Risk for Revictimization of Intimate Partner Violence by Multiple Partners.

A Case Control Study

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Summary

A substantial minority of intimate partner violence (IPV) victimized women are revictimized by more than one intimate partner (termed *multiple partners, MP*). This has received limited theoretical and empirical attention. It is important to consider victims' circumstances and vulnerabilities that reflect barriers to the ability, opportunity, or motivation to engage in self-protective behavior. The present study applied an interactional perspective to violence revictimization, including the complex, heterogeneous, and dynamic interaction within a person and between person and situation.

A systematic literature review and a case control study were conducted. Quantitative data were obtained through a structured interview with a stratified sample of help-seeking women (N = 154) categorized according to their recent intimate relationship: IPV in the recent relationship only (n = 55), IPV in the recent and previous relationships (n = 51), and no lifetime IPV (n = 48). The study investigated the association between specific independent variables within the categories (a) childhood family violence, (b) other childhood adversities, (c) victimization and perpetration of IPV in the recent relationship, (d) attachment anxiety and avoidance, and (e) controlling sociodemographic and contextual variables, and the following dependent variables: (a) IPV victimized women compared to non-victimized women and (b) women with IPV by MP compared to women with IPV from one partner. Multivariate logistic regression analyses were applied for simultaneous testing of significant risk factors in order to investigate their interaction and relative strength.

The extended number and aspects of distal and proximal risk factors analyzed and controlled for in this study was unique in this research field. The results indicated that, compared to women victimized by one partner, there were specific interactions for women revictimized by multiple partners. More childhood emotional abuse, increased attachment anxiety, and an interaction between more childhood emotional abuse and increased attachment anxiety were risk factors for IPV by MP in particular. In addition, shorter education, disability benefits, shorter relationship and being native Norwegian increased the likelihood for IPV by multiple partners. Neither childhood family violence, nor characteristics of IPV victimization or perpetration were risk factors for IPV by MP.

The results must be interpreted with a number of limitations in mind. Especially, with the cross sectional format, the study reported interactions, not causal factors.

List of papers

1. Ørke, E.C., Vatnar, S.K.B., & Bjørkly, S. (2018). Risk for revictimization of intimate partner violence by multiple partners: A systematic review. *Journal of Family Violence, 33*(5), 325-339. doi:10.1007/s10896-018-9952-9

2. Ørke, E. C., Bjørkly, S., & Vatnar, S. K. B. (2020). IPV characteristics, childhood violence, and adversities as risk factors for being victimized in multiple IPV relationships. *Journal of Interpersonal Violence*, 88626052093303. doi:10.1177/0886260520933037

3. Ørke, E.C., Bjørkly, S., Dufort, M., & Vatnar, S.K.B. (in press). Attachment characteristics among women victimized in no, one and multiple IPV relationships. A case control study. *Violence Against Women*.

Abbreviations

0IPVR	Group of participants with no lifetime Intimate Partner Violence Relationship
1IPVR	Group of participants with one Intimate Partner Violence Relationship
2IPVR	Group of participants with two or more Intimate Partner Violence Relationships
AAI	Adult Attachment Interview
ATV	Alternativ til Vold/Alternative to Violence treatment center
CDC	Centers for Disease Control and Prevention
CI	Confidence Interval
CSA	Childhood sexual abuse
CTQ-SF	Childhood Trauma Questionnaire, short form
CTS-2	Revised Conflict Tactics Scale
ECR-N	Experiences in Close Relationships, Norwegian version
Freq.	Frequency
IPV	Intimate Partner Violence
IPVR	Intimate Partner Violence Relationship
IT	Intimate Terrorism
M	Mean
MINI	MINI International Neuro-psychiatric Interview
MP	Multiple Partners
N	number of participants in sample
n	number of participants in study group
ns	not significant
OR	Adjusted Odds Ratio
p	*P* value or significance level
PMWI	Psychological Maltreatment of Women Inventory
Prev.	Prevalence
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	Post-Traumatic Stress Disorder
SD	Standard Deviation
SARA V-3	Spousal Assault Risk Assessment Guide version 3
SCV	Situational Couple Violence
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

Introduction

Intimate partner violence (IPV) is a serious, heterogenic, and complex issue, associated with significant health, social, and economic costs to individuals and society (Cattaneo & Goodman, 2005; Cornelius & Resseguie, 2007; Costa et al., 2015; Mears, 2003). In contrast to other types of violence, IPV is commonly repetitive and tends to escalate in both frequency and severity along with the duration of the relationship (Cochran, Sellers, Wiesbrock, & Palacios, 2011). Chronicity of IPV across multiple partners and time periods is linked to more profound psychological suffering than acute exposure (Stein, Grogan-Kaylor, Galano, Clark, & Graham-Bermann, 2016). The mental health issues associated with victimization of IPV include depression, posttraumatic stress disorder (PTSD), anxiety, self-harm, sleep disorders, eating disorders, suicidality, substance dependence, antisocial personality disorders, and non-affective psychosis. The physical health issues include poor functional health, somatic disorders, chronic disorders and chronic pain, gynecological problems, and increased risk of sexually transmitted infections (Dillon, Hussain, Loxton, & Rahman, 2013; Dufort, Stenbacka, & Gumpert, 2015; Nerøien & Schei, 2008; Wathen & MacMillan, 2003). In addition come fear of bodily injury, time lost from work, injuries, and use of medical, mental health, and justice system services (Tjaden & Thoennes, 2000), and spillover of IPV-related problems into paid work (Alsaker, Moen, Baste, & Morken, 2016). The negative effects are evident not only in women who are direct victims of IPV; they also affect the health and well-being of child witnesses (Miller-Graff, 2016). Estimates placed the annual costs associated with the consequences of family violence in Norway at 4.5 – 6 billion Norwegian kroner in 2010 (Rasmussen, Strøm, Sverdrup, & Vennemo, 2012). IPV is an issue of vast psychological, social, and financial concern.

Empirical knowledge regarding risk factors for revictimization of IPV by multiple partners is sought by clinicians and victimized women for the prevention of future intimate partner violence relationships (IPVR). Decades ago, “blaming the victim” was a common feature of the institutional response to IPV. Rejecting a pathologizing of women, advocates worked hard to change the culture and rather focus on the perpetrator. During the last decades, a large amount of research focused on a wide array of perpetrator characteristics that influence risk for repeat partner violence. Although a perpetrator must be held accountable for the violence, focusing on only a perpetrator may distract attention from a possible vulnerability in some women for being revictimized by multiple partners. Little is known

about how victim-related factors affect risk for revictimization of IPV and IPV by multiple partners (MP) and how to reduce IPV victims' risk for future violence from an intimate partner (Goodman, Dutton, Vankos, & Weinfurt, 2005; Kropp & Hart, 2015; Kuijpers, Knaap, & Winkel, 2012; Smith & Stover, 2016). This is a significant gap in the literature because IPV revictimization is an all too common experience for women, even among those who have left violent partners (Bybee & Sullivan, 2002; Cattaneo & Goodman, 2005).

Prevalence of Intimate Partner Violence Victimization

Worldwide, almost one third of women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner, according to the World Health Organization (WHO) (2013). Prevalence rates vary considerably across the world: In a multi-site study, between 15% (Japan, city) and 71% (Ethiopia, province) of women who had ever had a partner, reported physical or sexual violence, or both, by an intimate partner at some point in their lives (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The National Intimate Partner and Sexual Violence Survey reported the following lifetime IPV experiences among women in the United States: severe physical violence (24.3%), stalking (10.7%), rape (9.4%), and sexual violence other than rape (16.9%). Nearly half of women in the U.S.A. had experienced psychological aggression by an intimate partner (Black et al., 2011). The most recent report of lifetime prevalence of IPV victimization in Norway showed that 17.1% of the women were victimized by any physical violence and among these, 2.4% reported only severe physical violence. Rape was reported by 3.8% and sexual violence other than rape, by 5.5% (Thoresen & Hjemdal, 2014). Most victims of physical violence are subjected to multiple acts of violence over extended periods of time (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

The problem of IPV by multiple partners characterizes more than a small minority of IPV victimized women (Alexander, 2009). Sizeable proportions of women with recent experiences of IPV reported prior relationships with IPV, from 22.9% (Vatnar & Bjørkly, 2008) to 61% (Dufort, Gumpert, & Stenbacka, 2013) in IPV victimized female samples.

Even though rates of IPV were found to be similar between women and men (Straus, 2011), there were substantial differences in severity and the consequences reported. Meta-analyses of sex differences in physical aggression to heterosexual partners reported that women were slightly more likely and more frequently than men to use physical aggression. Men were more likely to inflict an injury, and, overall, 62% of those injured by a partner were women (Archer, 2000). A recent Norwegian prevalence study confirmed a gender bias: Comparable numbers of women (14.4%) and men (16.3%) reported victimization of minor

physical abuse, while more women (8.2%) that men (1.9%) reported victimization of severe physical violence (Thoresen & Hjemdal, 2014). Globally, the proportion of murdered women killed by a partner was 6 times higher than the proportion of murdered men killed by a partner (Stöckl et al., 2013). Intimate partner homicide in Norway between 1990 and 2012 was committed by men toward women in 89% of the cases (Vatnar, Friestad, & Bjørkly, 2018).

Johnson and colleagues proposed specific patterns of IPV (Johnson, 2008) that were differently gendered regarding mutuality. Situational couple violence (SCV), referring to isolated violent acts commonly caused by specific conflicts, was more likely to be mutual. Intimate terrorism (IT), referring to violent coercive control over one's partner, was more likely to be perpetrated by men towards women (Johnson, 2011; Johnson & Leone, 2005). Exploring this typology and gender, Jasinski and coworkers reported that women were not more likely than men to be the victims of IT, but female sufferers of IT were significantly more likely than males to be injured from the violence, to attempt to leave their husbands, and to report desistance (Jasinski, Blumenstein, & Morgan, 2014). Others reported that victimized women experienced more physical and emotional impairment than men did and sought help more frequently than male IPV victims did. Victimized women also reported more fear and intimidation than men did when their partner initiated violence (Archer, 2000; Askeland, 2015; Caldwell, Swan, & Woodbrown, 2012; Nybergh, Taft, Enander, & Krantz, 2013; Stöckl et al., 2013; Wathen & MacMillan, 2003). Female victims were more likely to suffer more severe consequences than males were. Given the above findings, the present study of IPV revictimization by MP focused female victims.

Central Concepts

Intimate Partner

An intimate partner is a person with whom one has a close personal relationship that may be characterized by the partners' emotional connectedness, regular contact, ongoing sexual behavior and/or physical contact, identity as a couple, and familiarity and knowledge about each other's lives. The relationship needs not involve all of these dimensions (Breiding, 2015). In the present study, participants were included if they had been intimate partners for more than half a year. This excluded short dates, single rapes, one-night encounters, and devastating relationships that were quickly terminated.

Intimate Partner Violence (IPV)

Many different terms have been used to describe violence-related behaviors toward partners. Among these are marital violence, domestic violence, dating violence, battering, spouse or partner abuse, domestic abuse, partner aggression, violence against women, and

intimate partner violence. Researchers from different traditions have employed different terms and definitions of the phenomena. The present study applied the term *intimate partner violence*.

According to the literature, there is no consensus on one uniform definition of intimate partner violence. For participant inclusion in the present study and the dependent variable, the commonly referred to description and definitions by Breiding and coworkers were applied (Breiding, 2015).

Intimate partner violence (IPV) includes physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (Breiding, 2015).

Physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts (Breiding, 2015).

Sexual violence is defined as a sexual act that is committed or attempted by another person without the victim's freely given consent or against someone who is unable to consent or refuse. It includes forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party (Breiding, 2015).

Stalking is a pattern of repeated, unwanted attention and contact that causes fear or concern for one's own safety or the safety of someone else (e.g., family member, close friend) (Breiding, 2015).

Psychological aggression is the use of verbal and non-verbal communication with the intent to (a) harm another person mentally or emotionally and/or (b) exert control over another person (Breiding, 2015).

Pattern of violence is the way that violence is distributed over time in terms of frequency, severity, or type of violent episode (i.e., physical violence, sexual violence, stalking, and/or psychological aggression) (Breiding, 2015).

Revictimization

One of the most compelling findings in victimization research was that interpersonal victimization was not random; rather, once a woman was physically or sexually victimized, she was at increased risk for subsequent victimization (Aakvaag, Thoresen, Wentzel-Larsen, & Dyb, 2017; Cole, Logan, & Shannon, 2008; Messman-Moore & Long, 2003). This was variously termed, for example, as repeated victimization, repeat victimization, re-abuse, multiple victimization, and revictimization. The present study focuses on IPV victimization in more than one relationship and uses the term *revictimization* to refer to that phenomenon. Generally, however, the literature refers to a variety of experiences as revictimization. For example, childhood sexual victimization followed by teenage rape or adulthood sexual victimization was referred to in one study as revictimization and was followed by substantial empirical evidence (Casey & Nurius, 2005). Repeated victimization through a lifetime and relationships has also been referred to as revictimization. Several experiences of victimization by the same violent partner, as well as victimization of IPV in more than one intimate relationship have both been referred to as revictimization. This latter usage is the focus of interest in the present study: revictimization of IPV by more than one intimate partner (not simultaneously as in polyamory). In this study, it is termed *intimate partner violence by multiple partners* (IPV by MP). The term *multiple partners* refers to two or more intimate partners after a woman is 16 years old.

Risk Factor

A risk factor is a characteristic, a condition, a behavior, or an event that precedes or is associated with a higher likelihood (risk) of a negative outcome. Persons with certain risk factors have a higher likelihood (risk) of becoming or being victims or perpetrators of IPV. Certain risk factors may contribute to IPV but might not be causes. Not everyone who is at risk for IPV becomes involved in it. An interaction of individual, relational, and societal factors contributes to the risk of IPV. Understanding these multivariate factors can help identify various opportunities for prevention.

Theoretical Perspectives Regarding Victimization and IPV

The Relationship between Childhood Adversities and Adulthood Victimization

Social Learning Theories. For males, a strong direct effect was reported of childhood physical violence on later partner violence perpetration (Herrenkohl et al., 2004). A link between childhood experiences of family violence and later adult perpetration of violence has been referred to as the *intergenerational transmission of violence*. Different theoretical models, such as social learning theory, social information processing, and attachment theory,

have attempted to explain an intergenerational transmission of violence. Social learning theory holds that individuals learn violent patterns of interaction in their families of origin when they witness aggression between their parents and/or experience abusive parenting (Stith et al., 2000; Sutton, Simons, Wickrama, & Futris, 2014). This theory is based on the principle that both the perpetration and acceptance of physical and psychological abuse is a conditioned and learned behavior (Ali & Naylor, 2013). It has been argued that men perpetrate violence because they have seen their fathers being violent towards their mothers and that women accept violence because they have seen their mothers being abused by their fathers (Ali & Naylor, 2013). From a social learning perspective, Cochran, Sellers, Wiesbrock, and Palacios (2011) hypothesized that women exposed to more childhood violence may be more tolerant of violence in adult relationships. The objective of these researchers was to examine the extent to which measures of Akers' social learning constructs were able to predict repetitive intimate partner victimization. Witnessing violence and aggression in one's family of origin should not only transmit messages consonant with the perpetration of violence but also its victimization. These researchers reported that the following two of four social learning constructs significantly predicted IPV victimization and revictimization: (1) differential associations -- exposure to definitions and behaviors of others with whom one interacted which had a powerful effect on one's own definitions and behaviors; and (2) differential reinforcement -- persons most inclined to experience repetitive IPV victimization were those who viewed tolerating such victimization as more rewarding than costly, or less costly than the alternatives.

Psychoanalytic Views. Classical psychoanalytic theory proposed the existence of drives within people. It was thought that victimized women harbored a conscious or unconscious need for pain and punishment. This thought was used to explain seemingly irrational behaviors like "provocation" followed by abuse and a lack of motivation for leaving violent partners. A husband's aggressive behavior was thought to fill the wife's masochistic needs and to be necessary for the wife's (and the couple's) equilibrium (Anderson & Saunders, 2003; Celani, 1999; Snell, Rosenwald, & Robey, 1964). Associating victimized women with a masochistic personality disorder, later labeled *self-defeating personality disorder* (Widiger, 1987), was highly debated (Caplan, 1984; Walker, 1987).

The object relations theory proposed that humans were motivated not by drives, but by the need for significant relationships (Zosky, 1999). Lack of love in a young child's life would be traumatic and disruptive to the child's attachment. Fairbairn voiced the view that a vulnerable child, finding himself unloved and unprotected by parents, would take on the

parent's view that he (the child) was "bad" while the parent was "good" -- a defensive strategy described by Fairbairn as The Moral Defence Against Bad Objects (Celani, 1999; Nicholas, 2013). The child's need for the parent was increased because his earlier needs were never fulfilled. Neither the need nor the focus on others to meet these needs would change as the child developed into adulthood; however, the object of the focus could shift from the parents to the lover or spouse (Celani, 1999).

Celani claimed that regarding IPV victimization, Fairbairn's object relations theory could only be applied to women who had the choice to leave their abusive partner, yet refused to do so or returned again and again despite real danger to themselves.

Attachment Theory. Attachment theory stipulated that we develop patterns of relating to others, or internal working models, based on the quality of our early relationships with caregivers (Bowlby, 1969). Attachment is an emotional bond with another person. The attachment behavioral system was conceptualized as a biologically based, innate system that served to protect individuals by promoting proximity with caregivers in the face of danger or threat (Ainsworth & Bell, 1970; Bowlby, 1969). If attachment figures were available and responsive, people developed a sense of attachment security and came to believe that caregivers were dependable sources of support and comfort. However, if people found that attachment figures were unresponsive or erratically responsive, they might develop a sense of attachment-related insecurity (Finkel & Eastwick, 2015). Childhood maltreatment (physical, sexual, or emotional abuse), neglect (disengaged and extremely insensitive parenting), and child witnessing family violence were consistently found to increase the rate of children's attachment insecurity (Mikulincer & Shaver, 2016). Attachment theory postulated that the effects of atypical parental behavior, development of insecure attachment styles in children, tended to persist over time and would continue into adulthood. This would contribute to attachment patterns during adolescence and adulthood, frequently cause disruptions in adult relationships, and lead to an increased risk for intimate partner violence victimization (Mikulincer & Shaver, 2016).

Although Bowlby's attachment theory dealt primarily with the bonds that form between infants and their caregivers, theoretical work dating from the early 1980s argued for attachment as an organizational framework for research on adults' close relationships as well (Feeney, 2016; Hazan & Shaver, 1994). In addition to the developmental approach of attachment theory, this social attachment approach gained increasing attention. Adult attachment style was significantly associated with fundamental components of romantic relationships, including the capacity for intimacy, partner caretaking and support, sexual

behavior, conflict management, and relational aggression (Riggs, 2010). Slootmaeckers and Migerode (2018) argued that the attachment pattern in a given romantic relationship was the result of attachment disposition (childhood), past romantic attachment, and contemporary interaction and experience with this partner. Dispositional attachment and situational attachment interacted.

Attachment insecurity could take either or both of two forms. Attachment anxiety means that an individual is hyper vigilant for signs of rejection, highly preoccupied with attaining closeness and protection, and worries whether he/she is loved and lovable. Attachment avoidance means that an individual is uncomfortable with close relationships and prefers not to depend on others. Individuals who were low on both the attachment anxiety and the attachment avoidance dimensions were secure with respect to attachment; they generally expected romantic partners to be available and responsive, and they were comfortable with closeness and interdependence (Finkel & Eastwick, 2015; Fraley, Niedenthal, Marks, Brumbaugh, & Vicary, 2006).

Betrayal Trauma Theory. The betrayal trauma theory (Freyd, 1994) suggested that abuse perpetrated by someone on whom a victim depends is a fundamental betrayal that will result in survival pressure to limit awareness of the abuse (Wright, Dmitrieva, & DePrince, 2020). When dependent on a perpetrator, a child may be better able to preserve the necessary attachment with the caregiver by remaining unaware of the abuse. Thus, the victim may develop psychogenic amnesia and a compromised capacity to detect violations of social contracts in the caregiving relationship. In turn, generalized problems in detecting violations of social contracts – like detecting cheaters, social regulation, safety assessments -- may increase risk for future victimization in adulthood (DePrince, 2005).

Traumagenic Dynamics. Traumagenic dynamics was a framework proposed by Finkelhor and Browne (1985) for a systematic understanding of the effects of child sexual abuse. Four traumagenic dynamics -- traumatic sexualization, betrayal, stigmatization, and powerlessness -- were identified as the core of the psychological injury inflicted by abuse. It was hypothesized that these dynamics could be used to anticipate increased vulnerability to revictimization. Senn and coworkers compared the traumagenic dynamics model and the Information-Motivation-Behavioral skills model (Senn, Carey, & Coury-Doniger, 2012). They reported that the traumagenic dynamics constructs mediated the relationship between child sexual abuse and the number of sexual partners. Canton-Cortes and coworkers studied the role of traumagenic dynamics on the psychological adjustment of survivors of child sexual

abuse. Feelings of powerlessness, self-blame, and traumatic sexualization were supported, in particular, and betrayal, to a lesser extent (Cantón-Cortés, Cortés, & Cantón, 2012).

Victims' Role

Some theories have tried to understand and explain women's decisions to either remain in or terminate violent relationships. Principles of intermittent reinforcement were applied, as in the cycle of violence theory (Walker, 1984). The theory of traumatic bonding hypothesized that power shifts and intermittent abuse in unilateral abusive relationships would produce strong attachment in IPV victimized women (Dutton & Painter, 1993).

Rhatigan and coworkers concluded in a critical review that general approaches like reasoned action/planned behavior and the investment model were better for understanding this complex and multifaceted decision (Rhatigan, Street, & Axsom, 2006). Reasoned action essentially stated that women intended to stay or leave violent relationships depending on their outcome expectancies and social norms. The investment model postulated that women who reported feeling satisfied, possessed lower quality alternatives, and had more invested in current relationships tended to feel more strongly committed and less inclined to leave.

Foa, Cascardi, Zoellner, and Feeney (2000) constructed two complementary models of women's ability to curtail partner violence. Their models focused on psychological factors (e.g., attachment, problem-solving skills) and environmental factors (e.g., tangible resources, domestic violence shelters). Three key factors were present in both models: partner violence, psychological difficulties, and resilience. An interaction between the factors was central. Their model was mostly based on cross-sectional studies. Kuijpers, van der Knaap, and Lodewijks (2011) reviewed longitudinal studies in order to test the factors. The researchers reported that partner violence (severity and frequency of prior IPV) was a strong predictor for IPV revictimization. Evidence regarding victim's psychological difficulties and resilience was more mixed.

IPV Victimization and Perpetration

Feminist Perspectives. Over the last century, many theories and frameworks have been proposed to explain IPV perpetration. Among these, perspectives that may inform the understanding of IPV victimization are presented here.

Feminist scholars maintain that explanations of violence against women should center on gendered social arrangements and power. Exclusive focus on individual characteristics of victim, offender, or situation is seen as problematic. These scholars claim that an individual focus conceals the ways in which every act of violence against women is embedded in a larger social organization. The feminist perspective asserts that IPV is asymmetric, related to

the oppressing structures in patriarchal society and tactics of male right (Bartholomew, Cobb, & Dutton, 2015). The concept of patriarchy denotes systems of male dominance and female subordination and anchors the problem of violence against women in social conditions, rather than individual attributes (Hunnicutt, 2009). Men resort to domestic violence as a mechanism to maintain power, control, and privilege in a patriarchal society (Zosky, 1999). According to the feministic perspective, female violence is used mainly in self-defense or fighting back, and male violence is used primarily as a means of patriarchal control (DeKeseredy, 2016).The main risk factor for being victimized by IPV is being a woman, and gender equality is seen as a prerequisite for the reduction of violence against women.

One of the key issues for contemporary feminism is intersectionality. Different axes of oppression, like color, class, and sex, intersect (Munro, 2013).

