotional distance between themselves and others, or not engaging in long-term relationships, protects them from being vulnerable or susceptible to violence again (Cherlin et al., 2004). In addition, emotions such as fear could be very present after IPV and interfere with establishing or maintaining new relationships, for a fear of revictimization (Flasch et al., 2015; Fernández-Fillol et al., 2021).

In summary, the present study supported the fit of the six-factor first-order correlated model (Model 2) in a Spanish population of women survivors of IPV, extending previous findings from the limited number of studies conducted on trauma survivors. Notably, previous studies were based on data from different trauma-exposed samples. Thus, this research helps to further support the implementation of the ICD-11 and ITQ as a reliable and valid measure of PTSD and CPTSD in diverse populations and contexts (Karatzias et al., 2016).

5. 5. Limitations and future directions

Despite the contributions of this study there are some limitations that should be taken into account. First, this was a cross-sectional study that was based on the collection of data from participants at a single, specific point in time. Ideally, longitudinal data would have allowed us to understand the latent dimensions of CPTSD in this population over time and corroborate the results of more recent temporal studies which indicate that PTSD and CPTSD are stable constructs (Hyland et al., 2020). Finally, a self-report measure was used and, therefore, the data are subject to the various limitations that are not readily present in clinical diagnostic instruments. However, it should be noted that there are currently no publicly available clinical diagnostic interviews for ICD-11 PTSD and CPTSD in Spanish. Nevertheless, early validation studies of the International Trauma Interview according to ICD-11 criteria, have indicated that this interview is a promising method for assessing ICD-11 PTSD and CPTSD (Bondjers et al., 2019; Gelezelyte et al., 2022). Therefore, future studies may consider collecting data across existing clinical diagnostic instruments and self-report measures, as well as investigating diagnostic concordance rates.

5. 6. Conclusions

In conclusion, our study aimed to examine the psychometric properties of the ITQ in a sample of female IPV survivors. Findings suggest that the ITQ is a valid measure of ICD-11 PTSD and CPTSD in this population, as indicated by satisfactory factorial validity, internal consistency, and concurrent validity. With the aim of expanding knowledge in the field of CPTSD, future research could explore the psychometric properties of the ITQ in other Spanish-speaking populations and clinical samples to determine whether it is a useful tool for researchers and practitioners.

Capítulo 6.

Complex PTSD in survivors of intimate partner violence: risk factors related to symptoms and diagnoses

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6. 1. Introduction

IPV definition and prevalence

Intimate partner violence (IPV) is a critical international public health problem. It refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm (World Health Organization [WHO], 2012) and is one of the main causes of death and disability among women worldwide (WHO, 2013). One out of three women worldwide has suffered physical and/or sexual violence from an intimate partner, and in some regions this rate can reach 38% (WHO, 2013). In Spain, a large-sample survey about violence against women carried out every four years with women ages 16 and over, revealed that 32.4% of the Spanish female population had experienced IPV. Moreover, in a total of 9568 interviewed women survivors of IPV, 11% reported that they had suffered physical violence, 8.9% reported they had suffered sexual violence, 27% had suffered psychological control violence and 23.2% had suffered psychological emotional violence (Ministry of Health, Social Services and Equality, 2020).

PTSD and CPTSD in survivors of IPV

Experiencing interpersonal violence by a partner or ex-partner may increase the risk of onset of mental health disorders (Dillon, Hussain, Loxton, & Rahman, 2013; Sugg, 2015; Thurston & Miller, 2019). This is also the case with PTSD, which appears to be the most common mental health problem that female survivors of IPV may develop. According to Golding (1999), the PTSD prevalence may range from 31% to 84.4% within this population. Subsequent similar studies in different populations of female IPV victims and survivors confirmed similar rates of prevalence of PTSD (e.g., Kastello et al., 2016; Kelly, 2010; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Nerøien & Schei, 2008; Pico-Alfonso et al., 2006). The definition of PTSD includes symptoms of intrusion and re-experiencing, avoidance and a current sense of threat following a traumatic experience (American Psychiatric Association; APA, 2013). Interpersonal traumatic experiences are associated with an increased risk of PTSD (Kessler et al., 2017), leading the ICD-11 (World Health Organization's International Classification of Diseases, ICD-11, 2018) to propose a distinction between PTSD and Complex Posttraumatic Stress Disorder (CPTSD). Therefore, according to ICD-11, some people could develop PTSD or CPTSD after

suffering traumatic events. In addition to the aforementioned PTSD symptoms of re-experiencing, avoidance and current sense of threat, CPTSD contains a set of symptoms called disturbances in self-organisation (DSO), which in turn are comprised of affective dysregulation, negative self-concept and disturbances in relationships (Brewin et al., 2017).

Up to now, the studies about CPTSD have been carried out with adult clinical samples (Cloitre et al., 2018; Hyland et al., 2017b; Karatzias et al., 2016; Kazlauskas, Gegieckaite, Hyland, Zelviene, & Cloitre, 2018; Simon, Roberts, Lewis, van Gelderen, & Bisson, 2019; Stadtmann, Maercker, Binder, & Schnepf, 2018; van Dijke, Hopman, & Ford, 2018), non-clinical community-based samples (Karatzias, Hyland, Ben-Ezra, & Shevlin, 2018a; Murphy, Elklit, Dokkedahl, & Shevlin, 2018), child and adolescent victims of maltreatment (Bertó et al., 2017), trafficked children (Ottisova, Smith, & Oram, 2018), former child soldiers (Murphy et al., 2018), women's clinical samples (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Hyland, Shevlin, Fyvie, & Karatzias, 2018b), male perpetrators of IPV (Gilbar, Hyland, Cloitre, & Dekel, 2018), refugees (Vallières et al., 2018) and war prisoners (Zerach, Shevlin, Cloitre, & Solomon, 2019). In addition, some of these studies compared PTSD and CPTSD prevalences in the same populations (Cloitre et al., 2014, 2018; Gilbar et al., 2018; Hyland et al., 2017b; 2018b; Karatzias et al., 2016; Murphy et al., 2018; Simon et al., 2019; Vallières et al., 2018; Zerach et al., 2019). Despite the fact that IPV is a type of interpersonal violence that is difficult to escape for its particular bond between the survivors and perpetrators, and despite its possible consequences, such as low self-esteem and deconstruction of identity (Hyland et al., 2018b; Matheson et al., 2015; Pill, Day, & Mildred, 2017), research on CPTSD in women survivors of IPV is scarce. So far there is only one study that has studied the presence of CPTSD in this population (Dokkedahl, Kristensen, Murphy, & Elklit, 2021), which found a prevalence of PTSD = 56.5% and CPTSD = 21.1% in a Danish sample recruited in four shelters. Therefore, the present study aims to explore the prevalence of PTSD and CPTSD, as well as the variables that could increase the risk of the onset of this disorder and its symptomatology among women survivors of IPV who attend women's information centres but who are not currently living in shelters.

Risk factors related to PTSD and CPTSD after suffering IPV

An important factor that may facilitate the onset or aggravation of PTSD symptoms is the severity of the violence experienced (Lagdon, Armour, & Stringer, 2014). In a study carried out by Ferrari et al. (2016), three-quarters of the female participants who had experienced high levels of recent violence showed PTSD scores above the clinical threshold. This is consistent with the argument that the risk of PTSD is higher than of any of the other mental health issues experienced by IPV survivors (Howarth & Feder, 2013). Furthermore, the amount of time passed since the event may also influence the current manifestation of the PTSD symptoms (Badour, Resnick, & Kilpatrick, 2017). In terms of remission, it should be noted that treatment could be a factor influencing symptom remission. However, most remission studies do not include populations that have received a specific PTSD treatment. On the other hand, it has been observed that the average time to remission of PTSD symptoms is longer in people who have experienced interpersonal trauma, in comparison to those who have experienced a non-interpersonal trauma (Chapman et al., 2012; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Several studies have shown a positive association between the level of fear experienced and subsequent appearance of PTSD symptoms (Hebenstreit, Maguen, Koo, & DePrince, 2015), as well as with the number of symptoms presented (Amstadter, Nugent, & Koenen, 2009; Mahan & Ressler, 2012; Milad et al., 2008). However, fear has not been linked yet to the DSO symptoms of CPTSD, since PTSD is conceptualised as a fear-based disorder, whereas CPTSD is conceptualised as a broader clinical disorder that is defined by the impact of trauma on emotion regulation, identity, and the interpersonal domain (Hyland et al., 2017b).

A variable that has been shown to be a protective factor in risky situations and post trauma is resilience (Horn & Feder, 2018). According to Connor and Davidson (2003), resilience embodies the personal qualities that enable one to thrive in the face of adversity (measure tenacity, pressure and control, adaptability and support, control and purpose, and spirituality). Therefore, resilience could be understood as a measure of a successful stress-coping ability. In line with this, other authors reported that active coping strategies were negatively related to the development of PTSD symptoms, as opposed to negative coping (Thompson, Fiorillo, Rothbaum, Ressler, & Michopoulos,

2018). In women survivors of IPV, possessing fewer effective coping strategies was related to a greater number of PTSD symptoms (Sullivan, Weiss, Price, Pugh, & Hansen, 2018).

Finally, emotion regulation strategies is another important variable in IPV related to affect, cognition and behaviour and it is defined as an attempt, whether implicit or explicit, to modify one's emotional response (Werner & Gross, 2010). It has been shown that greater emotion regulation difficulties and maladaptive strategies were related to greater severity of PTSD (Chang, Kaczurkin, McLean, & Foa, 2018; Moore, Zoellner, & Mollenholt, 2008; Short, Boffa, Clancy, & Schmidt, 2018; Weiss et al., 2012). Likewise, higher levels of emotion dysregulation difficulties were related to more severe PTSD symptoms in IPV survivors (Lilly & Lim, 2012). In the case of emotion regulation strategies and CPTSD, there is only one study that indicates that emotion regulation maladaptive strategies were significantly related to receiving a CPTSD diagnosis. That maladaptive strategy was expressive suppression, which is understood as efforts to conceal, inhibit or reduce emotional expression (Karatzias et al., 2018b). Nevertheless, these results should be considered with caution in relation to CPTSD, due to the lack of CPTSD measures and the cross-sectional designs of the previous studies.

In summary, even though factors such as severity of violence, level of fear, resilience and emotion regulation strategies have been shown to be related to PTSD and in the case of emotion regulation to CPTSD too, these factors have not been studied in relation to CPTSD within women survivors of IPV. The current study attempts to fill the gap in research since it is crucial to explore the presence of CPTSD in this population and to also look into whether the aforementioned PTSD factors could be related to CPTSD symptoms.

6. 1. 1. Objectives and hypotheses

The first objective was to analyse the prevalence of women survivors of IPV who met the criteria for PTSD or CPTSD. It was hypothesised that the frequency of CPTSD would be higher than PTSD due to the characteristics of the violence suffered by these women. This was based on the fact that IPV is a repeated trauma that involves a difficulty in escaping the situation and the violence is perpetrated by someone within the context of an intimate relationship. This high CPTSD prevalence was also observed on other

populations of survivors and victims of interpersonal violence (Cloitre et al., 2014, 2018; Hyland et al., 2017b, 2018b; Karatzias et al., 2016; Murphy et al., 2018; Simon et al., 2019; Vallières et al., 2018). However, Dokkedahl et al. (2021) found the opposite. We therefore consider it is important to analyse the prevalence of both diagnoses according to ICD-11 criteria in the present sample of women survivors.

The second objective was to analyse whether the severity of violence, the level of fear, resilience and emotion regulation strategies were related to CPTSD symptomatology. Based on previous literature, we hypothesised that women who suffer more severe violence, show a higher level of fear, show dysfunctional emotion regulation strategies and a low level of resilience, would present a higher level of CPTSD symptoms. Finally, we analysed which risk factors may be the deciding ones between presenting with CPTSD and presenting with PTSD after suffering IPV. Although there are no previous studies on this topic, we hypothesised that maladaptive emotion regulation strategies could be considered risk factors that would be associated with CPTSD symptoms.

6. 2. Method

6. 2. 1. Participants and procedures

Participants were 162 women who had suffered IPV from their ex-partners at some point in their lives. They were recruited in associations and women's centres from 30 localities in six different regions of Spain (Andalucía, Asturias, Castilla la Mancha, Castilla y León, Extremadura and Comunidad Valenciana). All of them were over 18 years old ($M = 41.42$ years old; $SD = 11.55$; age range: 20–75), survivors of IPV (psychological, physical and/or sexual) perpetrated by ex-partners, none of them were still in the relationship or lived with the perpetrator and all spoke and wrote fluent Spanish ($M = 46.11$ months from the end of the relationship until the assessment; $SD = 61.54$). The exclusion criteria were: not having suffered IPV by their partner/ex-partner, being under 18 years old and not being able to read, understand and write in Spanish.

The sample was composed entirely of women residents in Spain (including native Spanish from other nationalities such as Venezuela ($N = 1$), Morocco ($N = 3$), Russia ($N = 1$) and Ecuador ($N = 1$). Data on the nationalities of the non-Spanish women were not

provided by all centres. They had a $M = 14.30$ of academic years of studies ($SD = 5.25$) and 83.33% shared children with their violent ex partners. Table 1 shows other socio-demographic and violence-related information.

The study was approved by the Ethics Committee of the University of Granada (933/CEIH/2019. Ethics Committee on Human Research, CEIH) and the data were collected after agreeing on a collaboration with the centres and associations where women attended. Contact with the women's centres and associations was made by telephone and email. Firstly, information about the study was given and collaboration was proposed. The centres dependent on regional or local governments needed permission from the authorities in order to be able to proceed with the assessments. In the case of non-governmental associations, permission was given by the associations themselves.

From the different centres that were contacted, the professionals informed us of their acceptance to participate in the study and they referred the women to us for evaluation. The professionals of the women's centres made the first contact and the women who agreed to know about the study were informed in detail by members of our research team. Our team directly requested the women's permission to participate by means of informed consent, previously approved by the ethics committee. Participants were invited to collaborate in the study on a voluntary and anonymous basis and they had the right to withdraw from the study at any time. Of the total number of women, only one was unable to take part in the assessment despite her willingness to do so, due to severe symptoms of disorientation and memory loss. The evaluation consisted of completing a brief interview and self-reporting questionnaires and participants were assessed by at least one psychologist during all evaluations. The data collection period was from November 2019 to January 2021. They did not receive incentives or payments for their participation. Confidentiality was kept and guaranteed according to the Spanish legislation on personal data protection (Organic Law 15/13 December 1999).

Table 1. Socio-demographic and violence data.

	<i>N</i>	%
Primary Education	42	25.90%
Secondary Education	41	25.30%
Vocational Training	48	29.60%
University Degree	25	15.40%
Master's Degree	5	3.10%
Doctorate (PhD)	1	0.60%
Intimate partner violence	162	100%
Psychological violence	159	98.15%
Physical violence	115	70.99%
Sexual violence	54	33.33%
Other trauma	76	49.91%
Other interpersonal trauma	45	27.78%
Contact with perpetrator due to common issues	60	37.03%
Current legal proceeding with perpetrator	101	62.34%
Current perpetrator restraining order	71	43.87%

6. 2. 2. Measures

Socio-demographic and violence interview The research team developed a self-reported structured interview in which they collected socio-demographic data (date of birth, information about children, total years of school attendance, level of education, current education); yes/no questions about the violent relationship (types of violence suffered, duration of the violence, number of violent relationships); previous trauma and its type, current relationship status with the perpetrator (i.e. Are you still in the relationship?; Are you currently living together?); contact with perpetrator due to common issues (legal issues, parenting, custody) (i.e. text messages, conversations with the aggressor and what they may involve or indirect messages through the children); ongoing legal proceedings (i.e. Are you currently in any kind of legal proceedings with your partner/ex-partner?; Does he currently have a restraining order?; Has your partner/ex-partner been or is currently in prison?); or whether they have contact with

the perpetrator because they have legal issues in regards to shared children (i.e. Do you and your partner/former partner have children in common?; Are your children under 18 years old?; and a description about the type of custody and whether they see ex-partners at legal meeting points).

Fear

The level of current fear they feel towards the perpetrators was assessed with a Likert scale developed where they reported the level of fear that they felt in the moment of the assessment in one of the six levels of fear proposed, ranging from 'no fear at all' to 'the most intense possible fear': no fear (0), very slight fear (1), mild fear (2), moderate fear (3), intense fear (4), very intense fear (5) and the most intense possible fear (6).

ICD-11 CPTSD and PTSD

The International Trauma Questionnaire (ITQ: Cloitre et al., 2018) is a brief measure of CPTSD developed according to ICD-11 (WHO) criteria. The ITQ was used to measure PTSD and CPTSD and as the original version includes 18 items. Symptom severity is measured on a scale of 0 to 4 where 0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quit a bit and 4 = Extremely. In turn, this test allows for the diagnosis of PTSD and CPTSD. PTSD diagnosis requires the endorsement of one of two symptoms (scores ≥ 2) from each PTSD cluster, plus endorsement of functional impairment associated with these symptoms. Diagnosis of CPTSD requires the endorsement of all the six PTSD and DSO clusters, plus endorsement of functional impairment associated with these symptoms. According to the ICD-11 taxonomic structure, ITQ only allows one diagnosis of PTSD or CPTSD, but not both. The internal reliability for both scales is satisfactory, with Cronbach's $\alpha \geq .79$.

Severity of IPV

The Composite Abuse Scale (Revised)-Short Form (CASR-SF) (Ford-Gilboe et al., 2016) was used for this variable. This is a 15-item self-report measure that assesses the severity and intensity of intimate partner violence in the past 12 months. It includes measures for psychological, physical and sexual violence. CASR-SF assesses the

frequency of each type of violence on a scale of 0–5 with a range of 0–75 (higher total score means a higher severity of violence). The original CASR-SF has an internal consistency of .942 (Ford-Gilboe et al., 2016) and was translated into Spanish for the sample of this study following the International Test Commission Guidelines for Translating and Adapting Tests Second Edition (ITC, 2018). Since many women had suffered violence for years but not in the last year, we also used this measure for a period prior to the last 12 months, in order to know the type of violence and its frequency.

Resilience

The Connor-Davidson Resilience Scale (CD-RISC) (Connor & Davidson, 2003) was used to assess resilience. This measure has different subscales (tenacity, pressure control, adaptability and support, control and purpose, and spirituality) and the sum total of these subscales constitutes the resilience construct. It contains 25 items, each scored on a 5-point scale (0–4), with higher scores reflecting greater resilience (0–100). In terms of internal consistency, Cronbach's α for the full scale is .89 and item-total correlations range from .30 to .70 (Connor & Davidson, 2003). Similar results are obtained in the Spanish version, Cronbach's α for the full scale is .86 and the mean of the correlations between each item and the total scale was .42 ($SD = .13$) (León, González-Gómez, Robles-Ortega, Padilla, & Peralta-Ramirez, 2019).

Emotion regulation

The Emotion Regulation Questionnaire (ERQ) (Gross & John, 2003) was used to evaluate the participants' emotion regulation. This is a 10-item scale designed to measure the tendency of respondents to regulate their emotions in two ways: cognitive reappraisal as an adaptive strategy and expressive suppression as maladaptive strategy. The response to each item is given on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). A higher total score on the cognitive reappraisal subscale means a greater use of adaptive emotion regulation strategies (range 0–42) and a higher total score on the expressive suppression subscale means a greater use of maladaptive emotion regulation strategies (range 0–28). The reliability of the subscales in the validated Spanish version is similar and as adequate as the original version, with

Cronbach's $\alpha = .75$ for emotional suppression and $.79$ for cognitive reappraisal strategies (Cabello, Salguero, Fernández-Berrocal, & Gross, 2013).