The feminist perspective has been heavily criticized as being a theory that has arisen from ideological motives rather than methodologically sound empirical evidence (Dixon & Graham-Kevan, 2011). However strongly debated, feminist perspectives have been instrumental in generating awareness of violence against women and highlighting the potential role of gender in understanding such violence. They continue to be highly influential in forming societal views of IPV and in guiding public policy and domestic violence services (Bartholomew et al., 2015).

Family Violence Perspectives. The feminist perspective of IPV as a problem of men assaulting women has been opposed by family violence researchers. These scholars focus on gender symmetry and maintain that about the same percentage of women as men physically assault a partner (Straus, 2011). IPV is seen as a conflict tactic (Straus, Hamby, Boney-Mccoy, & Sugarman, 1996). Straus and coworkers draw on conflict theory which assumes that conflict is an inevitable part of the human condition, including marriage, and a useful and necessary part of life, but maintains that violence as a tactic to deal with conflict is not inevitable. Conflict management and problem-solving counseling has been associated with the reduction of IPV (Straus, Hamby, Boney-Mccoy, & Sugarman, 1996; Winstok, 2011).

Slootmaeckers and Migerode (2018) argue that situational couple violence arises from negative interaction patterns, and that aggressive behavior within the context of common couple violence should be interpreted as a natural reaction to attachment and loved-related transgressions. They claim that both partners contribute to episodes of IPV. According to these authors, IPV could be discussed and treated in Emotionally Focused Therapy (EFT), placing IPV within the scope of different versions of the attachment dance (Slootmaeckers & Migerode, 2018, p. 308).

Nested Ecological Frameworks. Arguing that IPV theories should be more comprehensive, taking into consideration the perspectives of both the victims and the perpetrators, as well as integrating views from multiple academic disciplines, new theoretical frameworks have been suggested (Bell & Naugle, 2008; Dutton, Goodman, Lennig, Murphy, & Kaltman, 2006; Emery, 2011; Foa et al., 2000; Winstok, 2007). The nested ecological framework theory is a widely used account of IPV, and Bronfenbrenner is one of its most widely cited authors (Ali & Naylor, 2013). The framework offers a comprehensive view of IPV by looking at different factors at various levels: individual, relationships, community, and societal levels. The model suggested that behavior is shaped through interaction between individuals and their social surroundings (Ali & Naylor, 2013). The levels are overlapping, denoting the interrelationship and interdependence of the factors to one another. The model also suggested that to deal with the issue of IPV, various factors at various levels need to be considered and dealt with simultaneously. It is the interaction of all these factors that needs to be understood for planning preventive strategies to combat the problem of IPV and violence against women (Dutton et al., 2006).

Kuijpers, van der Knaap, and Lodewijks (2011) argued that such a multilevel ecological approach clearly illustrates that we cannot expect victims to be able to fully control or change their risk by themselves. Victims may be able to change individual risk factors to a certain extent, yet part of these factors probably remain outside victims' control because they are in continuous interaction with other interpersonal and systemic factors.

A key advantage of an ecological model is that it can suggest multiple strategies for intervention (Campbell, Dworkin, & Cabral, 2009). Both the Centers for Disease Control and Prevention (CDC) and the WHO have adapted this ecological framework to develop multilevel models for the prevention of gender-based violence (Campbell et al., 2009). Applying the ecological model, Grauerholtz (2000) suggested how sexual revictimization was multiply determined by factors related to victims' personal history (e.g., traumatic sexualization), the relationship in which revictimization occurs (e.g., decreased ability to resist unwanted sexual advances), the community (e.g., lack of social support), and the larger culture (e.g., blaming the victim's attitude).

Interactional Perspective. Expanding on an integrative model, Winstok (2007, 2013) proposed an interactional approach to the study of IPV. According to an interactional perspective on human functioning, psychological events are determined by two types of interaction processes: (a) the continuously ongoing bidirectional process of interaction between the individual and his/her environment and (b) the continuously ongoing reciprocal

interaction among subsystems of factors within the individual (Magnusson, 1985). In order to understand the functioning of individuals in their environments, Magnusson proposes that we need (a) knowledge about the effective characteristics of the individuals, (b) knowledge about the effective operating situational/environmental variables and their interrelations, and (c) a theory linking these two networks of factors together in the framework of dynamic interaction. The question is how individuals by their perceptions, thoughts, and feelings function in relation to the environment (Magnusson, 1985). Much developmental research can be characterized as variable oriented; that is, variables are the main conceptual and analytical unit. It is the nature of the relationship among variables – simultaneously and across age – that is the main object of interest in this approach (Magnusson, 1985). In this perspective, the traditional person-situation dichotomy is questioned and replaced by an emphasis on the interaction between individuals and the various situations they encounter (Vatnar & Bjørkly, 2012). Vatnar and Bjørkly (2008) studied the interactions related to IPV and reported different dynamic factors linked to physical, psychological, and sexual IPV. A woman who had been subject to different violent categories on separate occasions had different experiences and perceptions of the escalation, interaction, and consequences.

Briere and Jordan (2004) suggested that, for example, effects of an earlier trauma may magnify the impacts of a later trauma or that a later trauma may trigger a resurgence of symptoms from an earlier assault. Child abuse, for example, may produce symptoms that ultimately complicate or intensify a woman's response to an adult trauma; previous traumas may alter the intensity of her peritraumatic response to later traumas; living in poverty or working as a prostitute may increase the likelihood of later assault; and current victimization experiences may activate or trigger psychological responses to similar traumas earlier in life.

Research Regarding Victim-Related Risk Factors for IPV

Victim-Related Risk Factors for IPV

The exposure to interpersonal traumatic events during childhood is considered a crucial explanatory variable for IPV victimization in adulthood (Cascio et al., 2020). An ample body of scientific literature studied the impact of specific types of traumatic childhood experiences on IPV victimization. Childhood exposure to parental abuse was reported as a risk factor (Krishnan, Hilbert, Pase, & Krishnan, 2001). Ehrensaft et al. (2003) reported from a 20-year longitudinal study that childhood exposure to domestic violence between parents, or witnessing IPV, conferred the greatest risk of receiving IPV. In the large Adverse Childhood Experiences (ACE) study, Whitfield, Anda, Dube, and Felitti (2003) found that childhood physical and sexual abuse and growing up with a battered mother (witnessing IPV) increased

the risk of IPV victimization in women about two-fold. The relationship was graded, and among persons who had all three forms of violent childhood experiences, the risk for IPV victimization was increased 3.5-fold for women.

The impact of childhood physical abuse/punishment for adult IPV victimization was confirmed by others (see, e.g., Afifi, Mota, Sareen, & MacMillan, 2017; Barrios et al., 2015). Likewise, childhood sexual abuse is a well-established risk factor for adult victimization in women (see, e.g., Barrios et al., 2015; Daigneault, Hebert, & McDuff, 2009; Iverson, Mercado, Carpenter, & Street, 2013; Messman-Moore & Long, 2003; Whitfield et al., 2003; Xu et al., 2013). A 23-year longitudinal study (Trickett, Noll, & Putnam, 2011) found that sexually abused females showed deleterious sequelae across a host of biopsychosocial domains. Victims of sexual abuse were about twice as likely as comparison females to be revictimized physically or sexually at subsequent times during later adolescence and young adulthood and to become victims of more severe domestic abuse. In addition, sexually abused females who had a propensity to enact subtle or mild forms of aggression toward a domestic partner may be the most likely victims of more severe domestic violence.

Stroem, Aakvaag, and Wentzel-Larsen (2019) reported that exposure to childhood abuse, regardless of type, was associated with adult victimization. Among the separate categories, individuals who had experienced childhood sexual abuse had the highest odds for later victimization. An increase in the number of childhood violence types led to higher odds of later victimization. Aakvaag et al. (2017) also emphasized that researchers and clinicians need to take into account the full spectrum of violence exposure.

Childhood psychological abuse and maltreatment, (see, e.g., Reyome, 2010; Wekerle & Wolfe, 1998) were reported as risk factors. Berzenski and Yates (2010) concluded that among several prevalent childhood adversities, emotional abuse was an especially pernicious form of maltreatment that warranted greater research and clinical attention. They reported that childhood emotional abuse predicted both relationship violence victimization and perpetration above and beyond the contributions of childhood physical abuse, sexual abuse, and domestic violence exposure. Cascio and coworkers (2020) included in their study several of these types of childhood maltreatment that were considered relevant in the literature for the explanation of IPV victimization. The researchers reported from multivariate analyses of antipathy, neglect, physical abuse, sexual abuse, psychological abuse, and witnessing violence that among these, childhood psychological abuse and childhood sexual abuse were the only significant childhood predictors of IPV victimization.

Cascio et al. (2020) suggested that contradictory results regarding childhood risk factors could be partially explained by a multifactorial ecological model. Childhood abuse and neglect occur within a wider family, social, and cultural context. The role played by family and social environment may interact with childhood maltreatment and may influence the likelihood of adult IPV (Cascio et al., 2020).

A number of studies have reported victim-related risk factors specifically for physical, psychological, and sexual IPV (see, e.g., Vatnar & Bjørkly, 2008).

Velotti, Zobel, Rogier, and Tambelli (2018) reported from their literature review that there seemed to be a relationship between the attachment dimensions anxiety and avoidance and IPV victimization, although a great number of studies failed to find significant associations. Most reviewed studies on attachment and IPV victimization focused on specific violence types, primarily physical IPV. Only 1.46% (7) of the reviewed studies did not distinguish between different forms of IPV. Some of these studies on generic IPV victimization reported victim's anxious (Bond & Bond, 2004; Shechory, 2013), avoidant (Shechory, 2013; Weiss, MacMullin, Waechter, & Wekerle, 2011; Wekerle & Wolfe, 1998), and preoccupied attachment characteristics (Henderson, Bartholomew, Trinke, & Kwong, 2005) as risk factors for IPV victimization. Different patterns of relationship IPV were suggested to manifest as a result of the interacting attachment styles of both members of the couple (Dixon & Graham-Kevan, 2011). Doumas, Pearson, Elgin, and McKinley (2008) explored the "pairing" of partners' attachment styles. Their study indicated that a "mispairing" of a male with high attachment avoidance and a female with high attachment anxiety was a risk factor for male IPV.

Previous studies have found that women who reported high levels of substance use or abuse were more likely to report experiencing IPV (Testa, Livingston, & Leonard, 2003). From their systematic review of risk factors for IPV, Capaldi, Knoble, Shortt, and Kim (2012) reported that there was evidence for an association of indicators of alcohol use with IPV victimization, but that it was not as strong or as consistent as had generally been supposed.

Studies also reported increased risk associated with certain ethno-racial groups, impoverished conditions, and lower educational attainment (e.g., Stein et al., 2016). Cascio et al (2020) reported that the presence of poor social support showed a strong association with IPV victimization.

Victim-Related Risk Factors for IPV Revictimization

While some studies looked at victimization, others examined revictimization. Extant literature showed that compared to women who had not been subjected to IPV, a higher

proportion of women who were subjected to IPV revictimization witnessed spousal abuse as children and/or were abused as children (e.g., Alexander, 2009; Cole et al., 2008; Trickett et al., 2011). Vatnar and Bjørkly (2008) expanded on this, reporting that exposure to parent's physical IPV increased the risk of IPV by MP significantly more than if the woman had been subjected to childhood physical victimization herself. However, the most prominent risk factor for revictimization found in their study of help-seeking women was childhood sexual abuse. Women subjected to childhood sexual abuse in family of origin were at almost 25 times increased risk of IPV victimization in more than one relationship.

Alexander (2009) reported that women with IPV by MP were significantly more likely to have experienced role reversal with their mothers, with a trend toward role reversal with their fathers. Regarding attachment, she reported that IPV by MP interacted with unresolved attachment. Kuijpers, van der Knaap, and Winkel (2012a) reported that an avoidant attachment style was a strong predictor of IPV revictimization, in particular for victims with high and average anger levels.

A review of prospective evidence reported that there was only mixed evidence for a much-suggested predictive relationship between PTSD symptoms and revictimization of IPV (Kuijpers, van der Knaap, & Lodewijks, 2011). The same review study reported that none of four studies reported a significant effect of depression on revictimization, but current substance abuse, and especially alcohol abuse, might be related to the risk of any future revictimization. Alexander (2009) reported that although affect dysregulation (dissociation and borderline traits) differentiated between victimized women and women revictimized by multiple partners, multivariate analyses indicated that it did not predict IPV by MP above and beyond the effects of childhood trauma (witnessing IPV in childhood and a history of child sexual abuse).

Victims of IPV were reported to be at high risk for revictimization (Cattaneo & Goodman, 2005; Iverson, Litwack, et al., 2013; Kuijpers, et al., 2012a). Kuijpers and coworkers (2012a) studied the link between victimization and revictimization of IPV. They reported from their review study of prospective evidence (2011) that partner violence, involving the severity and frequency of prior IPV, was a strong predictor for IPV revictimization (Kuijpers et al., 2011). In their own prospective study (2012a), the researchers found that male physical IPV predicted revictimization of physical IPV; male psychological IPV predicted revictimization and severity of psychological IPV. Victim-perpetrated IPV was an important risk factor for her subsequent physical and psychological IPV revictimization (Kuijpers, et al., 2012b).

Psychological distress and coping strategies following IPV victimization may impact a victim's risk for future IPV. Iverson and coworkers (2013) found in a sample of women seeking service for IPV that disengagement coping was associated with a higher revictimization risk. Disengagement coping referred to passive attempts at coping and encompassed strategies such as problem avoidance, wishful thinking, self-criticism, and social withdrawal. Engagement coping was associated with lower revictimization risk. Engagement coping referred to proactive steps to manage the abuse and its consequences and included strategies such as problem-solving, cognitive restructuring, emotional expression, and eliciting social support. The researchers reported that when examined together with PTSD and dissociation, which also had been found as contributing to a victim's risk for physical revictimization, only the coping strategies were significant predictors of revictimization (Iverson, Litwack, et al., 2013). Goodman and coworkers, too, reported some resistance and coping strategies as risk factors for IPV revictimization (e.g., fight back, sleep separately, refuse to do what he says, use or threaten to use a weapon) (Goodman et al., 2005).

In their review study on revictimization, Kuijpers and coworkers (2011) found mixed evidence that social support might serve as a protective factor against revictimization of IPV. Social support was not related to the risk of revictimization among victims who experienced the most severe prior violence but was strongly related to the risk of victims from the low violence group. For this group, social support proved to be critical in protecting them from future revictimization. Socioeconomic status was reported to have a negative relationship with revictimization (Cattaneo & Goodman, 2005). Being employed protected against further violence (Alsaker, Moen, & Kristoffersen, 2008).

Witte and Kendra (2009) studied whether female victims of physical IPV displayed deficits in risk recognition or the ability to detect danger in video vignettes of physically violent dating encounters. The results indicated that compared to non-victims, victims of IPV were less likely to recognize the danger involved.

The above preliminary review of scientific results is not exhaustive but indicates both distal and proximal victim-related vulnerability and risk factors for IPV victimization and revictimization. Most theory and empirical studies on IPV revictimization do not distinguish between revictimization by the same partner and revictimization by subsequent partners. This implies mixed and inaccurate results and precludes a clear understanding of victim-related risk factors for IPV by MP in particular. Risk factors related to recurrent violence within a single violent relationship may not be the same as the risk factors related to IPV by MP.

Starting Point for the Study

Aim of the Study

Empirical studies suggested several distal and proximal risk factors for revictimization of IPV. However, it appeared unclear as to what extent theory and research on IPV victimization and revictimization were applicable for understanding IPV by MP. Science-based knowledge is critical to informing prevention efforts, for practitioners guiding victims in decision making and safety planning (Cattaneo & Goodman, 2005), and for theory development. Hence, it appeared urgent to investigate victim-related risk factors for IPV by MP.

The interactional perspective is an integrative framework for studying both distal and proximal risk factors of IPV by MP and an interaction between them. Within this framework, the current study focused on victim-related factors at the individual and relationships levels. The study had an exploratory approach; thus, research questions, rather than specific research hypotheses, were formulated. Multivariate analyses allowed simultaneous testing of several significant variables in order to investigate their interaction and relative strength. Investigating victim-related factors was done by comparing victimized (IPVR) to non-victimized (0IPVR). Investigating variables specific to women with IPV by multiple partners was done by comparing women with IPV by MP (2IPVR) to women victimized in one relationship (1IPVR). This two-step exploration might indicate what was specifically associated with victims of IPV by MP apart from victimized in general and from non-victimized.

This study investigated victim-related risk factors for revictimization of IPV by multiple partners. The aim was to add new understanding of IPV revictimization as complex, heterogeneous, and dynamic phenomena by applying a literature review and a case control study with a multivariate design based on an interactional perspective.

Research Questions

Paper 1.

1. What is the extent of research on female IPV revictimization by multiple partners?
2. What does existing research say about significant differences between female victims of IPV by multiple partners and female victims of IPV by one partner?
3. What does existing research say about possible specific victim-related risk factors for IPV by multiple partners?

Paper 2.

1. Are women with IPV relationships different from women with no IPV relationship regarding childhood family violence and other childhood adversities?
2. Are women with multiple IPV relationships different from women with one IPV relationship regarding childhood family violence and other childhood adversities?
3. Are women with multiple IPV relationships different from women with one IPV relationship regarding characteristics of victimization and perpetration of IPV?

Paper 3.

1. Are women victimized by IPV from one or multiple partners different from women with no IPV relationships regarding adult attachment characteristics, adjusting for childhood adversities and sociodemographic variables?
2. Are women victimized by IPV from one partner different from women victimized by IPV from multiple partners regarding adult attachment characteristics, adjusting for childhood adversities and sociodemographic variables?

Methods

In order to meet the above-mentioned needs and answer the research questions, a systematic literature review was conducted to ascertain what knowledge related to this issue had thus far been documented in the research. Subsequently a case control study was conducted to address systematically some of the shortcomings in the existing literature.

Study Design and Settings

Part 1. Systematic Review

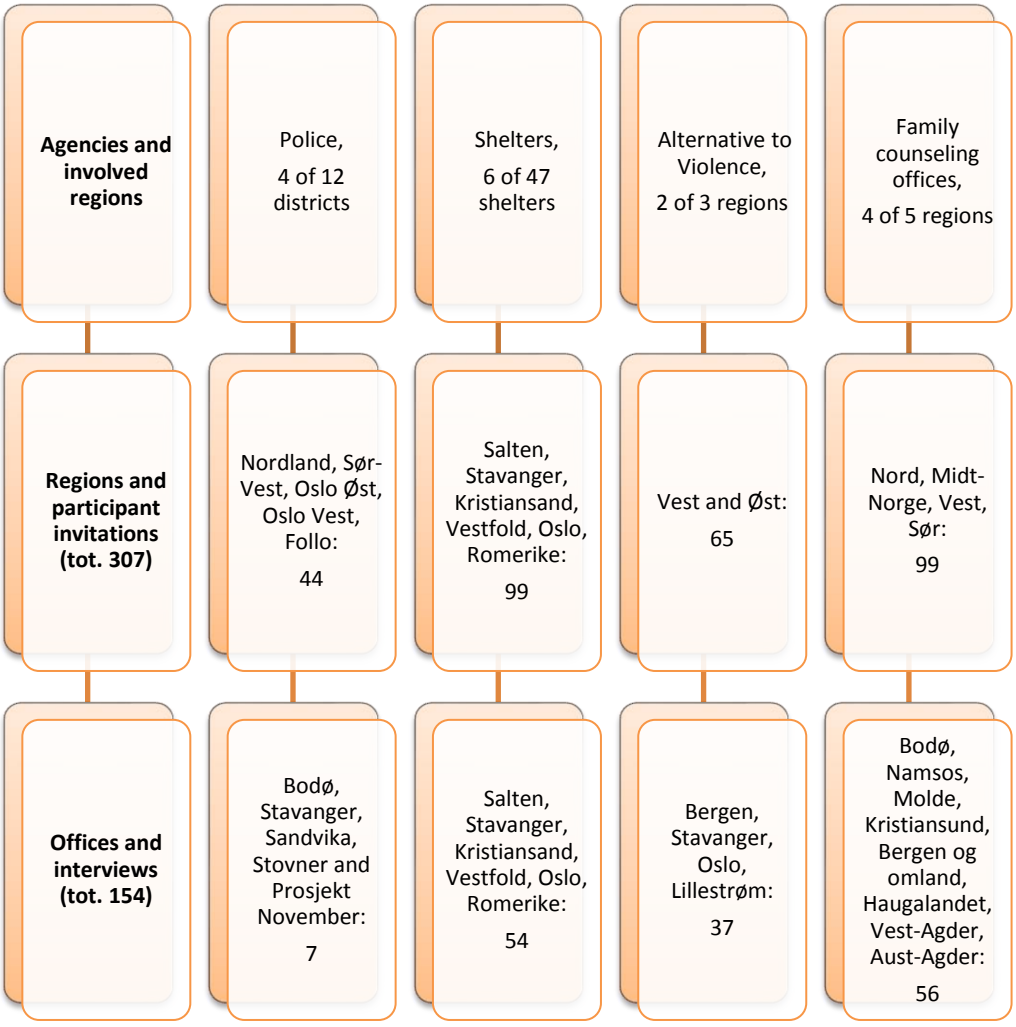
A systematic review of the scientific literature (Paper 1; Ørke, Vatnar, & Bjørkly, 2018) was conducted according to the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009). With a detailed list of key words, a systematic digital literature search was conducted in the following databases: Ovid Medline, PsychInfo, NICE Guidance (UK), UpToDate, Cochrane Library (bases Cochrane Reviews, Technology Assessment), Web of Science, and Swemed. The digital search was conducted on June 3, 2015, and an identical digital update search was conducted on November 29, 2016. A recent updated identical systematic literature search was completed on April 1, 2020, where no more studies were retrieved.

Part 2. Case Control Study

A case control study was conducted obtaining quantitative data from a structured interview with a stratified sample of help-seeking women.

Figure 1

Recruitment per agency and local offices.



The researcher sent an email to the four leaders of the nationwide agencies of the police (Politidirektoratet), shelters (Krisesentersekretariatet), Alternative to Violence treatment center (ATV), and the family counseling agency of Norway (Bufdir) and asked for cooperation with local offices to obtain participants in the study. Three leaders forwarded our request to districts or local offices while one did not respond. Eventually, the researchers sought contact with local offices around the country. Positive and negative responses were as follows: From the police, one district declined our request and four accepted (Nordland, Sør-

Vest, Oslo, Øst). From these, five police stations accepted our request (Bodø, Follo, Oslo Vest Sandvika, Oslo Øst Stovner and Project November, and Stavanger). Six shelters accepted our request (Salten, Vest-Agder, Oslo, Romerike, Stavanger, and Vestfold). One ATV region declined our request and two accepted (Vest and Øst), from which four local ATV offices accepted our request (Bergen, Lillestrøm, Oslo, and Stavanger). Among the family counseling regions, in Nord, one local office accepted (Bodø); in Midt-Norge, three offices accepted (Namsos, Molde, Kristiansund); in region Vest, two offices declined and two accepted (Bergen og omland, Haugalandet); in Sør, one office declined and two accepted (Aust-Agder, Vest-Agder); in Øst, two local offices declined our request.

A total of 23 local offices across Norway agreed to contribute to the study, and in each office, a contact person coordinated the recruitment process. The personnel were asked to invite all clients who met the inclusion criteria to participate in the study. Participants were recruited continuously from March 2018 to January 2019. Recruitment was terminated when I had made appointments with at least 50 participants in each of the three research categories.

Figure 1 depicts recruitment per agency and local offices.

Inclusion Criteria.

- Participants were at least 18 years old.
- They had made contact with police, family counseling, women's shelter, or ATV for intimate partner related problems.
- They were in, or had lately been in, an intimate relationship that had lasted at least 6 months.
- They held either Norwegian citizenship or a residence permit.
- They had sufficient language fluency to understand the information letter and to make an appointment on the phone.
- They had experienced intimate partner violence either within the last 3 years or not at all.

Dependent Variables. Violent relationship, or violent partner, was the dependent variable. Relationships with at least 6 months' duration were included. The women were recruited to the designated case and control groups according to the definition of physical, psychological, and sexual violence (Breiding, 2015) in the study's information-consent letter (Appendix A). They were asked (both on the phone and, initially, in the interview) in how many adult intimate relationships they had experienced IPV victimization. According to self-

report, the participants were included in one of the following three research categories of intimate partner violence relationships (IPVR):

- Help-seeking women with no lifetime IPV relationships (0IPVR).
- Help-seeking women victimized by IPV in the most recent relationship (1IPVR).
- Help-seeking women victimized by IPV in the recent and more relationships (2IPVR).

All participants in the control group (0IPVR) were recruited from family counseling offices. These participants shared with the case groups the characteristics of being adult women experienced with a recent intimate relationship and seeking help for intimate partner related problems, but having no lifetime IPV victimization.

Procedure

Part 1. Systematic Review

From the digital search and removal of duplicates, 1,190 original references remained (Paper 1; Ørke et al., 2018). References were recorded and managed in EndNote Version 6 (software). All references were screened by title, abstract, and key words by the first author. If this step did not provide clear information that answered the eligibility questions, the full text was obtained. Both first and second author assessed full texts according to the following items: authors, year published, description of empirical study, discussion of partner violence, inclusion of separate analyses for IPV in one and more than one relationship, and whether it was a review study. References that were considered by consensus to meet the criteria were included in the review study. References were included if they (a) were peer-reviewed empirical studies (not theories or discussions), (b) described victims of IPV (not perpetrators only and not dating violence/rape/assault by an acquaintance or stranger), and (c) were written in English or in Scandinavian languages. References were included if their analyses compared victims of one IPV relationship to victims of IPV by MP and were either (1) systematic reviews of empirical studies on this specific topic or (2) papers reporting individual studies that met the inclusion criteria. After the study selection process, the introduction part of the eligible articles was screened for additional relevant references and the same selection process was applied. Three references were retrieved in this hand search. Including these three, a total of seven original articles were included in the study (Paper 1, Figure 1, Flow diagram; Ørke et al., 2018). Each of these seven was registered chronologically with the following items: authors, year, aim of the study, sample, methods, statistical analyses, and results. All results pertaining to differences between women with one and women with multiple violent partners were registered. Based on a preliminary review, the categories used for registration were (1)

background characteristics, including childhood trauma, lifetime victimization, and attachment style, including family-of-origin characteristics and attachment; (2) psychopathology, including personality disorders, affect dysregulation, post-traumatic stress symptoms, substance and alcohol abuse, anxiety, and depression; (3) IPV characteristics; and (4) a category of "other" characteristics. A more detailed description of the systematic review is outlined in Paper 1.

Part 2. Case Control Study

(1) The recruitment of participants was conducted by office personnel by presenting the study's information-consent letter (Appendix A), either in person or by phone, to all their female users who met the inclusion criteria. The contact persons sent the signed information-consent letters with contact information to the researcher. (2) The researcher sought contact with the recruited women, gave more detailed information about the study and considered whether the participants fulfilled inclusion criteria. (3) The participating women came to a face-to-face interview with the same researcher, a female clinical psychologist, at the local recruitment or researcher's office (see Paper 2, Figure 1, Recruitment Process; Ørke, Bjørkly, & Vatnar, 2020). All questions and response alternatives were presented orally and the participants were shown the response alternatives on a sheet. The researcher registered the answers by hand in the codebook. Time breaks were used when needed. The interviews lasted on average 2¼ hours within a time range from 55 minutes (controls) to 5 hours (translated interviews).

Power Analysis. In order to attain statistical power to compare subgroups, a power analysis was conducted prior to initiating Part 2 of the study. One goal of the proposed study was to test the null hypothesis that the event rate is identical in the three groups (no, one, or multiple IPV relationships). The odds ratio for any comparison was 1.0, the log odds ratio (beta) was 0.0, and the relative risk was 1.0. Estimates for the alternate hypothesis were based on the following event rates: No partner IPV = 0.15, one partner IPV = 0.40, and multiple partners IPV = 0.50. The study included a total of 120 subjects with 40 persons in each group. Alpha was set at 0.05 (two-tailed). For this distribution, effect size (0.15, 0.40, 0.50), sample size (120), and alpha (0.05, 2-tailed), power was 0.83. This means that with 120 subjects, 83% of studies would be expected to yield a significant effect, rejecting the null hypothesis that the odds ratio is 1.0.

Population and Sample

The population consisted of help-seeking women from the police, shelters, ATV, and the family counseling agency in Norway. These agencies were chosen as they are the largest

nationwide, state-funded, violence-informed agencies offering professional help for IPV victimized women. The police consider safety issues for the victimized and provide advice and investigation as part of their many tasks. Norway has 12 police districts and 225 police stations. Shelters grant protection, safety, advice, and counseling to women, men, and children victimized by family violence. There are 47 shelters in Norway. ATV provides psychological consultations and treatment for perpetrators and some victims of family violence and has three regional leaders and 14 local offices in Norway. Providing individuals and couples with therapeutic counseling regarding family issues is among the tasks of the family counseling offices. Five regions, encompassing 50 family counseling offices, cover Norway.

The total sample (N = 154) consisted of 36.4% (n = 56) participants recruited from family counseling offices, 35.1% (n = 54) from shelters, 24% (n = 37) from ATV, and 4.5% (n = 7) participants from the police. The participants were recruited in 13 Norwegian counties, from Nordland in the north to Vest-Agder in the south, from Rogaland in the west to Akershus (now Viken) in the east, and in rural as well as urban areas.

Distributed into the case and control groups, the sample consisted of 48 (31.2%) women in the control group (0IPVR), 55 (35.7%) women with one IPV relationship (1IPVR), and 51 (33.1%) women with multiple IPV relationships (2IPVR).

The 154 women were between the ages of 20 and 69 (M = 39.85, SD = 10.28) and had a history of 1 to 13 intimate relationships (M = 2.92, SD = 1.824) (Paper 1, Table 1; Ørke et al., 2018). Among the women with multiple IPV relationships, the range was from 2 (62.7%, 32), 3 (23.5%, 12), 4 (7.8%, 4), and 5 (3.9%, 2) to 6 IPV relationships (2%, 1). Most of the women (85.7%, 132) regarded themselves as native Norwegians, while 14.2% (22) were immigrants with (7) and without (15) Norwegian citizenship. Most women were mothers (90.3%, 139), and these had between one and six children (M = 2.29, SD = 1.030). Mean years of completed education was 15 years, ranging from 7 to 24 years (SD = 3.282). In five interviews (3.2%), a professional interpreter was hired. Significant sociodemograpic and contextual group differences among women with no (0IPVR), one (1IPVR), and multiple IPV relationships (2IPVR) are presented in Paper 3, Table 1(Ørke, Bjørkly, Dufort, & Vatnar, in press).

Measures

The case control study addressed some of the shortcomings of earlier research and investigated some of the main themes revealed in the literature review.

Described in earlier studies:	**Present study:**	**Assessment instruments:**
Sociodemography	Age, education, work/income, etc.	UngVold2015 (accommodated)
Childhood domestic trauma	Childhood adversities	UngVold2015 (accommodated)
Violence characteristics	Conflict tactics: victimization and perpetration	CTS-2 Conflict Tactics Scale
Violence characteristics	Psychological maltreatment: victimization and perpetration	PMWI psychological maltreatment (extended)
IPV risk factors	IPV and risk factors	SARA-V3 Spousal Assault Risk Assessment Guide
Attachment characteristics	Attachment anxiety and avoidance	ECR-N Experiences in Close Relationships
Psychiatric diagnoses	Psychiatric diagnoses	M.I.N.I. psychiatric interview (Version 6.0 and modules from 5.0)
Substance abuse	Psychiatric diagnoses	M.I.N.I.

All questionnaires were available in authorized validated Norwegian versions. The interview was prepared as a codebook with a structured assembly of the instructions and questionnaires.

Childhood Adversities. UngVold2015 (Mossige & Stefansen, 2016) was based on specified questionnaires developed in 2007, and later revised in 2015, to explore the experiences of domestic violence among Norwegian high school students. Some questions were modified or removed in order to meet our adult population, and some questions were removed as they appeared in other questionnaires. UngVold2015 was applied in order to investigate the following themes.

***Violence Between Parents*.** The term *parent* in this study referred to parent, step-parent, parent's new partner, and guardian. All questions about violence between the parents specified each parent separately. Questions from the original study were combined to one question for each violence category, specifying acts as stated in the original study: Mother victimized by physical IPV (specified as acts like shoved, shaken vigorously, hair pulled, pinched, slapped, beaten, and hit with an object), Mother victimized by psychological IPV (specified as acts like shouted at, humiliated, mocked, threatened with violence), Mother victimized by sexualized IPV, Mother victimized by other IPV, Mother injured by father or her new partner in a way that should have medical attention. Likewise, Father victimized by physical IPV, Father victimized by psychological IPV, Father victimized by sexualized IPV,

Father victimized by other IPV, Father injured by mother or his new partner. Answer alternatives were as in the original version, from 0 (*never*) to 6 (*daily*).

***Violence from Parents to Child*.** All questions about violence from parents to child specified each parent separately and specified acts separately. Questions regarding psychological violence from each parent (4 questions) investigated to what degree they had yelled, scolded, humiliated or mocked the child, thrown, hit or kicked close to the child, or threatened with violence. Questions regarding mild physical violence (2 questions) specified shoved, shaken vigorously, hair pulled, pinched, and slapped. Questions regarding serious physical violence (2 questions) included hit, beat, and spanked. Answer alternatives were as in the original version, from 0 (*never*) to 6 (*daily*).

***Childhood Sexual Abuse*.** There were nine questions regarding sexual abuse by anybody before the age of 16, covering unwanted experiences like sexualized touching and penetration. As in the original version, answer alternatives were *never, once,* and *more than once.* An additional variable ("Forced penetration") was computed by combining the three questions regarding Forced intercourse, Anal, and Oral sex.

Childhood Maltreatment. Three subcategories of the Childhood Trauma Questionnaire Short Form (CTQ-SF) (Bernstein, Stein, Newcomb, & Walker, 2003) were included with the UngVold2015 (Mossige & Stefansen, 2016): Physical neglect, Emotional neglect, and Emotional abuse within the family: 15 questions. Answer alternatives were as in the original version from 0 (*never*) to 5 (*very often*).

***Peer Victimization*.** Six questions investigated victimization of bullying and violence by peers before age 18. Answer alternatives were as in the original version from 0 (*never*) to 6 (*daily*).

Single responses of UngVold2015 were analyzed initially, followed by grouping questions into index categories. Frequency scores were calculated by summarizing the scaled responses. Prevalence scores were computed by dichotomizing variables as 0 (*never*) and 1 (*once or more*).

Violence Characteristics. *The Revised Conflict Tactics Scale (CTS-2)*. The CTS-2 (Straus et al., 1996) is a widely used instrument in research on family violence (Straus & Ramirez, 2004). License and per-user fees for the revised Conflict Tactics Scale, CTS-2, Norwegian version, were purchased from Western Psychological Services (WPS website www.wpspublish.com; contract #WPS-001121).

The questionnaire contains 74 questions with 8 response alternatives ranging from 0 (*never)* to 8 (*never last year but has happened earlier)*. The questions within the following

index categories about victimization and perpetration of IPV were applied: Minor psychological aggression, Severe psychological aggression, Minor physical assault, Severe physical assault, Minor sexual coercion, Severe sexual coercion, Minor injury, and Severe injury.

There were a few distinctions regarding wording and amount of questions in the Norwegian version of CTS-2 compared to the original CTS-2 (Bendixen, 2005). The changes regarding sexual coercion were applied, but not to Norwegian questions pertaining to psychological aggression. These could easily be misunderstood by the population studied. To the instruction was added that we were interested in registering all partner violence the last 12 months of the relationship, whether it occurred during conflicts or was independent of conflict situations.

The original score for each answer alternative was recoded to average frequency value for each score according to the following instructions in the scoring sheet: 0 and 7 (n*ever last year; never last year but has happened earlier)* = 0; 1 (o*nce last year)* = 1; 2 (t*wice last year)* = 2; 3 (*3-5 times last year)* = 4; 4 (*6 – 10 times last year*) = 8; 5 (*11 – 20 times last year*) = 15; 6 (*more than 20 times last year*) = 25. All recoded answers within each index category were summarized to calculate frequency of each index category. Prevalence was computed as 0 (*never*) and 1 (*once or more*).

Spousal Assault Risk Assessment Guide version 3 (SARA V-3). The SARA V-3 is a structured professional risk assessment and management tool for IPV (Kropp & Hart, 2015; Vatnar, Knoph-Karlsen, Nesset, Sandvik, & Trønnes, 2017). One category from Appendix B in this guide was applied: Partner violence characteristics (8 items) regarding the last (index) relationship. The 8 items pertain to frightening behavior, threats, physical violence, sexual violence, severe partner violence, continued partner violence, escalated violence, and disobeying restrictions. The SARA V-3 is originally an assessment tool and not a questionnaire, and specifications of each item were listed in the handbook. These were read to the participants when needed. Answers for *recent year* and *previous* were combined and each item was dichotomized as 0 (*no and unknown*) and 1 (*partly and yes*) before analysis.

Psychological Maltreatment of Women Inventory (PMWI). The PMWI, short version, (Alsaker, Kristoffersen, Moen, & Baste, 2011; Tolman, 1999) is a 14-item instrument designed to measure the level of psychological maltreatment of women by their male partners in intimate relationships. It contains two internally consistent subscales labeled Dominance-Isolation (e.g., "my partner was jealous or suspicious of my friends"; "my partner restricted my use of the telephone") and Emotional-Verbal (e.g., "my partner blamed me for his

problems"; "my partner told me my feelings were irrational or crazy"). Three emotional/verbal items were withdrawn from the code book as they were similar to statements in the CTS2. The items were included in the analysis of the subscales. A list of 11 mirrored statements was added to the questionnaire in order to get a picture of maltreatment perpetration as well as victimization throughout the relationship. The scoring system of the PMWI was according to Alsaker and coworkers (Alsaker, Moe, Baste, & Morken, 2014) where the responses were dichotomized to 0 (*never, rarely,* or *sometimes*) and 1 (*often* or *very often*). All women scoring 1 on at least two victimization or perpetration questions were categorized as victimized by psychological violence or perpetrated psychological violence.

Attachment Characteristic. The Experiences in Close Relationships (ECR) investigates attachment orientations in adults (Brennan, Clark, & Shaver, 1998). The Norwegian validated version (ECR-N) is a 36-item questionnaire comprising the following two subscales of 18 statements each: Attachment avoidance (e.g., "I prefer not to show how I feel deep down") and Attachment anxiety (e.g., "I worry about being abandoned") (Olssøn, Sørebø, & Dahl, 2010). The ECR-N was reported to be a psychometrically adequate self-rating instrument of attachment style in a general population of young adults (Olssøn et al., 2010). Both subscales exhibit high internal consistency reliability with Cronbach's alpha of each subscale at 0.85 and higher for both the English and the Norwegian version (Alonso-Arbiol, Balluerka, Shaver, & Gillath, 2008; Brennan et al., 1998; Cassidy & Shaver, 2016; Olssøn et al., 2010). In the present study, Cronbach's alpha for Attachment avoidance was 0.92 and for Attachment anxiety 0.88.

Along with the two subscales, a five-factor model was applied. One study (Pedersen, Eikenæs, Urnes, Skulberg, & Wilberg, 2015) reported that exploratory factor analysis of the ECR indicated five sub factors of 4 to 6 items each, comprising two different aspects of Attachment avoidance and three aspects of Attachment anxiety: Avoidance of closeness, Uncomfortable with openness, Separation frustration, Anxiety for abandonment, and Frantic desire for closeness (Five-Factor Model, ECR-FF).

Respondents were asked to indicate how they in general experience romantic relationships, referring not only to their most recent but also to their prior romantic relationships. The statements were scored on a 7-point scale ranging from 1 (Not true) to 7 (Very much true) anchored by Point 4, "neutral/mixed". The results were derived by computing the mean of the 18 items for the two subscales and of the items for each subfactor, with a possible range from 1 to 7. Higher scores indicated higher levels of Attachment anxiety (labeled *Anxiety* in the tables) and Attachment avoidance (labeled *Avoidance* in the tables)

(Olssøn et al., 2010). Mean score in the Norwegian normative female population was 2.55 for Avoidance and 2.75 for Anxiety (Olssøn et al., 2010). Categories of high and low Attachment anxiety and high and low Attachment avoidance were computed using the mean of the Norwegian normative female sample as the cutoff score, "high" being equal to or greater than cutoff. The categories were analyzed initially for descriptive purposes but not in advanced analyses (Brennan et al., 1998; Mikulincer & Shaver, 2016).

Sociodemographic and Contextual variables. Sociodemographic and contextual variables were drawn from UngVold2015 (Mossige & Stefansen, 2016) and a study of intimate partner homicides by Vatnar and coworkers (Vatnar, Friestad, & Bjørkly, 2017a). Two questions about parents' finances and parents' drug/alcohol problem were drawn from the same study by Vatnar (Vatnar et al., 2017a). One question was developed by the current research group to test a clinical hypothesis regarding how much time the participants generally spend on considering a new partner: "I take my time when I choose a new partner" (Considers partner). The response (1, *no, not true* or 2, *yes, true* or *partly true*) was analyzed separately among the sociodemographic control variables.

The following single items were developed especially for this study. "Are you presently involved in an IPV relationship?" (1, *no* or 2, *yes*); Duration of index relationship (labeled *Length of relationship*); Age of index partner; "If not in a relationship, how long time is it since it was terminated?"; "How many intimate relationships that lasted for more than six months have you been involved in after turning 16?"; "Number of intimate relationships (> 6 months) where you were victimized of IPV"; "Number of intimate relationships (> 6 months) where you perpetrated IPV"; three identical questions regarding any intimate relationships before turning 16; Age at initiation of first intimate relationship; "Do you have a person you can confide in?" (1, *no* or 2, *yes*) (reversed and labeled "*No confidants*" in the table); and "I take my time when I choose a new partner" (0, *no* or 1, *partly/completely true*) (labeled *Considers partner*). At the end of the interview: "Were there language misunderstandings during the interview?" (0, *no* or 1, *a few/ quite a bit*) ("Language challenges"); "In case we establish a follow-up study within five years after this study is finished, would you allow us to seek contact with you?" (1, *no* or 2, *yes*, and contact information). The two final questions were drawn from a study by Vatnar (Vatnar, 2009): "How did you experience this interview?" (Four answer alternatives); and "Do you have any comments on the questions or are there things of importance I did not ask about?"

Other Measures. Some measures pertaining to other research questions were applied but analyses were not within the scope of this PhD study. Psychiatric Axis I diagnoses were

covered by the Mini International Neuropsychiatric Interview (Sheehan et al., 1998), Norwegian translation version 6.0.0. and MINI plus, version 5.0.0. Perpetrator risk, victim vulnerability factors, and questions regarding children, pregnancy, and parents were investigated applying parts of the SARA V-3 (Kropp & Hart, 2015). A questionnaire regarding responsibility, shame, and guilt for the IPV was drawn from Vatnar (Vatnar & Bjørkly, 2010).

Statistical Analyses

In the case control study, frequency and descriptive analyses were applied initially to describe the sample and subgroups and search for significant group differences. The Kruskal-Wallis test was used to test for possible independent group differences for variables with nonparametric score distributions for more than two independent groups, and the Mann-Whitney U test, for two independent groups. The Pearson chi-square test was used for nominal data and unrelated groups.

Two dichotomies were analyzed in the multiple logistic regression analyses:

(1) Victim (1IPVR+2IPVR) – non-victim (0IPVR).

(2) Victim in one IPV relationship (1IPVR) – victim in two or more IPV relationships (2IPVR).

Univariate and bivariate analyses were conducted to compare these subgroups and to inform the selection of variables to be included in the multivariate analyses. Multivariate logistic regression analyses were used to examine risk and protective factors associated with (1) IPV victimization in general (1IPVR and 2IPVR) and (2) IPV revictimization by MP (2IPV).

The stepwise options recommended for logistic regression for small samples were used (Altman, 1991; Pallant, 2010). Step 1: Initial comparisons of the two groups were carried out by simple descriptive cross-tabulations with Pearson chi-square for categorical and nominal variables. For continuous variables, *t* tests for independent samples were used. Non-parametric tests were used in case of skewed distribution. Step 2: In the first multivariate logistic regression analyses, variables with significance ($p \leq 0.05$) or trend ($p \leq 0.10$) in bivariate analyses were adjusted for other variables with significance or trend within the same category. Step 3: Significant differences remaining within each variable category after each of the comparisons in Step 2 were forwarded to Step 3 where all remaining group differences across categories were adjusted for. Variable selection method was Forward Wald. Suitability for multivariate logistic regression analysis was investigated by the Hosmer-Lemeshow test. Cox & Snell R Square and Nagelkerke R Square were used to estimate the proportion of

explained variance in the multivariate models that were tested (Pallant, 2010). This is referred to as model strength in the presentation of results. Values were estimated as model fit indices for the regression models.

Paper 2: Categories for analyses in Paper 2, Step 2 were (a) victimization and perpetration of IPV in index relationship, (b) childhood family violence, (c) other childhood adversities, and (d) sociodemographic and contextual variables.

Paper 3: Category for analysis in Paper 3, Step 2 was sociodemographic and contextual variables. Attachment variables with significant or trend group differences from Step 1 were forwarded to Step 3 where each of them was tested in a separate multivariate logistic regression model adjusted for all remaining sociodemographic and contextual group differences from Step 2. In Step 4, significant variables of childhood adversities were added, retrieved from analyses reported in Paper 2. These were included as possible meditators. In two extended models, interaction effects between the attachment factor and each of the significant childhood adversities were adjusted for. Only models with significant attachment variables were reported.

Statistical analyses were performed using the statistical program package SPSS, version 25. A conventional *p*-value of ≤ 0.05 was used.

Ethics

The case control study was approved by the Norwegian Regional Ethics Committee (2016/2304) (Appendix B, Regional Ethics Committee Approval) and Oslo University Hospital (2017-2490). All ethical and safety recommendations from the World Health Organization were observed (WHO, 2001). All cases were included irrespective of socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, and age. Women were included regardless of the sex of their partner.

An information-consent letter (Appendix A) informed the participants about the objectives and that some questions were of an intimate nature. They were assured that their participation was voluntary, that they were free to withdraw from the study at any time, that withdrawal would not affect services they received at the recruitment office, that information would be stored confidentially, and that they were welcome to call the researcher on a given phone number. Safety pertains to physical safety as well as emotional well-being (Hamberger, Larsen, & Ambuel, 2020). Safety issues in the present study were taken care of by arranging the interview in a safe place and assuring the research protocol protected privacy and

confidentiality. For emotional well-being, time breaks were used when needed, and participants were welcome to call the interviewer afterwards.

Women who were not fluent in the Norwegian language were informed that a professional interpreter could be hired for the interview.

In interviews where suicidal ideation was confirmed, the follow-up of this was discussed with the participant at the end of the interview. These participants identified a trusted person whom the researcher contacted personally in the immediate aftermath of the interview.

A reference group was established according to prerequisites from the Norwegian Regional Ethics Committee. The intention with the group was to present and discuss the study and results with persons having academic, political, or personal interest in the topic. It was assumed that they had valuable experience, knowledge, ideas, and reflections that could improve the research, analyses, and dissemination of results.

The members came from Karolinska Institutet and the Swedish National Board of Health and Welfare, Shelter management, Representatives of victimized women, the Department of Justice, and the Shelter High Quarter. The invited police representative was no longer working in the police. The group met with the head of the project and main supervisor and the researcher. Two meetings were arranged, and one more is planned.

Results

Paper 1. Systematic Review of Research on IPV Revictimization by Multiple Partners

Ørke, E., Vatnar, S., & Bjørkly, S. (2018). Risk for revictimization of intimate partner violence by multiple partners: A systematic review. *Journal of Family Violence, 33*(5), 325-339. doi:10.1007/s10896-018-9952-9

The systematic literature review findings from this study indicated that empirical research on IPV by multiple partners appeared to be scarce and with only limited recent development. Seven scientific articles reported results regarding women victimized by IPV by MP as opposed to women victimized by one partner.