6. 2. 3. Data analysis

Data were analysed using the Statistical Package for the Social Sciences, version 26.0 (SPSS; IBM Corp., 2019). For the first objective, we used a frequency analysis to find out the prevalence of women who met the CPTSD or PTSD diagnosis. Through this analysis, the percentage of women who met each of the CPTSD symptoms could also be explored.

For the purpose of analysing which risk factors (severity of violence in two periods, level of fear, resilience and two strategies of emotion regulation as Independent Variables (IV)) were related with the presence of each one of the CPTSD symptoms (re-experiencing, avoidance, current sense of threat, affective dysregulation, negative self-concept and disturbances in relationships) as dependent variables (DV), we carried out six logistic regression analyses. For each logistic regression model, the method of entering all variables together as independent variables (IV) was used. Statistical significance of contribution of each IV was obtained using t tests. The presence of the symptom was coded as 1 and the absence of the symptom as 0. We used this same analysis to analyse which risk factors were related to the fulfilment of diagnostic criteria for PTSD to become CPTSD as it has previously been reported in other studies (Karatzias et al., 2018b).

Data and analyses are available on request due to the privacy and safety of research participants.

6. 3. Results

Prevalence rates and descriptive statistics

ITQ follows the structure of ICD-11, which allows the diagnosis of CPTSD or PTSD, but not both at the same time. 57.40% ($N = 93$) of women survivors of IPV met the diagnostic criteria for either CPTSD or PTSD. Specifically, 39.50% ($N = 64$) met the diagnostic criteria for CPTSD and 17.90% ($N = 29$) met the criteria for PTSD. Descriptive data and frequencies for each CPTSD symptom are presented in Table 2.

Table 2. Descriptive data and frequencies according to CPTSD symptomatology.

CPTSD symptom	Item	<i>N</i>	<i>M(SD)</i>	Women who meet symptom criteria (<i>N</i>)	Women who meet symptom criteria (%)
Re-experiencing in the here and now (RE)	Total (RE)	162	3.60 (2.36)	113	69.75%
	ITQ P1		1.65 (1.36)		
	ITQ P2		1.95 (1.27)		
Avoidance (AV)	Total (AV)	162	4.93 (2.28)	138	85.18%
	ITQ P3		2.40 (1.20)		
	ITQ P4		2.54 (1.26)		
Current sense of threat (TH)	Total (TH)	162	4.83 (2.66)	124	76.54%
	ITQ P5		2.45 (1.43)		
	ITQ P6		2.38 (1.39)		
Affective dysregulation (AD)	Total (AD)	162	4.32 (1.91)	138	85.18%
	ITQ C1		1.99 (1.04)		
	ITQ C2		2.33 (1.21)		
Negative self-concept (NSC)	Total (NSC)	162	3.52 (2.66)	99	61.11%
	ITQ C3		2 (1.39)		
	ITQ C4		1.52 (1.41)		
Disturbances in relationships (DR)	Total (DR)	162	3.45 (2.43)	105	64.81%
	ITQ C5		1.77 (1.29)		
	ITQ C6		1.69 (1.33)		

Note: ITQ P1 = Re-experiencing in the here and now item 1; ITQ P2 = Re-experiencing in the here and now item 2; ITQ P3 = Avoidance item 1; ITQ P4 = Avoidance item 2; ITQ P5 = Current sense of threat item 1; ITQ P6 = Current sense of threat item 2; ITQ C1 = Affective dysregulation item 1; ITQ C2= Affective dysregulation item 2; ITQ C3 = Negative self-concept item 1; ITQ C4 = Negative self-concept item 2; ITQ C5 = Disturbances in relationships item 1; ITQ C6 = Disturbances in relationships item 2.

Association between severity of violence, fear, resilience and emotion regulation with manifestation of CPTSD symptoms after suffering IPV

Descriptive data for the totals of each measure used are detailed in Table 3 and the results of the logistic regression analysis for each of the CPTSD symptoms (dependent variables) are shown in Table 4. A higher level of fear was related to the

presence of symptoms such as ‘re-experiencing’ ($R^2 = 0.14$, $OR = 1.33$, $95\%CI: 1.08–1.63$), ‘avoidance’ ($R^2 = 0.09$, $OR = 1.43$, $95\%CI: 1.10–1.87$), ‘current sense of threat’ ($R^2 = 0.24$, $OR = 1.68$, $95\%CI: 1.29–2.19$) and ‘disturbances in relationships’ ($R^2 = 0.15$, $OR = 1.27$, $95\%CI: 1.03–1.57$). On the other hand, lower levels of resilience were related to the presence of symptoms such as ‘affective dysregulation’ ($R^2 = 0.14$, $OR = 0.93$, $95\%CI: 0.89–0.97$), ‘negative self-concept’ ($R^2 = 0.23$, $OR = 0.93$, $95\%CI: 0.90–0.96$) and ‘disturbances in relationships’ ($R^2 = 0.15$, $OR = 0.96$, $95\%CI: 0.93–0.99$). Finally, a higher level of expressive suppression was related to ‘affective dysregulation’ ($R^2 = 0.14$, $OR = 1.08$, $95\%CI: 1.00–1.17$), ‘negative self-concept’ ($R^2 = 0.23$, $OR = 1.07$, $95\%CI: 1.01–1.14$) and ‘disturbances in relationships’ ($R^2 = 0.15$, $OR = 1.07$, $95\%CI: 1.01–1.14$).

Table 3. Descriptive data for each measure.

Measure	<i>M(SD)</i>
CD-RISC (Resilience)	63.42 (1.29)
CAS-A (Severity of violence in the last year)	29.90 (1.30)
CAS-B (Severity of violence over a year ago)	10.34 (1.11)
ERQ-CR (Cognitive reappraisal strategies)	28.63 (0.64)
ERQ-ES (Expressive suppression strategies)	15.84 (0.50)
Level of Fear	3.33 (0.15)

Table 4. Risk factors related to the presence of CPTSD symptoms.

Symptom	Risk factor	β	<i>SE</i> β	<i>Wald's</i> χ^2	<i>p</i>	e^β	95%CI for e^β	R^2
Re-experiencing in the here and now	Resilience	-0.02	0.01	2.92	0.087	0.97	(0.95-1.00)	0.14
	Fear	0.28	0.10	7.20	0.007	1.33	(1.08-1.63)	0.14
	CAS-A	0.02	0.01	2.37	0.12	1.02	(0.99-1.06)	0.14
	CAS-B	0.01	0.01	1.65	0.19	1.01	(0.94-1.04)	0.14
	ERQ-CR	-0.01	0.02	0.05	0.81	0.99	(0.94-1.04)	0.14
	ERQ-ES	0.01	0.03	0.27	0.60	1.01	(0.95-1.07)	0.14
Avoidance	Resilience	-0.01	0.17	0.21	0.64	0.99	(0.96-1.02)	0.09
	Fear	0.36	0.13	7.08	0.008	1.43	(1.10-1.87)	0.09
	CAS-A	0.03	0.02	1.69	0.19	1.03	(0.98-1.09)	0.09
	CAS-B	-0.00	0.01	0.02	0.87	0.99	(0.96-1.02)	0.09
	ERQ-CR	0.02	0.03	0.43	0.51	1.02	(0.95-1.09)	0.09
	ERQ-ES	0.01	0.03	0.22	0.63	1.01	(0.94-1.09)	0.09

Current sense of threat	Resilience	-0.01	0.01	1.17	0.27	0.98	(0.95-1.01)	0.24
	Fear	0.52	0.13	15.30	<0.001	1.68	(1.29-2.19)	0.24
	CAS-A	0.04	0.02	2.79	0.09	1.04	(0.99-1.10)	0.24
	CAS-B	0.01	0.01	1.40	0.23	1.01	(0.98-1.04)	0.24
	ERQ-CR	0.16	0.03	0.27	0.59	1.01	(0.95-1.08)	0.24
	ERQ-ES	0.05	0.03	2.30	0.12	1.05	(0.98-1.13)	0.24
Affective dysregulation	Resilience	-0.73	0.02	10.67	0.001	0.93	(0.89-0.97)	0.14
	Fear	-0.17	0.13	0.01	0.905	0.98	(0.75-1.29)	0.14
	CAS-A	-0.11	0.01	0.38	0.53	0.98	(0.95-1.02)	0.14
	CAS-B	-0.00	0.01	0.01	0.91	0.99	(0.96-1.02)	0.14
	ERQ-CR	-0.02	0.03	0.28	0.59	0.98	(0.91-1.05)	0.14
	ERQ-ES	0.83	0.04	4.00	0.045	1.08	(1.00-1.17)	0.14
Negative self-concept	Resilience	-0.06	0.01	18.15	<0.001	0.93	(0.90-0.96)	0.23
	Fear	0.00	0.10	0.00	0.96	1.00	(0.81-1.23)	0.23
	CAS-A	0.00	0.01	0.16	0.68	1.00	(0.97-1.03)	0.23
	CAS-B	-0.00	0.01	0.62	0.43	0.99	(0.96-1.019)	0.23
	ERQ-CR	-0.02	0.02	0.68	0.40	0.97	(0.92-1.03)	0.23
	ERQ-SE	0.07	0.03	5.27	0.022	1.07	(1.01-1.14)	0.23
Disturbances in relationships	Resilience	-0.37	0.01	6.95	0.008	0.96	(0.93-0.99)	0.15
	Fear	0.24	0.10	5.35	0.021	1.27	(1.03-1.57)	0.15
	CAS-A	-0.01	0.01	0.72	0.39	0.98	(0.96-1.01)	0.15
	CAS-B	0.00	0.01	0.01	0.90	1.00	(0.97-1.02)	0.15
	ERQ-CR	0.00	0.02	0.00	0.98	1.00	(0.95-1.05)	0.15
	ERQ-SE	0.75	0.03	6.18	0.013	1.07	(1.01-1.14)	0.15

Note: CAS-A = Severity of violence in the last year; CAS-B = Severity of violence over a year ago; ERQ-CR = Cognitive reappraisal strategies; ERQ-SE = Expressive suppression strategies.

Risk factors associated with the development of PTSD or CPTSD after IPV

The results of a final logistic regression showed that high expressive suppression scores were related to a CPTSD diagnosis, compared to a PTSD diagnosis in women survivors of IPV ($\beta = 0.14$, $SE = .048$, $Wald = 8.64$, $p = .003$, $R^2 = 0.14$, $OR = 1.15$, $95\%CI: 1.04-1.26$).

6. 4. Discussion

To the authors' knowledge, there is only one previous study that has analysed the presence of CPTSD in women survivors of IPV and this is the first study to analyse the different risk factors related to its symptomatology. Although CPTSD has been

addressed in other victims and survivors that have experienced continuous interpersonal violence (Kessler et al., 2017), the studies of this disorder in this population are scarce. Moreover, it is important to emphasise that women survivors of IPV usually seek care in victim and survivor`s services to cope with issues associated with emotion regulation, self-esteem and interpersonal relationships (Lilly & Lim, 2012; Matheson et al., 2015; St. Vil, Carter, & Johnson, 2018), which are all related to CPTSD symptomatology.

The main results of this study showed that the prevalence of CPTSD was twice (39.50%) the prevalence of PTSD (17.90%). Moreover, results indicated that high levels of fear were related to re-experiencing, avoidance, current sense of threat and relationship disturbances. Low resilience and high expressive suppression were related to affective dysregulation, negative self-concept and disturbances in relationships. Finally, a high tendency towards the maladaptive emotion regulation strategy of suppressing expression made the difference between PTSD and CPTSD in women survivors of IPV. In line with previous studies of PTSD, our results indicated that more than half of the women survivors of IPV developed a disorder related to posttraumatic stress (Golding, 1999; Kastello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien & Schei, 2008; Pico-Alfonso et al., 2006). However, in our sample, CPTSD was the most common type of traumatic stress disorder. Thus, this possible sequela which occurs in a very considerable prevalence, could be currently underdiagnosed within the population and therefore, not receiving targeted treatment. In respect to the only previous study showing the prevalence of PTSD and CPTSD in women survivors (Dokkedahl et al., 2021), the results obtained in the present study show opposite prevalences. One possible reason for this difference may be that although the ITQ test was used in both studies, the versions of the test were not the same. For example, there were differences in the number of items, the name and number of symptoms, as well as the diagnostic criteria for the two disorders. In the study of Dokkedahl et al. (2021), they used a prior version of the ITQ to the publication of the WHO ICD-11 criteria (Cloitre et al., 2015 in Dokkedahl et al., 2021). To the contrary, the present study used a more updated version of the ITQ, which follows ICD-11 criteria established by the WHO, that was psychometrically and internationally supported (Cloitre et al., 2018). The diagnostic criteria used in the

present study, as described in the methods section above, are different from the previous version and this may be the reason for the difference in the results in terms of prevalence. Despite this possible explanation, it is important to further explore the prevalence of both diagnoses in order to clarify the extent to which they occur in the population of women survivors of IPV.

Additionally, we explored how each of the symptoms that makes up CPTSD was presented in this population. To analyse their presence after experiencing IPV, we studied the factors related to the six CPTSD symptoms. We found that high levels of fear of the perpetrator were especially important in presenting symptoms of re-experiencing, avoidance, current sense of threat and alterations in social relationships. The present results are consistent with the aforementioned three PTSD symptoms, and with PTSD being understood as a fear-based disorder according to the ICD-11 (Hyland et al., 2017b). The associations of these factors with the three PTSD symptoms could be explained by the proximity of the perpetrator, considered as the source of violence (Hecker, Ainamani, Hermenau, Haefele, & Elbert, 2017). This would explain the tendency to avoid anything related to the perpetrators, while also experiencing fear or a current sense of threat when continuing to be in contact due to judicial matters or because of a lack of a restraining order that would provide a sense of safety. In the present study, fear was also related to disturbances in relationships, a DSO symptom. This could be explained by the fact that fear can be very present after IPV and interfere with establishing or maintaining new relationships, for a fear of repetition of the abuse (Flasch, Murray, & Crowe, 2015; St. Vil et al., 2018).

Furthermore, a low level of resilience was found to be a factor related to the occurrence of all three DSO symptoms. These findings are in line with other studies that analysed interpersonal violence survivor populations. Such studies concluded that resilience was related to dysregulation, self-esteem and social relationships after trauma (Gao et al., 2019; Poole, Dobson, & Pusch, 2017). Low scores on resilience that involve non-use of adaptive coping strategies (tenacity, pressure and control, adaptability and support, control and purpose, and spirituality) (Connor & Davidson, 2003) could be explained by the helplessness experienced after suffering deliberate repeated interpersonal violence from men who were their partners.

Another variable that may underpin each DSO symptoms and made the most difference between meeting PTSD and meeting CPTSD criteria, was the maladaptive emotion regulation strategy of expressive suppression. Matheson et al. (2015) found that expressive suppression in IPV survivors may be explained by the devastation of self-esteem and identity. Therefore, survivors may feel a lack of self-importance and may tend to suppress emotional expression, which is a maladaptive strategy. Likewise, this could explain why expressive suppression was a variable related to the occurrence of disturbances in social responses and relationships (Tackman & Srivastava, 2016). This result may be attributed to women survivors of IPV having difficulties in regulating positive emotions (Weiss, Dixon-Gordon, Peasant, & Sullivan, 2018) and it could also be related to the fact that survivors may prefer not to express or to avoid judgements, may reserve their intimacy, or they may feel vulnerable and seek to protect themselves from others (Cloitre, Cohen, Ortigo, Jackson, & Koenen, 2020).

Considering these results, a double pattern may emerge. On one hand, risk factors related to the circumstances of the violence and/or to specific events in time (e.g., fear of being assaulted again by the abuser) may be more related to classic PTSD symptoms such as re-experiencing, avoidance and arousal. On the other hand, risk factors related to the psychological resources of survivors such as resilience and emotion regulation strategies would be related to DSO but not to classic PTSD symptoms. Future studies should further explore this hypothesis.

Finally, it is essential to identify the factors that make the difference between receiving a PTSD or CPTSD diagnosis. The present results indicate that expressive suppression is the variable that most contributes to the difference between both diagnoses. It should be noted that this result is congruent with the fact that the variable related to all symptoms of DSO may be also related to the frequency of the most common CPTSD symptoms in this study: avoidance and affective dysregulation. Hence, it could be considered that high avoidance may be related to the suppressive component and in turn, these maladaptive emotion strategies may be implicated in all emotional problems related to DSO symptoms.

6. 5. Limitations and future directions

The sample size is the main limitation of this study. For this reason, it is necessary to continue these assessments and replicate this study to obtain information from a larger sample of women survivors of IPV. This would allow to study the prevalence of both diagnoses after suffering IPV and to investigate in depth the risk factors that are related to symptoms and diagnoses, with the aim of improving targeted treatments in this population. For example, this could include adapting specific treatments that have been effective in other interpersonal trauma populations presenting with DSO symptoms, to CPTSD symptoms. For instance, the STAIR-MPE treatment (Cloitre et al., 2020). It would also be necessary to study the present findings in other interpersonal violence survivor populations, as the characteristics of the sample in this study are very specific and the results cannot be generalised to other populations. Another limitation of this study could be that it is a cross-sectional design and, therefore, cause-effect relationships cannot be established. Other limitations may include the absence of specific diagnostic interviews for CPTSD that do not currently exist in Spanish, the use of retrospective reports and the inability to access the census of women victims and survivors and all nationalities in each of the 30 centres. Finally, there may be some conceptual overlap in measures referring in some way to emotion regulation and future studies should explore this. These limitations have to be taken into account in order to improve future studies.

6. 6. Conclusion

This study shows that CPTSD is a mental health issue that a high percentage of the women survivors of IPV of this sample are suffering from. These results may reflect what could be happening within this population. IPV survivors may be suffering from symptoms that have so far not been assessed and, therefore, not properly treated. This disorder may disrupt their lives in numerous ways, while factors such as fear of the perpetrator, low levels of resilience and, in particular, a tendency to suppress the expression of emotions may increase the risk of them developing symptoms of CPTSD. The results of this study highlight the need for multidisciplinary action focused on increasing women's protection to reduce fear of perpetrators, as well as the need for

specific interventions in CPTSD. This could include treatments focused on emotion regulation through the improvement of adaptive strategies, while reducing maladaptive strategies.

Capítulo 7.

Resilience and ICD-11 CPTSD: Results from a sample of women survivors of intimate partner violence in Spain

Este estudio se encuentra en preparación para ser enviado y publicado como:

Fernández-Fillol, C., Hidalgo-Ruzzante, N., Perez-Garcia, M., Hyland, P., Shevlin, M., & Karatzias, T. (2022). ICD-11 Complex Post Traumatic Stress Disorder (CPTSD) symptoms and emotion regulation strategies in a sample of women IPV survivors: A network analysis.