Study Characteristics

The seven articles were published between 2002 and 2016 (see Paper 1, Table 1, Summary of reviewed studies). All studies used quantitative analyses. Six out of seven studies used multivariate analyses (MANOVA, logistic regression analysis and linear regression

analysis), and one study (Coolidge & Anderson, 2002) only used a series of analysis of variance (ANOVA).

All studies were conducted in the United States except for one which was conducted in Norway (Vatnar & Bjørkly, 2008). Five studies had a cross-sectional design (Alexander, 2009; Bogat, Levendosky, Theran, von Eye, & Davidson, 2003; Coolidge & Anderson, 2002; Stein et al., 2016; Vatnar & Bjørkly, 2008), whereas two applied a longitudinal design with a 12-month span between measurements (Cole et al., 2008; Testa et al., 2003). One study (Stein et al., 2016) identified primarily victim-related characteristics associated with the number of violent partners with whom the women had been involved, but in addition, group differences between 1IPVR and 2IPVR were reported. Sample sizes ranged from 93 (Alexander, 2009) to 412 women (Cole et al., 2008). The populations consisted of women in a heterosexual relationship (Testa et al., 2003), women who had been involved in a romantic relationship for at least 6 weeks during a pregnancy (Bogat et al., 2003), and women who had been exposed to IPV (Stein et al., 2016) or were seeking service from police, shelters, family counseling, or educational treatment groups (Alexander, 2009; Cole et al., 2008; Coolidge & Anderson, 2002; Vatnar & Bjørkly, 2008). Race was reported in five studies, ranging from 28% (Stein et al., 2016) to 75% White women (Testa et al., 2003). Mean age of the women ranged from 24 (Testa et al., 2003) to 37 years (Alexander, 2009). No reliable prevalence estimates of IPV by MP were found. In the victimized populations, there were from 22.9% (Vatnar & Bjørkly, 2008) to 56% women with IPV by MP (Alexander, 2009). Theories and perspectives that were investigated related to victim psychopathology (Coolidge & Anderson, 2002), attachment (Alexander, 2009), the interactional perspective (Vatnar & Bjørkly, 2008), stress (Bogat et al., 2003), and substance use (Testa et al., 2003).

Risk of Bias within Studies

Violence was measured with varying questions. All studies except for one (Coolidge & Anderson, 2002) applied some subscales or selected questions from the Conflict Tactics Scale or a revised version of it (Straus et al., 1996). Other selected or modified questions were drawn from the Severity of Violence Against Women Scales (SVAWS) (Bogat et al., 2003), Tolman's Psychological Maltreatment of Women Inventory (PMWI) (Cole et al., 2008), the British Crime Survey 1996 (Vatnar & Bjørkly, 2008), and the National Violence Against Women Survey (Cole et al., 2008). One study included stalking explicitly (Cole et al., 2008). The Coolidge study (2002) used a 12-item demographic questionnaire to cover both current and past history of violence (Coolidge & Anderson, 2002). Trauma history was recorded in four studies (Alexander, 2009; Cole et al., 2008; Coolidge & Anderson, 2002; Vatnar &

Bjørkly, 2008), with the number of items ranging from less than 12 questions in one investigation (Coolidge & Anderson, 2002) to 54 questions in another (Vatnar & Bjørkly, 2008). None of the studies used a specific instrument to identify women with IPV by MP for sample selection. Four studies recorded retrospectively whether or not there had been violence in previous intimate partnerships (Alexander, 2009; Coolidge & Anderson, 2002; Vatnar & Bjørkly, 2008) or the number of violent previous partners (Stein et al., 2016), and three studies used separate violence scores for separate relationships (Bogat et al., 2003; Cole et al., 2008; Testa et al., 2003). Some studies reported IPV characteristics in prior relationships (Cole et al., 2008; Testa et al., 2003), some in present (Alexander, 2009; Stein et al., 2016), and one across relationships (Bogat et al., 2003). For presentation of all outcomes, see Paper 1, Table 2.

Synthesis of Results

The seven articles reported significant group differences between women with IPV by one partner and women with IPV by MP and specific victim-related statistical risk factors for IPV by MP (Table 2).

Group differences reported from simple bivariate analyses were within the following domains: (a) childhood domestic trauma, like physical, emotional, and sexual abuse by a parent or guardian, and witnessing IPV; (b) lifetime victimization, like cumulative lifetime victimization, non-sexual assault, and being held hostage; (c) family-of-origin characteristic (parent-child role reversal with mother); (d) attachment (unresolved attachment); (e) psychopathology, like higher scores on some Axis II scales; post-traumatic stress symptoms, anxiety, depression, and use/abuse of illicit drugs and alcohol; (f) IPV characteristics in previous or across relationships, like more severe prior IPV, more prior stalking, and higher IPV severity in the current relationship; and (g) socio-demographic measures like age, social security benefits recipients, longer involvement with the partner, lower relationship satisfaction, lower emotional support, and maladjustment. Group differences reported from multivariate analyses regarding risk factors for IPV by MP were the following: (a) childhood domestic trauma, including emotional abuse, sexual abuse, physical violence, witnessing IPV, and multiple forms of childhood trauma; (b) lifetime victimization, including cumulative lifetime victimization, non-sexual assault, and being held hostage; (c) unresolved attachment; (d) use/abuse of illicit drugs and alcohol; (e) long involvement with new partner; (f) lower age; and (g) being social security recipients.

Risk of Bias Across Studies

There were no explicit, uniform operational definitions of IPV, childhood trauma, the psychopathological variables, drug or alcohol use, or other variables of interest, and, thus, conclusions on summarized between-study comparisons must be made with caution.

The study that used ANOVA (Coolidge & Anderson, 2002) could be expected to produce different results than the six investigations that conducted multivariate statistical testing.

Two studies used a longitudinal design (Cole et al., 2008; Testa et al., 2003) and thus registered which risk factors were present before the initiation of a new relationship. With the five cross-sectional studies, it is not known whether the outcomes were precursors, predictors, or consequences of IPV (Bogat et al., 2003).

The data in all seven studies were self-reported and thus subject to response biases such as social desirability and recall bias.

Paper 2. IPV Characteristics, Childhood Violence, and Adversities

Ørke, E. C., Bjørkly, S., & Vatnar, S. K. B. (2020). IPV characteristics, childhood violence, and adversities as risk factors for being victimized in multiple IPV relationships. *Journal of Interpersonal Violence.* doi:10.1177/0886260520933037

IPV Victimized Women Compared to Non-Victimized Women

In order to attain goodness-of-fit, the variables were analyzed in two multivariate logistic regression models. Model 1 contained 10 variables: 4 significant childhood family violence variables; childhood physical neglect; childhood sexual abuse; peer victimization; immigrant partner; work/income status; and length of education (Paper 2, Table 3, Model 1). Hosmer and Lemeshow test = .937, indicating goodness-of-fit of the model. Three of the variables made a unique statistically significant contribution to the model: childhood sexual abuse (OR = 2.817, 95% CI [1.196, 6.635], p = .018), peer victimization (OR = 1.115, 95% CI [1.003, 1.238], p = .044), and immigrant partner (OR = 12.553, 95% CI [2.795, 56.207], p = .001). Model 1 explained between 20.5% (Cox & Snell R Square) and 28.9% (Nagelkerke R Square) of the variance between the victimized and the non-victimized group.

Model 2 contained the same variables as Model 1, excluding childhood sexual abuse, including length of relationship (Paper 2, Table 3, Model 2). Hosmer and Lemeshow test = .216, indicating goodness-of-fit of the model. Three of the variables made a unique statistically significant contribution to the model: peer victimization (OR = 1.130, 95% CI [1.016, 1.256], immigrant partner (OR 13.146, 95% CI [2.833, 60.990], p = .001), and length

of relationship (OR 0.995, 95% CI [0.991, 0.998], p = .006). This model explained between 21.8% (Cox & Snell R Square) and 30.6% (Nagelkerke R Square) of the variance between the victimized and the non-victimized group.

These results indicated that compared to non-victimized women, the victimized women had more than two and a half times higher likelihood of reporting childhood sexual abuse, they had 11 – 13% higher likelihood of reporting peer victimization, and risk of victimization was marginally increased by shorter index relationship. Having an immigrant partner was the variable that indicated the highest risk of reporting IPV. However, the 95% confidence interval (CI) for this factor was wide (Paper 2).

Women Revictimized by Multiple Partners Compared to Women Victimized by One Partner

The final multivariate logistic regression model contained the following eight variables: victim perpetrated minor physical assault, psychological violence from father, father victimized by physical IPV, childhood emotional abuse, years of education, immigrant victim, length of relationship, and work/income (Paper 2, Table 4). Hosmer and Lemeshow test = .324, indicating goodness-of-fit of the model. Three of the variables made a unique statistically significant contribution to the model: Childhood emotional abuse (OR = 1.140, 95% CI [1.052, 1.235], p = .001), years of education (OR = 0.859, 95% CI [0.740, 0.996], p = .044), and immigrant victim (OR = 0.130, 95% CI [0.028, 0.592], p = .008). This model explained between 24.6% (Cox & Snell R Square) and 32.8 % (Nagelkerke R Square) of the variance between the women victimized by one and multiple partners.

These results indicated that compared to women victimized in one relationship, women with IPV by multiple partners had a 14% higher likelihood of reporting more childhood emotional abuse. They had shorter education, and they were more likely to be of Norwegian origin.

Childhood family violence did not appear in multivariate analyses a risk factor for IPV by multiple partners. Moreover, the two groups of IPV victimized women were indistinguishable regarding characteristics of victimization and perpetration of IPV.

Paper 3. Attachment Characteristics

Ørke, E.C., Bjørkly, S., Dufort, M., & Vatnar, S. (in press). Attachment characteristics among women with no, one and multiple IPV relationships. A case control study. *Violence Against Women*.

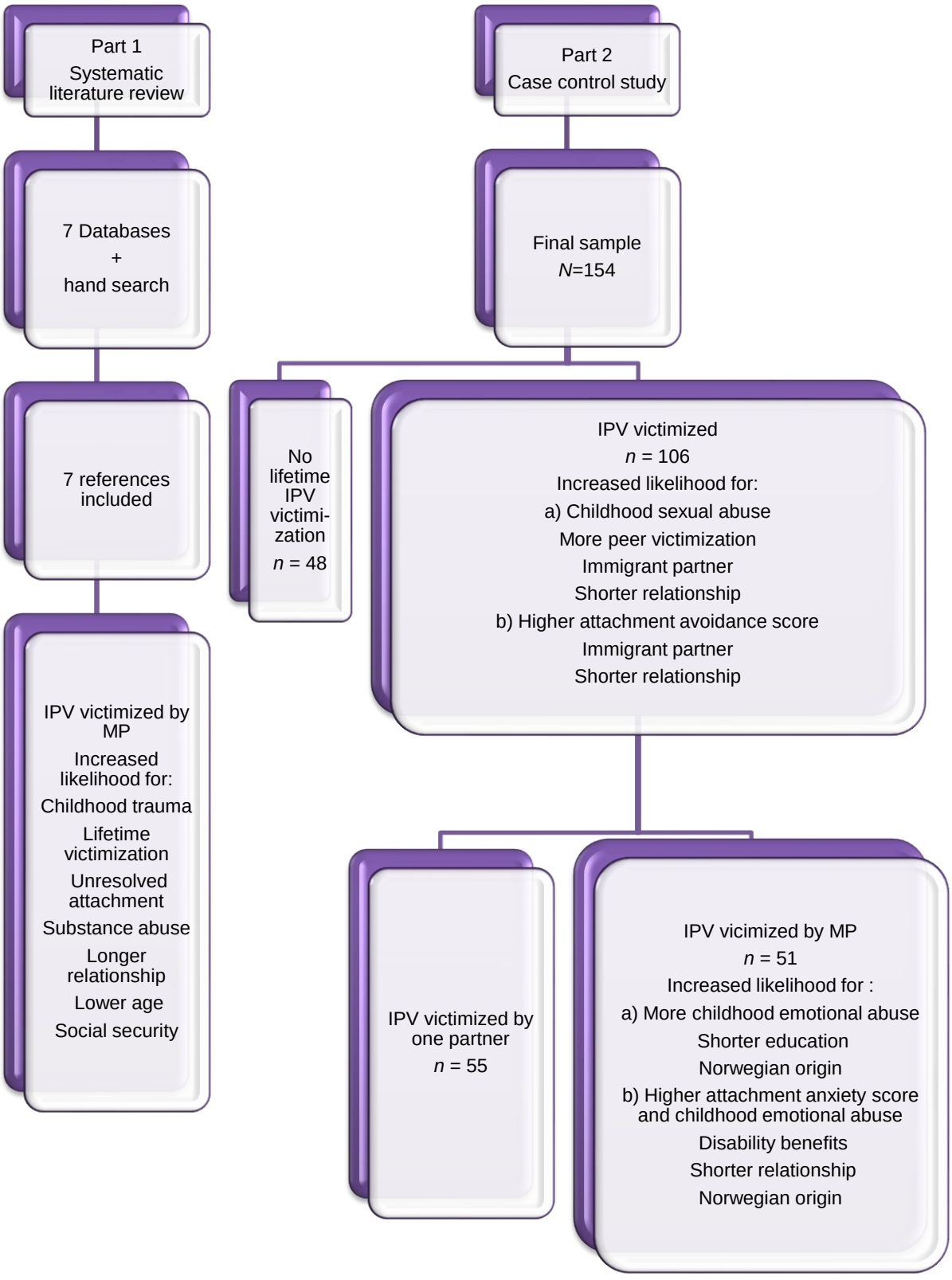
IPV Victimized Women Compared to Non-Victimized Women

Each of the six significant or trend attachment variables, namely, attachment anxiety, attachment avoidance, avoidance of closeness, uncomfortable with openness, anxiety for abandonment, and frantic desire for closeness, was analyzed in separate logistic regression models, adjusted for the two significant contextual variables: immigrant partner and length of index relationship (Paper 3, Table 3, Model 1). The results showed that three avoidance variables impacted the likelihood for reporting IPV victimization: Compared to the non-victimized group, the IPV victimized group had more than 3 times increased likelihood of having a higher attachment avoidance score (OR = 3.352, 95% CI [2.036, 5.517], $p \leq .001$). Hosmer and Lemeshow Test = .856, indicating goodness-of-fit of the model. This model explained between 34.7% (Cox & Snell R Square) and 48.6% (Nagelkerke R Square) of the variance between the two groups. Moreover, the IPV victimized group had more than 2 times increased likelihood of a higher avoidance of closeness score (OR = 2.214, 95% CI [1.525, 3.213], $p \leq .001$). Hosmer and Lemeshow Test = .996, indicating goodness-of-fit. This model explained between 29.4% (Cox & Snell R Square) and 41.2% (Nagelkerke R Square) of the variance between the two groups (Paper 3, Table 3, Model 2). The IPV victimized group had more than two and a half times increased likelihood of a higher uncomfortable with openness score (OR = 2.700, 95% CI [1.741, 4.188], $p \leq .001$). Hosmer and Lemeshow Test = .212, indicating goodness-of-fit. This model explained between 32.4% (Cox & Snell R Square) and 45.4% (Nagelkerke R Square) of the variance between the two groups (Paper 3, Table 3, Model 3a).

When each of the three remaining avoidance variables were adjusted for two significant sociodemographic variables (immigrant partner and length of index relationship) and two significant childhood adversity variables (childhood sexual abuse and peer victimization) retrieved from a previous part of the study (Paper 2; Ørke et al., 2020), uncomfortable with openness was the only attachment variable that remained explanatory for the variance between the two groups. In this final model (Paper 3, Table 3, Model 3b), the following four of the five variables made a unique statistical significant contribution: Uncomfortable with openness (OR = 2.656, 95% CI [1.697, 4.157], $p \leq .001$), childhood sexual abuse (OR = 2.784, 95% CI [1.071, 7,236], $p = .036$), immigrant partner (OR = 22.494, ,95% CI [4.215, 120.025], $p \leq .001$), and (shorter) index relationship (OR = 0.993, 95% CI [0.989, 0.997], $p = .001$). Hosmer and Lemeshow Test = .149, indicating goodness-of-fit of the model. This model explained between 34.4% (Cox & Snell R Square) and 48.3% (Nagelkerke R Square) of the variance between the two groups. The results indicated that both childhood sexual

Figure 2

Main results: Part 1 displays results from Paper 1. Part 2 displays results from a) Paper 2 and b) Paper 3.



abuse and uncomfortable with openness were independent risk factors for IPV. As in the analyses presented in Paper 2 (Ørke et al., 2020), having an immigrant partner was the variable that indicated the highest risk of reporting IPV. However, the 95% CI for this factor was wide. Moreover, victimized women had shorter relationships than non-victimized, but the likelihood was marginal.

Women Revictimized by Multiple Partners Compared to Women Victimized by One Partner

Compared to women victimized by one partner, women revictimized by multiple partners had a 78% increased likelihood of a higher attachment anxiety score (OR = 1.776, 95% CI [1.085, 2.909], p = .022).

The final model (Paper 3, Table 4, Model 4b) contained the significant attachment variable attachment anxiety adjusted for three significant sociodemographic variables (work/income, length of relationship, and immigrant), one significant childhood adversity variable (childhood emotional abuse) retrieved from a previous part of the study (see Paper 2; Ørke et al., 2020) and an interaction effect between attachment anxiety and childhood emotional abuse. The following four of the variables made a unique statistically significant contribution to the model: The interaction variable attachment anxiety by childhood emotional abuse (OR = 1.031, 95% CI [1.010, 1.053], p = .004), disability benefits (OR = 13.551, 95% CI [1.603, 114.558], p = .017), length of relationship (OR = 0.990, 95% CI [0.983, 0.997], p = .004), and immigrant (OR = 0.114, 95% CI [0.020, 0.649], p = 0.14). Hosmer and Lemeshow test = .416, indicated goodness-of-fit of the model. The model explained between 37.5% (Cox & Snell R Square) and 50.1% (Nagelkerke R Square) of the variance between the two groups victimized by one or multiple partners. The model showed that an interaction of attachment anxiety and childhood emotional abuse increased the likelihood of IPV by multiple partners. Being a disability benefits recipient indicated the highest risk of reporting IPV by multiple partners. However, the 95% CI for this factor was wide. Immigrant women had reduced risk of IPV by multiple partners.

A flow diagram with the main results is presented in Figure 2, Main results.

Discussion

Main Findings

The results indicated that there are specific victim-related risk factors for IPV by MP. The systematic literature review revealed a small body of previous research on differences between women with IPV from one and MP. Some victim-related risk factors were reported

from multivariate analyses: Women with IPV by MP reported more childhood domestic trauma, lifetime victimization, unresolved attachment, and use/abuse of illicit drugs and alcohol (substance). They had longer involvement with new partner, lower age, and higher risk of being social security recipients. In the subsequent case control study, some of the retrieved themes were explored, expanded, and compared.

Results from the case control study indicated that compared to non-victimized, IPV victimized women had nearly 3 times increased likelihood of reporting prevalence of childhood sexual abuse. They reported higher frequency of childhood peer victimization and had increased likelihood of having an immigrant partner. In addition, length of the intimate relationship was shorter for IPV victimized women. The strongest multivariate model comparing victimized to non-victimized indicated that victimized women had more than 3 times increased likelihood of higher attachment avoidance score.

The results indicated risk factors specific for IPV by MP. Compared to women victimized in one relationship, women with IPV by MP had higher likelihood of reporting more childhood emotional abuse, had less education, and were more likely to be native Norwegian than women with one IPV relationship. Women with IPV by MP had almost 2 times increased likelihood for higher scores on Attachment anxiety. The strongest multivariate model comparing the two groups of victimized women indicated that a small but significant interaction between attachment anxiety and childhood emotional abuse was a risk factor for IPV by MP. Other risk factors in this model were disability benefits, shorter relationship, and being native Norwegian.

The two groups of victimized women were indistinguishable regarding perpetration and victimization of IPV in the most recent relationship.

Compared to non-victimized in bivariate analyses, IPV victimized women reported more childhood family violence witnessing and victimization. However, these group differences disappeared when controlled for other adversities in multivariate analyses.

Systematic Review of Research on IPV by Multiple Partners

There is massive body of IPV research. Prevalence and adverse consequences of IPV victimization are clearly documented. Still, little was known about victim-related factors that contribute to women having repeated experiences of IPV by MP. The systematic literature review study revealed that the body of research on IPV by MP in particular was limited. In spite of public and clinical awareness of the seriousness of IPV by MP, it appeared to have attracted limited scientific attention (see Paper 1; Ørke et al., 2018).

The systematic review retrieved seven studies that reported victim-related differences between women victimized by one partner and women with IPV by MP (Paper 1; Ørke et al., 2018). All studies had an acceptable sample size. Several significant group differences were reported from bivariate analyses. Except for one (Coolidge & Anderson, 2002), the studies conducted multivariate statistical analyses allowing testing of risk factors. Here some initial group differences disappeared.

The reports of multivariate analyses indicated that women subjected to IPV by MP reported more childhood victimization, like childhood emotional, physical, and sexual abuse and witnessing parents' physical abuse (Alexander, 2009; Stein et al., 2016; Vatnar & Bjørkly, 2008). This was the factor with the strongest empirical evidence in the review study. Only one study failed to find this association significant; notably this was the study with the weakest methodology in terms of measurement and statistical analyses (see Paper 1; Ørke et al., 2018).

The use of a standard case definition is one key factor needed to ensure that information is collected in a systematic fashion (German et al., 2001). Among the seven reviewed studies, there were no explicit, uniform operational definitions of intimate partner violence or other central variables of interest. The risk of bias increased when measurement scales had been developed by the authors and had not been adequately validated before the investigations took place (Fellmeth, Heffernan, Nurse, Habibula, & Sethi, 2013; Ørke et al., 2018).

The limited number of studies on risk of IPV by MP and the absence of the use of similar measurement tools in these investigations precluded making firm conclusions about risk factors (Ørke et al., 2018). Four of seven studies were cross sectional risk studies. The suggested risk factors were far from establishing causal relationships. Risk factors do not predict or explain an outcome; they contribute to an explanation of an estimated amount of the variance between the outcome groups. There were no studies assessing which targeted causal factors were likely to change outcomes (Schooling & Jones, 2018). The findings in the review offered no valid evidence for a single-factor explanation or for a multifactorial trajectory of IPV by MP. However, they offered hypotheses of differences between women victimized by one and MP and suggested variables that needed further testing.

Childhood victimization (e.g., sexual abuse, physical violence, and witnessing IPV) was the risk factor with the strongest empirical support in the review study (Paper 1; Ørke et al., 2018). This topic was chosen for comparative investigation in the case control study. Should childhood variables be supported in the present study, an investigation is needed

regarding mediating factors between these distal childhood experiences and present adulthood experiences of IPV by MP.

A history of childhood family violence has been reported among IPV perpetrators. IPV perpetration was reported as a risk factor for revictimization in general. The review study was inconclusive regarding present IPV characteristics among women with one or MP. No studies had investigated victim perpetration. Therefore, both IPV perpetration and victimization were investigated in the case control study.

Unresolved attachment was reported from one study (Alexander, 2009), but evidence regarding attachment was too weak to promote conclusions (see Paper 1; Ørke et al., 2018). In line with this, adult attachment was included in the case control study.

The literature review indicated longer involvement with new partner, lower age, and being social security recipients as risk factors for IPV by MP. Consequently, these variables were included among sociodemographic control variables in the subsequent study.

Two reviewed studies used a longitudinal design (Cole et al., 2008; Testa et al., 2003) and were as such of special interest. They registered variables before the initiation of a new relationship allowing hypotheses of chronology. Moreover, a possible recall bias difference between the groups was reduced. Both studies reported drug use/abuse ahead of victimization by new partner. This topic has so far not been analyzed in the present study but wants further investigation.

Summing up the above, in the case control study, the themes childhood family violence, other childhood adversities, IPV characteristics, and attachment characteristics became systematically investigated as risk factors for IPV by MP, controlling for sociodemographic and contextual variables.