7. 1. Introduction

Intimate Partner Violence (IPV) refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship (including slapping, hitting, kicking, beating, forced sex and other forms of coercion, insults, humiliation, threats of harm or taking away children, isolating, monitoring and restricting access to financial resources, education or health care) (WHO, 2012). Globally, IPV is one of the leading causes of death and disability. One in three women worldwide suffers physical and/or sexual violence from an intimate partner, and in some regions, this figure can be as high as 38 % (WHO, 2013). More recent statistics indicate that up to 307 million ever-married/partnered women aged 15 years and older have been subjected to recent physical and/or sexual violence from an intimate partner (WHO, 2021; WPP, 2019). In Spain, 32.4% of the Spanish female population has experienced IPV (Ministry of Health, Social Services and Equality, 2020). Therefore, the World Health Organisation (WHO, 2013) highlights this type of violence as an international health problem and a global priority that needs to be addressed.

Among other psychopathological disorders, one of the possible consequences of IPV is the development of complex posttraumatic stress disorder (CPTSD). The occurrence of psychopathological disturbances in women survivors has been related to protective factors, such as resilience. Resilience has been shown to protect against the development of posttraumatic stress disorder (PTSD) (Thompson et al., 2018; López-Fuentes and Calvete, 2015). However, the relationship between resilience and CPTSD has not yet been studied in the population of women IPV survivors. Therefore, the following study looks in depth at resilience in this population, examining its influence on the possible symptoms that make up CPTSD after having suffered this type of violence.

The consequences of IPV on the mental health of women survivors

Female IPV survivors may suffer mental disorders as a result of this traumatic experience (Dillon, 2013). Traditionally, research has considered PTSD is one the most common mental disorders that IPV survivors develop, with a weighted mean prevalence of 63.8% (Golding, 1999; Castello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien & Schie, 2008; Pico-Alfonso et al., 2006). However, in the World Health

Organisation's new version of the International Classification of Diseases (ICD-11; WHO, 2018), a distinction has been made between PTSD and CPTSD. Following this classification, the definition of PTSD includes symptoms of intrusion and re-experiencing, avoidance, and current sense of threat following a traumatic experience. In addition to the aforementioned PTSD symptoms, CPTSD contains a set of symptoms called disturbances of self-organisation (DSO), which in turn are composed of affective dysregulation, negative self-concept, and relationship disturbances (Brewin et al., 2017). Although the diagnosis is not determined by trauma history but rather by symptom profile (Kazlauskas et al., 2018), the risk of suffering CPTSD increases after exposure to *interpersonal* traumatic events, particularly those from which it is difficult or impossible to escape (Hyland et al, 2018a). Considering the similarity between such characteristics and the type of violence suffered by women exposed to IPV (interpersonal and difficult or impossible to escape), it is surprising that only one study has addressed CPTSD in women IPV survivors. Recently, Fernandez-Fillol et al. (2021) observed a higher prevalence of CPTSD (39.5%) compared to PTSD (17.9%) in female IPV survivors. Nevertheless, we do not know what factors are related with the severity of the symptoms of CPTSD in this population.

A tentative candidate for explaining the severity of CPTSD symptoms is the severity of violence. Severity of violence may facilitate the onset or increase the severity of PTSD symptoms (Lagdon et al., 2014; Hobfoll et al., 2011). This factor can be understood as the amount of violence received in a specific period of time from the violent ex-partner that includes specific experiences of physical, psychological, and sexual violence (Ford-Gilboe et al., 2016). A study by Ferrari et al. (2016) found that the majority of female IPV survivors who experienced high levels of violence showed PTSD scores above the clinical threshold. Furthermore, the amount of time since the event may also be related to the current manifestation of PTSD symptoms (Badour et al., 2017). In this regard, it has been observed that the mean time to remission of PTSD symptoms is longer in people who have experienced interpersonal trauma compared to those who have experienced non-interpersonal trauma (Chapman et al., 2012; Kessler et al., 1995). However, the relationship between the severity of violence and the severity of CPTSD symptoms has not yet been assessed in IPV women survivors.

CPTSD and Resilience

Another tentative candidate for explaining the severity of CPTSD symptoms is resilience. Resilience, defined as a dynamic process in which individuals show positive adaptation despite significant experiences of adversity or trauma, is considered a protective factor in risk situations and post-traumatic events (Horn & Feder, 2018). It is made up of a two-dimensional construct, involving exposure to adversity and the manifestation of positive adaptive outcomes (Luthar & Cicchetti, 2000). Recent studies show that CPTSD is related to low resilience in survivors and descendants of genocide (Shrira et al., 2019) and young survivors of sexual abuse (Alie-Poirier et al., 2020). In the same vein, sexually abused children and youth (Hébert & Amédee, 2020) and refugees (Hyland et al., 2018a) who were considered resilient had very low probability of meeting criteria for CPTSD. In the case of female survivors of IPV, Fernandez-Fillol et al. (2021) found that low levels of resilience are related to the presence of all three DSO symptoms of CPTSD (affective dysregulation, negative self-concept and relationship disturbances).

In addition, several studies have found that chronic exposure to violence or exposure to severe violence may work to erode resilience (Howell et al., 2010; Klasen et al., 2010; Margolin & Gordis, 2004; Nishimi et al., 2020; Portnoy et al., 2018). The deterioration of resilience, in this case, may be explained by the fact that violence influences one's ability to manage or cut off negative reactions or consequences related to the traumatic experience. That is, violence can prevent effective problem solving or responding effectively to the support of others in the aftermath of violence (Margolin & Gordis, 2004). As a consequence, mechanisms that are dedicated to growth and development for learning from the experience are replaced by fight, flight or freeze responses that focus on survival when the integrity of the person is threatened (van der Kolk et al., 2014). Again, this relationship has not been studied in women survivors of IPV and in terms of CPTSD symptoms.

In summary, although interpersonal violence has been shown to influence resilience, and resilience in turn is related to the presence or absence and severity of CPTSD symptoms, the relationships between these variables has not yet been studied together. Therefore, the present study attempts to fill this research gap by

understanding the potential mediating role of resilience in the relationship between the severity of experienced IPV and the severity of subsequent CPTSD symptoms in female IPV survivors. Thus, it would provide the first clue as to whether incorporating resilience enhancement in treatments for IPV survivors would contribute to minimising the severity of CPTSD symptoms (Giordano et al., 2019).

7. 1. 1. Objectives and hypotheses

For these reasons, the main aim of our study was to determine whether resilience plays a mediating role in the relationship between severity of violence and severity of CPTSD symptoms in female survivors of IPV. Based on previous literature on CPTSD, we hypothesised that severity of violence would be positively related to CPTSD severity and negative related to levels of resilience, while resilience would be negatively related to CPTSD severity (Ferrari et al., 2016; Lagdon et al., 2014). Given that in the presence of violent interpersonal trauma severity of violence is highly related to low resilience (Klasen et al., 2010; Margolin & Gordis, 2004; Nishimi et al., 2020; Portnoy et al., 2018), we hypothesise that low resilience mediates the association between severity of violence and severity of CPTSD.

7. 2. Method

7. 2. 1. Participants and procedures

Participants were 202 women survivors of IPV (physical, sexual and/or psychological) perpetrated by former partners. None of them were still in a relationship or lived with the perpetrator ($M = 33.41$ months from break up to assessment; $SD = 43.88$). The population sample was composed of participants recruited from women's battered centres from 30 localities in six different regions of Spain (Andalucía, Asturias, Castilla la Mancha, Castilla y León, Extremadura and Comunidad Valenciana). They were over 18 years old ($M = 41.41$ years old; $SD = 11.45$; age range: 20-75) and they spoke and wrote fluent Spanish. They had a $M = 14.48$ of academic years in education ($SD = 6.01$) and 68% shared children with their violent ex partners. Women who have not suffered IPV from their partner/ex-partner, being under 18 years old and not being able to read or understand and write in Spanish, could not participate in this study. The

sample was composed entirely of women residents in Spain. Only one participant was unable to take part in the assessment due to severe symptoms of disorientation and memory loss (Table 1 shows other socio-demographic and violence-related information).

The study was approved by the Ethics Committee of the University of Granada (933/CEIH/2019. Ethics Committee on Human Research, CEIH) and the data were collected after agreeing on a collaboration with the centres and associations where women attended. First, information about the study was given and collaboration was proposed. In the case of non-governmental associations, permission was given by the associations themselves. Centres dependent on regional or local governments needed permission from the authorities in order to be able to participate. From the different centres that were contacted, the professionals informed us of their acceptance to participate in the study and they referred the women to us for evaluation. The professionals of the women's centres made the first contact and the women who agreed to know about the study were informed in detail by members of our research team. Our team directly requested the women's permission to participate by means of informed consent, previously approved by the ethics committee. Participants were invited to collaborate in the study on a voluntary and anonymous basis and they had the right to withdraw from the study at any time.

Assessment consisted of completing a brief interview and self-reporting questionnaires and participants were assessed by at least one psychologist. That is, at the time of the assessment participants were always supported by a psychologist in person or via video call in cases where participants lived further away. All questionnaires were completed in individual sessions previously arranged with each participant and lasted approximately 90 minutes. The majority was done via an electronic device (either face-to-face or remotely) but as some participants had resource problems to have a device or were not comfortable with the technology, some of them were given the possibility to do it in paper format. In the online format there was no loss of data due to the mandatory nature of the questions. However, among those who completed the paper version, 9 participants were excluded because they had not fully completed some

of the tests. Therefore, of the initial 211 participants, data from 202 were considered in our analysis.

The data collection period was from November 2019 to July 2021. Participants did not receive incentives or payments for their participation. Confidentiality was kept and guaranteed according to the Spanish legislation on personal data protection (Organic Law 3/2018, December 5).

Table 1. Socio-demographic and violence data.

	<i>N</i>	%
University studies	155 (<i>N</i> = 199)	77.89%
No university studies	44 (<i>N</i> = 44)	22,11%
Currently studying	44 (<i>N</i> = 195)	22,56%
Intimate partner violence	202	100%
Psychological violence	50	24,8%
Psychological and physical violence	84	41.6%
Psychological, physical and sexual violence	68	33.7%
Other traumatic event	91	45.7%
Other interpersonal trauma	51	25.5%
Children witness of IPV	74 (<i>N</i> = 200)	37%
Current legal proceeding with perpetrator	121 (<i>N</i> = 200)	60.5%
Current perpetrator restraining order	77 (<i>N</i> = 200)	38.5%
Perpetrator currently in prison	11 (<i>N</i> = 201)	5.5%
Contact for minor children in common	43 (<i>N</i> = 197)	21.8%

7. 2. 2. Measures

Socio-demographic and violence-related interview

A self-reported structured interview developed for the purposes of this research. It was completed by the participants themselves but always in the presence of at least one psychologist, the survey was never distributed outside the previously scheduled sessions. In this interview, socio-demographic (date of birth, information about children, school attendance, level of education, current education) and violent relationship data

were collected. For instance, types of violence suffered, duration of the violence, previous trauma and its type, current relationship status and contact with perpetrator due to legal issues such as parenting custodies, restraining order or prison (i.e. Are you currently in any kind of legal proceedings with your partner/ex-partner?; Do you and your partner/former partner have children in common?; Are your children under 18 years old?; Does he currently have a restraining order?; Has your partner/ex-partner been or is currently in prison?).

Resilience

In the present study, the Spanish version of Connor-Davidson Resilience Scale (CD-RISC; Connor and Davidson, 2003; García-León et al., 2019) was used to assess resilience. This measure has demonstrated good psychometric properties and was designed to be applicable to different population groups (Burns & Anstey, 2010; Gillespie et al., 2007; Karairmak, 2010; García-León et al., 2019). Nevertheless, there is no consensus on its internal structure. Connor and Davidson (2003) defined five factors, other studies found one-dimensionality (Arias-González et al., 2015; García-León et al., 2019), two dimensions (Perera & Ganguly, 2016), three (Xie et al., 2016), four (Solano et al., 2016), five (Jung et al., 2012) and a second-order model (Yu et al., 2011). Cronbach's α to the original version scale is .86 and item-total correlations ranged from 0.30 to 0.70 (Connor and Davidson, 2003). In this case, the present sample has Cronbach's $\alpha = .91$.

ICD-11 CPTSD and PTSD

The International Trauma Questionnaire (ITQ; Cloitre et al., 2018) is a brief measure of CPTSD developed according to ICD-11 (WHO) criteria. The ITQ was used to measure PTSD and CPTSD and as the original version includes 18 items. Symptom severity is measured on a scale of 0 to 4 where 0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit and 4 = Extremely. In turn, this test allows for the diagnosis of PTSD and CPTSD. PTSD diagnosis requires the endorsement of one of two symptoms (scores ≥ 2) from each PTSD cluster, plus endorsement of functional impairment associated with these symptoms. Diagnosis of CPTSD requires the endorsement of all the six PTSD and DSO clusters, plus endorsement of functional impairment associated with these symptoms. According to the ICD-11 taxonomic structure, ITQ only allows one

diagnosis of PTSD or CPTSD, but not both. The internal reliability for both scales is satisfactory, with Cronbach's $\alpha \geq .79$. In our sample the Cronbach's $\alpha = .87$ for PTSD and $.89$ for DSO.

Severity of IPV

The Composite Abuse Scale (Revised)-Short Form (CASR-SF: Ford-Gilboe et al., 2016) was used to measure the severity of psychological, physical and sexual violence. This is a 15-item self-report measure that assesses the severity and intensity of IPV in the past 12 months. CASR-SF assesses the severity of each type of violence on a scale of 0-5 with a range of 0-75 (higher total score means a higher severity of violence). The original CASR-SF has an internal consistency of $\alpha = .94$ (Ford-Gilboe et al., 2016) and was translated and adapted into Spanish for the sample of this study following the International Test Commission Guidelines for Translating and Adapting Tests Second Edition by the members of Project Believe (ITC, 2018). Since all of the women participants of this study weren't in a violent relationship at the moment of the assessment, many of them had suffered violence for years but not in the last year. For this reason, we also considered using this measure for a period prior to the last 12 months.

7. 2. 3. Data Analysis

Before the mediational analysis, given that the test used to measure resilience (CD-RISC) has a different factor structure depending on the population to which it is administered, we considered it necessary to carry out a prior factor analysis of the structure of CD-RISC in our population. This lets us know in order to know exactly how we should treat this variable we could use in the mediation analysis. Hence, we determined the factorial structure of resilience in female survivors of IPV using the R package 'MVN' (Korkmaz et al., 2014) and R package 'psych' (Revelle, 2021) in statistical environment R (R Development Core Team, 2021), for assessing multivariate normality and to test for the optimal number of factors to extract respectively. Bartlett's test of sphericity (Bartlett, 1954) and the Kaiser-Meyer-Olkin statistic (KMO: Kaiser, 1974) were used to ensure all the variables and model are suitable for factor analyses. For the factor analyses, we used an iterated principal component method (principal axes) to extract

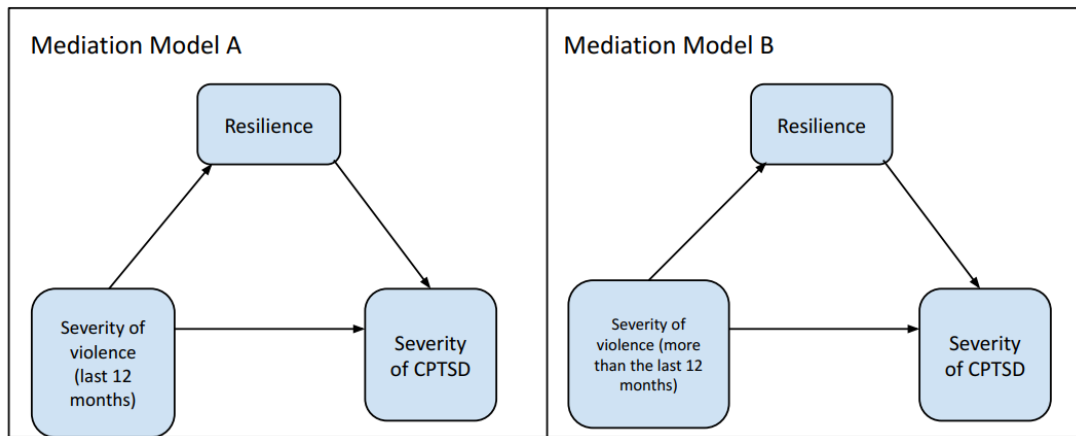
the factors (López-Aguado & Gutiérrez-Provecho, 2019). The number of factors to retain was based on the Kaiser–Guttman rule (Guttman, 1954; Kaiser, 1960; 1961) (eigenvalues > 1). If more than one factor was retained, an oblique rotation (Promax) was to be used, and no rotation would be employed if one factor was retained.

Once we knew the number of factors of the CD-RISC in our sample, we explored the role of resilience in the relationship between severity of violence (measured in two periods) and CPTSD severity, we used the Statistical Package for the Social Sciences, version 26.0 (SPSS; IBM Corp., 2019). We carried out a mediation analysis with Hayes PROCESS macro for SPSS and SAS (Hayes, 2013). The conditions were examined by the bias-corrected percentile bootstrap method with 95% bias-corrected confidence interval (CI) with 10000 replacements. The indirect effect would be determined if the 95% CI does not include zero. Model 4 of Hayes PROCESS macro was employed to estimate parameters for the mediation effect.

We conducted a first mediation analysis (Analysis A) taking the severity of violence as independent variable (IV) measured in the last 12 months, the total resilience score as mediator (M) and the severity of CPTSD (made up of the sum of the six CPTSD symptoms of re-experiencing in the here and now, avoidance, current sense of threat, negative self-concept, affective dysregulation and disturbances in relationships) as dependent variable (DV). Secondly, we conducted another mediation analysis (Analysis B) with severity of violence more than 12 months as independent variable (IV), resilience total score as a mediator (M) and severity of CPTSD as a dependent variable (DV) (Figure 1 shows the figures of the proposed mediation models A and B).

Data and analyses are available on request due to the privacy and safety of research participants.

Figure 1. Proposed mediation models A and B.



CPTSD = Complex Posttraumatic Stress Disorder.

7. 3. Results

Of all women who completed the ITQ ($N = 199$), 74 (37.2%) met ICD-11 diagnostic criteria for CPTSD, 41 (20.6%) for a diagnosis of PTSD, while 84 (42.2%) did not meet the criteria for any of the diagnoses. All participants also completed the CD-RISC questionnaire ($N = 202$), 192 completed CASR-SF referred to the last 12 months and 190 completed CASR-SF referred to the period from more than 12 months ago. Table 2 shows the mean scores and standard deviations for each total measure.

Table 2. Means and standard deviations of the measures used.

	<i>N</i>	<i>M(SD)</i>	Range
Total CD RISC	202	65.23 (16.72)	0-100
Total CASR-SF (Last 12 months)	192	29.87 (16.50)	0-75
Total CASR-SF (More than the last 12 months)	190	10.94 (14.62)	0-75
ITQ PTSD	199	10.92 (6.39)	0-24
ITQ DSO	199	13.34 (6.19)	0-24
Total ITQ	199	24.26 (10.93)	0-48

Factorial structure of the CD-RISC in our sample

The results of the exploratory factor analysis describing the dimensional structure of the CD-RISC questionnaire in a sample of female survivors of IPV are shown below. Bartlett's test of sphericity was found significant ($\chi^2(300) = 1920.08, p < .001$).