Childhood Violence and Adversities

IPV Victimized Women Compared to Non-Victimized Women

Childhood Sexual Abuse. Prevalence of childhood sexual abuse (CSA) increased risk of adult IPV almost 3 times and was a main risk factor for victimization of adult IPV. Regarding the most severe forms of CSA, every participant who reported victimization of forced penetration in childhood (n = 26) was found in the IPV victimized sample. None of the participants in the non-victimized sample reported this form of CSA. In the total sample, 41% reported childhood sexual abuse. In comparison, two Norwegian prevalence studies reported CSA among 21% - 29% of the women (Mossige & Stefansen, 2016; Thoresen & Hjemdal, 2014). Consequences of CSA have been studied extensively. The present results of CSA as a risk factor for IPV corresponded to the massive literature about problems in the aftermath of

CSA. Sexually abused subjects have reported higher levels of general psychological distress; higher rates of both major psychological disorders and personality disorders; higher rates of substance abuse; binge eating; somatization; suicidal behaviors; poorer social and interpersonal relationship functioning; greater sexual dissatisfaction, dysfunction, and maladjustment, including high-risk sexual behavior; a greater tendency toward physical and sexual revictimization at subsequent times during later adolescence and young adulthood; and more severe physical partner violence (Polusny & Follette, 1995; Trickett et al., 2011). In addition, Trickett and coworkers reported that sexually abused females had earlier onset of puberty, more teen motherhood, and more dropping out of high-school. The present results of multivariate logistic regression reinforced the body of literature pointing to CSA as an important risk factor for IPV victimization in general (e.g., Barrios et al., 2015; Coid et al., 2001; Stroem et al., 2019; Vézina & Hébert, 2007; Whitfield et al., 2003).

While results of the present study indicated CSA as a risk for IPV in general, some other studies have reported CSA as a risk for IPV by MP in particular. Alexander (2009) asked only one single question about sexual abuse. Stein and coworkers (2016) combined CSA with other traumas in one category (CSA, being held hostage, torture) while CSA was investigated separately in the present study. Vatnar and coworkers (2008) restricted CSA to household members only, reporting that women who had been subjected to sexual abuse in their family of origin were at almost 25 times increased risk of IPV victimization in more than one partnership (Vatnar & Bjørkly, 2008). The present study posed nine specific questions about a variety of sexual transgressions perpetrated by anybody. The divergent results may partly be due to measurement differences. In the present study, CSA constituted a risk for IPV in general and was highly prevalent in the victimized group.

As described in the Introduction section, Finkelhor and Browne (1985) proposed four trauma-causing factors - traumagenic dynamics - for understanding the psychological injury inflicted by sexual abuse. The factors were stigmatization, powerlessness, traumatic sexualization, and betrayal. There was no one-to-one correspondence between dynamics and effects, and it was argued that the conjunction of these four dynamics was what made the trauma of sexual abuse unique. Stigmatization distorted children's sense of their own value and worth. Negative connotations – for example, badness, shame, and guilt – were communicated to the child around the experiences and incorporated into the child's self-image and self-esteem. Powerlessness referred to the process in which the child's will, desires, and sense of efficacy were continually contravened. The dynamics of powerlessness distorted children's sense of ability to control their lives. Traumatic sexualization referred to a

process in which a child's sexuality including both sexual feelings and sexual attitudes were shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. Betrayal referred to the dynamic by which children discovered that someone on whom they were vitally dependent had caused them harm. Sexual abuse victims suffered from grave disenchantment and disillusionment. Betrayal was associated with an intense need to regain trust and security and an impaired judgment about the trustworthiness of other people (Finkelhor & Browne, 1985). Feiring, Taska, and Lewis (1996) presented a model that specified psychological mechanisms related to the traumagenic dynamics of stigmatization in child and adolescent victims of sexual abuse. The model proposed that sexual abuse lead to shame. This was mediated through cognitive attributions about the abuse (e.g., self-blame). Shame, in turn, led to poor adjustment.

Betrayal was emphasized in betrayal trauma theory, too (Freyd, 1994). Here it was argued that repeated dissociation resulting from caregiver-perpetrated childhood maltreatment might lead to a generalized problem in detecting violations of social contracts and increase risk for future victimization in adulthood (DePrince, 2005). In Alexander's (2009) study, significantly more women with IPV by MP had elevated levels of borderline personality traits and dissociation, but the conclusion after multivariate analyses was that neither dissociation nor borderline traits differentiated the two groups (p. 84). Neither Kuijpers' review regarding revictimization of IPV (Kuijpers et al., 2011) or our own review regarding revictimization of IPV by MP (Ørke et al., 2018) found that PTSD or dissociation increased the likelihood of subsequent IPV. The betrayal aspect is interesting, but with the emphasis on dissociation, betrayal trauma theory did not increase understanding of particular risk of IPV by MP.

Peer Victimization. Peer victimization has received little attention in IPV victimization risk studies. An association was reported between the perpetration of both bullying and IPV (Corvo & Delara, 2010). One study among Norwegian teenagers reported an association between teenage IPV victimization and bullying victimization (Hellevik & Øverlien, 2016). The present study was the first to scrutinize the link between peer victimization and adult IPV victimization. In the present study, frequency of peer victimization in childhood increased the risk for IPV in general. The increase was slight, but significant. Controlling for significant attachment variables in multivariate analysis, frequency of peer victimization appeared non-significant (Paper 3, Table 3, Model 3b; Ørke, in press).

Finkelhor and coworkers (2007) stated that poly-victimization was a neglected component in child victimization. They argued that poly-victims suffered from more symptoms than children with only repeated episodes of the same kind of victimization. The

researchers emphasized a need to assess for a broader range of victimizations and avoid studies and assessments organized around a single form of victimization (Finkelhor, Ormrod, & Turner, 2007). IPV victimized women in the present study reported high prevalence of child sexual abuse. An interaction with peer victimization may have even more deleterious effects on the victims' sense of their own value and worth.

Women Revictimized by Multiple Partners Compared to Women Victimized by One Partner

Childhood Emotional Abuse. Frequency of childhood emotional abuse was the main risk factor for IPV by MP in particular. Among the childhood family variables, other childhood adversities, IPV characteristics, and sociodemographic variables, frequency of childhood emotional abuse was the risk factor with highest odds ratio for IPV by MP. Emotional abuse was domestic "verbal assaults on a child's sense of worth or well-being or any humiliating or demeaning behavior" (Bernstein et al., 2003).

The present study distinguished between different kinds of childhood violence and adversities, and between psychological violence and emotional abuse. This allowed an improved understanding of risk factors. It became apparent that specific childhood adversities represented specific risk factors. Initial bivariate analyses indicated that women with IPV by MP had experienced more physical violence among the parents, more physical violence from the father, and more physical and emotional neglect at home, than women with IPV by one partner. However, these variables diminished in the multivariate analyses. Childhood family violence did not appear as a risk factor for IPV or for IPV by MP. However, childhood emotional abuse did.

Cascio and coworkers (2020) suggested that psychological abuse perpetrated by attachment figures in childhood impairs emotional regulation and fosters maladaptive models of the self and the other. This type of abuse may promote a model of the self as bad and unworthy and a model of the other as abusive, hostile, or rejecting, introducing the expectation of abusive or violent interactions in adulthood, too.

While Cascio and coworkers suggested expectation of abusiveness as a risk factor for IPV, the object relations theory suggested craving for love. The object relations theory argued that lack of love in a young child's life was traumatic and disruptive to the child's attachment (Nicholas, 2013). A rejected child had increased need for love and protection because her earlier needs were never fulfilled. In adulthood, the object of the focus can shift from the parents to the lover, or spouse (Celani, 1999). Fairbairn posited that the intense idealization of someone who seems to everyone else to be a bad choice is the repetition of this specific

survival strategy learned in childhood (Celani, 1999). The results of the present study suggested that women with IPV by MP experienced lack of love in childhood. It may be an intense need for love as formulated in the object relations theory that increased women's vulnerability for IPV by MP.

Attachment theory suggests that if attachment figures were unresponsive or erratically responsive, people might develop a sense of attachment-related insecurity (Finkel & Eastwick, 2015). Childhood maltreatment (physical, sexual, or emotional abuse), neglect (disengaged and extremely insensitive parenting), and child witnesses to family violence were consistently found to increase the rate of children's attachment insecurity (Mikulincer & Shaver, 2016). Attachment theory postulates that development of insecure attachment styles in children tend to persist over time and will continue into adulthood. This could contribute to attachment patterns during adolescence and adulthood, frequently cause disruptions in adult relationships, and lead to an increased risk for intimate partner violence victimization (Mikulincer & Shaver, 2016).

Attachment characteristics were found to distinguish the two groups of victimized women and will be discussed below.

A study with multivariate analyses of several specific forms of childhood maltreatment reported that sexual and psychological abuse significantly predicted IPV (Cascio et al., 2020). Results from the present study suggested a deleterious effect of an interaction between the two adversities among women with IPV by MP. As reported above, the whole group of IPV victimized women indicated more childhood sexual abuse. According to the traumagenic dynamics, the group of sexually victimized women may have higher levels of self-blame and shame; a distorted sense of their own value and worth; incorporated badness, self-blame, shame, and guilt into their self-image and self-esteem; a distorted sense of ability to control their lives; dysfunctional sexual feelings and sexual attitudes; an intense need to regain trust and security, and impaired judgment about the trustworthiness of other people (Finkelhor & Browne, 1985; Feiring et al., 1996). Adding peer victimization to this group, and increased childhood emotional abuse as was the case for the group of women with IPV by MP, one may speculate about an interactional effect supporting and reinforcing the child's self-blame, shame, and poor self-esteem and increasing the risk of IPV by MP (Feiring et al., 1996). A detrimental interaction is suggested. Conversely, a warm and secure family relationship and the availability of extrafamilial support (e.g., peers, teachers) at the time of sexual abuse may buffer the consequences of the abuse (Cascio et al., 2020). The present

results did not allow exploration of the suggested interaction, and future investigation would be needed.

Cochran and coworkers (2011) reported that the intergenerational transmission of violence hypothesis was partly in effect for victims, through differential associations and differential reinforcement. However, in the present study, none of the childhood family violence factors sustained in multivariate analyses -- neither as risk factors for IPV nor for IPV by MP. Hence, a social learning intergenerational transmission hypothesis of IPV victimization was not supported in this study; accordingly, it did not promote understanding of victimization of IPV or IPV by MP.

IPV Characteristics in the Victimized Groups

Victimization of IPV

Victims of IPV were reported to be at high risk for revictimization (Iverson, Mercado, et al., 2013; Kuijpers et al., 2011; Kuijpers et al., 2012b). Characteristics of IPV, such as frequency, severity, mutual IPV, and if a woman initiated violence towards her male partner were associated with revictimization (see, e.g., Dixon & Graham-Kevan, 2011; Goodman et al., 2005; Iverson et al., 2013; Kuijpers et al., 2012b; Witte & Kendra, 2010; Zayas & Shoda, 2007). As discussed in the Introduction section, it was uncertain to what extent studies on revictimization reflected dynamics within a relationship or revictimization by MP. Studies on IPV by MP in particular reported some differences regarding IPV characteristics in prior relationships, like severe physical violence, psychological abuse, stalking, physical abuse, and threatened/forced sex among women with IPV by MP (Paper 1, Table 2; Ørke et al., 2018). No studies reported victimization differences in recent relationship. Alexander (2009) reported that women's involvement in multiple IPV relationships was unrelated to their experience of IPV in their current relationship. In the present study, too, there were no significant group differences regarding any kind of characteristics of IPV victimization in the index relationship. That is, there were no significant group differences between women with IPV from one and MP regarding prevalence or frequency of victimization of minor or severe psychological aggression, minor or severe physical assault, minor or severe sexual coercion, minor or severe injury (CTS2), frightening behavior, threats, physical violence, sexual violence, severe partner violence, continued partner violence, escalated violence and disobeying restrictions (SARA-V3), dominance-isolation, or emotional-verbal maltreatment (PMWI).

The results from the present study indicated that women with IPV by MP did not have a "typical" IPV relationship or typical IPV characteristics different from women with IPV by

one partner. Moreover, women with IPV by MP did not have a relationship with more or less prevalence or frequency of violent conflict tactics from either part. There was no indication in the results that women with IPV by MP engage in relationships with a particular IPV pattern like situational couple violence or intimate terrorism (Johnson, 2008).

Perpetration of IPV

Social learning theory suggests an intergenerational transmission of violence; that children who witness or receive parental violence in childhood display more violent behavior in adulthood. Men with a violent family background have been found to be more violent as adults (Askeland, Evang, & Heir, 2011; Stith et al., 2000). Results from an umbrella review of meta analysis showed that the most important historical risk factor for IPV was witnessing or being a victim of violence in childhood (Fazel, Smith, Chang, & Geddes, 2018). Those who engage in violence are at a higher risk of being subjected to violence (Archer, 2000). Female resistance strategies were reported to increase the risk of revictimization. For female victims, angry and aggressive behavior, violence perpetration, and resistance strategies like fighting back, and use of weapon were associated with revictimization (Goodman et al., 2005; Kuijpers et al., 2012). Trickett and coworkers (2011) reported that sexually abused females who had a propensity to enact subtle or mild forms of aggression toward a domestic partner might be the most likely victims of more severe domestic violence.

One might speculate that childhood victimized women would exhibit an acting-out pattern similar to men and be at greater risk for perpetration, victimization, and violence escalation. There are no previous studies that included female perpetration of violence in the comparison of women victimized by one and MP.

Initial analyses in the present study indicated significant group differences with more childhood family violence witnessing and victimization among women with IPV by MP. Initial analyses did display a trend for more minor physical assault perpetration among women with IPV by MP. However, these group differences disappeared in the multivariate analyses. The results of multivariate logistic regression analyses did not indicate a relationship between childhood family violence and IPV by MP. Moreover, the results did not indicate a relationship between IPV perpetration or victimization characteristics and IPV by MP. The present study did not support a social learning intergenerational transmission theory for understanding violence revictimization by MP.

It has been proposed that female violence is used mainly in self-defense or fighting back and male violence used primarily as a means of patriarchal control (Dekesedy, 2016). In the present study, female violence perpetration was reported among women victimized by one

and multiple partners as well. Regardless of whether the female violence perpetration was defensive or offensive, there were no significant differences pertaining to perpetration between the two victimized groups in multivariate analyses.

The previous studies did not differentiate explicitly between revictimization of IPV within and across relationships. The present study suggested that the previous studies may have described perpetration as risk of revictimization of IPV within a cycle of a single violent relationship rather than revictimization of IPV by MP. Women revictimized by multiple partners did not perpetrate more partner violence than women victimized by one partner.

Attachment Characteristics

IPV Victimized Women Compared to Non-Victimized Women

Earlier studies have reported increased attachment avoidance (Kuijpers et al., 2012a; Shechory, 2013; Weiss et al., 2011; Wekerle & Wolfe, 1998) as well as increased attachment anxiety among victimized women (Bond & Bond, 2004; Kuijpers et al., 2012a; Lewis et al., 2017; McClure & Parmenter, 2017; Shechory, 2013). Smith and Stover (2016) reported that attachment anxiety moderated the relationship between traumatic experiences and IPV revictimization.

According to the systematic literature review on IPV by MP (Paper 1; Ørke et al., 2018), one study suggested unresolved attachment and parent-child role reversal as mediating factors between child sexual abuse and IPV by MP (Alexander, 2009). Alexander reported that IPV by MP interacted with unresolved attachment to predict passivity of thought on the Adult Attachment Interview (AAI). Adult attachment has been studied in two research traditions that apply somewhat different methodologies: the developmental approach and the social approach. Within the developmental approach, attachment styles are measured through an adult's narratives of childhood experiences with caregivers (Bartholomew & Shaver, 1998). This was the approach of Alexander (2009) who applied the AAI. Within the social attachment approach, measurements of attachment styles are based on self-reports regarding qualities in current close relationships in adulthood (Pedersen et al., 2015). This was the approach of the present study, applying the Experiences in Close Relationships. Some of the concepts have similar wording across measurements but are not identical (e.g., secure, preoccupied, dismissive-avoidant, and fearful-avoidant within the developmental approach and secure, anxious, and avoidant within the social approach). Different aspects of the concepts are weighted differently in the various measurements.

Adult attachment style has been conceptualized and measured in terms of both types and dimensions. Mikulincer and Shaver (2016) concluded that adult attachment styles assessed with self-report measures were best characterized by dimensional measures.

In addition to applying the frequently used subscales attachment avoidance and attachment anxiety, this study explored the application of five sub factors (Pedersen et al., 2015). Comparing victimized to non-victimized, the strongest model showed that the sub factor uncomfortable with openness and childhood sexual abuse were separate risk factors for IPV. Adding childhood sexual abuse did not contribute to significant changes of the OR value for uncomfortable with openness (Paper 3: Table 3, Model 3b; Ørke et al., in press). Except for this, the application of the five sub factors did not add substantially to the results.

The results of multivariate logistic regression analyses pointed to specific attachment issues among victimized women. Compared to non-victimized, IPV victimized women had more than 3 times increased likelihood of a higher score on the attachment avoidance subscale. This was nuanced by the significance of two of the avoidance sub factors: IPV victimized had more than 2 times higher likelihood of having increased avoidance of closeness and uncomfortable with openness compared to their non-victimized counterparts.

Velotti et al. (2018) suggested that avoidant individuals had typical difficulties in seeking help. This was thought to relate to dysfunctional beliefs about being psychologically immune to emotional threats and about others being fundamentally unavailable. Regarding relationship initiation strategies, avoidant individuals cared less than non-avoidant people about the emotionally intimate components of romantic relationships (Finkel & Eastwick, 2015).

Attachment avoidance involves need for self-reliance and fear of interpersonal closeness. It was associated with a reduced desire for intimacy and an exclusive relationship (Cassidy & Shaver, 2016; Finkel & Eastwick, 2015; Pedersen et al., 2015). This tendency to be uncomfortable with close relationships and to prefer not to depend on others (Brennan et al., 1998) may well be expected in the aftermath of a violent relationship. Due to the absence of physical safety, a woman may suppress her attachment needs and withdraw to protect herself (Slootmaeckers & Migerode, 2018). Experiences with violence from partner could commonly cause avoidance of closeness and discomfort with openness. Although the participants were asked to report how they felt in intimate relationships in general, they may possibly have had their most recent relationship in mind. For some, violence victimization may thus instigate a situational increase in avoidant attachment characteristics.

Violence victimization may reinforce an avoidant attachment style developed from adverse childhood experiences. Brenner and coworkers (2019) reported that sexual abuse was associated with attachment avoidance. In the present study, women victimized by IPV had increased likelihood of reporting childhood sexual abuse as well as higher scores on the attachment sub factor uncomfortable with openness. However, in the present study, the childhood sexual abuse category encompassed sexual transgressions from anybody, both within and outside of the family. Attachment styles were thought to develop from the interaction with primary caregivers. Thus, there may not be a relationship between the two variables childhood sexual abuse and higher attachment avoidance score reported by the victimized women in the present study. The present results pointed to CSA and the avoidance sub factor uncomfortable with openness as independent risk factors for IPV and did not reveal any interaction effect between them. It is merely a speculation.

Slootmaeckers and Migerode (2018) argued that it is not simply a question of understanding individual attachment mechanisms but also the attachment dynamics of the relationship itself. Unsafe attachment and negative interaction cycles between partners could be seen as a context that leads to IPV (Doumas et al., 2008). It has been argued that in situational couple violence (SCV), the violent pursuer becomes aggressive in order to force engagement of the avoidant partner and maintain a desired level of proximity to the partner (Slootmaeckers & Migerode, 2018). Kuijpers and coworkers (2012a) reported from their prospective study that victim's avoidant attachment was a significant predictor for revictimization of physical and psychological IPV two months later. The researchers suggested that the withdrawal from closeness and intimacy by avoidant victims led to partner violence in a dysfunctional attempt by the male partner to keep the victim close. It must be noted that a predictor is not a causal factor. The studies discussed associations; they did not report cause and effect. An association between victim's withdrawal and subsequent violence does not imply that a victim is responsible for the violence because of her withdrawal.

Most research on adult attachment was based on the assumption that working models were relatively general and trait-like. Recent research, however, suggests that people develop attachment representations that are hierarchical (Cassidy & Shaver, 2016) and relationship-specific, leading people to hold distinct working models in different relationships (Fraley, Heffernan, Vicary, & Brumbaugh, 2011). Slootmaeckers and Migerode (2018) argued that the attachment pattern in a given romantic relationship is the result of attachment disposition (childhood), past romantic attachment, and contemporary interaction and experience with this partner and that dispositional attachment and situational attachment interact. A person's

position on the anxiety and avoidance dimensions could move across different, temporarily separated assessments, partly due to contextual factors, partly due to normal measurement error, and partly due to real change over time (Mikulincer & Shaver, 2016). Dutton and Painter (1993) reported that attachment scores had decreased by about 27% six months after separation from a violent partner. Thus, attachment avoidance can possibly both wax and wane in the aftermath of a violent relationship. The interactional perspective provides a framework for understanding a malleability of attachment avoidance as an interaction between processes within the individual and between the individual and the environment.

The results indicated neither that attachment avoidance caused IPV nor that attachment avoidance was a consequence of IPV. Rather than focusing each significant variable separately, the interactional perspective encourages the study of the interaction between these variables. For the group of women victimized by IPV, the developmental interaction between childhood sexual abuse, attachment avoidance, and IPV victimization needs further investigation.

Women Revictimized by Multiple Partners Compared to Women Victimized by One Partner

High attachment anxiety involves excessive need for approval from others, fear of interpersonal rejection or abandonment, and distress when one's partner is unavailable or unresponsive (Cassidy & Shaver, 2016; Feeney, 2016; Pedersen et al., 2015).

Compared to women with IPV in a single relationship, women with IPV by MP in the present study had a 77.6% increased likelihood of having a higher attachment anxiety score. Both victimized groups had scores above the mean in the Norwegian normative sample. Still, women with IPV by MP had significantly higher scores than victimized women in general. The association between attachment anxiety and IPV by MP was mediated by childhood emotional abuse, but the effect size was low. The final multivariate model (Paper 3, Table 4, Model 4b; Ørke et al., in press) indicated that an interaction between attachment anxiety and childhood emotional abuse was a risk factor for IPV by MP. The model also included higher likelihood of receiving disability benefits, shorter intimate relationship, and being native Norwegian. This was the strongest statistical model regarding women with IPV by MP, explaining 37.5% - 50.1% of the variance between the groups.

Attachment characteristics are thought to develop in the interplay with primary caretakers. The group of women with IPV by MP reported childhood emotional abuse. A statistically significant interaction variable of attachment anxiety by childhood emotional abuse increased the likelihood for IPV by MP. This suggested that experiences of childhood emotional abuse increased the association between attachment anxiety and IPV by MP. This

was supported by Valdez and colleagues who reported a childhood emotional trauma trajectory associated with a desire for intimacy, fear of loneliness, IPV, and deficits in navigating interpersonal relationships (Valdez, Lim, & Lilly, 2013). Having grown up with humiliating and invalidating caregiving, this group of women with increased attachment anxiety may view adult relationships as opportunities for acceptance. A propensity to seek closeness and ingratiate themselves with their partners (Downey & Feldman, 1996) may prevent their recognition of a partner's early risk behaviors, putting themselves at risk for further maltreatment (Hocking, Simons, & Surette, 2016).

Research following from attachment theory demonstrated that attachment shaped (a) how people experienced and regulated emotion, (b) how they thought about their romantic relationships, (c) their motives and goals in those relationships, (d) how they behaved and interacted with their partners (e.g., how they provided and sought support), and (e) how they initiated and maintained relationships and responded to relationship dissolution or loss (Pietromonaco & Beck, 2015).

According to Finkel and Eastwick (2015), emerging evidence suggests that the desire for an attachment bond may be a strong motivator of relationship initiation. People who were high in attachment anxiety were highly motivated to establish relationships. Finkel and Eastwick (2015) described people who were high in attachment anxiety as having a hyper activated attachment system which meant that they engaged in intense, obsessive acts of proximity seeking, support behavior, and passionate love as a means of achieving closeness with romantic partners. Furthermore, this hyper activation interfered with their ability to assess interpersonal threat accurately. Therefore, individuals who were high in attachment anxiety experienced an approach–avoidance conflict in close relationships: They strongly desired close relationships, but they feared that they would be rejected. McClure and coworkers provided evidence of the approach-oriented inclinations of anxious individuals, reporting that participants who were high in attachment anxiety were generally more likely to say yes to their speed-dating partners; that is, they tended to be unselective in initial attraction contexts, willing to view an especially wide swath of potential romantic partners as acceptable (McClure, Lydon, Baccus, & Baldwin, 2010). Attachment anxiety may have affected the way women approached relationship initiation. Revictimized women have been reported to have trouble identifying "cheaters" (DePrince, 2005) as well as recognizing danger in physically violent dating encounters (Witte & Kendra, 2010). These results may indicate that women with IPV by MP have a vulnerability regarding partner choice. More investigation regarding the relationship initiation phase could possibly reveal valuable insight.

It has been reported that anxiously attached adults tend to sexualize their desire for affection; that they are likely to have sex for reasons such as gaining a partner's reassurance and reducing the possibility of abandonment. Gratifying sexual experiences were likely to instill a sense of being loved and to be interpreted as a sign of a good romantic relationship (Birnbaum, 2016). Sexual difficulties were likely to be misinterpreted as a sign of rejection and to have further negative implications for the relationship (Birnbaum, 2016).

Alexander suggested that attachment anxiety could also be a consequence of involvement in IPV relationships and reinforced a the current IPV (Alexander, 2009). Summarizing research literature, Feeney (2016) described individuals who were highly anxious responding to hurtful partner behavior with more distress and self-blame, which exacerbated their fears and self-doubts.

Slootmaeckers and Migerode (2018) suggested a pattern of situational couple violence, which had its origins in a negative interaction cycle of clinging and withdrawal. Violence was seen as an attempt to regulate distance from the continuous contact-seeking of the clinging partner. While yearning for contact, the clinging partner is pushed aside and may in turn seek even more comfort, connection and proximity. Due to their heightened sense of insecurity, the clinging partners become increasingly overwhelmed by powerlessness and separation anxiety. Doumas and coworkers (2008), too, reported that the "mispairing" of an avoidant male partner with an anxious female partner was associated with both male and female violence. However, when the researchers controlled for partner violence, the relationship between attachment and violence was significant for males only.

A recent longitudinal study reported that attachment anxiety was associated with increased risk for experiencing physical assault, while attachment avoidance was unrelated to subsequent IPV victimization (Sandberg, Valdez, Engle, & Menghrajani, 2019).

To measure causality, one must have a prospective design. As it has a cross-sectional design, the present study did not indicate causality between attachment avoidance and IPV or between attachment anxiety and IPV by MP in particular. The present study indicated risk factors. Risk factors do not explain the outcome; rather, they explain a certain part of the variance between the outcome groups. Instead of arguing for a linear causeway, the interactional perspective suggests that it is a dynamic interaction which includes the identified risk factors that should inform our understanding. A dynamic interaction between the identified risk factors childhood emotional abuse and attachment anxiety and IPV by MP informs our understanding of the phenomenon.

Results from the present study supported Alexander's study (2009) that there were specific attachment issues among women with IPV by MP. Results from the present study and Alexander's study cannot be compared in detail as measurements from two different approaches were involved. The attachment concepts were not operationalized in the same way. The AAI applied by Alexander, measured attachment to the primary caregiver. The ECR applied in the present study, measured attachment in adult romantic relationships.

Compared to non-victimized, victimized women had higher attachment avoidance scores in the present study. Compared to women victimized by one partner, women with IPV by MP had higher attachment anxiety scores. To speculate, the findings might imply that compared to non-victimized, women with IPV by MP may display a mixed attachment strategy with higher scores on both avoidance and anxiety dimensions than non-victimized do. This might have an especially destructive effect, possibly trapping the women in a cycle of conflict-riddled attempts to meet personal needs while trying to avoid rejection and mishandling (Mikulincer & Shaver, 2016).

In the present study, non-victimized individuals scored below the normative mean regarding attachment avoidance, whereas both victimized groups scored above the mean. Regarding attachment anxiety, all three groups had increased attachment anxiety scores above the Norwegian normative mean for females. These generally elevated scores may reflect a sample of only help-seeking women. Still, the three groups had significant differences amongst them. The results highlight the importance of differentiating among victimized women in order to understand a person – situation interaction, vulnerability for IPV by MP, and certain needs for this subgroup of women.

Sociodemographic and Contextual Factors

Sociodemographic Factors

Immigrant Partner. The results regarding ethnicity were opposite for men than for women. Having an immigrant partner increased the women's risk for IPV in general. Being an immigrant, on the other hand, decreased the risk of IPV by MP.

Having an immigrant partner in the index relationship was associated with 18 - 22 times higher risk of IPV victimization in general. The wide confidence interval indicated great uncertainties of the magnitude of the risk (Paper 3, Table 3; Ørke et al., in press). The findings should be interpreted with caution.

The increased risk associated with immigrant partner was regardless of the victim's or the partner's country of origin. A Norwegian study of IPV victimized help-seeking women

reported that immigrant women had increased likelihood of having an immigrant partner (Vatnar & Bjørkly, 2010).

An American study (Gupta et al., 2010) reported that among immigrant men, those who were non-recent immigrants and reported limited English-speaking ability were at the highest risk for IPV perpetration, compared to recent immigrants with high English-speaking ability. Studies have shown that immigrants were proportionally overrepresented in intimate partner homicide (IPH) statistics both as victims and perpetrators (see, e.g., Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Dobash & Dobash, 2015; Garcia & Hurwitz, 2007; Vatnar, Friestad, & Bjørkly, 2017b). Partner's immigration status may be associated with increased vulnerability due to accumulated welfare deficiencies (Vatnar et. al, 2017b). Low income, low academic achievement, lack of non-violent social problem-solving skills, having few friends, unemployment, belief in strict gender roles, and attitudes accepting or justifying IPV are all factors known to be associated with IPV perpetration (CDC). There was no group difference between women victimized by one or multiple partners regarding having immigrant partner.

If immigrant women have increased likelihood of having an immigrant partner, as reported by Vatnar and Bjørkly (2010), there are still twice as many immigrant partners as there are immigrant victims in the sample. Should this mix include some language, cultural, and emotional distance within the couple, the results are interesting in the light of higher attachment avoidance among the victims. Avoidant individuals were reported to care less than non-avoidant people about the emotionally intimate components of romantic relationships (Finkel & Eastwick, 2015).

This issue is not settled yet and more research is needed. The topic can be nuanced in future studies. Couples can be distinguished regarding relationship initiation pre or post immigration, attachment, closeness, and combinations of immigrant victim, immigrant partner or both.

Immigrant Woman. A women's immigrant status, on the other hand, did not increase risk of IPV. There was no group difference between victimized and non-victimized participants regarding immigrant status. This contrasts with other studies that reported disproportionately higher rates of IPV among ethnic minorities (e.g., Vatnar & Bjørkly, 2010). From an analysis including 16 nations, Archer (2016) reported that women's victimization was inversely correlated with gender equality and individualism. The women in the present study were not assessed regarding cultural background.

The present study indicated the importance of differentiating between perpetrator's and victim's immigration status regarding risk of IPV. Although perpetration and

victimization seem like two aspects of the same phenomenon, theories of perpetration among immigrants may not necessarily promote understanding of victimization among immigrants (Winstok, 2013).

The victim's immigrant status was statistically a protective factor against IPV by MP in the present study. Ethnic Norwegians had higher risk of IPV by MP than immigrant women had. However, the adjusted odds ratio of 0.114 indicated a 1.1% difference among the two victimized groups, a result of no practical importance (Paper 3, Table 4, Model 4b; Ørke et al., in press).

The majority of victimized immigrant participants were victimized in only one relationship. A suggestion is that immigrant women stay longer in one relationship, and the general prevalence of divorce might be lower for immigrants than for native Norwegian women. Bredal (2020) argued that when control was exerted in a classic patriarchal context, it seemed to be based on material restrictions and economic and practical dependency. Within a context of gender equality, a psychological violence and control repertoire was more common. Hence, women from cultures with gender hierarchy may be less inclined to divorce than women from cultures that value gender equality. Bredal's qualitative study from Norway suggested that immigrant women may have family or social networks that do not accept divorce, and divorced women may be stigmatized, blamed, and outcast. Moreover, they may have limited knowledge about to how to establish a life on their own (Bredal, 2020). Further, as a consequence of stigmatization of divorced immigrant women, these may have a reduced potential to remarry.

Length of Relationship. Theories have discussed why women keep staying in violent relationships (see the Introduction section). One study reported that some women tried to remain in a relationship in spite of the violence, believing that a next relationship would also contain violence (Valdez et al., 2013). Longer involvement with a partner was reported in one study to increase the likelihood of experiencing IPV (Cole et al., 2008). Other results showed that IPV relationships had a shorter duration than non-violent relationships (Ahmadabadi, Najman, Williams, Clavarino, & D'Abbs, 2017) and that women responded to increasing violence by terminating their relationships, not remaining involved in them (Rhatigan et al., 2006). The present study supported that victimized women had shorter index relationships than non-victimized had (Paper 3, Table 3; Ørke et al., in press). Moreover, women with IPV by MP -- who had the highest levels of attachment anxiety -- had shorter index relationship than women with IPV by one partner. This appeared as a significant risk factor when all significant group differences were controlled for (Paper 3, Table 4; Ørke et al., in press). The

difference between the two victimized groups was significant. However, the adjusted odds ratio of .995 pointed to a 0.05% difference among the two groups, indicating a result of no practical importance.

The result may indicate that the subsequent IPV relationship was shorter than the initial IPV relationship. The women may reason that longer involvement with a partner could increase the likelihood of experiencing IPV by MP (Cole et al., 2008). Quicker termination of subsequent IPV relationships did not seem to be instigated by characteristics of the violence: There were no statistical group differences regarding frequency, prevalence, or characteristics of violence in the present study. Hence, there was no indication that women with IPV by MP had a quicker termination of the relationship due to more severe violence victimization. The other way around, there was no indication that women with IPV by MP were victimized by less violence. Thus, there was no indication that women with IPV by MP terminated the subsequent IPV relationship in an earlier phase when the violence had not yet reached severe dimensions.

Shorter index relationship among women with IPV by MP may also indicate that women with IPV by MP were of a kind who had swifter partner changes in general than women with IPV by one partner. Several studies have reported an association between child sexual abuse and more sexual partners in adulthood (Senn, Carey, & Vanable, 2008). Shorter relationships can increase the rates of partner change. Increased rates of new partner encounters may itself pose a risk of new violent relationships. Women victimized by one or multiple partners were on average of the same age; still, one group had established more violent relationships. One may speculate about shorter relationship as a characteristic of women with IPV by MP. The group of IPV by MP reported more childhood emotional abuse and may have other specific needs than women victimized by one partner. According to object relations theory, this is a need for love which was not satisfied in childhood. Realizing that the violent relationship did not fill this need, women with IPV by MP may be less eager to stay.

An individual with anxious attachment is usually described as suffering from fear of abandonment and high levels of separation anxiety. Velotti and coworkers (2018) speculated that these women might find it difficult to leave abusive relationships. The present study, however, did not indicate that women high in attachment anxiety held on to their partners. Instead, increased attachment anxiety posed a risk factor for more than one IPV relationship and for shorter relationship.

Including the result that victimized women in general had a higher score on attachment avoidance (Paper 3, Table 3; Ørke et al., in press) may inform this finding. Attachment avoidance involves need for self-reliance and fear of interpersonal closeness (Cassidy & Shaver, 2016; Pedersen et al., 2015). Shorter, destructive relationships among women with IPV by MP may follow a combination of high levels of both attachment anxiety and attachment avoidance in this group. As previously suggested, this might have an especially destructive effect, possibly trapping the women in a cycle of conflict-riddled attempts to meet personal needs while trying to avoid rejection and mishandling (Mikulincer & Shaver, 2016).

Education and Disability Benefits. In contrast to two studies that reported no association (Alexander, 2009; Stein et al., 2016), the present study found that women with IPV by MP had less education than women with one violent partner (Paper 2, Table 4; Ørke et al., 2020). Moreover, women with IPV by MP had higher risk of receiving disability benefits (Table 4). The wide confidence interval indicated great uncertainties of the magnitude of the risk of receiving disability benefits. This finding should be interpreted with caution. Trickett and coworkers (2011) reported that sexually abused females had more dropping out of high school. An association between economic hardship and economic dependency on a romantic partner and IPV exposure has been reported (Golden, Perreira, & Durrance, 2013). IPV may thwart educational attainment. It has been reported that actions by violent partners negatively affected women's ability to be and stay employed (Alsaker et al., 2014). Work life includes potentials for economic independency, social support, and self-esteem. Women who receive disability benefits have limited access to this. The results suggested a negative interaction between less education and being a disability benefit recipient, and IPV by MP (Ørke, et al., in press; Ørke et al, 2020).

Contextual Factors

Contextual factors pertained to the interview context like language challenges, use of interpreter, and rating of the interview experience. These factors were controlled for in the analyses. There were no contextual group differences that remained significant in the multivariate models. This implied that the contextual factors could not explain the systematic differences between the groups.

The Interactional Perspective

Family systems theory is largely directed at the interpersonal level while feminist theory is directed to a sociopolitical level of understanding. The ecological model integrates factors at different levels: individual, relationships, community, and societal levels. Zosky (1999) argued that, although the feminist and family systems theories were useful, the

intrapersonal level was largely overlooked. The interactional perspective emphasized the importance of studying the interactions (psychological and biological) within a person and between person and situation for understanding individual functioning (Magnusson, 1985). Theories that were investigated in the reviewed research on IPV by MP (see Paper 1; Ørke et al., 2018) related to victim psychopathology (Coolidge & Anderson, 2002), attachment (Alexander, 2009), the interactional perspective (Vatnar & Bjørkly, 2008), stress (Bogat et al., 2003), and substance use (Testa et al., 2003).

Magnusson (1985) argued that the current functioning of an individual had its background in her past course of development; contemporary readiness to respond to current situations were formed in sequences of continuous interaction with situations in which she previously had taken part. The results of the present study highlighted interactions related to developmental origins in an improved understanding of IPV by MP. There appeared to be different interactions between distal and proximal factors among women with IPV by MP than among women victimized by one partner. Applying the interactional perspective, this case control study with a multivariate design contributed with new understanding of revictimization of IPV by MP as complex, heterogeneous, and dynamic phenomena.

Theories describing effects of empathically attuned – or insufficient - nurturance in childhood were discussed. Attachment theory, in particular, informed the understanding of IPV by MP.

The present study was not of a format that enabled investigation of the nested ecological model. Factors at community and societal levels were outside the scope of this study.

The present study identified group differences between women victimized in one and in multiple IPV relationships. Risk factors for IPV by MP were suggested by multivariate analyses. The strongest model explained 37.5% – 50.0% of the variance between women victimized by one or MP (Paper 3, Table 4, Model 4b; Ørke et al., in press). Magnusson (1985) argued against the tendency in psychology to make perfect predictions the ultimate goal and high predictions the overriding criteria for a scientific status of psychology. An interactional view emphasizes the dynamic character of development, in which both the individual and the environment change in a multi-determined, spiral process over time. There is a complex, often non-linear, interplay of factors within the individual and between the individual and the environment. It is unrealistic to hope for high prediction of molar, social behavior over any considerable age span (Magnusson, 1985). Rather than studying the impact

of each separate risk factor, the interactional perspective encourages studying the continuous interaction between them.

Considerations and Implications

Ethical Considerations

Researchers may have resisted an inclusion of victim-related variables, worrying that this places too much of the responsibility for stopping the violence at the victim's door (Cattaneo & Goodman, 2005). However, we must emphasize women's security in tandem with perpetrator accountability (Goodman & Epstein, 2005). It is impossible to get a full picture of risk factors without considering victims' unique circumstances; vulnerabilities; and factors that reflect common barriers to victims' ability, opportunity, or motivation to engage in self-protective behavior (Kropp & Hart, 2015).

There are several ethical aspects regarding conducting a study of victimized women. It must be assured that the benefits of research do not override the costs of the participants. Safety issues need to be considered as well as worries about reactivating traumas. Moreover, the act of labelling victims is debatable.

Safety issues include privacy protection and confidentiality of participation. IPV-specific procedures must be followed to prevent any intervention by the perpetrator at any time in the research process. The WHO presented ethical and safety recommendations for research on domestic violence against women (WHO, 2001). Additional considerations were presented in 2016 (WHO, 2016), adding that all research team members should be carefully selected and receive specialized training and ongoing support.

Studies of traumatized, victimized, and bereaved women reported that, when safety issues were taken care of, participation was well tolerated and respondents believed that the benefits received from participation outweighed the costs (Deprince & Freyd, 2006; Hamberger et al., 2019; Newman, Walker, & Gefland, 1999; Vatnar & Bjørkly, 2008). Adverse reactions to participation appeared less common than previously anticipated (Newman et al., 1999). In a research summary of studies about trauma conducted with those who had experienced it, Hamberger and coworkers (2019) found several consistent findings across study populations. First, studies that directly inquired about harm from research participation reported none. Second, although a small percentage of participants did experience distress, the distress experienced was short-lived and unlikely to have been more than would have been experienced from the stress of everyday life. Further, respondents believed that the benefits received from participation outweighed the costs. Third, participants in trauma research generally found the experience personally meaningful, interesting, and

important. The vast majority would consider participating in other, similar research in the future (Hamberger et al., 2019). This was supported by comments from participants in the present study, as well.

However, both Dyregrov and Hamberger pointed to a vulnerable female subgroup. Hamberger and coworkers noted that some participants in each study reported upset at participating in research asking trauma-related questions. Females or participants who felt more vulnerable were more likely to view the questions asked as too personal. Low coping self-efficacy was related to experiencing upset (Hamberger et al., 2019). Dyregrov reported that being a woman and high levels of psychic distress were the most important predictors of a painful interview experience (Dyregrov, 2004). We must expect a set of these women in the present sample. Probably some vulnerable women declined the invitation, and some completed the interview. Dyregrov reported from her study that many who chose not to would in fact have benefited from participation. She advised that researchers should take steps to screen potential participants for specific vulnerabilities - not to exclude the participants from the study, but to take special precautions. When recruiting participants, it may be important to inform them about the benefits reported by former participants who found that talking about their pain was part of the healing process (Dyregrov, 2004).

Existing ethical codes were strictly applied in the present study (see, e.g., Methods section). The information-consent letter informed potential participants of possible benefits and strains associated with participation. Ethical recommendations called for trained researchers (Dyregrov, 2004; WHO, 2016) to prevent harm and secure help if the need is detected during the interviews. In accordance with these recommendations, the interviewer in this study was an experienced, violence-informed clinical psychologist.

Based on the systematic literature review, there were several items that called for exploration. Presupposing challenges within the sample regarding concentration and time frame, a careful selection of items was needed. This was one of the reasons why stalking was not explored in the study, even though it was included in the applied description of violence (Breiding, 2015).

There are concerns related to being associated with a vulnerable group, both whether one identifies with the group or one does not have everything in common with the group. This implies a risk of stigmatizing some women. In the present study, however, all participants were included according to problems that already were identified.

Methodological Considerations

Design. Magnusson (1985) argued that longitudinal research is necessary for effective analysis of important developmental problems. However, careful studies of single factors, yielding valid results, are important prerequisites for effective studies of individuals as totalities (Magnusson, 1985). Revictimization of IPV by MP was an empirically understudied field. A systematic review and a case control study were initiated for the identification of central factors for future investigations.

The limitation of a cross-sectional design is that it does not determine directionality or establish temporal ordering of the variables. Should there be a causation between, for example, childhood emotional abuse and IPV by MP, it would be at best a molar causal inference, as there are many molecular elements that can be involved in the causation (Shadish, 2002). Shadish discussed the relabeling of internal validity to local molar causal validity, recognizing that there is a complex package of many components between A and B. Many factors are usually required for an effect to occur, but all of them are rarely known and nor is how they relate to each other. The molar package can be divided into molecular parts that can be tested individually or against each other like, in the present study, interparental IPV, childhood family violence, childhood sexual and emotional abuse, sexual, psychological, physical IPV, attachment anxiety, and avoidance. But even those molecular parts are packages consisting of many components (Shadish, 2002).

This investigation was based on retrospective self-reports of childhood and IPV experiences. In other studies, recall bias was associated with underreporting of IPV (Schwartz, 2005). Because the reports of IPV vary in terms of recency, they may also vary in salience (Bogat et al., 2003). It has been claimed that retrospective questions about childhood events cannot differentiate between an actual history of severe abuse and selective recollection (Dovran et al., 2013). It is possible that more severe events are recalled with greater frequency than less severe events. Costa and coworkers (2015) stated that recall of childhood experiences resulted in a substantial rate of false negatives, measurement error, and bias that could elevate Type I errors. Higher well-being could be linked to retrospective forgetting and lower well-being could be tied to greater retrospective reporting (Costa et al., 2015). Sexually abused women may have processed and retrieved additional childhood victimization in another fashion than non-traumatized adults. According to the object relation theory, one might expect that a childhood abused woman could adopt a parent's view of her (the woman's) being "bad" and the parent being "good." Hence, IPV revictimized women

might be expected to underreport abuse due to shame, as well as to recall childhood traumas more vividly than non-victimized women.

Sample. Power analysis was conducted prior to the initiation of the case control study. With 120 subjects, 83% of studies would be expected to yield a significant effect. The participants were expected to have demanding life situations that could possibly hamper attendance. Considering this, 50 appointments were aimed at for each of the three groups. With the resulting sample of 154 subjects, conclusion validity was good. This was a satisfactory sample size for detecting moderate-to-strong effects. Weak, systematic group differences may not reach statistical significance with this sample size.

The women in the present study were help-seeking women. They were recruited from offices where they sought help in various ways: shelter, security assistance, psychological treatment, or counseling. Only 4.5% of the participants were recruited from the police. Reasons for this limited recruitment were procedures within the police; the police were undertaking a time-consuming reorganization at the time, and IPV cases appeared not to be prioritized. Although many women in the sample sought help from more than one office, victimized women aided by the police may be under-represented in this study.

The recruitment process was prolonged in the family counseling offices due to a nation-wide, time-consuming parallel study. Moreover, reports from counseling offices were that surprisingly many non-victimized women approached for recruitment informed of unassessed previous IPV relationships. These were not included in the sample.

Women who found a two-hour long interview too exhausting, women who were at work, women who needed a drink before the interview, as well as women who did not seek help were not represented in the sample. As found in several studies of IPV help-seeking women, a significant number of the women declined the invitation to participate. There was no information regarding these women concerning group differences. As discussed above (Ethical Considerations), some women with low coping self-efficacy and high levels of psychic distress (Dyregrov, 2004; Hamberger et al., 2020) may have declined the invitation. These might have represented and reported different experiences.

Results from the present sample do not necessarily generalize to a community sample. The problems of help-seeking women may have another etiology than the problems of non-help-seekers. Moreover, the results can not directly be generalized to women outside of Norway, due to cultural, social, and societal differences. Norway is a country where gender equality is valued and enforced. This may affect the sex difference in partner violence (Archer, 2016). Cultural context is important in understanding IPV risk markers (Mallory et

al., 2016; Vandello & Cohen, 2008). This calls for careful interpretation of the generalizability of the findings. Further, inferences cannot be made that the same risk factors would occur in a group of men with IPV by MP.

There have been reported mixed findings regarding IPV prevalence in general and gender symmetry or asymmetry. Suggested explanations are the failure of some measures to distinguish between offensive and defensive forms of violence and to assess the context, motives, causes, and consequences of IPV. Gender differences in the likelihood of reporting IPV affect the results (Chan, 2011; DeKeseredy, 2016). Jasinski and coworkers (2014) claimed that when research is lacking a sufficient means to measure control, conclusions cannot be drawn regarding gender symmetry. Regarding external validity, inconsistent definitions of IPV make it difficult to compare data across communities or nations (Krug et al., 2002), that is, whether emotional and verbal abuse, stalking, and rape were considered. In addition, clinical and shelter samples of IPV victimized women may not be representative of the general population of women who experience IPV (Woffordt, Mihalic, & Menard, 1994).Whether the respondents were asked to restrict their responses to abuse in the current relationship would also affect the results (Wathen & MacMillan, 2003). As well as to measuring methods and definitions applied, the variation of the cross-cultural results may be due to culture, welfare, educational level, and other socioeconomic factors (Garcia-Moreno et al., 2006).