Hence, the theoretical correlations between each pair of variables is not null and it is possible to proceed to factor analysis. At the same time, the value obtained for the KMO test was .9 which indicates that all the variables are accepted in the model for factorial analyses.

Using the iterated principal component extraction method, 3 factors and one component were suggested. However, only one factor had an eigenvalue greater than 1 and the other two factors showed much lower values, with the quotient between the first and second factor being very high (8.33) (Figure 2). Table 3 presents the eigenvalues of the factors, as well as the proportion of total variance that is explained by each factor, and Figure 2 presents factors' eigenvalues. Root mean squared error of approximation is (RMSEA) = .058, 90% CI = .049-.069. These results support the one-dimensional solution of CD-RISC in female IPV survivors.

Figure 2. Graphic of factors' eigenvalues.

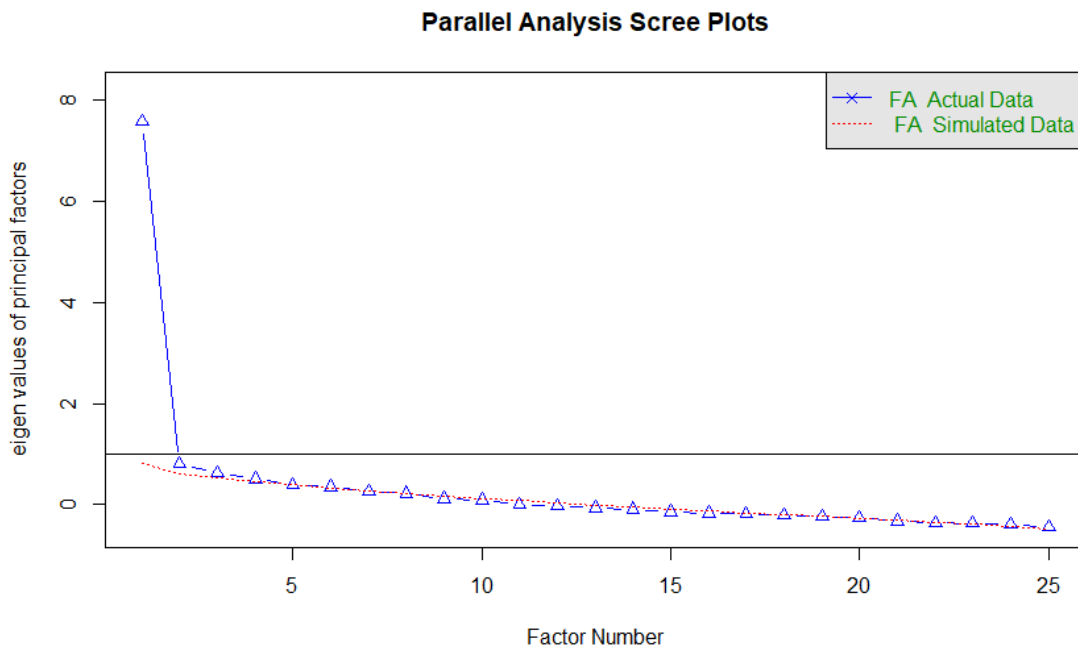


Table 3. Eigenvalues of the factors and proportion of total variance that is explained by each factor.

Factor	Eigenvalue	% Variance
1	7.66	31
2	.92	4
3	.73	3

The Mediating effect of Resilience in the relationship between Severity of Violence and CPTSD

It was hypothesised that the level of resilience would mediate the relationship between severity of violence and CPTSD.

Analysis A (N = 192)

Severity of violence (last 12 months) was related to CPTSD severity ($\beta = .139, p = .039$) (see Model 1 in Table 4). Secondly, severity of violence measured in the last 12 months was not associated with resilience ($\beta = -.093, p = .265$) (see Model 2 in Table 4). Thirdly, resilience was associated with CPTSD symptoms ($\beta = -.251, p < .001$) (see Model 3 in Table 4). Simultaneously, the direct effect of severity of violence on CPTSD symptoms in presence of the mediator of resilience was also found significant ($b = .139, p = .003$). Finally, the indirect effect of severity of violence via resilience in CPTSD wasn't significant ($ab = .023, SE = .047, 95\% CI = [-.022, .073]$) (Figure 3 shows mediation model A results). Anova results of mediation model A are shown in Table 6.

Table 4. Mediation model A (N = 192)

	Model 1 (CPTSD)		Model 2 (Resilience)		Model 3 (CPTSD)	
	β	<i>t</i>	β	<i>t</i>	β	<i>t</i>
Severity of violence (last 12 months)	.139*	2.292	-.093	-1.117		
Resilience					-.251*	-6.077

CPTSD = Complex Posttraumatic Stress Disorder.

Analysis B (N = 190)

The results are similar when the independent variable was the severity of violence was more than the last 12 months. Severity of violence more than the last year was associated with CPTSD symptoms ($\beta = .114, p = .008$) (see Model 1 in Table 5). At the same time, severity of violence (more than the last 12 months) was not related to the mediator (resilience) ($\beta = -.039, p = .5970$) (Model 2 in Table 5). In addition, resilience was related to CPTSD severity symptoms ($\beta = -.256, p < .001$) (Model 3 in Table 5). In turn, the direct effect of severity of violence on CPTSD symptoms in presence of the mediator of resilience was also found significant ($b = .114, p = .008$). And finally, the indirect effect

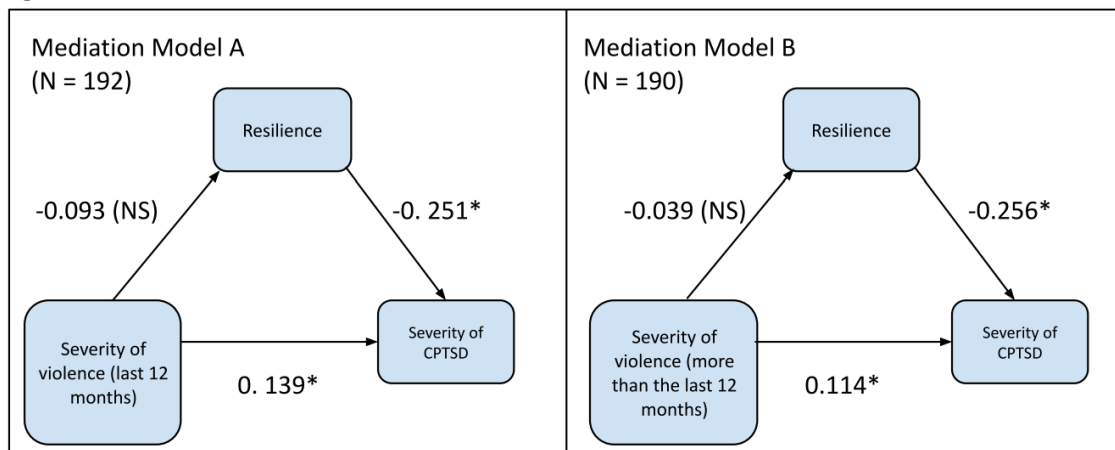
of severity of violence (more than the last 12 months) via resilience in CPTSD was not significant ($ab = .010, SE = .0200, 95\% CI = [-.028, .051]$) (Figure 3 shows mediation model B results). Anova results of mediation model B are shown in Table 6.

Table 5. Mediation model B (N = 190)

	Model 1 (CPTSD)		Model 2 (Resilience)		Model 3 (CPTSD)	
	β	t	β	t	β	t
Severity of violence (more than the last 12 months)	.114*	2.670	-.039	-.529		
Resilience					-.256*	-6.172

CPTSD = Complex Posttraumatic Stress Disorder.

Figure 3. Results of mediation models A and B.



NS = No significant; CPTSD = Complex Posttraumatic Stress Disorder.

Table 6. Anova results of mediation model A and model B.

Model	Variable	F	R ²	df1	df2	p
Mediation model A	Resilience (CD-RISC)	1.14	.065	1	190	.265
	CPTSD	24.33	.205	2	189	< .001
Mediation model B	Resilience (CD-RISC)	.28	.0015	1	188	.597
	CPTSD	23.28	.199	2	187	< .001

7. 4. Discussion

The main objective of this study was to explore the association between severity of IPV in different periods and the severity of ICD-11 CPTSD symptoms mediated by resilience in a sample of female IPV survivors. Our results showed that there was a direct

relationship between the severity of violence and the severity of CPTSD symptoms, and that there was a significantly inverse relationship between levels of resilience and the severity of CPTSD symptoms. On the other hand, there was no direct relationship between the severity of violence and resilience, suggesting there is no mediation of resilience between violence severity and CPTSD severity. The present results are detailed and explained below.

Regarding the direct relationship between the severity of violence and the severity of CPTSD symptoms, these results are in line with previous studies conducted with female survivors of IPV with PTSD diagnosis (Chandra et al., 2009; Ferrari et al., 2016; Varma et al., 2007) and other populations with CPTSD caused by severe traumas such as interpersonal and repeated violence, namely survivors of sex and labour trafficking and adults exposed to childhood abuse and neglect (Cloitre et al., 2019; Ho et al., 2021; Hopper & González, 2018; Karatzias et al., 2017b; Tian et al., 2021). As indicated above, there is only one study that explored the relationship between severity of violence and CPTSD in this population (Fernández-Fillol et al., 2021). Specifically, this study sought to know whether the severity of violence, understood as the amount of physical, psychological and sexual violence received in two different periods, could be a risk factor for meeting criteria for the six symptoms of CPTSD. However, as noted above, in this study there was no association between the severity of violence and the presence or absence of CPTSD symptoms. This may be due to the fact that CPTSD was not measured in the same way in both studies. In the present study, CPTSD was measured as a continuous variable and in the previous study, CPTSD was measured as a dichotomous variable (presence/absence).

Due to the fact that there were no differences between the two mediation models (less than 12 months or more than 12 months) in terms of the severity of violence's period, we can assume that severity of violence is associated directly to CPTSD symptoms severity, when violence happens in the last year or more than 12 months. These results do not accord with previous findings suggesting that the longer since the time of trauma, PTSD symptoms are less related to the severity of trauma (Badour et al., 2017). It may be that the reason for this non-difference from one period to another is related to the severity of the trauma. In this sense, while the diagnosis is not directly

related to the type of trauma, it may be related to the severity of the CPTSD symptoms (Chapman et al., 2012; Kessler et al., 1995).

In parallel, both mediation analyses coincide in the significantly inverse relationship between resilience levels and CPTSD symptom severity. Therefore, lower levels of resilience are related to higher severity of CPTSD symptoms. These results are in agreement with previous literature about resilience in female IPV survivors with DSO symptoms (Fernández-Fillol et al., 2021) and other populations survivors of interpersonal trauma with CPTSD (Alie-Poirier et al., 2020; Hébert & Amédée, 2020; Hyland et al., 2018a; Shrira et al., 2019). This inverse relationship with CPTSD symptoms may occur because low resilience has been shown to relate not only to classic PTSD symptoms (Anderson et al., 2012), but also to dysregulation, self-esteem and social relationships after trauma (Gao et al., 2019; Poole et al., 2017). Thus, these results suggest that resilience protects against the development of more severe CPTSD. If this is the case, then finding ways to improve resilience may prevent the development of CPTSD symptoms.

Simultaneously, our results suggest that there is no direct relationship between severity of violence and resilience. These results are contrary to our hypothesis based on previous studies on resilience and severe trauma (Howell et al., 2010; Klasen et al., 2010; Margolin & Gordis, 2004; Nishimi et al., 2020; Portnoy et al., 2018). We could consider that this inverse relationship between these two variables is not significant because, in our study, resilience is measured in the present and the severity of violence is assessed retrospectively. Therefore, it is possible that changes in resilience may have occurred between the trauma period and the moment of the assessment. In the case of female survivors of IPV, the changes and reconstruction in resilience after violence may happen as a result of, for example, physical activity, self-discovery, informal social support, and formal social support (López-Fuentes & Calvete, 2015). Most women survivors in our sample may also be part of therapy groups in the centres from which they were recruited. These support groups may have also helped them to learn about IPV, recognise the abuse, share their experiences, and advocate and support their peers, which could contribute to improving their resilience in this period (Crann & Barata, 2021).

Another secondary result of this study was the factor structure of the CD-RISC in a sample of Spanish women suffering IPV. The results of our study are consistent with other studies which have likewise found a one-dimensionality of CD-RISC in other populations, such as a census sample from several cities in Australia (Burns & Anstey, 2010), a post 9/11 US military population (Green et al., 2014) and general and non-clinical Spanish samples (Arias-González et al., 2015; García-León et al., 2019). This is supported by Green et al. (2014), who recommends not using CD-RISC factors as independent subscales. Thus, sub-dimensioning the CD-RISC is no more supported than separating different aspects of the same unidimensional operational construct (Arias-González et al., 2015; García-León et al. 2019). It was also quite interesting that the results in our sample are similar to those obtained in other samples in the Spanish population (Arias-González et al., 2015; García-León et al., 2019). However, this similarity does not occur in Chinese, Australian, or US samples (Burns & Anstey, 2010; Connor & Davidson, 2003; Mealer et al., 2016; Perera & Ganguly, 2016; Wu et al., 2017; Xie et al., 2016; Yu et al., 2011). Therefore, the results prior to this study and those obtained in the present work on the factor structure of this construct indicate that the number of resilience factors varies widely across developmental, social, cultural, and environmental contexts (Green et al., 2014). For this reason, it would be appropriate to consider and examine the role of cultural, contextual, and environmental factors in the factor structure of resilience. Hence, our results require replication in additional diverse samples of IPV.

7. 5. Limitations and future directions

The sample size is the main limitation of this study. There is a need to replicate these findings in a larger sample of women survivors of IPV and in other interpersonal violence survivor populations. Another limitation of this study is its cross-sectional design, which does not allow for causal relationships to be established. This could also pose difficulties in understanding how we measure the severity of violence at two different prior times. However, in trauma studies, especially those involving prolonged interpersonal violence, the only method of data collection is post-trauma. It is not possible to collect information on the severity of the violence during the experience of the violence or once the women denounce or report it to institutions. Therefore, the

difficulties that arise in the completion of this test have been addressed with the help of a psychologist, either online or in person, who helps to situate the participants temporally in the questions corresponding to the different periods and with very specific and precise questions (asking first whether or not they have suffered that particular experience and then specifying the severity of violence received for that particular type of violence in the specific time range). Finally, in terms of resilience assessment, more longitudinal research is needed to explore how resilience develops over time, whether participants receive resilience-enhancing treatments, and how this may protect against CPTSD following traumatic life events.

7. 6. Conclusion

In summary, our results suggest that severity of violence and resilience are directly and independently related to the severity of CPTSD symptoms. In our sample, there is no indirect effect of violence severity and CPTSD symptoms mediated by resilience. This would imply that, indeed, the severity of IPV (physical, sexual and/or psychological violence jointly or in isolation) leads to symptoms of CPTSD. At the same time, our findings suggest that resilience is a protective factor, as higher levels of resilience were related to lower levels of CPTSD symptoms. This suggests that future studies should explore other mediating or moderating variables between severity of violence and resilience and investigate the role of resilience-focused treatments in enhancing resilience.

Capítulo 8.

ICD-11 Complex Post Traumatic Stress Disorder (CPTSD) symptoms and emotion regulation strategies in a sample of women IPV survivors: A network analysis

Este estudio se encuentra en preparación para ser enviado y publicado como:

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8. 1. Introduction

Intimate partner violence (IPV) is one of the leading causes of death and disability worldwide, and in Spain it has a prevalence of 32.4% (Ministry of Health, Social Services and Equality, 2020; WHO, 2013). Since it is a type of interpersonal violence and from which it is difficult or impossible to escape, one of the possible mental consequences of this type of violence is complex post-traumatic stress disorder (CPTSD) (Fernández-Fillol et al., 2021; Hyland et al., 2018b). This disorder is characterised by symptoms of re-experiencing, avoidance, current sense of threat, and disturbances in self-organisation (DSO: affective dysregulation, negative self-concept, and the cluster of disturbances in relationships) (WHO, 2018). Taking these variables into account, Fernández-Fillol et al. (2021) examined the prevalence of PTSD and CPTSD in women survivors of IPV and found a higher prevalence of CPTSD (39.5%) compared to PTSD (17.9%). These results are consistent with previous literature on IPV, which indicate that women who have experienced IPV report problems with emotions, self-concept, social relationships, and the use of emotion regulation strategies (Lilly & Lim, 2012; Matheson et al., 2015; St. Vil et al., 2018). Nevertheless, the relationship between CPTSD symptoms and emotion regulation strategies is unknown. Hence, this study aims to investigate the relationship of emotion regulation strategies with CPTSD symptoms, especially with symptoms of emotional dysregulation.

Emotion regulation strategies are defined as an implicit or explicit attempt to modify one's own emotional response (Werner & Gross, 2010). It has been observed that there is a relationship between the inadequate use of emotional regulation strategies and self-esteem (Hsieh & Stright, 2012; Teixeira et al., 2015), and emotional (Garnefski et al., 2002; 2007) and interpersonal problems (Barthel et al., 2018; Kuzuku, 2016; Orobio de Castro et al., 2003). Moreover, inadequate use of emotion regulation strategies is related to the development, severity, and persistence of mental disorders such as PTSD (Chang et al., 2018; Cloitre et al., 2005; Moore et al., 2008; Short et al., 2018; Weiss et al., 2012). Specifically, the use of the expressive suppression strategy has been linked to the development of symptoms in a number of pathologies (McRae and Gross, 2020). In this vein, the most recent literature on CPTSD has shown that emotional regulation problems, negative self-concept, and relationship disturbances (DSO) are

related to the inadequate use of emotional regulation strategies following trauma. Specifically, symptoms of DSO and child maltreatment have been found to be indirectly related through emotional regulation (Knefel et al., 2019) or mediated by the latter factor (Haselgruber et al., 2021). Notably, the maladaptive emotional regulation strategy of suppressing expression, understood as efforts to conceal, inhibit, or reduce emotional expression, is significantly related to receiving a diagnosis of CPTSD (Karatzias et al., 2018b).

At the same time, affective dysregulation is one of the most studied CPTSD symptoms (Karatzias et al., 2016; Simon et al., 2019). The literature on affective dysregulation symptoms of CPTSD indicates that emotional regulation problems manifest themselves in hyperactivation (e.g., heightened emotional reactivity and anger outbursts) or hypoactivation (e.g., feeling emotionally numb or dissociated), being part of the same factor (Hyland et al., 2017b; Maercker et al., 2013; Karatzias et al., 2016). Some studies on patients suffering CPTSD have shown that hyperactivation and hypoactivation symptoms are relatively independent; and the correlation between these symptom clusters was lower than many other factor correlations such as re-experiencing and avoidance. Moreover, in studies where these symptoms have been observed in adult populations who have been exposed to armed conflict, problems of emotional hyperactivation are greater than those of hypoactivation (AD hyperactivation = 14.2%, AD hypoactivation = 5.7%) (Karatzias et al., 2018a) (AD hyperactivation = 20%, AD hypoactivation = 8.4%) (Ben-Ezra et al., 2018).

In the case of women survivors of IPV, one study conducted in women suffering IPV indicates that higher levels of emotional regulation difficulties were associated with more severe PTSD symptoms (Lilly & Lim, 2012). However, so far only one study has reported the relationship between IPV and CPTSD (Fernández-Fillol et al., 2021). This study found that the use of maladaptive emotional regulation strategies, such as suppression of expression, was a risk factor for DSO symptoms and made the difference between presenting CPTSD or PTSD in this population. Nevertheless, the relationship between emotional regulation strategies and the severity of CPTSD symptoms in this population provides a unique opportunity to study the relationship between affective dysregulation and emotional regulation strategies. Unlike other populations in which

hyperactivation have been investigated, women IPV survivors tend to exhibit more hypoactivation emotional problems such as shame (Beck et al., 2011; McCleary-Sills et al., 2016; Thaggard & Montayre, 2019), guilty (Beck et al., 2011; Nagae & Dancy, 2010) or alexithymia (Mannarini et al., 2021). Thus, studying regulation strategies related to hypoactivation emotional problems in this population is particularly of interest.

8. 1. 1. Objectives and hypotheses

For this reason, the aim of this study is to determine the relationship between emotional regulation strategies and DSO symptoms in a population of female survivors of IPV. Furthermore, this study is focused on to investigate the role of emotional hyperactivation and hypoactivation problems in this population in relation to the rest of the CPTSD symptoms and emotional regulation strategies, measured simultaneously through the International Trauma Questionnaire (ITQ; Cloitre et al., 2018) and the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003).

We hypothesise that DSO symptoms will be positively related to the maladaptive strategies of suppression of expression and more negatively related to the strategy of cognitive reappraisal, bearing in mind that the literature has linked the strategy of suppressive expression to the presence of psychopathology (McRae & Gross, 2020) and the use of this strategy would made the difference between PTSD and CPTSD in female survivors of IPV (Fernández-Fillol et al., 2021). In case of symptoms of affective dysregulation, we consider that hypoactivation will play a more central role in the relationships under study than hyperactivation. Therefore, we consider a predominance of emotional hypoactivation problems in the case of female IPV survivors.

8. 2. Method

8. 2. 1. Participants and procedures

Participants were 317 women survivors of IPV (physical, sexual and/or psychological) perpetrated by former partners. None of them were still in a relationship or lived with the perpetrator for at least a month. Users were recruited from women's centres from ten different regions of Spain. They were over 18 years old ($N = 322$, $M = 42.47$ years old; $SD = 11.23$; age range: 19-75) and they spoke and wrote fluent Spanish.

They had a $M = 14.76$ of academic years in education ($N = 312$; $SD = 6.46$) and 71.55% shared children with their violent ex partners. Women who have not suffered IPV from their partner/ex-partner, being under 18 years old and not being able to read or understand and write in Spanish, could not participate in this study. The sample was composed entirely of women residents in Spain. Four participants were unable to take part in the assessment due to severe symptoms of disorientation and memory loss and problems in understanding the questions due to the language. Table 1 shows other socio-demographic and violence-related information

The study was approved by the Ethics Committee of the University of Granada (933/CEIH/2019. Ethics Committee on Human Research, CEIH) and the data were collected after agreeing on a collaboration with the centres and associations where women attended. First, information about the study was given and collaboration was proposed. In the case of non-governmental associations, permission was given by the associations themselves. Centres dependent on regional or local governments needed permission from the authorities in order to be able to participate. Women who agreed to receive information about the study were contacted by members of our research team and requested informed consent. Participation in the study was voluntary and participants could withdraw at any time.

Assessment consisted of completing a brief interview and self-reporting questionnaires and participants were assessed by at least one psychologist. The data collection period was from November 2019 to May 2022. Participants did not receive incentives or payments for their participation. Confidentiality was kept and guaranteed according to the Spanish legislation on personal data protection (Organic Law 3/2018, December 5).

Table 1. Socio-demographic and violence data.

	<i>N</i>	%
University studies	99	31.2 %
No university studies	99	68.8 %
Currently studying	121	38.2 %
Intimate partner violence	317	100 %

Psychological violence	314	99.1 %
Psychological and physical violence	216	68.1 %
Psychological, physical and sexual violence	119	37.5 %
Other traumatic event	145	45.7 %
Other interpersonal trauma	63	19.9 %
Children witness of IPV	133	42 %
Moving to a new home to get away from the perpetrator	159	50.2 %
Currently she knows where the abuser lives	251	79.2 %
Current legal proceeding with perpetrator	191	60.3 %
Current perpetrator restraining order	119	37.5 %
Perpetrator currently in prison	15	4.7 %
Contact for minor children in common	65	20.5 %
Contact by children of legal age	23	70.3 %

8. 2. 2. Measures

Socio-demographic and violence-related interview

A self-reported structured interview developed for the purposes of this research. In this interview, socio-demographic (date of birth, information about children, school attendance, level of education, current education) and violent relationship data were collected. For instance, types of violence suffered, duration of the violence, previous trauma and its type, current relationship status and contact with perpetrator due to legal issues such as parenting custodies, restraining order or prison (i.e. Are you currently in any kind of legal proceedings with your partner/ex-partner?; Do you and your partner/former partner have children in common?; Are your children under 18 years old?; Does he currently have a restraining order?; Has your partner/ex-partner been or is currently in prison?).

ICD-11 CPTSD and PTSD

The International Trauma Questionnaire (ITQ: Cloitre et al., 2018) is a brief measure of CPTSD developed according to ICD-11 (WHO) criteria. The ITQ was used to

measure PTSD and CPTSD and as the original version includes 18 items. Symptom severity is measured on a scale of 0 to 4 where 0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quit a bit and 4 = Extremely. In turn, this test allows for the diagnosis of PTSD and CPTSD. PTSD diagnosis requires the endorsement of one of two symptoms (scores ≥ 2) from each PTSD cluster, plus endorsement of functional impairment associated with these symptoms. Diagnosis of CPTSD requires the endorsement of all the six PTSD and DSO clusters, plus endorsement of functional impairment associated with these symptoms. According to the ICD-11 taxonomic structure, ITQ only allows one diagnosis of PTSD or CPTSD, but not both. The internal reliability for both scales is satisfactory, with Cronbach's $\alpha \geq .79$. In this case, the present sample has a Cronbach's $\alpha = .90$.

Emotion Regulation

The Emotion Regulation Questionnaire (ERQ) (Gross & John, 2003) was used to evaluate the participants' emotion regulation strategies. This is a 10-item scale designed to measure the tendency of respondents to regulate their emotions in two ways: cognitive reappraisal as an adaptive strategy and expressive suppression as maladaptive strategy. The response to each item is given on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). A higher total score on the cognitive reappraisal subscale means a greater use of adaptive emotion regulation strategies and a higher total score on the expressive suppression subscale means a greater use of maladaptive emotion regulation strategies. The reliability of the subscales in the validated Spanish version is similar and as adequate as the original version, with Cronbach's $\alpha = .75$ for emotional suppression and $.79$ for cognitive reappraisal strategies (Cabello et al., 2012). In our sample the Cronbach's $\alpha = .77$ for emotional suppression and $.83$ for cognitive reappraisal strategies.

8. 2. 3. Data analysis

To examine the relationships between emotional regulation strategies and CPTSD symptoms, and the role of each strategy and symptom simultaneously in a sample of female IPV survivors, we conducted a network analysis. Specifically, we used the R package "qgraph" (Epskamp et al., 2012) to estimate a network using the ITQ

(Cloitre et al., 2018) and ERQ (Gross & John, 2003). We included the 12 ITQ items referring to the symptoms that make up PTSD and the 10 items defining adaptive and maladaptive emotion regulation strategies.

The present network is made up of nodes representing each PTSD symptom and emotional regulation strategy, which are connected by lines called edges that represent the associations between symptoms and strategies. Thicker edges represent stronger associations between nodes, blue edges correspond to positive correlations and red edges to inverse correlations. The nodes are ordered according to the expected influence with which they are associated with each other. The most central node in terms of strength that refers to the sum of weights that are connected to the focal node. Thus, the most strongly correlated nodes tend to be located in the central part of the network, and the least correlated ones in the periphery of the network (Epskamp et al., 2012). We use the `getWmat` function of “`qgraph`” to obtain a matrix of partial correlations and the `EBICglasso` function to compute a sparse gaussian graphical model with the graphical lasso (Friedman et al., 2008).

Additionally, we analysed the centrality of the nodes. The centrality of the network refers to the importance of each symptom within the network, the influence and number of connections a node has with other nodes. Centrality can therefore indicate the clinical relevance of a symptom or strategy within the present network and corresponds to the absolute sum of the weights of the edges. There are different types of centralities (betweenness, closeness, strength and expected influence). However, in the case of psychological networks, betweenness and closeness centrality seem particularly inadequate as measures of node importance (Bringmann et al., 2019). Thus, the most suitable for psychological networks is strength, which is defined as the sum of the absolute value of all edge weights of a node (Opsahl et al., 2010). Expected influence is similar to strength, but takes the directionality (i.e., if an edge weight is negative or positive) into account by removing the usage of absolute values of edge weights when computing a node’s strength in favour of actual values (Robinaugh et al., 2016; Spiller et al., 2020).

Therefore, the expected influence of bridges between symptom clusters was calculated to obtain centrality using the R package "networktools" (Jones et al., 2019). To obtain the centrality indices in the network, we applied the centralityPlot function from the "qgraph" package.

Also, we used the R package "bootnet" to assess individual network stability, expected influence centrality, edge stability and difference in edge weights. Therefore, the functionality of the bootnet package is used to estimate network structures and evaluate their accuracy (Epskamp et al., 2018). The bootstrap of 95% confidence intervals around network edge weights allows the estimation of a correlation stability coefficient for centrality metrics, with values above 0.5 implying strong stability; edge weight differences; and centrality differences (Astill Wright et al., 2021). The coefficient corStability also within the R package "bootnet" indicates the estimated maximum number of cases that can be removed from the data to retain, with 95 % probability, a correlation of at least .7 (default) between the original network-based statistics and the statistics computed with fewer cases. This coefficient should not be lower than .25 and preferably higher than .5. To plot the stability of the centrality we used the plotting method plot(boot2). We used the nonparametric bootstrap with 1000 samples to obtain the edge-weight accuracy and this can be set by using the argument nBoots. Finally, For the significant difference test we used the differenceTest function to compare edge weights and centralities using the bootstrapped difference test (Epskamp et al., 2018).

Data and analyses are available on request due to the privacy and safety of research participants.

8. 3. Results

A total of 317 women who completed the ITQ, 139 (43.84%) met ICD-11 diagnostic criteria for CPTSD, 66 (20.82%) for a diagnosis of PTSD, while 112 (35.33%) did not meet the criteria for any of the diagnoses. All participants also completed the ERQ questionnaire referring to adaptive ($M = 28.6$; $SD = 8.37$; range = 6-42) and maladaptive ($M = 16.07$; $SD = 6.29$; range = 4-28) emotional regulation strategies. Table 2 shows the mean scores and standard deviations for each of the ITQ and ERQ items.

Table 2. Cluster and symptoms of CPTSD, ERQ emotion regulation strategies, means and standard deviations of both measures.

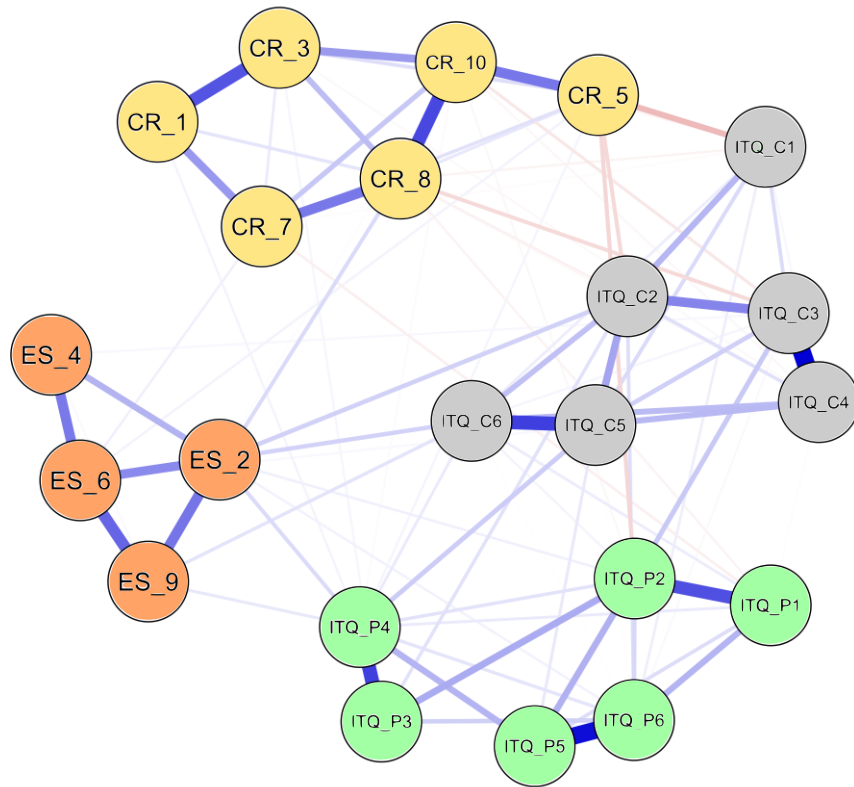
ITQ clusters and ERQ subscales	ITQ symptoms and ERQ strategies	<i>M(SD)</i>	Range
ITQ - Re-experiencing (Re)	ITQ P1 = distressing dreams	1.84 (1.37)	0-4
	ITQ P2 = intrusive recollections	2.12 (1.26)	0-4
ITQ - Avoidance (Av)	ITQ P3 = internal avoidance	2.54 (1.12)	0-4
	ITQ P4 = external avoidance	2.60 (1.27)	0-4
ITQ - Current sense of threat (Th)	ITQ P5 = hypervigilance	2.54 (1.38)	0-4
	ITQ P6 = exaggerated startle response	2.53 (1.34)	0-4
ITQ - Affective dysregulation (AD)	ITQ C1 = long time to be able to stay in calm	2.02 (1.03)	0-4
	ITQ C2 = emotional numbing	2.43 (1.23)	0-4
ITQ - Negative self-concept (NSc)	ITQ C3 = feelings of failure	1.99 (1.41)	0-4
	ITQ C4 = feelings of worthlessness	1.55 (1.40)	
ITQ - Disturbances in relationships (DR)	ITQ C5 = feeling distant or cut off from others	1.90 (1.35)	0-4
	ITQ C6 = difficulties feeling close to others	1.87 (1.37)	0-4
ERQ - Cognitive Reappraisal (CR)	CR 1 = When I want to feel more positive emotion, I change what I'm thinking about.	4.85 (1.96)	1-7
	CR 3 = When I want to feel less negative emotion, I change what I'm thinking about.	5.01 (1.89)	1-7
	CR 5 = When I'm faced with a stressful situation, I make myself think about it in a way that helps me stay calm.	4.79 (1.94)	1-7
	CR 7 = When I want to feel more positive emotion, I change the way I'm thinking about the situation.	4.69 (1.92)	1-7
	CR 8 = I control my emotions by changing the way I think about the situation I'm in.	4.70 (1.85)	1-7
	CR 10 = When I want to feel less negative emotion, I change the way I'm thinking about the situation.	4.64 (1.89)	1-7
ERQ - Suppressive Expression (ES)	ES 2 = I keep my emotions to myself.	4.80 (1.95)	1-7
	ES 4 = When I am feeling positive emotions, I am careful not to express them.	3.12 (2.07)	1-7
	ES 6 = I control my emotions by not expressing them.	3.78 (2.05)	1-7
	ES 9 = When I am feeling negative emotions, I make sure not to express them.	4.37 (2.06)	1-7

All assessments were done under the supervision of at least one psychologist. Most were done online, but as some women had problems with resources to have a device or were not comfortable with the technology, some of them preferred to do it in paper format. In the online format there was no loss of data due to the compulsory nature of the questions. However, in those who completed the paper version, 10 participants were excluded because they had not completed the ITQ or ERQ. Therefore, of the initial 327 participants, data from 317 were considered in our analysis.

Network structure, stability of centrality indices and stability of edge weights

Figure 1 shows network depiction of associations among CPTSD symptoms and emotion regulation strategies. The most central node in terms of expected influence belonged to the DSO symptom cluster. Concretely, “feeling distant or cut off from others” (ITQ C5). The following most central nodes according to centrality were ITQ P6 (exaggerated startle response), ITQ P4 (external avoidance) and ITQ C6 (difficulties feeling close to others). In the case of emotional regulation, the most central node was the maladaptive strategy of suppressive emotion. Specifically, “I control my emotions by not expressing them” (ES 6). Regarding symptoms of affective dysregulation, the hypoactivation symptom ITQ C2 (I feel numb or emotionally shut down) was more central than the hyperactivation node (ITQ C1) (long time to be able to stay in calm). In fact, the least central node in the whole network is the symptom of hyperactivation (ITQ C1). Expected influence centrality values of the network are visually presented in Figure 2. Network expected influence centrality values are detailed in the supplementary material.

Figure 1. Network depiction of associations among CPTSD symptoms and emotion regulation strategies.



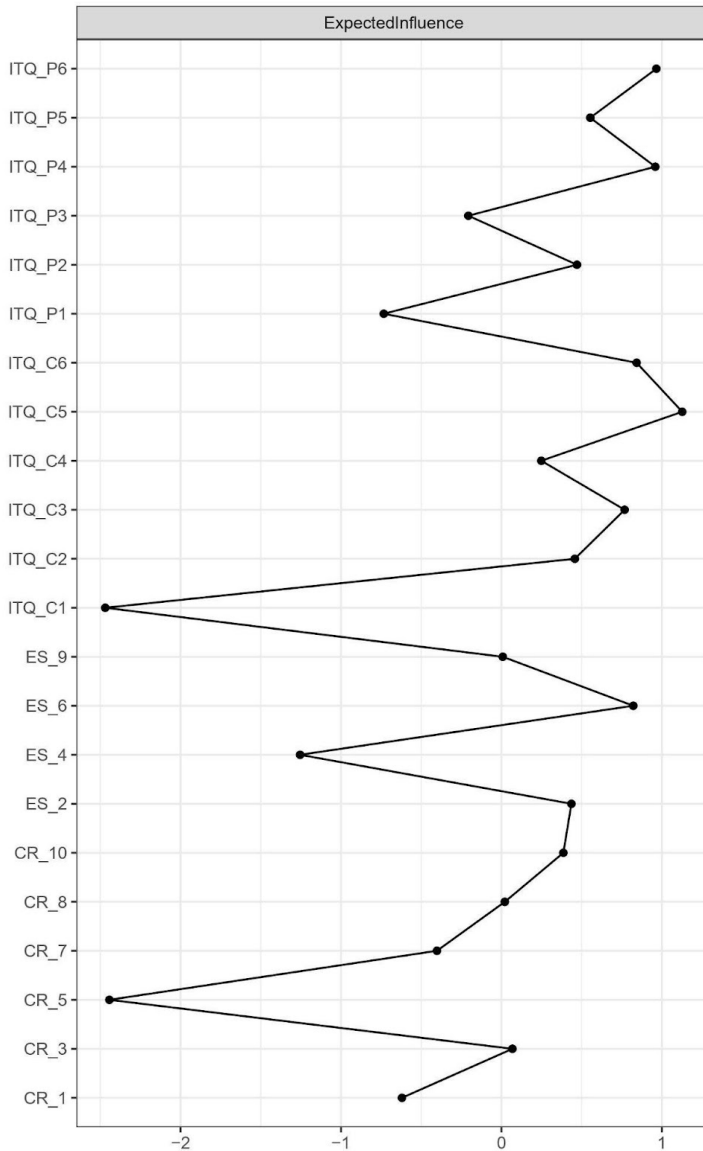
CPTSD symptoms (ITQ):

- ITQ_P1 = Re-experiencing - Distressing dreams.
- ITQ_P2 = Re-experiencing - Intrusive recollections.
- ITQ_P3 = Avoidance - Internal avoidance.
- ITQ_P4 = Avoidance - External avoidance.
- ITQ_P5 = Current sense of threat - Hypervigilance.
- ITQ_P6 = Current sense of threat - Exaggerated startle response.
- ITQ_C1 = Affective dysregulation - Long time to be able to stay in calm.
- ITQ_C2 = Affective dysregulation- Emotional numbing.
- ITQ_C3 = Negative self-concept - Feelings of failure.
- ITQ_C4 = Negative self-concept - Feelings of worthlessness.
- ITQ_C5 = Disturbances in relationships - Feeling distant or cut off from others.
- ITQ_C6 = Disturbances in relationships - Difficulties feeling close to others.