Setting. The participants underwent a structured interview face-to-face with the researcher. With the great proportion of sexually abused women in the sample, shame and under-reporting may have affected the results. Efforts to meet this were undertaken by creating a safe atmosphere where respondents were supported when needed.

An alternative pencil-and-paper questionnaire was considered in the preparation of the study. This would have left the respondents to answer in solitude. Due to the large amount of questions, and possibly weary participants with reduced concentration capacity, this would probably have increased the number of missing answers. Moreover, it would have excluded participants incapable of reading or writing.

A pencil-and-paper questionnaire would require translated paper versions for each language of immigrant participants. This time-consuming and expensive task could not be initiated for practical reasons. However, there is a reliability and validity question when applying simultaneous oral interpretation. The specific meaning of translated words was unknown to the researcher. Effort was taken for reliability and validity reasons by appointing

certified interpreters; familiarizing them with the code book in advance; and instructing the interpreters specifically to interpret bidirectional and not to explain the questions.

I conducted all the interviews myself. This may have increased the risk of systematic measurement error. The structured interview with behavior-specific questions and fixed-response options modified this risk. Interrater reliability was strengthened by having only one interviewer.

Data Collection. ***Intimate Partner Violence.*** Simply defining IPV to measure and quantify it in a meaningful way is fraught with difficulty, as no uniform definition of IPV exists (Bender, 2017). Defining intimate partner violence is not an exact science but a matter of judgment, depending on who is defining it and for what purpose. A definition for the purposes of arrest and conviction, for example, will be different from one for social service interventions. Notions of what is acceptable and unacceptable in terms of behavior and what constitutes harm are culturally influenced and constantly under review as values and social norms evolve (WHO, 2002). As far as public health is concerned, the challenge is to define violence in such a way that it captures the range of acts by perpetrators and the subjective experiences of the victims without becoming so broad that it loses meaning – or so broad that it describes the natural vicissitudes of everyday living in terms of pathology (WHO, 2002).

The National Center for Injury Prevention and Control, Division of Violence Prevention initiated a process to promote consistency in the use of terminology and data collection related to IPV, "Recommended Data Elements." According to this report, many changes had occurred in the IPV field after the first edition of the definitions document was created in 1999: Stalking was now more commonly used as part of IPV. Along with the recognition of dating violence, there was a need for clarity about the specific relationship types that might be classified as intimate. With regard to a completed sex act, questions were raised as to the importance of including the roles of the victim and perpetrator (i.e., who penetrated whom). Further, it was unclear how the changes in access brought about by new technologies were impacting violence victimization experiences. The panel considered whether (and how) to include unwanted, non-physical pressured sex and sexual harassment. Changes had been made to how psychological aggression (formerly labeled *psychological abuse*) was defined and whether it required the presence of other violence by an intimate partner. Other changes were the addition of control of reproductive or sexual health, gaslighting, and exploitation of vulnerability (Breiding, 2015). Further definitional issues must be solved as partner emotional abuse, unlike physical and sexual abuse, is typically

conceptualized as requiring a pervasive pattern rather than a single salient action (Schumacher, Feldbau-Kohn, Smith Slep, & Heyman, 2001).

Measurement methods are direct operative derivations of a definition (Winstok, 2011). There was no questionnaire which included all violence items as described by Breiding (2015). Each of the three questionnaires applied in this study named and operationalized IPV in separate ways. One regarded conflict tactics (CTS2), one looked at spousal assault (SARA-V3), and one looked at psychological maltreatment (PMWI). All three were applied in the study in order to cover the array of commonly defined violent behaviors and to analyze possible nuances in the understanding of intimate partner violence. The study as a whole was in accordance with the categories described by Breiding (2015), except that none of the instruments included stalking.

The Conflict Tactics Scale assesses acts associated with violence. Participants may define their acts as self-defense and not as violence. These participants may object to the assessment and under-report frequency, thus influencing the validity of the results.

Analyses using a dichotomized violence variable could produce different results from analyses using a continuous violence measure (Doumas, 2008). Items were analyzed according to prevalence and frequency in order to detect a wide spectrum of group differences. There were no significant group differences between women victimized by one and MP regarding either prevalence or frequency of the IPV variables.

Regarding childhood adversities, results of multivariate analyses indicated that the prevalence variable of child sexual abuse was a risk factor, but not the frequency variable. Regarding peer victimization, on the other hand, the frequency variable gave more significant results (Paper 2; Ørke et al., 2020).

The categorization of women according to no, one, and multiple violent relationships was conducted according to the participants' own evaluation of physical, sexual, and psychological IPV in all their intimate relationships. This included women commonly identified as victimized. This would make the results relevant for help-seeking women who defined themselves as victimized. However, the sample might not include participants who did not consider their experience as IPV but rather, for instance, as proper, well-deserved punishment. Further, some women may have had violent encounters without wanting to be labeled as IPV victimized women. There were other possible ways of defining the dependent variable for study groups. Victims could be assessed according to the number of violent relationships, like in the study of Stein and coworkers (Stein et al., 2016), which reported other results regarding current partner violence.

Attachment Anxiety and Avoidance. The terms *attachment anxiety* and *attachment avoidance* are widely used. However, different measures do not apply identical questions. According to Brennan, Clark, and Shaver (1998) the two dimensions avoidance and anxiety are the same two dimensions that Ainsworth and her colleagues identified in 1978, they underlie most self-report adult romantic attachment measures and capture important individual differences in adult romantic attachment. Still, the field has a lack of convergence on a common, reliable method for assessing adult attachment orientations. A common method is necessary if researchers are to communicate clearly with each other about the same constructs (Brennan et al., 1998).

In accordance with Brennan and coworkers (1998), categorization of research participants according to attachment styles was unnecessary when dimensional measures were available. The authors stated that it was difficult to justify categorical measures except on grounds of convenience. Some power and precision is lost when categories rather than continuous scales are used. The present study analyzed dimensional measures. The results indicated systematic group differences and thus confirmed the argument of Brennan and coworkers. If categorical measures were applied for analyses, these significant differences would not have been be detected in the present study.

Combinations of attachment anxiety and avoidance have been suggested to define four categories of attachment style. One style is characterized as secure (low anxiety/low avoidance) and three, as insecure: fearful (high anxiety/high avoidance), preoccupied (high anxiety/low avoidance), and dismissing (low anxiety/high avoidance) (Olssøn et al., 2010). A combination of high attachment anxiety and high avoidance among victims of IPV by MP, which is suggested in the present study, is mere speculation.

The ECR was reported to be perhaps the most frequently used questionnaire for the assessment of adult attachment in intimate relationships (Pedersen et al., 2015). Experiences during the interviews indicated that the statements constituting the questionnaire had a complicated structure. One may thus worry that some statements could be misunderstood, especially among participants with language challenges. This could pose a limitation, as there were significant differences between women victimized by one or multiple partners regarding immigration status. However, Cronbach's alpha for Attachment avoidance was 0.92 and for Attachment anxiety 0.88 in the present study. This was comparable with the Norwegian normative study (Olssøn et al., 2010) and indicated that there were no large systematic misunderstandings.

A person's position on the anxiety and avoidance dimensions can move across different, temporarily separated assessments, partly due to contextual factors, partly due to normal measurement error, and partly due to real change over time (Mikulincer & Shaver, 2016). Research has shown that the test-retest stability of global representations in romantic relationships is larger than the stability of relation-specific representations of partners (Cassidy & Shaver, 2016). The increased uncomfortable with openness score among the victimized women may primarily reflect the relationship with the recent violent partner. This affects the test-retest reliability of the results. While the instruction asked for thoughts in close relationships in general, comments along the way from some participants indicated that they had the recent perpetrator in mind. This affects the construct validity of attachment in the present study and may explain some of the variation of empirical results regarding attachment and IPV.

Childhood Family Violence. In the present study, childhood family violence was investigated in several subcategories. Witnessing IPV between parents was specified for each parent's victimization separately. Violence categories were specified separately (physical, psychological, sexual, injury, and other). Violence from parent towards child was specified for each parent separately. Here, psychological, mild physical, and severe physical violence from each parent were specified separately. Psychological violence from each parent encompassed shouting, yelling, scolding, humiliating, and threatening with violence and throwing/ hitting/ kicking something close to the child.

In addition to childhood family psychological violence, childhood family emotional abuse and emotional neglect were studied as separate entities. Emotional abuse was reported by endorsement of sentences like "I thought my parents wished I never were born," "I felt someone in the family hated me," "Persons in my family said hurtful or humiliating things to me," "As I see it, I was subjected to psychological abuse" (Bernstein et al., 2003). Emotional abuse encompassed humiliating or hostile behavior whereas psychological violence included statements of fear-inducing events. Childhood emotional abuse may pertain to self-worth while psychological violence may pertain more to fear. Teicher (2001) argued that there were two components to verbal abuse: the criticism component and a yelling and screaming component. Both factors exerted effects, but the criticism was more severe. The present study indicated that assessing the diversity of childhood adversities in separate entities revealed important results.

Childhood Sexual Abuse. Lack of a consistent definition of CSA across studies makes it difficult to compare results (Senn et al., 2008). In the present study, childhood sexual

abuse included unwanted experiences like sexualized touching as well as penetration. A variable regarding penetrative contact was computed based on three of the questions. As forced penetration was reported frequently but only in the victimized groups, the variable was not fit for multivariate analyses comparing victimized and non-victimized. While both variables were prevalent among victimized women, neither sexual abuse nor forced penetration were risk factors for IPV by MP in particular.

Casey and Nurius (2005) reported that rather than severity of the assault, younger age at the time of an initial sexual victimization emerged as a significant predictor of sexual victimization by different perpetrators throughout time. Vatnar and Bjørkly (2008) found group differences when they restricted assessment of childhood sexual abuse to household members. The betrayal trauma theory (Freyd, 1994) includes abuse by someone on whom the child depends. The general assessment in the present study might disguise important differences regarding the relationship to the sexual offender. Hence, future IPV studies could benefit from assessing age at the time of an initial sexual victimization as well as the victim's relationship to the sexual offender.

Statistical Analyses. Several, separate types of childhood violence and adversities, attachment variables, IPV victimization and perpetration, and sociodemographic variables were analyzed and controlled for in the present case control study. In the reviewed literature (Paper 1; Ørke et al., 2018), no study of IPV by MP had analyzed all these relevant aspects together in one study.

Bivariate analyses resulted in several group differences. A *p*-value of 0.05 was applied due to convention. With other *p*-values, other results would have been significant or non-significant. The selection of variables for the initial multivariate analyses was based on significant group differences ($p \leq 0.05$) and trend ($p \leq 0.10$) in initial bivariate analyses. In accordance with advice for multivariate logistic regression for small samples, trends were included in the first step of multivariate analyses (Altman, 1991). If the initial analyses were the final analyses in this study, including trends may have caused a Type I error, rejecting the null hypothesis (H_o) when H_o was true. Not including trends could have caused a Type II error, accepting H_o where H_o was false. With larger sample, some of these bivariate trends may have remained significant both in the initial analyses and in the multivariate models. In the multivariate analyses, a conventional *p*-value of 0.05 was applied. Multivariate logistic regression analyses allow testing of the relative strength of several variables, adjusted for the other variables included in the model. Moreover, the analyses estimate the explanatory value of the interaction between the variables in a model.

Multivariate logistic regression analyses estimate the confidence interval of the odds ratio. Large confidence intervals imply that the results must be analyzed with caution. Large confidence intervals point to uncertainties regarding the size of the interaction between bivariate group differences and the dependent variable. In the present sample, this pertained in particular to the variables immigrant partner and disability benefits.

Stepwise analyses, forwarding significant differences to next step, allowed structured and systematic testing of more variables than one multivariate analysis would allow for this sample size. In multivariate analyses, some of the significant and trend effects from bivariate analyses disappeared.

Conducting multivariate logistic regression analysis in a small sample study has increased risk for Type II errors. Applied in this study, Type II errors indicate that the three groups no IPV, IPV by one partner, and IPV by multiple partners might differentiate by even more variables than reported significant in this study.

Clinical Implications

Health professionals are urged to recognize that women with a history of childhood adversities need special attention. As part of risk assessment for IPV among adults, screening for a history of childhood emotional abuse, childhood sexual abuse, and peer victimization is needed. The type of therapy provided to victims of partner violence must be tailored to fit the unique victimization experience and its psychological effects. Accordingly, all IPV victimized women would not benefit from the same treatment. Given the number of potentially symptom-producing trauma experiences in some clients' histories, treatment in such instances may have to be extended significantly beyond the months specified by some therapies (Briere & Jordan, 2004). Risk reduction interventions for women who were sexually abused should target not only the constructs from health behavior models -- for example, motivation and skills to reduce risk -- but also constructs that are specific to sexual abuse such as, for example, stigmatization and shame, in particular; traumatic sexualization; betrayal; powerlessness; and the contribution of the pre- and post-abuse situations (Feiring & Taska, 2016; Finkelhor & Browne, 1985; Senn et al., 2012).

A recent systematic literature review assessed the effectiveness of psychological therapies for women who experience IPV (Hameed et al., 2020). The study concluded that psychological therapies probably improved emotional health (depression and anxiety). Still, it was unclear if women's ongoing needs for safety, support, and holistic healing from complex trauma were addressed. The researchers called for more interventions focused on trauma

approaches. The present study supported the need for addressing trauma in therapies for IPV victimized women.

The present results suggested that the group of women revictimized by multiple partners had specific attachment issues: higher on avoidance than non-victimized women and higher on anxiety than women victimized in one relationship. Victimized women should be assessed regarding attachment anxiety and avoidance. Promoting an understanding of interactions between distal individual childhood risk factors and proximal attachment variables would be valuable. Women should be invited step-by-step to talk about these topics in therapy and might be guided toward an increased awareness of how attachment issues have affected their relationship (Velotti et al., 2018). Therapy should target fears of rejection and excessive need of approval in relation to the choice of a new partner. Clinicians might help in developing skills so that when attachment anxiety or avoidance is triggered, clients are less likely to react automatically and more likely to respond consciously and constructively in ways that do not compromise their dignity and well-being (Park, 2016). Improved insight in these therapy topics may inform the women to engage in the prevention of future IPV relationships.

Focusing on the discrepancy between partners' needs for intimacy and distance within the couple has been suggested as a strategy for treating intimate partner violence (Doumas et al., 2008). Emotionally Focused Therapy (EFT) emphasizes emotions and attachment (Johnson, 2007). Within EFT, negative interaction cycles may be discussed with couples. It is essential that this only applies to couples suffering from situational couple violence (SCV), not intimate terrorism (IT) (Slootmaeckers & Migerode, 2018). However, it is important to keep in mind that very few risk factors establish a causal relationship (Park, 2016). Clinicians should avoid the reinforcement of the erroneous attribution of internal blames for IPV that anxious victims may show (Velotti et al., 2018).

The present study supported other studies indicating that IPV victimized women perpetrated partner violence (Langhinrichsen-Rohling, 2005). Studies have reported an association between victim perpetration and future victimization. Hence, both victimization and perpetration need to be assessed and discussed with victimized women.

Individuals can develop attachment style differentially for each parent. Where there is insecure attachment in relation to one parent or one sex, therapy might benefit from attending to a woman’s preference regarding the sex of the therapist.

It is important to understand childhood risk factors in order to enable society to address and prevent them. The results of this study indicated that the devastating effects of

childhood emotional abuse are greater than those of childhood family violence. Relevant to child care services as well as to therapy with IPV families, the present study supported the high importance of addressing supportive parenting and emotional care beyond the termination of physical violence.

Research Implications

A major implication of an interactional view is to follow the same individuals over time in order to understand how individuals as totalities develop in a process of maturation and learning in continuous interaction with their environments (Magnusson, 1985). The evolving nature of IPV by MP would benefit from longitudinal studies like a follow-up study of the sample included in the present study. Prospective studies testing high and low risk groups and the development of future IPV relationships would add to the field. However, longitudinal studies of vulnerable people are fraught with pragmatic difficulties and ethical concerns (Rhatigan et al., 2006). One of the concerns pertains to obtaining information on the status of women's relationship at multiple time points and identifying vulnerable groups, without intervening. Participants' safety is of paramount importance and must not be suppressed because of the benefits accrued from research.

Qualitative studies investigating risk factors and their interaction would be valuable. The interaction between risk factors related to individuals, and the interaction between individuals and intimate partners, can shed light on IPV revictimization by multiple partners. Results from the present study suggested that future investigations of IPV by MP would benefit from investigating the dynamic interaction between the following factors: childhood sexual abuse; childhood emotional abuse; peer victimization; attachment avoidance and attachment anxiety; immigrant status of victim and partner; length of the intimate relationship; length of education; and disability benefits. Substance use appeared in the literature as a topic that should be included in investigations. Shame and guilt form a central theme in the aftermath of childhood sexual and emotional abuse. The interaction between shame and guilt and IPV by MP needs further investigation.

More research is needed in order to investigate the interaction between attachment anxiety and IPV by MP. Investigation regarding the IPV relationship initiation phase could possibly reveal valuable information and shed light on how increased attachment anxiety affects the initial process of partner choice.

There has been a call for prospective research on the role of a victim's resilience in risk for revictimization of IPV (Foa et al., 2000; Kuijpers et al., 2011). Studies would benefit

from inclusion of a group of previously IPV victimized women in presently healthy relationships.

An evaluation of efforts designed for the protection of IPV by MP is needed.

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Appendix

A Forespørsel om deltakelse i forskningsprosjektet (Information - consent letter)

B Regional Ethics Committee Approval

Paper 1

Paper 2

Paper 3

Oslo universitetssykehus HF

Klinikk psykisk helse og avhengighet, Avdeling for psykisk helse, nasjonale og regionale funksjoner,
Kompetansesenter for sikkerhets-, fengsels- og rettspsykiatri for Helseregion Sør-Øst

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

RISIKO FOR PARTNERVOLD I MER ENN ETT PARFORHOLD

Dette er et spørsmål til deg om å delta i et forskningsprosjekt.

Kompetansesenter for sikkerhets-, fengsels- og rettspsykiatri ved Oslo Universitetssykehus, Helse Sør-Øst, gjennomfører en studie om partnervold. Formålet er å identifisere risikofaktorer for å bli utsatt for vold fra flere partnere. Vi ønsker å sammenligne erfaringer hos kvinner som har blitt utsatt for partnervold i flere forhold, kvinner som har blitt utsatt for partnervold i ett forhold, og kvinner som har vært i parforhold men ikke opplevd partnervold. Du er valgt ut til å bli forespurt om å delta fordi du har erfaringer innenfor en av disse kategoriene.

Med partnervold mener vi fysisk vold, seksualisert vold og psykisk vold inkl. krenkelser, tvang, kontroll og stalking fra en intim partner (ektefelle, samboer eller kjæreste).

Forskning viser at kjennetegn både ved voldsutøveren og den utsatte påvirker risiko for ny vold. Det er i denne sammenheng viktig for oss å formidle at den utsatte ikke er ansvarlig for den volden hun er blitt utsatt for.

HVA INNEBÆRER PROSJEKTET?

Deltakelse i prosjektet innebærer å bli intervjuet i ca. to timer. I intervjuet vil vi gå gjennom fem spørreskjema. Du vil få konkrete spørsmål om oppvekst-opplevelser, helserelaterte forhold, voldserfaringer og hvordan du har det i nære forhold. Blant oppvekst-opplevelser og helserelaterte forhold vil vi bl.a. spørre om forhold til foreldrene dine og til venner, rus, vold og seksuelle erfaringer, skolegang, og fysisk og psykisk helse både i oppveksten og nå. Med voldserfaringer mener vi erfaringer med å bli utsatt for eller utøve fysisk, psykisk eller seksualisert vold.

Intervjuer vil være en av to erfarne psykologer, Elisabeth Christie Ørke og Solveig Karin Bø Vatnar, hhv. prosjektmedarbeider og prosjektleder for denne studien. Intervjuet kan foretas i våre lokaler ved Oslo Universitetssykehus, på det stedet hvor du er blitt forespurt om å delta i denne undersøkelsen, eller et annet egnet sted hvor intervjuet kan foregå uforstyrret av andre og i trygge omgivelser. Svarene dine registreres ved å krysse av på skjema.

Du kan når som helst be om at intervjuet stoppes, og at deler eller hele intervjuet slettes. Spørsmål du ikke ønsker å svare på kan du selvsagt la være å besvare uten at dette får konsekvenser for videre deltakelse. Intervjuet er et rent forskningsintervju, og vil ikke bli registrert hos politiet eller av noen andre etater/hjelpeinstanser.

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Internet: www.sifer.no

MULIGE FORDELER OG ULEMPER

Spørsmålene dekker en rekke opplevelser gjennom livet, og noen av spørsmålene er svært private. Det vil kunne innebære en påkjenning å få spørsmål om opplevelser som en ikke har tenkt på i det siste eller som det er knyttet vonde følelser til. Samtidig vil det kunne oppleves som positivt og meningsfylt å delta i denne type forskning. Det er særlig knyttet til det å kunne bidra til mer kunnskap på dette området, som igjen kan forbedre tilbudet og forebygge at andre kommer i tilsvarende situasjon.
Dersom du i etterkant av intervjuet skulle få reaksjoner, kan du ringe Solveig K.B.Vatnar på telefon 22 02 92 20 for nærmere avtale angående oppfølging.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side, og leverer den tilbake til den du fikk det fra. 1-2 uker etter at du har levert ditt samtykke, vil Solveig K. B. Vatnar eller Elisabeth Christie Ørke ringe deg for å avtale tid og sted for intervjuet og svare på eventuelle spørsmål.
Om du nå sier ja til å delta, kan du når som helst senere og uten å oppgi noen grunn trekke ditt samtykke. Dette vil ikke få konsekvenser for deg eller evt. videre behandling. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte Solveig K. B. Vatnar, tlf. 22 02 92 20, UXVASO@uos-hf.no

HVA SKJER MED INFORMASJONEN OM DEG?

Oslo Universitetssykehus er ansvarlig for data som samles inn i studien. Informasjonen du gir i intervjuet skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.
Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste. Det er kun prosjektleder og prosjektmedarbeider som har adgang til navnelisten og som kan finne tilbake til deg. Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest åtte år etter prosjektslutt.
Som deltaker i studien har du rett til å få informasjon om resultatene av studien. Publikasjoner fra studien kan tilsendes.

OPPFØLGINGSPROSJEKT

Du vil i dette intervjuet bli spurt om du tillater at vi tar kontakt igjen, hvis det blir et oppfølgingsprosjekt. Det er av interesse å gjennomføre et oppfølgingsprosjekt innen fem år etter at denne studien er avsluttet. Selv om du sier ja til å delta i studien nå, står du fritt til å bestemme om du vil bli kontaktet senere eller ikke.

ØKONOMI

Dersom du har utgifter til offentlig transport for å komme til intervjuet, dekker vi reiseutgiftene dine.

GODKJENNING

Prosjektet er godkjent av Regional komite for medisinsk og helsefaglig forskningsetikk (REK), ref.nr. 2016/2304.