Emotion regulation strategies (ERQ):

- CR_1 = When I want to feel more positive emotion, I change what I'm thinking about.
- ES_2 = I keep my emotions to myself.
- CR_3 = When I want to feel less negative emotion, I change what I'm thinking about.
- ES_4 = When I am feeling positive emotions, I am careful not to express them.
- CR_5 = When I'm faced with a stressful situation, I make myself think about it in a way that helps me stay calm.
- ES_6 = I control my emotions by not expressing them.
- CR_7 = When I want to feel more positive emotion, I change the way I'm thinking about the situation.
- CR_8 = I control my emotions by changing the way I think about the situation I'm in.
- ES_9 = When I am feeling negative emotions, I make sure not to express them.
- CR_10 = When I want to feel less negative emotion, I change the way I'm thinking about the situation.

Figure 2. Network expected influence centrality of CPTSD symptoms and emotion regulation strategies.



Our bootstrapping procedure shows measures of network stability, centrality stability, proof of expected influence centrality (Figure 3), edge stability (Figure 4) and difference in edge weights (Figure 5). The estimation of the confidence intervals of edge weights was used to assess the stability of the network and the validity of our findings by estimating the confidence intervals of edge weights by using a bootstrapping method that estimates the robustness of the expected influence centrality measure (Fried et al., 2018).

The stability of the order of the centrality indices based on subsets of data allows us to know the accuracy of the obtained centralities. Thus, we can indicate whether the

order of the centrality indices remains the same after re-estimating the network with fewer cases or nodes. The stability of the centrality indices is obtained using the correlation stability coefficient. The correlation stability coefficient for the expected influence centrality metric in this research was .672, which is above the cut-off score of .25 and over the recommended score of .50 as a reliable indicator of stability (Epskamp et al., 2018). Therefore, the value of this coefficient indicates that the stability of the network is adequate (Cohen et al., 1977).

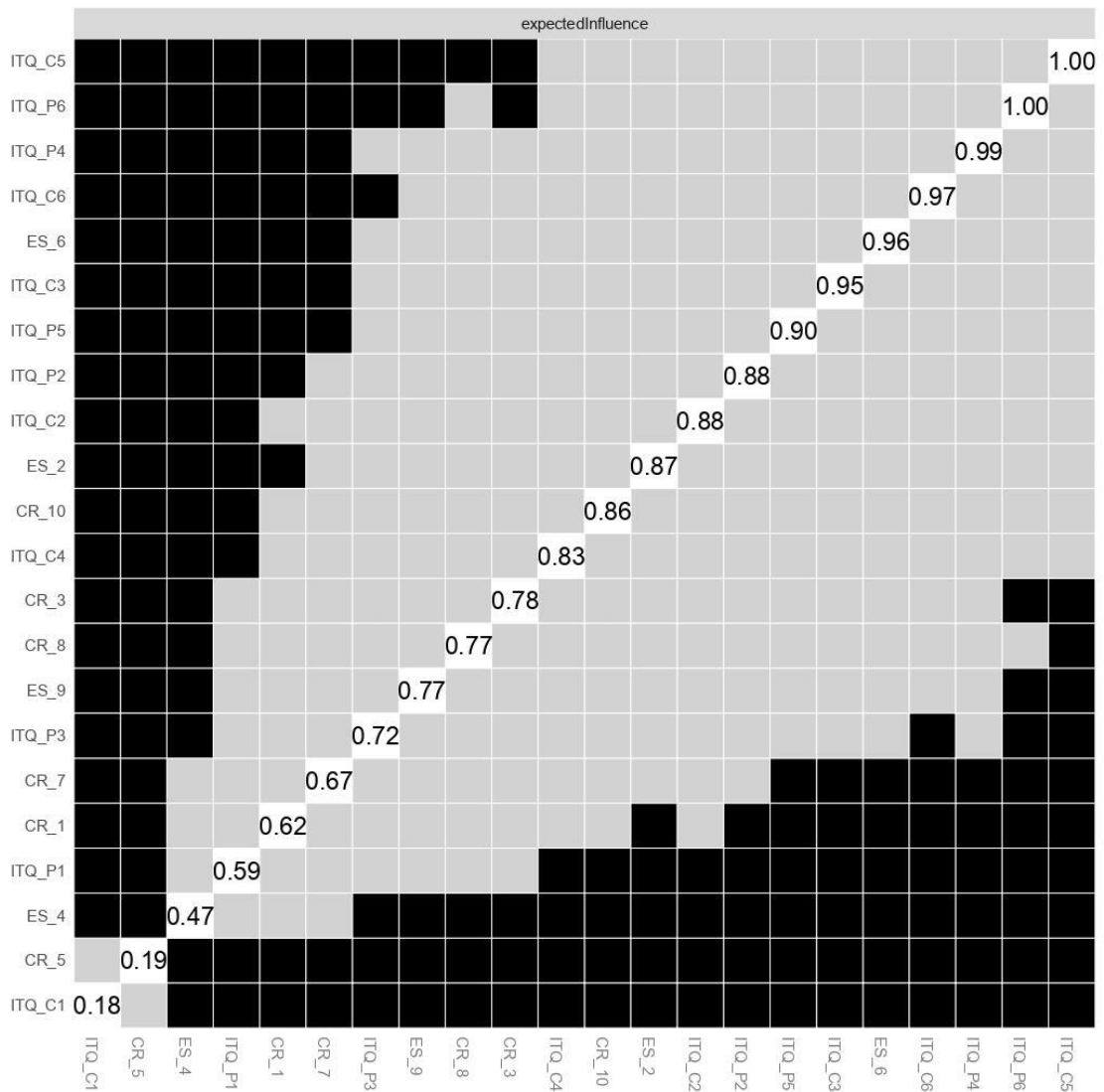
To find out whether the value of the expected influence centrality is substantially more central and to check whether the difference between the means of the nodes is significantly, we use the centrality difference test (Figure 3). In this case, for the two most central nodes (ITQ C5 and ITQ P6), the centrality difference is not significant. This would indicate that both nodes are strongly correlated with other nodes in the network (Marian et al., 2022). In contrast, for example ITQ C5 is significantly more central than ITQ P3. Between the most central node of ERQ (ES 6) and the next most central node of the same measure (ES 2), there are no significant differences in terms of expected influence centrality. However, there are differences between ES 6 and CR 7 nodes. This might suggest that expressive suppression strategies are more central than cognitive reappraisal strategies. Concerning DSO symptoms, we found no significant differences between the negative self-concept nodes (ITQ C3 and ITQ C4). We also found no significant differences between the nodes of disturbances in relationships (ITQ C5 and ITQ C6). However, we did find significant differences in the centrality of the affective dysregulation (hyperactivation and hypoactivation) nodes (ITQ C1 and ITQ C2). Therefore, within the affective dysregulation symptoms, we may conclude that hypoactivation has greater centrality strength in the whole network compared to hyperactivation. Moreover, this weight could also be intuited if we observe and compare the means of these symptoms with each other and compared to the difference of other symptoms belonging to other symptom groups (Table 2).

At the same time, edge stability allows one to know the accuracy of the edge weights (Epskamp et al., 2018). In the simple visualisation of our network (Figure 1), while certain edges appear stronger than some weaker edges, they are actually no different from each other because their 95% CIs overlap (Figure 4). This means that with

22 nodes we would prefer to have more participants and we would need another test to check the difference between edges. The edge weight observed in the network map can be tested by constructing a matrix of partial correlations with the previously mentioned `getWmat` R command (Supplementary materials). Thus, we can see that the strongest edges are ITQ C3-ITQ C4, followed by ITQ P5-ITQ P6 and ITQ C5-ITQ C6. Thus, in terms of DSO symptoms we observe that the edges between the symptoms of negative self-concept (ITQ C3-ITQ C4) and disturbances in relationships (ITQ C5-ITQ C6) are stronger than the edge between the symptoms of affective dysregulation (ITQ C1-ITQ C2). In fact, there are stronger edges between the hypoactivation symptom and other symptoms of negative self-concept (ITQ C2-ITQ C3) and disturbances in relationships (ITQ C2-ITQ C5).

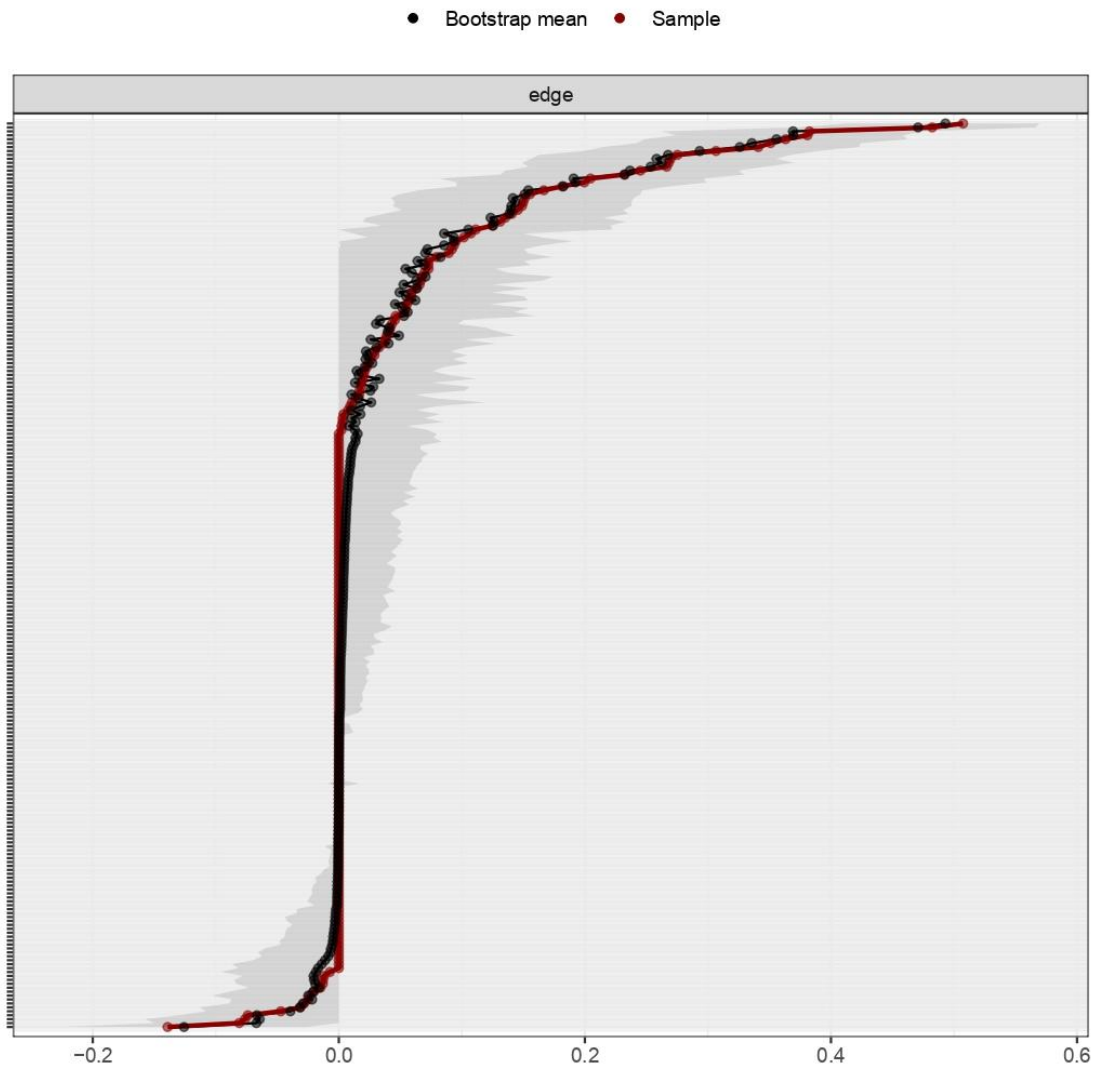
To check if the difference between the weights of the different strongest edges is significant, we will use the different edge weights test (Figure 5). Using this test, we observe that the differences between the weights of the edges ITQ C3-ITQ C4 and ITQ P5-ITQ P6 are not significant. In contrast, there are significant differences between the edge weights ITQ C3-ITQ C4 and ITQ P1-ITQ P2. Between the symptom edges of each DSO group, we observed that between affective dysregulation (ITQ C1-ITQ C2) and negative self-concept and between affective dysregulation and disturbances in relationships (ITQ C5-ITQ C6) there are significant differences in terms of weight. However, there are no significant differences between the negative self-concept and disturbances in relationships symptom edges. Simultaneously, we found no significant differences between different edges between the hypoactivation node with other nodes belonging to different DSO symptoms (long time to be able to stay in calm, feelings of failure, feeling distant or cut off from others).

Figure 3. Centrality difference test. Node expected influence of the 12 CPTSD symptoms and 10 emotion regulation strategies.



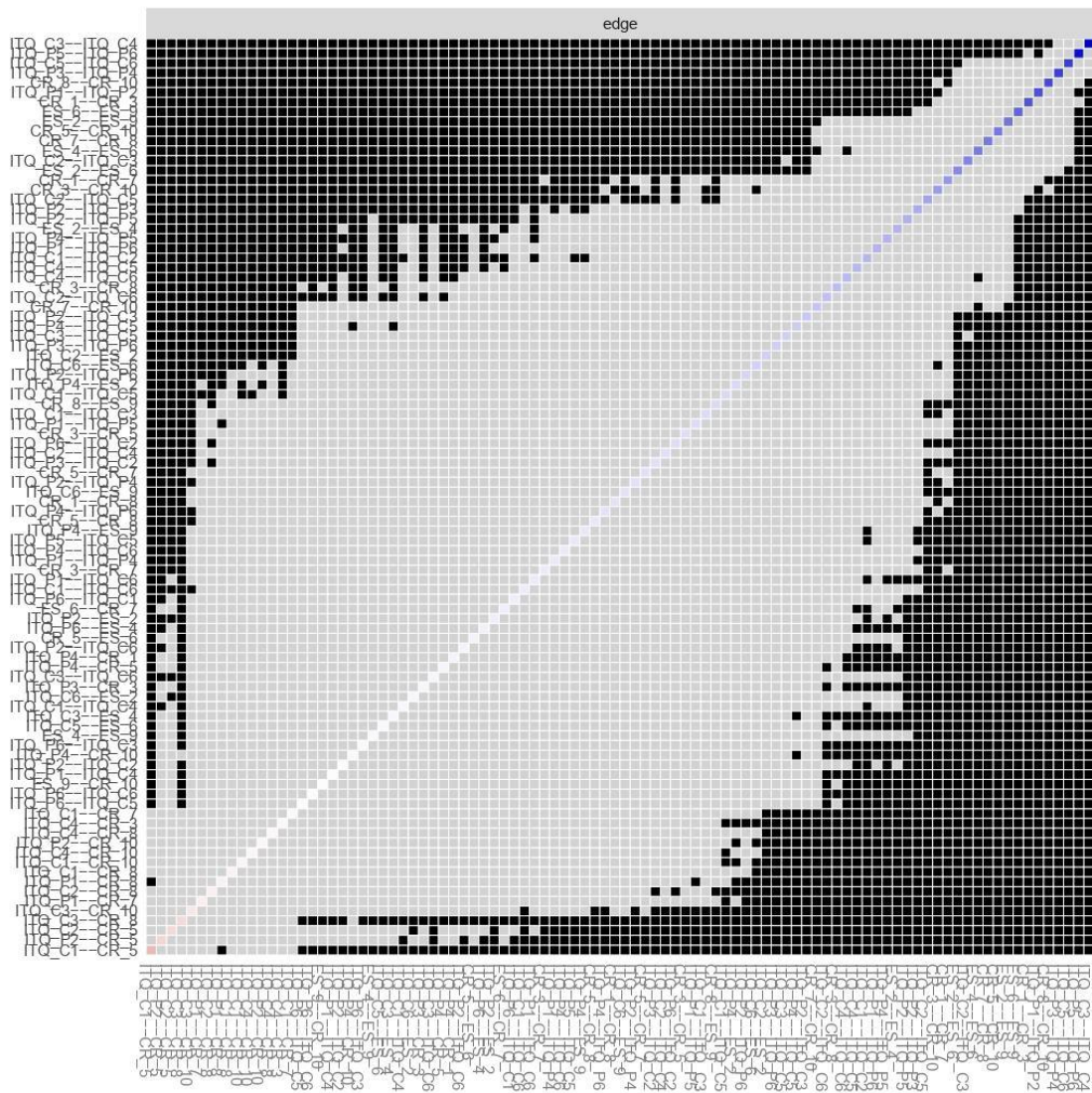
Note: Grey boxes indicate nodes or edges that do not differ significantly from one-another and white boxes show the value of node expected influence. In this case, for the two ITQ nodes ITQ C5 and ITQ P6 the box where they coincide is grey, so the centrality expected influence difference is not significant. In contrast, for example for the ITQ C5 and ITQ P3 nodes, the black box indicates that ITQ C5 is significantly more central than ITQ P6. In the case of the ERQ test, node ES6 is not more centrally significant than node ES2 but more centrally significant than node CR7.

Figure 4. Bootstrapped confidence intervals of estimated edge-weights for the estimated network of 12 CPTSD symptoms and 10 emotion regulation strategies.



Note: On the y-axis, all edges of the network are ordered from the highest edge (top) to the lowest edge (bottom). The red dots are the edge weights of the network and the grey area indicates the 95% CI around the edge weights. The more powerful the network estimation (fewer nodes/ more participants), the more reliable the estimated edges and the smaller the CI around the edges.

Figure 5. Edge-weights different test.



Note: Black boxes indicate a significant difference in weights between 2 edges.

8. 4. Discussion

The purpose of this study was to understand the relationship between emotional regulation strategies and CPTSD symptoms, targeting emotional hyperactivation and hypoactivation in female survivors of IPV. To do so, we examined a network structure that simultaneously includes these variables, as measured by the International Trauma Questionnaire (ITQ; Cloitre et al., 2018) and the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003).

In relation to the whole structure of the network, we observed a greater proximity and strength between the nodes belonging to the symptoms of the same cluster (PTSD and DSO). This result is supported by other studies on the network

structure of CPTSD and has also been found in mathematically equivalent models (Kruis and Maris, 2016), such as confirmatory factor analysis (CFA) (Ben-Ezra et al., 2018; Hyland et al., 2017b; Kazlauskas et al., 2018; Knefel et al., 2016; Knefel et al., 2019; Knefel et al., 2020; Shevlin et al., 2017). The distribution of the nodes for emotional regulation strategies has been underscored by a study conducted by Suwartono & Bintarmur (2019), where the ERQ test was validated using CFA and network analysis. Hence, emotional regulation strategies measured with the ERQ can be divided into adaptive (cognitive reappraisal) and maladaptive (suppression of expression) strategies (Gross and John, 2003). Furthermore, the network obtained is supported by evidence of network stability. Therefore, these results contribute to the literature on the stability of a CPTSD symptom network and can be interpreted with a high level of confidence.

Regarding the centrality analysis, results show that the most central node is the symptom of feeling distant or isolated from others (ITQ C5). This is consistent with findings in other populations of interpersonal violence (adult or childhood physical or sexual violence) (Knefel et al., 2019; Knefel et al., 2020). In this sample, ITQ C5 may have emerged because IPV is often marked by constant devaluation by their ex-partners, making them feel inadequate in countless interactions (Troisi and Cèsaro, 2021). This is contrary to the image of an ideal romantic relationship which is marked by a healthy and mutual bond and support (Lelaurain et al., 2021). Feeling isolated from others, in addition to gender expectations, generates feelings of discomfort, failure and worthlessness, as the victim/survivor is unable to fulfil the expectation of a successful relationship (Alsaker et al., 2016; White & Satyen, 2015). In addition, they often perceive that others judge them, make them feel like a failure or ashamed, which further contributes to social avoidance (Goffman, 1963, in Murray et al., 2018; Troisi and Cèsaro, 2021). Simultaneously, the fear of repeated abuse by others may interfere with their capacity to establish or maintain relationships (Flasch et al., 2015; St. Vil et al., 2018). This fear may cause them to adopt suppression of expression in order to avoid being judged or feel vulnerable, to secure their privacy, and protect themselves from others (Cloitre et al., 2020; Tackman and Srivastava, 2016). Furthermore, victims may also cut off communication with loved ones so that abusers do not find them (Thomas et al., 2015).

In addition, the centrality analysis confirms our hypothesis that maladaptive emotional regulation strategies (such as expressive suppression) are more strongly associated with DSO symptoms. This close relationship may occur because suppression of expression in women survivors of IPV corresponds with a breakdown in identity and the devastation of self-esteem following violence (Matheson et al., 2015) and with the emergence of altered social responses and relationships (Tackman and Srivastava, 2016). Focusing on the ERQ, the most central symptom was the maladaptive emotion regulation strategy described as "I control my emotions by not expressing them" (ES 6). This is similar to a study that analysed the ERQ network in an Indonesian sample (Suwartono & Bintamur, 2019). Among the items in the network, item ES 6 would have the most control relative to other ERQ items, and more information would pass through this item because it has strong associations with other very connected items with the rest of the nodes in the network (ES 2 - "I keep my emotions to myself"). Even though ES 2 is not the most central element, it is closer to other nodes outside the set of nodes that refer to expression suppression. Furthermore, it has a strong edge with the most central element, ES 6. In fact, ES 6 is not directly connected to the DSO symptoms. Instead, the ERQ node that is most connected to ITQ items is ES 2 ("I keep my emotions to myself"). These findings fall in line with the claim that survivors of interpersonal trauma prefer not to express themselves, probably with the aim of avoiding judgments, preserving their identity or avoiding feeling vulnerable by seeking to protect themselves from others (Cloitre et al., 2020).

In addition, ES 2 node has the strongest edge with ITQ C2, which refers to emotional hypoactivation ("I feel numb or emotionally shut down"). Emotional hypoactivation and the tendency to not express emotions be a consequence of learning to measure one's words, to be silent (Herrero-Arias et al., 2021) or less assertiveness (Orchowski et al., 2020) under the pressure of dangerous situations such as IPV. A survival learning that, even when the violent relationship is over, is transferred to safe situations. Their maintenance of this learned response may explain the consequent symptom of being alert (Litz et al., 2002).

Our results also support the hypothesis that emotional hypoactivation plays a more prominent role within the network. We observed heavy edges between negative

self-concept and disturbances in relationships, as well as between the symptoms of affective dysregulation. These findings support the resulting structure in the population of female survivors, which follows the structure proposed for DSO symptoms (Ben-Ezra et al., 2018; Cloitre et al., 2018; Karatzias 2018a). Furthermore, the edge between ITQ C1-ITQ C2 is significantly less weighted compared to other edges between DSO symptoms. This result is in agreement with previous studies indicating that both symptoms are encompassed in the symptom of affective dysregulation and are at the same time relatively independent (Ben-Ezra et al., 2018). However, in contrast to other studies, we were able to confirm the predominance of hypoactivation symptoms in women survivors of IPV. This antagonism may manifest itself in problems expressing and experiencing positive emotions. One possible explanation for this is that people who have experienced chronic traumatic stress require more intense and clearer stimulation to elicit full expressions of positive emotions (Litz et al., 2002). At the same time, this difficulty may be facilitated by cognitions such as fearfulness towards positive emotions e.g., "I find it difficult to trust positive feelings" or "happiness never lasts, when I feel happy, I am always waiting for something bad to happen" and compassion (e.g., "getting ahead in life is about being tough rather than compassionate" and "I fear that if I become more self-pitying, I will become weak") that contribute to the occurrence of negative emotions and alexithymia (Lyvers et al., 2022).

At the same time, we hypothesised that we would find a stronger inverse relationship between DSO symptoms and the adaptive strategy of cognitive reappraisal. This is consistent with previous results in terms of cognitive reappraisal observed in other CPTSD populations (Karatzias et al., 2018a). However, we observed a lower connection between DSO symptoms and adaptive cognitive reappraisal strategies than between DSO symptoms and suppressive expression. This difference could be due to expressive suppression and cognitive reappraisal being independent constructs (Moore et al., 2008). Despite the high levels of expressive suppression, this finding would explain why in our network, there were high levels of cognitive reappraisal and vice versa, but not necessarily an inverse relationship.

Finally, this network study may have clinical implications, where certain core symptoms of the obtained network could be the focus of interventions. A person-

centred approach could be adopted to treat CPTSD symptoms, which could target and prioritise the severity or salience of a particular cluster (Karatzias et al., 2020), as these symptoms are an integral part of supporting the network structure (Borsboom, 2017). Thus, taking into account the prevalence of PTSD and CPTSD, and the difficulties in emotional regulation in the present population, the proposal of cognitive, exposure-based interventions and emotional regulation in the treatment of both diagnoses is suggested (Schnyder et al., 2015). Treatment focused on emotional regulation could be centered on emotional hypoactivation through coping, acceptance and pleasurable activities. And given that the most central node obtained is "I feel distant or cut off from people," there may be particular value in incorporating the adaptive management of social relationships in treatment (Cloitre et al., 2002).

Therefore, for the specific treatment of CPTSD in female survivors of IPV, multicomponent and modular interventions could be beneficial, as has been suggested in populations of other types of interpersonal trauma (Coventry et al., 2020; Karatzias and Cloitre et al., 2019). Hence, specific treatments for women survivors of IPV who experience symptoms of CPTSD should be investigated in future studies.

8. 5. Limitations and future directions

One of the limitations of this study is the size of the study sample. Future studies with more statistical power are needed to replicate the present finding on CPTSD in this particular population. Furthermore, our sample lacked ethnic heterogeneity, as most participants were born in the same country. Therefore, it is important to confirm these findings in different cultural groups with larger samples. Thus, future research should investigate the structure of the CPTSD network in diverse populations that are also culturally and socioeconomically diverse (Knefel et al., 2019). On the other hand, given that this study focuses on the population of women survivors of IPV in Spain, it is unclear whether our results would generalise to other traumatised populations (Knefel et al., 2020). At the same time, different authors have suggested that treating the symptoms identified as most important in cross-sectional network analyses may result in the greatest overall treatment gains (McNally et al., 2015; Rodebaugh et al., 2018), and change in the most central node should be a particularly good predictor of change in the rest of the network (Robinaught et al., 2016). However, node centrality is not an

absolute measure and should be interpreted with caution and explored in detail in future intervention studies (Fried et al., 2018).

Hence, our results represent a preliminary step toward understanding CPTSD network in women survivors of IPV. Characterising the role of emotion regulation strategies on DSO symptom severity may advance our understanding of the symptom onset and evolution of CPTSD. Future research should consider investigating the association of cross-sectional (between-person) networks with longitudinal (within-person) networks. These findings would add support to the questioned replicability of network analytical studies (Knefel et al., 2019). Finally, the lack of direction in our networks in the current study may be addressed in future studies exploring mechanistic pathways between the CPTSD of IPV. As such, each emotion regulation strategy and the development or adaptation of treatments for CPTSD in women survivors may work more specifically on the DSO cluster.

8. 6. Conclusion

The present study confirms that maladaptive emotional regulation strategies such as suppression of expression are positively related to DSO symptoms. At the same time and to a lesser extent, the inverse relationship between the use of adaptive emotional regulation strategies (such as cognitive reappraisal) and DSO symptoms is also supported. Furthermore, the present study confirms a stable structure of CPTSD following the ICD-11 criteria. In addition, this diagnostic criteria allows us to know the prevalence of CPTSD and PTSD and indicates that CPTSD is the most prevalent of the two diagnoses in the present sample. Finally, it is confirmed that within the symptoms of affective dysregulation, hypoactivation plays a more prominent role than hyperactivation. Further, it also plays a more prominent role in the entire network structure, as this is the node with the most important connection in relation to suppressive strategies of expression. Therefore, this study could be the first to contribute to the support and planning of effective treatments focused on emotion regulation strategies (such as suppressive expression), emotional regulation problems, and the rest of the symptoms of DSO in the population of female survivors of IPV.

Supplementary materials

Network expected influence centrality values.

Node	Expected influence value
ITQ C5	1.12621545
ITQ P6	0.96514075
ITQ P4	0.95848668
ITQ C6	0.8421705
ES 6	0.82130091
ITQ C3	0.76751054
ITQ P5	0.55325637
ITQ P2	0.4703321
ITQ C2	0.4570474
ES 2	0.43577926
CR 10	0.38571978
ITQ C4	0.24824858
CR 3	0.06823279
CR 8	0.02112212
ES 9	0.00830976
ITQ P3	-0.20618543
CR 7	-0.40214428
CR 1	-0.62001233
ITQ P1	-0.73341349
ES 4	-1.25476965
CR 5	-2.44318593
ITQ C1	-2.46916188

Matrix of partial correlations of the weights of the network edges.

	ITQ P1	ITQ P2	ITQ P3	ITQ P4	ITQ P5	ITQ P6	ITQ C1	ITQ C2	ITQ C3	ITQ C4	ITQ C5	ITQ C6	CR 1	ES 2	CR 3	ES 4	CR 5	ES 6	CR 7	CR 8	ES 9	CR 10
ITQ P1	0	0.350	0	0.041	0.067	0.148	0	0	0	0.003	0	0.038	0	0	0	0	0	0	0.031	0.024	0	0
ITQ P2	0.350	0	0.166	0.057	0.155	0.079	0	0.003	0.107	0	0	0.022	0	0.028	0	0	-0.080	0	0	0	0	-0.012
ITQ P3	0	0.166	0	0.380	0	0.093	0	0.058 9	0	0	0	0	0	0	0.018	0	0	0	0	0	0	0
ITQ P4	0.041	0.057	0.380	0	0.149	0.053	0	0	0	0	0.101	0.041	0.021	0.072	0	0	0.020	0	0	0	0.045	0.007
ITQ P5	0.067	0.155	0	0.149	0	0.482	0	0	0	0	0.043	0	0	0	0	0	0	0	0	0	0	0
ITQ P6	0.148	0.079 3	0.093	0.053	0.482	0	0.032	0.065	0.009	0	0.002	0.002	0	0	0	0.025	0	0	0	0	0	0
ITQ C1	0	0	0	0	0	0.032	0	0.145	0.069	0.016	0.072	0.036	0	0	0	0	-0.139	0	-0.007	-0.023	0	-0.020
ITQ C2	0	0.003	0.058	0	0	0.065	0.145	0	0.245	0.062	0.181	0.124	0	0.092	0	0	-0.076	0	0	-0.028	0	0
ITQ C3	0	0.107	0	0	0	0.009	0.069	0.245	0	0.507	0.095	0.019	0	0	0	0.016	0	0	0	-0.073	0	-0.047
ITQ C4	0.003	0	0	0	0	0.016	0.062	0.507	0	0.140	0.135	0	0	0	-0.011	0	0	0	0	-0.012	0	-0.014
ITQ C5	0	0	0	0.101	0.043	0.002	0.072	0.181	0.095	0.140	0	0.382	0	0	0	0	0	0.013	0	0	0	0
ITQ C6	0.038	0.022	0	0.041	0	0.002	0.036	0.124	0.019	0.135	0.382	0	0	0.018	0	0	0	0.089	0	0	0.055	0
CR 1	0	0	0	0.021	0	0	0	0	0	0	0	0	0	0	0.340	0	0	0	0.204	0.054	0	0
ES 2	0	0.028	0	0.072	0	0	0	0.092	0	0	0	0.018	0	0	0	0.151	0	0.232	0	0	0.275	0
CR 3	0	0	0.018	0	0	0	0	0	0	-0.011	0	0	0.340	0	0	0	0.066	0	0.038	0.131	0	0.199
ES 4	0	0	0	0	0	0.025	0	0	0.016	0	0	0	0	0.151	0	0	0	0.266	0	0	0.010	0

CR 5	0	-0.080	0	0.020	0	0	-0.139	-0.076	0	0	0	0	0	0	0.066	0	0	0.023	0.058	0.04	0	0.269
ES 6	0	0	0	0	0	0	0	0	0	0	0.013	0.089	0	0.232	0	0.266	0.023	0	0.028	0	0.306	0
CR 7	-0.031	0	0	0	0	0	-0.007	0	0	0	0	0	0.204	0	0.038	0	0.058	0.028	0	0.268	0	0.111
CR 8	-0.024	0	0	0	0	0	-0.023	-0.028	-0.073	-0.012	0	0	0.054	0	0.131	0	0.046	0	0.268	0	0.072	0.363
ES 9	0	0	0	0.045	0	0	0	0	0	0	0	0.055	0	0.275	0	0.010	0	0.306	0	0.072	0	0.003
CR 10	0	-0.012	0	0.007	0	0	-0.020	0	-0.047	-0.014	0	0	0	0	0.199	0	0.269	0	0.111	0.363	0.003	0

**IV. DISCUSIÓN GENERAL,
CONCLUSIONES Y PERSPECTIVAS
FUTURAS**

Capítulo 9.

Discusión general, conclusiones y perspectivas futuras

9. 1. Discusión general

El objetivo principal de la presente Tesis Doctoral fue estudiar el trastorno de estrés postraumático complejo definido según la CIE-11 (WHO, 2018) en la población de mujeres supervivientes de VG sufrida por ex parejas, dado que este trastorno se ha estudiado en poblaciones de otros tipos de traumas y, sobre todo, en poblaciones de trauma interpersonal (Cloitre et al., 2014; Hyland et al., 2017b; Karatzias et al., 2016; Kessler et al., 2017). Sin embargo, en la población de mujeres supervivientes de VG este diagnóstico aún no se ha explorado, a pesar de que estas mujeres presentan altos niveles de TEPT (Golding, 1999; Kastello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien y Schie, 2008; Pico-Alfonso et al., 2006), informan de problemas de regulación emocional, autoconcepto negativo y dificultades en la relaciones sociales y, además, han sufrido un tipo de trauma interpersonal, crónico, de dificultad escape y con un vínculo singular con la fuente de violencia (Hyland et al., 2018b; Potter et al., 2021).

El presente trabajo se compone de cuatro estudios que analizan las propiedades psicométricas de la prueba que permite diagnosticar TEPT y TEPTC en la población de mujeres supervivientes de VG; la prevalencia de ambos diagnósticos en dicha población; los factores de riesgo asociados a la presencia de síntomas y diagnóstico de TEPT; la influencia de la severidad de la violencia en relación a la severidad de TEPTC y a la vez; el papel protector y mediador de la resiliencia entre la severidad de la violencia y la severidad del diagnóstico objeto de estudio; y por último, la relación de los síntomas que componen el TEPTC entre sí y en relación a estrategias de regulación emocional adaptativas y desadaptativas.

De modo global, hemos obtenido que la prueba ITQ es una medida fiable y válida para medir el TEPT y TEPTC en mujeres supervivientes de violencia de género. A la vez, se ha demostrado que el TEPTC es el doble de prevalente que el TEPT en esta población, teniendo en cuenta los recientemente definidos criterios diagnósticos en la CIE-11 (WHO, 2018). También se ha obtenido que factores como el miedo hacia el agresor, bajos niveles de resiliencia y mayor uso de estrategias de regulación emocional desadaptativas están relacionados con la presencia de síntomas de TEPTC en mujeres

supervivientes. Al mismo tiempo, la estrategia desadaptativa de regulación emocional de supresión de la expresión se ha considerado un factor que marca la diferencia entre presentar TEPT o TEPTC en las mujeres supervivientes. En cuanto a factores protectores, los resultados de la presente Tesis avalan que altos niveles de resiliencia es un factor protector que reduce los niveles de TEPTC. Por otro lado, y de modo contrario a lo esperado según la literatura previa, nuestro estudio muestra que la resiliencia no es una variable mediadora entre la severidad de la violencia y la severidad de TEPTC. Por último, se ha mostrado que existe una relación entre las estrategias de regulación emocional de supresión de la expresión y reevaluación cognitiva y los síntomas de TEPTC. Concretamente esta relación ha sido mayor entre los síntomas de AAO previamente descritos que en relación a los síntomas clásicos de TEPT. Además, la estructura de red estudiada ha permitido conocer el papel importante de síntomas como las alteraciones en las relaciones interpersonales y las estrategias de regulación emocional como la supresión de la expresión en dicha red. A la vez, se ha mostrado la importancia de la hipoactivación emocional sobre la hiperactivación en la muestra de mujeres supervivientes de VG.

9. 1. 1. Implicaciones teóricas

Los resultados de esta Tesis están contribuyendo por primera vez al estudio teórico de un constructo en la población de mujeres supervivientes de VG pero que es conocido con detalle en otras poblaciones. De este modo, en el presente trabajo se evidencia que el TEPTC se comporta de un modo singular de cómo lo hace en poblaciones de supervivientes de otros traumas anteriormente estudiadas. Ello da pie a un estudio más detallado considerando también la influencia de otras variables que puedan estar influyendo en la manifestación del TEPTC en mujeres supervivientes de VG. A continuación, detallamos las implicaciones teóricas de esta Tesis Doctoral.

En relación a la obtención de los resultados sobre prevalencia, en el presente trabajo se ha buscado conocer cómo evaluar este trastorno en la presente población española. Como indicamos en la introducción, la prueba ITQ (Cloitre et al., 2018) ha recibido un elevado apoyo empírico internacional en cuanto a su fiabilidad y validez (Hyland et al., 2017b). Sin embargo, no se ha investigado en la población objeto de

estudio de la presente Tesis ni en ninguna población española, a pesar de las singularidades del tipo de violencia y la heterogeneidad de la muestra (Potter et al., 2021). Por consiguiente, con los resultados de la presente tesis se evidencia que la prueba ITQ es fiable, permite medir el TEPT y TEPTC, y su estructura factorial confirma que todos los síntomas considerados para el TEPTC aparecen correlacionados en una muestra española de mujeres supervivientes de VG. Con ello, podemos afirmar que la ITQ se comporta en esta población como en otras poblaciones clínicas no homogéneas.

Al mismo tiempo, el estudio en profundidad de la estructura de dicho diagnóstico nos ha permitido conocer que síntomas como las alteraciones en las relaciones (sentirse distante o aislado/a de la gente y dificultad para estar emocionalmente cercano/a a la gente) son centrales e influyentes en otros síntomas de TEPTC. A la vez que los resultados obtenidos nos permiten confirmar que el problema más grave de desregulación emocional es de hipoactivación emocional. Estos resultados avalan que la estructura resultante de TEPTC en esta población es similar a otras poblaciones de trauma interpersonal (violencia física o sexual en la edad adulta o en la infancia) (Knefel et al., 2019; Knefel et al., 2020). Por otro lado, difieren de los resultados mostrados en otras poblaciones en lo relacionado a la desregulación emocional presentada en las mujeres supervivientes. Así, dichos problemas de regulación emocional asociados al TEPTC son de tendencia a la hipoactivación emocional. Es decir, las mujeres supervivientes tienden a sentirse aletargadas o emocionalmente apagadas.

Al mismo tiempo, la presente tesis contribuye al conocimiento de factores de riesgo y protección relacionados con la presencia y ausencia de síntomas de TEPTC. Concretamente, el miedo hacia el agresor se relaciona con los síntomas de TEPT. Sin embargo, en las mujeres supervivientes de VG, inesperadamente este factor también se relaciona con alteraciones en las relaciones sociales. Por otro lado, un mayor uso de estrategias desadaptativas de regulación emocional basadas en la supresión emocional, se relacionan con la presencia de síntomas de AAO y, simultáneamente, marcan la diferencia entre cumplir criterios para el diagnóstico de TEPT o de TEPTC. En relación a esta última variable, se corrobora su importancia y predominio de la relación con los síntomas de TEPTC en la presente población, comparada con la relación entre dichos síntomas con estrategias de regulación emocional adaptativas de reevaluación

cognitiva. Estos resultados apoyan la idea de que ambas estrategias son constructos independientes (Moore et al., 2018). En cuanto a la severidad de la violencia, nuestros resultados confirman que en esta población la severidad de los síntomas de TEPTC está directamente relacionada con la severidad del trauma. Por último, altos niveles de resiliencia en mujeres supervivientes de VG es un factor protector que facilita la ausencia de síntomas de AAO y reduce la severidad del conjunto de síntomas de TEPTC.

9. 1. 2. Implicaciones prácticas

Los resultados de nuestros estudios apoyan la investigación previa realizada a nivel internacional, y concluyen que una consecuencia en la salud mental de las mujeres supervivientes de violencia de género es el TEPTC, siguiendo los criterios diagnósticos recogidos en la CIE-11. Por consiguiente, de la presente Tesis surgen algunas implicaciones prácticas que desarrollamos a continuación.

En primer lugar, a partir de los resultados obtenidos sería necesario contemplar el TEPTC como una posible consecuencia en la salud mental de mujeres supervivientes de VG por parte de los/as psicólogos/as que atienden esta población. Nuestros resultados han mostrado que el TEPTC, de hecho, es el doble de prevalente que el TEPT. Esto implica que los síntomas específicos del TEPTC probablemente están siendo infra diagnosticados, a pesar de ser síntomas que interfieren considerablemente con el funcionamiento cotidiano familiar y/o laboral de las pacientes.

En segundo lugar, y como una necesidad para alcanzar el anterior, los/as profesionales de la salud deben recibir formación específica, actualizada y basada en la evidencia sobre cómo detectar y diagnosticar TEPTC, ya que de un buen diagnóstico deriva un adecuado tratamiento. Como es lógico, para poder realizar esto, los/as profesionales de la salud mental tendrían que contar con instrumentos avalados científicamente, como la prueba ITQ, que permitan diagnosticar y diferenciar entre el TEPT y TEPTC. Por esta razón, que esta Tesis haya adaptado el ITQ a población española y haya realizado el primer estudio sobre las propiedades psicométricas en mujeres supervivientes consideramos que tendrá un gran impacto en la mejora de la detección del TEPTC en esta población. Para facilitar y aumentar dicho impacto, seleccionamos una

prueba con altos estándares científicos, pero, al mismo tiempo, de distribución gratuita y accesible a todos/as los/las profesionales que atienden a mujeres supervivientes.

Finalmente, nuestros resultados tienen importantes implicaciones para el tratamiento de estas mujeres. Los tratamientos enfocados al TEPTC en mujeres supervivientes tendrían que estar dirigidos al trabajo de los síntomas clásicos de TEPT y, a la vez, a la mejora de los síntomas AAO. Concretamente, trabajando en el entrenamiento en habilidades sociales para el inicio, mantenimiento y cercanía en las interacciones y relaciones; en la reducción del autoconcepto negativo y, en especial, los sentimientos de inutilidad fomentando la autocompasión; y en promover la experimentación y mantenimiento de emociones positivas para combatir las emociones negativas, el aletargamiento emocional y la sensación de aplanamiento emocional. También, a nivel de tratamiento, sería interesante promover estrategias que potencian la resiliencia, y estrategias de afrontamiento y regulación emocional adaptativas que combatan la tendencia a la evitación y la supresión de la expresión de emociones. Por ejemplo, a través de la psicoeducación sobre regulación emocional y el trabajo en asertividad. Todos estos resultados apuntan a la necesidad de desarrollar tratamientos específicos para el TEPTC.

9. 2. Conclusiones

Como resultado de los varios hallazgos de la presente Tesis, se derivan las siguientes conclusiones generales:

- Los resultados sugieren que el ITQ es una medida válida del TEPT y del TEPTC usando criterios diagnósticos CIE-11 en esta población, tal y como indican satisfactoriamente la validez factorial, la consistencia interna y la validez concurrente.
- El TEPTC es dos veces más prevalente que el TEPT en la presente muestra de mujeres supervivientes de VG.
- El miedo hacia el agresor es un factor de riesgo principalmente para los síntomas de TEPT. Asimismo, una baja resiliencia y una alta supresión de

la expresión se relacionan más con la aparición y mayor severidad de los síntomas AAO.

- La supresión de la expresión es una variable que marca la diferencia entre cumplir los criterios diagnósticos según CIE-11 para TEPTC o TEPT.
- Finalmente, se confirma que, dentro de los síntomas de desregulación afectiva, la hipoactivación emocional juega un papel más destacado que la hiperactivación en el caso de las mujeres supervivientes.

9. 3. Perspectivas futuras

Los resultados y conclusiones de los estudios que componen la presente Tesis dan lugar a nuevas perspectivas para la investigación en la línea del TEPTC en mujeres supervivientes de VG. En el futuro, consideramos oportuno que se aborden los siguientes aspectos:

- Futuras investigaciones podrían explorar las propiedades del ITQ en español en otras poblaciones, para sumar evidencia sobre que el ITQ puede representar una herramienta útil para investigadores y profesionales en nuestro ámbito, y así ampliar el conocimiento en el campo del TEPTC.
- Adaptar, recopilar datos de supervivientes en España y validar otros instrumentos de diagnóstico clínico existentes y medidas de autoinforme, e investigar las tasas de concordancia diagnóstica como, por ejemplo, la International Trauma Interview (ITI; Roberts et al., 2018) y el Inventario de Trauma Complejo (CTI; Litvin et al., 2017).
- Llevar a cabo estudios longitudinales para comprender las dimensiones latentes del TEPTC en esta población a lo largo del tiempo, y corroborar si el TEPT y el TEPTC son constructos estables. También este tipo de estudios nos permitirían establecer relaciones causales entre las variables que han resultado relacionadas en la presente Tesis.

- Investigar la prevalencia de ambos diagnósticos con muestras de mayor tamaño de mujeres supervivientes, para conocer si las cifras de porcentajes obtenidas en el presente trabajo se mantienen.
- Adaptar y aplicar tratamientos específicos efectivos para síntomas de TEPTC en mujeres supervivientes de VG, trabajando los síntomas de TEPT y los síntomas AAO. En el estudio de la efectividad de estos tratamientos, se podrían incluir técnicas para la mejora de la resiliencia y reducción de la supresión de la emoción, promoción de la autocompasión y aceptación, y combatir la hipoactivación emocional con la experimentación de emociones positivas y el manejo de las emociones negativas.

Por tanto, los resultados de la presente Tesis doctoral suponen la unión y continuación de dos relevantes y novedosas líneas de investigación: el recientemente definido TEPTC y el estudio de nuevas secuelas en mujeres supervivientes de VG. De esto, podrán derivarse diferentes proyectos de investigación de carácter aplicado que esperamos que contribuyan a mejorar la evaluación, tratamiento y calidad de vida de las mujeres supervivientes de este tipo de violencia.

V. INTERNATIONAL DOCTORATE

Capítulo 10. General discussion, conclusions, and future perspectives

9. 1. General discussion

The main objective of the present Doctoral Thesis was to study complex posttraumatic stress disorder (CPTSD) defined according to ICD-11 (WHO, 2018). We investigated CPTSD in the population of female IPV survivors because this disorder has been studied in populations of other types of traumas and above all, in populations of interpersonal trauma (Cloitre et al., 2014; Hyland et al., 2017b; Karatzias et al., 2016; Kessler et al., 2017). However, in the population of female IPV survivors this diagnosis has not yet been explored, even though these women present high levels of PTSD (Golding, 1999; Kastello et al., 2016; Kelly, 2010; Nathanson et al., 2012; Nerøien and Schie, 2008; Pico-Alfonso et al., 2006), report problems with emotional regulation, negative self-concept and disturbances in relationships. Moreover, they experienced a type of interpersonal, chronic, difficult to escape trauma with a singular bond to the source of violence (Hyland et al., 2018b; Potter et al., 2021).

This Thesis is composed of four studies analysing the psychometric properties of the test for diagnosing PTSD and CPTSD in the population of female survivors of IPV; the prevalence of both diagnoses in this population; the risk factors associated with the presence of symptoms and diagnosis of CPTSD; the influence of the severity of violence in relation to the severity of the diagnosis of CPTSD; the protective and mediating role of resilience between the severity of violence and the severity of CPTSD; and finally, the relationship between the symptoms that make up CPTSD and emotion regulation strategies.

Overall, we have found the ITQ to be a reliable and valid measure of PTSD and CPTSD in women survivors of IPV. At the same time, it has been shown that CPTSD is twice as prevalent as PTSD in this population, considering the recently defined diagnostic criteria in the ICD-11 (WHO, 2018). It has also been found that factors such as fear of the perpetrator, low levels of resilience, and greater use of maladaptive emotional regulation strategies are related to the presence of CPTSD symptoms in female survivors. Furthermore, the maladaptive emotional regulation strategy of expressive suppression has been found to be a factor that makes the difference between PTSD and CPTSD in female survivors. In terms of protective factors, the results of the

present Thesis show that high levels of resilience is a protective variable that reduces levels of CPTSD. Contrary to previous findings, our study shows that resilience is not a mediating variable between the severity of violence and the severity of CPTSD. Finally, it has been shown a relationship between the emotional regulation strategies and CPTSD symptoms. Specifically, this relationship was stronger among the previously described DSO symptoms than in relation to classic PTSD symptoms. In addition, the network structure studied has revealed the important role of symptoms such as disturbances in interpersonal relationships and emotional regulation of suppressive expression in this network. At the same time, the importance of emotional hypoactivation over hyperactivation has been shown in the sample of female survivors of IPV.

9. 1. 1. Theoretical implications

The results of this Thesis are contributing for the first time to the theoretical study of a construct in the population of female IPV survivors, but which is known in detail in other populations. Thus, the present work shows that CPTSD behaves in a unique way from how it does in previously studied populations of survivors of other traumas. This finding provides the basis for a more detailed study also considering the influence of other variables that may be influencing the manifestation of CPTSD in female survivors of IPV. The theoretical implications of this Doctoral Thesis are detailed below.

In relation to the results on prevalence, in the present study we sought to find out how to assess this disorder in the present Spanish population. As indicated in the introduction, the ITQ test (Cloitre et al., 2018) has received high international empirical support in terms of its reliability and validity (Hyland et al., 2017b). However, it has not been investigated in the population of the present Thesis or in neither Spanish population, despite the singularity of the type of violence and the heterogeneity of the sample (Potter et al., 2021). Therefore, the results of this Thesis show that the ITQ test is reliable, it can measure PTSD and CPTSD, and its factor structure confirms that all the symptoms considered for CPTSD appear correlated in a Spanish sample of female IPV survivors. Thus, we can affirm that the ITQ behaves in this population as in other non-homogeneous clinical populations.

Moreover, the in-depth study of the structure of this diagnosis has allowed us to know that symptoms such as disturbances in relationships (feeling distant or isolated from people and difficulty in being emotionally close to people) are central and influential in other symptoms of CPTSD. The obtained results allow us to confirm that the most serious problem of emotional dysregulation is emotional hypoactivation. These results support that the resulting structure of CPTSD in this population is like other interpersonal trauma populations (physical or sexual violence in adulthood or childhood) (Knefel et al., 2019; Knefel et al., 2020). On the other hand, they differ from the results shown in other populations regarding emotional dysregulation in female survivors. Thus, the emotional regulation problems associated with CPTSD tend to be emotional hypoactivation. That is, women survivors tend to feel lethargic or emotionally numb.

Furthermore, the present Thesis contributes to the knowledge of risk and protective factors related to the presence and absence of CPTSD symptoms. Specifically, fear of the perpetrator is related to PTSD symptoms. However, in female IPV survivors, this factor is unexpectedly also related to disturbances in relationships. In addition, a greater use of maladaptive emotional regulation strategies based on emotional suppression is related to the presence of DSO symptoms, and makes the difference between meeting criteria for the diagnosis of PTSD and CPTSD. Concerning the latter variable, its importance and predominance of the relationship with CPTSD symptoms in the present population is corroborated, compared to the relationship between these symptoms and adaptive emotional regulation strategies of cognitive reappraisal. These results support the idea that the two strategies are independent constructs (Moore et al., 2018). Regarding the severity of violence, our results confirm that in this population the severity of CPTSD symptoms is directly related to the severity of trauma. Finally, high levels of resilience in female survivors of IPV is a protective factor that facilitates the absence of DSO symptoms and reduces the severity of the CPTSD symptoms.

9. 1. 2. Practical implications

The results of our studies support previous international research and conclude that one mental health outcome in women survivors of IPV is CPTSD, following the

diagnostic criteria of ICD-11. Consequently, some practical implications emerge from this Thesis, which we develop below.

Firstly, based on the results obtained, it would be necessary to contemplate CPTSD as a possible consequence on the mental health of women survivors of IPV by psychologists working with this population. Our results have shown that CPTSD is twice prevalent as PTSD. It implies that the specific symptoms of PTSD are probably being underdiagnosed, despite being symptoms that interfere considerably with patients' daily family and/or work functioning.

Secondly, to achieve the above, health professionals should receive specific, up-to-date, and evidence-based training on how to detect and diagnose CPTSD, since a good diagnosis leads to adequate treatment. Logically, mental health professionals would have to have scientifically endorsed instruments, such as the ITQ test, to diagnose and differentiate between PTSD and CPTSD. For this reason, this Thesis has adapted the ITQ to the Spanish population and carried out the first study on its psychometric properties in women survivors, and we believe that it will have a great impact on improving the detection of PTSD in this population. To facilitate and increase this impact, we selected a test with high scientific standards but, at the same time, freely distributed and accessible to all professionals who care for women survivors.

Finally, our results have important implications for the treatment of these women. Treatments focused on CPTSD in female survivors should be aimed at addressing classic PTSD symptoms and improving DSO symptoms. Specifically, working on social skills training for the initiation, maintenance and closeness of interactions and relationships; on reducing negative self-concept and feelings of worthlessness by promoting self-compassion; and on promoting the experience and maintenance of positive emotions to combat negative emotions, emotional lethargy, and feelings of emotional numbing. Moreover, at the treatment level, it would be interesting to promote strategies that enhance resilience, and adaptive coping and emotional regulation strategies that combat the tendency to avoidance and suppression of emotional expression. For example, through psychoeducation on emotional regulation

and work on assertiveness. All these results point to the need to develop specific treatments for CPTSD.

9. 2. Conclusions

As a result of the various findings of this thesis, the following general conclusions are drawn:

- The results suggest that the ITQ is a valid measure of PTSD and CPTSD using ICD-11 diagnostic criteria in this population, as indicated satisfactorily by factorial validity, internal consistency, and concurrent validity.
- CPTSD is twice as prevalent as PTSD in the present sample of female IPV survivors.
- Fear of the perpetrator is a risk factor mainly for PTSD symptoms. Furthermore, low resilience and high suppression of expression are more related to the occurrence and greater severity of DSO symptoms.
- Expressive suppression is a variable that makes the difference between meeting ICD-11 diagnostic criteria for PTSD and CPTSD.
- Finally, it is confirmed that within the symptoms of affective dysregulation, emotional hypoactivation plays a more prominent role than hyperactivation in the case of women survivors.

9. 3. Future perspectives

The results and conclusions of the studies in this Thesis open new perspectives for research along the lines of CPTSD in women survivors of IPV. In the future, we consider opportune to address the following aspects:

- Future studies could explore the properties of the ITQ in Spanish in other populations, to add evidence that the ITQ may represent a useful tool for researchers and practitioners, and thus expand knowledge in the field of CPTSD.

- Adapt, collect data from survivors in Spain, validate other existing clinical diagnostic instruments and self-report measures, and investigate diagnostic concordance rates such as the International Trauma Interview (ITI; Roberts et al., 2018) and the Complex Trauma Inventory (CTI; Litvin et al., 2017).
- To carry out longitudinal studies to understand the latent dimensions of PTSD in this population over time, and to corroborate whether PTSD and CPTSD are stable constructs. This type of study would also allow us to establish causal relationships between the variables that have been found to be related in this thesis.
- To investigate the prevalence of both diagnoses with larger samples of surviving women, to see if the percentage figures obtained in the present study are maintained.
- Adapt and implement effective specific treatments for CPTSD symptoms in women survivors of IPV, working on PTSD symptoms and DSO symptoms. In studying the effectiveness of these treatments, techniques for enhancing resilience and reducing emotion suppression, promoting self-compassion and acceptance, and combating emotional hypoactivation by experiencing positive emotions and managing negative emotions could be included.

Therefore, the results of this Doctoral Thesis represent the union and continuation of two relevant and novel research lines: the recently defined CPTSD, and the study of new sequelae in women survivors of IPV. Starting from this, different applied research projects can be derived that we hope will contribute to improve the evaluation, treatment, and quality of life of women survivors of this type of violence.

VI. REFERENCIAS

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