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Oslo universitetssykehus HF

Klinikk psykisk helse og avhengighet, Avdeling for psykisk helse, nasjonale og regionale funksjoner,
Kompetansesenter for sikkerhets-, fengsels- og rettspsykiatri for Helseregion Sør-Øst

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG ER VILLIG TIL Å DELTA I PROSJEKTET «RISIKO FOR PARTNERVOLD I MER ENN ETT PARFORHOLD»

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

Telefonnummer deltaker vil bli kontaktet på

Besøksadresse:
Bygn. 7 Gaustad
Sognsvannsveien 21
Postadresse:
Gaustad, Bygg 7 - N - 0407 Oslo

Telefon: 220 29 220
Telefaks: 220 29 221
E-post:: Post.kps@ous-hf.no
Internet: www.sifer.no

HELSE SØR-ØST

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Tor Even Svanes	22845521	19.04.2017	2016/2304/REK sør-øst C
			Deres dato:	Deres referanse:
			08.03.2017	

Vår referanse må oppgis ved alle henvendelser

Solveig Karin Bø Vatnar
Klinikk psykisk helse og avhengighet, Oslo universitetssykehus HF

2016/2304 Risiko for å bli utsatt for partnervold i mer enn ett parforhold

Forskningsansvarlig: Oslo universitetssykehus HF
Prosjektleder: Solveig Karin Bø Vatnar

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 23.03.2017. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

Prosjektomtale
Dette er en case-control studie om reviktimisering av partnervold. Forskningslitteraturen om partnervoldsrisiko fokuserer sjelden på forskjeller mellom kvinner utsatt for vold i ett versus flere forhold. Empirisk kunnskap om dette er avgjørende for forebygging av nye voldelige forhold, for å gi adekvat behandling til voldsutsatte, og for å motvirke opprettholdelsen av myter og fordommer knyttet til pasient-/klientgruppen. Denne studien undersøker i hvilken grad det er forskjeller mellom kvinner som blir utsatt for vold i hhv. ingen, ett eller flere parforhold, på følgende områder: Barndomsopplevelser med vold, tilknytningsstil, kjennetegn ved partnervolden, rusmiddelbruk, psykiske lidelser og sosiodemografiske faktorer. Studien gjennomføres med to kasus-grupper og en kontrollgruppe, 50 kvinner i hver gruppe, N=150. Data innhentes gjennom strukturerte personlige intervjuer. Univariate og multivariate logistiske regresjonsanalyser vil bli brukt.

Saksgang
Komiteen behandlet prosjektet første gang i møtet 19.01.2017, og utsatte den gang å fatte vedtak. Komiteen hadde spørsmål knyttet til beredskapen i prosjektet, og man ba om konkrete tilbakemeldinger på ulike scenario hvor kvinnenes trygghet potensielt kunne være truet. Komiteen hadde videre merknader til styrkeberegningen i prosjektet, og ba om en analyseplan hvor de variablene som skal sammenliknes er spesifisert, sammen med antakelsene om forskjeller mellom gruppene.

Prosjektleders tilbakemelding ble mottatt 08.03.2017.

Prosjektet ble tatt til ny behandling i komiteens møte 23.03.2017. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Prosjektleders tilbakemelding
Prosjektleders tilbakemelding i forhold til beredskap i prosjektet gjengis i sin helhet:

Vi forstår på komiteens kommentarer om beredskap, at noen sentrale punkter vedrørende potensielle hendelser og håndteringen av disse i dette forskningsprosjektet trenger utdypende forklaring. Vi vil også vise hvordan vår erfaringsbaserte kunnskap fra gjennomføring av forskningsprosjekter med tilsvarende design, er med på å begrunne våre vurderinger og valg i dette prosjektet.

Selve utgangspunktet for inklusjon i forskningsprosjektet, er at kvinnen kan ha vært og/eller er utsatt for alvorlig kriminalitet; partnervold. Flere krevende dilemmaer kan oppstå i en slik undersøkelsespopulasjon, og komiteen fremhever særlig tre: a) håndtering av uventede hendelser som kan true deltakerens sikkerhet; b) beredskap knyttet til relasjonsdynamikk, og c) håndtering av informasjon om psykiske problemer som avdekkes i forbindelse med datainnsamlingen.

Før vi går inn på hvert punkt komiteen ønsker tilbakemelding på, vil vi presisere at deltakelse i dette forskningsprosjektet, i likhet med alle prosjekter av liknende type som utgår fra vår gruppe, er basert på frivillig deltakelse og informert, skriftlig samtykke. Personer uten samtykkekompetanse, uansett årsak, inngår ikke i rekrutteringsgrunnlaget. Det innebærer at forskningsprosjektet har som utgangspunkt at deltakerne har rett til selv å vurdere hvilken informasjon de vil at vi som forskere går videre med, og at vi som forskere er forpliktet til å respektere deres valg, med mindre det finnes særlig rettslig grunnlag for å overstyre deres beslutning. Dette aktualiserer etiske problemstillinger i skjæringspunktet mellom taushetsplikt og avvergeplikt, samt hvilke praktiske og kliniske vurderinger som kan og bør gjøres. Flere har påpekt at spørsmål om framgangsmåter og etikk innenfor denne type forskning er komplisert, og at det sjelden er mulig å følge en oppskrift (Forskeres taushetsplikt og meldeplikt, Forskningsetiske komiteer). Samtidig lister straffeloven § 196 opp en rekke hendelser som alle borgere er forpliktet til å anmelde eller avverge. Dette utgjør en varslingsplikt også i dette forskningsprosjektet.

Loven lister opp lovbrudd som regnes som alvorlige nok til å utløse denne plikten, herunder vold i nære relasjoner, og det er derfor viktig å ta stilling til hvordan vi skal forholde oss til denne type kunnskap dersom vi får den. Vi må også vurdere hvordan det er forsvarlig å gjennomføre studier i et fagfelt der slike dilemmaer kan oppstå. Som i tidligere forskningsprosjekt med den aktuelle gruppen informanter vil alle regler og retningslinjer for helsefagligforskning bli fulgt. Utover dette vil vi gjøre en rekke etiske, praktiske og faglige vurderinger og tiltak for å styrke sikkerheten til deltakerne. Vi forsøker nedenfor å tydeliggjøre våre vurderinger og konkretisere hvilke praktiske prosedyrer vi har utledet fra dem i dette prosjektet.

a) Håndtering av uventede hendelser som kan true deltakerens sikkerhet

Alle deltakerne i prosjektet vil allerede ha etablert kontakt med institusjonen som bidrar til å rekruttere dem (krisesenter, familievern, politi, Alternativ til vold). Dette samsvarer med våre tidligere prosjekter. Ved alle disse institusjonene arbeider fagutdannet personale med minimum 3-årig høgskoleutdanning. Rekrutteringsinstansene gjør en selvstendig faglig vurdering av hvorvidt det er forsvarlig å presentere forespørselen om deltakelse i forskningsprosjektet vårt for sine brukere/klienter. For personene som mottar forespørsel om deltakelse understrekes frivilligheten og retten til å trekke seg fra studien. Rekrutteringsinstitusjonen avklarer deretter på hvilken måte informanten ønsker å bli kontaktet av forskerne, og om informanten selv eller rekrutteringsinstansen vurderer at det er spesielle hensyn som skal tas når det gjelder sikkerhet eller personlige forhold.

Vår erfaring i allerede gjennomførte forskningsprosjekt både på partnervold og partnerdrap er at dersom det er særskilte hensyn å ta må disse vurderes individuelt, og i samråd med rekrutteringsinstansen og informanten. Det lar seg derfor ikke gjøre å sette opp en generell oppskrift for dette (Forskeres taushetsplikt og meldeplikt, Forskningsetiske komiteer). Tiltak som har vært iverksatt i tidligere prosjekt er avtale om at all kontakt skal skje per sms/mail/telefon/via en tredjeperson, følge til og fra intervjusituasjon, samt risikovurdering av sikkert sted for intervjusituasjon. Dette har medført at intervjusted for eksempel har blitt flyttet fra politistasjon til familievernkontor, fra familievernkontor til lensmannskontor, og fra krisesenter, politi og familievernkontor til prosjektleders kontor på OUS, Gaustad.

I konkrete situasjoner har forsker i etterkant av forskningsintervju bistått med å kontakte beskyttelsestilbud som krisesenter og politi, og fulgt opp informanten til en slik kontakt var etablert. Dette har hittil alltid skjedd i samråd med informanten, og rekrutteringsinstansen, og etter avtale om at informanten settes i

kontakt med de aktuelle instansene. Etter forskning på 177 partnerdrap og 157 partnervoldsutsatte kvinner har vi så langt ikke kommet i situasjoner der vi har vært forpliktet til å kontakte etater eller institusjoner uten at vi hadde informantens samtykke til dette. Alle rekrutteringsinstitusjonene er på selvstendig grunnlag forpliktet både til å overholde avvergeplikten og har meldeplikt til barneverntjenesten, slik at i en betydelig del av sakene som tidligere har inngått i forskningsprosjektene våre er det allerede opprettet samarbeid med barnevern, spesialisthelsetjeneste og/eller politi.

b) Beredskap knyttet til risikorelatert relasjonsdynamikk

Komiteen refererer til «partners oppførsel» og etterspør redegjørelse for hvordan prosjektet vil håndtere «voldelige partnere med et særlig behov for å kontrollere eller overvåke kvinnenes adferd». Kvinnene som samtykker til å delta i forskningsprosjektet vil være i ulik situasjon mht pågående kontakt med partner; noen er i beskyttede omgivelser der slik kontakt ikke er aktuelt, mens andre fortsatt lever i en relasjon der de både blir utsatt for vold – og i enkelte tilfeller også selv utøver vold. Vi har hittil ikke erfart at deltakelse i forskingsprosjektet innebærer økning i allerede eksisterende risiko knyttet til at informanten har etablert kontakt med krisesenter, politi, familievern og/eller Alternativ til vold.

Vår erfaring er at de aktuelle informantene allerede har utarbeidet en rekke mestringsstrategier for å redusere risiko, både individuelt og i samarbeid med institusjonen som de er rekruttert fra. Vi har ikke mottatt noen tilbakemeldinger om at informanter har blitt sanksjonert eller utsatt for ny vold som en konsekvens av deltakelse i forskningsprosjektene våre. Forskningsprosjektet må likevel gjennomføres på måter som aktivt søker å unngå forhøyet risiko for deltakerne. Vi gjør dette ved å utvise stor forsiktighet i all kontakt med informantene; ved å innlede all kontakt med om det passer at vi kontakter dem nå, avtaler at de kun svarer på telefon fra oss dersom de er i en trygg situasjon, avtaler fast tidspunkt for når de ønsker å bli kontaktet etc.

c) Håndtering av informasjon om psykiske problemer som avdekkes i forbindelse med datainnsamlingen

Komiteen påpeker at datainnsamlingen kan avdekke «psykisk uhelse» og ønsker en redegjørelse for hvordan informasjon om «reelle og pågående psykiske problemer» er tenkt håndtert i forskningsprosjektet. Vi gjentar at alvorlig psykisk lidelse er et eksklusjonskriterium i forskningsprosjektet. De aktuelle rekrutteringsinstansene har selvstendige regler og prosedyrer for brukere/klienter med (mistanke om) alvorlig psykisk lidelse. Ved alle krisesentrene i Norge er det i inntaksreglementet tydelig avklart at personer med alvorlig psykisk lidelse og/eller rusavhengighet ikke kan være beboer ved krisesentrene. Denne gruppen er derfor allerede selektert ut fra denne rekrutteringsinnsatsen. Krisesentrene har rutiner for hvordan de setter disse brukerne i kontakt med annet relevant hjelpeapparat. I familievernet er det også klare retningslinjer for hvilke klienter som skal henvises til spesialisthelsetjenesten. Dette gjøres da av personale ved familievernkontorene som har henvisningskompetanse. Alle familievernkontor skal ha en eller flere ansatte som har henvisningsrett til spesialisthelsetjenesten (psykolog/psykiater). Også politiet har kompetanse og egne retningslinjer for når de skal be om helsefaglig vurdering av vitner og andre personer de kommer i kontakt med. Dette inngår som en betydelig del av politiutdanningen, og det finnes etablerte politifaglige rutiner for dette. Ved Alternativ til vold arbeider psykologer og psykologspesialister som har selvstendig behandlingsansvar og henvisningskompetanse. I vår tidligere forskning med partnervoldsutsatte rekruttert fra til dels de samme instansene som i dette prosjektet, har vi ikke erfart at personer med alvorlig psykisk lidelse har blitt rekruttert som informanter. Dersom dette likevel skulle inntreffe i dette forskningsprosjektet vil prosjektleder og prosjektmedarbeider, som begge er psykologspesialister med henvisningskompetanse og lang erfaring fra klinisk arbeid, i samråd med informanten og rekrutteringsinstansen sørge for at informanten tilbys nødvendig og adekvat helsehjelp. Avdekking av mindre alvorlig, men like fullt behandlingstrengende psykisk lidelse, har vi erfaring med fra tidligere prosjekter. Dette ble publisert i en av artiklene som utgikk fra partnervoldsstudien (N=157):

Sixty-one percent perceived their general health as “good” or better. At the same time, 64% perceived that they were in need of mental health treatment. Almost all (97 out of 100 women) of those who perceived that they were in need of mental health treatment claimed that the IPV had caused the need of treatment. Forty-two percent had received mental health treatment, most of them (53 of 66 women), outpatient treatment. Thirty percent had used psychotropic medication, 19%, antipsychotic medication (Vatnar& Bjørkly 2009).

Noen få informanter har, på bakgrunn av informasjon fremkommet i intervjusituasjonen, blitt satt i kontakt med relevante helsetjenester, herunder spesialisthelsetjenesten. Dette har i hvert enkelt tilfelle blitt gjort i samråd med informanten og i samarbeid med rekrutteringsinstansen. En langt vanligere situasjon enn at psykisk lidelse avdekkes første gang under intervjuet, er at deltakerne allerede har etablert kontakt med psykisk helsevern basert på behov som er avdekket før deltakelse i forskingsprosjektet. Vi har ikke erfart at noen informanter rekruttert gjennom politi, krisesenter, eller familievern har hatt behov for akutt innleggelse, eller motsatte seg helsehjelp når behovet ble avdekket og påpekt.

Dersom en slik situasjon skulle oppstå vil både prosjektleder og prosjektmedarbeider som begge er spesialister i klinisk voksenpsykologi følge regler og prosedyrer for henvisning til spesialisthelsetjenesten knyttet til den aktuelle situasjonen. Inklusjon i forskningsprosjekter av personer som befinner seg i sårbare, noen ganger også svært risikofylte, livssituasjoner, omfattes av flere vanskelige etiske dilemmaer. Slik vi ser det, kreves det en særlig sensitivitet og årvåkenhet fra forskerens side overfor deltakerne for å avdekke så raskt som mulig om deltakelsen på noen måte forverrer deres situasjon. Det er ingen enkel metode for å garantere seg mot slike negative utfall, men vi har i all kontakt med informantene eksplisitt etterspurt deres opplevelse av det å delta. Vi vil gjerne presentere noen av erfaringene vi har fått formidlet fra dette.

Både i forskningsprosjektet om partnerdrap og om partnervold ble deltakerne avslutningsvis spurt hvordan det hadde vært å delta i studien. I partnervoldsstudien (N=157) rapporterte 76% av informantene at de syntes de hadde blitt tatt vare på og at intervjuet var meningsfylt for dem, og 23% rapporterte det samme, men at noen av spørsmålene var ubehagelige. Kun èn informant syntes at hun ikke hadde blitt tatt nok vare på. Hun uttrykte likevel at intervjuet hadde vært meningsfylt (Vatnar, 2009). I etterkant undersøkte vi om vi kunne bistå med noe for den aktuelle informanten som ikke følte seg godt nok ivaretatt. I samråd med rekrutteringsinstansen ble det avklart at dette var en situasjon som hadde oppstått gjentatte ganger for den aktuelle informanten – ingen instanser eller personer hadde hittil klart å ivareta henne tilstrekkelig. I partnerdrapsstudien ga alle informantene som ble personlig intervjuet (N=12, kvalitative intervju) tilbakemelding om at deltakelsen var en positiv opplevelse, at de ble tilstrekkelig ivaretatt, selv om tema for intervjuet var svært krevende.

I etterkant av begge studier har noen informanter tatt kontakt med prosjektleder. Hovedsakelig har dette dreid seg om å få vite mer om når studien vil bli publisert. I partnerdrapsstudien ønsket alle som ble intervjuet å få tilsendt forskningsrapporten som ble utarbeidet, og vi gjorde avtale om hvordan de ønsket denne tilsendt. En informant i partnerdrapsstudien kontaktaktet prosjektleder flere ganger med supplerende informasjon i etterkant av intervjuet. Dette ble lagt til, og etter avtale sendt tilbake til informanten for kontroll/sitatsjekk. Et par av deltakerne i partnerdrapsstudien kontaktet prosjektleder etter at de hadde fått tilsendt forskningsrapporten, og spurte om de kunne få flere eksemplarer som de ønsket å dele med andre. De fikk også lenken til rapporten slik at de eventuelt kunne dele den med andre. I partnervoldsstudien ønsket en deltaker å bruke egne svar fra studien i forbindelse med en rettsak hun var involvert i. Prosjektleder rådførte seg med Personvernombudet ved Oslo Universitetssykehus. Informanten fikk da personlig overlevert egne data fra prosjektleder. I denne saken ble prosjektleder innkalt til å avgi forklaring hos politiet, etter at kvinnen selv hadde opplyst politiet om at hun hadde deltatt i forskningsprosjektet, og ønsket at politiet skulle kontakte prosjektleder. Informanten undertegnet da informert samtykke til at prosjektleder kunne snakke med politiet, og fritok prosjektleder fra taushetsplikten. I etterkant av rettssaken kontaktet informanten prosjektleder og takket for måten vi hadde håndtert situasjonen på, og for faglige bidrag inn i rettssaken.

I etterkant av et foredrag prosjektleder holdt om partnervold kom en kvinne bort, og sa hun ville takke. Dette viste seg å være en informant prosjektleder hadde satt i kontakt med politi og krisesenter i forbindelse med forskningsintervjuet. Hennes budskap var at deltakelsen i forskingsprosjektet hadde bidratt til at hun nå i flere år hadde klart å ikke gå tilbake til en partner som utsatte henne for vold. Hun hadde påbegynt høyere utdanning, og gav uttrykk for at livssituasjonen hennes nå var meget god. Selv om vi her har drøftet dilemmaer som er involvert når vi forsker innenfor fagfeltene partnervold og partnerdrap, er det viktig at vi ikke blir handlingslammet av kunnskapen om alle problemene dette impliserer. Det er mulig å forske i slike miljøer, men det bør gjøres med varsomhet og erfaring (Skilbrei i Forskeres taushetsplikt og meldeplikt, De nasjonale forskningsetiske komiteene).

Tilbakemeldingen inneholdt videre en detaljert og revidert analyseplan, med justerte styrkeberegninger. Denne planen refereres ikke i selve vedtaksbrevet; for ytterligere informasjon vises det til prosjektleders tilbakemelding av 08.03.2017.

Komiteens vurdering
Som komiteen kommenterte allerede ved førstegangsbehandling, anser man dette som en studie på en viktig problemstilling.

Komiteen mener prosjektgruppen har levert en svært grundig tilbakemelding. Når det gjelder beredskapen i prosjektet, opplever komiteen at det ligger klare og betryggende sikkerhetsprosedyrer til grunn for prosjektet. Også merknader til styrkeberegninger og analyseplan er solid besvart.

Komiteen har etter dette ingen innvendinger til design eller beredskap i prosjektet.

Vedtak
Prosjektet godkjennes, jf. Helseforskningslovens §§ 9 og 33.

Tillatelsen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen, og de bestemmelser som følger av helseforskningsloven med forskrifter.

Tillatelsen gjelder til 31.12.2021. Av dokumentasjonshensyn skal prosjektopplysningene likevel bevares inntil 31.12.2026. Opplysningene skal lagres atskilt i en nøkkel- og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato.

Komiteens avgjørelse var enstemmig.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jf. Forvaltningslovens § 28 flg. Eventuell klage sendes til REK Sør-Øst. Klagefristen er tre uker fra mottak av dette brevet.

Sluttmelding og søknad om prosjektendring
Prosjektleder skal sende sluttmelding til REK sør-øst på eget skjema senest 01.11.2021, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK sør-øst dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Med vennlig hilsen

Britt-Ingjerd Nesheim
Professor dr.med
leder REK sør-øst C

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ORIGINAL ARTICLE

Risk for Revictimization of Intimate Partner Violence by Multiple Partners: a Systematic Review

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Abstract
Are victims of intimate partner violence (IPV) by multiple partners (MP) different from victims of IPV by one partner? Are there different victim-related risk factors for IPV by MP? This systematic literature review identified seven empirical studies that related to these issues. The review findings indicated that (1) empirical research on IPV by MP appears to be scarce, with only limited recent development; (2) there were significant differences between women who had been subjected to IPV in a single relationship and women with IPV by MP; (3) IPV by MP was significantly associated with childhood domestic trauma, drug abuse, IPV characteristics, and attachment style; (4) regarding PTSD and personality disorders, the results were mixed and inconclusive; and (5) depression did not appear as a salient risk factor for IPV by MP. Interpretations must be made cautiously because of the wide diversity in measurement approaches. It is important that service personnel and researchers attend with increased awareness to women with IPV by MP.

Keywords Intimate partner violence · Domestic violence · Multiple partners · Revictimization · Risk · Vulnerability · Multiple victimization

In spite of public and clinical awareness of intimate partner violence (IPV), risk of future violent relationships for women who have left abusive partners has received limited attention. Identification of empirically validated victim-related risk factors may help practitioners guide victims in decision making and safety planning (Cattaneo and Goodman 2005) and ensure that this vulnerable group receives optimal and adequate help and treatment. Toward this end, the authors conducted a review of the literature to ascertain what knowledge related to this issue has thus far been documented in the research.

Rationale

IPV comprises physical and sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (Breiding et al. 2015). An intimate partner is a person with whom one has a close personal relationship characterized by emotional connectedness, regular contact, and ongoing physical and/or sexual contact, identity as a couple, and familiarity with each other's lives (Breiding et al. 2015). Worldwide, almost one-third of women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (World Health Organization 2013). The National Intimate Partner and Sexual Violence Survey (Black et al. 2011) reported the following lifetime IPV experiences among women in the United States: rape (9.4%), sexual violence other than rape (16.9%), severe physical violence (24.3%), and stalking (10.7%). Nearly half of women in the U.S. had experienced psychological aggression by an intimate partner (Black et al. 2011). The mental health issues associated with IPV include depression, PTSD, anxiety, self-harm, and sleep disorders; the physical health issues include poor functional health, somatic disorders, chronic disorders and chronic pain, gynecological problems, and increased risk of sexually transmitted infections (Dillon et al. 2013). A sizeable

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proportion (27 – 59%) of women with recent experiences of IPV have prior histories of IPV (Alexander 2009). In general, IPV research does not differentiate between revictimization by one partner or multiple partners (MP). This lack of differentiation makes the research findings appear mixed and unclear.

Risk Factors

Surprisingly little is known about how victim-related factors affect risk for revictimization of IPV (Kuijpers et al. 2012b). This review specifically addresses victim-related risk for IPV by multiple partners (MP), that is, victim-related risk for future abusive relationships (Kropp and Hart 2015). Researchers may have avoided identifying victim characteristics for fear of blaming the victim and reducing the focus on the offender. We clearly agree that a perpetrator must be held accountable for the violence. Focusing on only the perpetrator may, however, distract attention from a possible vulnerability in some women for being revictimized. It is important to incorporate vulnerability factors that reflect common barriers to victims' ability, opportunity, or motivation to engage in self-protective behavior (Kropp and Hart 2015). It is troubling to overlook the experiences of a significant percentage of battered women who remain vulnerable to violence even when they have succeeded in leaving an abusive partner (Alexander 2009).

Regarding victim-related **background characteristics**, extant literature shows that a higher proportion of women who have been subjected to IPV revictimization have witnessed spousal abuse as children and/or were abused as children, compared to women who have not been subjected to IPV (e.g., Alexander 2009; Cole et al. 2008; Trickett et al. 2011). Various adult attachment styles have also been suggested as risk factors for IPV revictimization (e.g., Alexander 2009; Doumas et al. 2008; Kuijpers et al. 2012a). Several **psychopathological factors** have been claimed to increase the risk for IPV revictimization: PTSD, substance abuse, and personality disorders (e.g., Coolidge and Anderson 2002; Iverson et al. 2013; Kuijpers et al. 2011). **Characteristics of IPV**, such as frequency, severity, and mutual IPV, may increase the risk of revictimization (e.g., Kuijpers et al. 2012b; Witte and Kendra 2010; Zayas and Shoda 2007). In one study, revictimized women had reduced ability to detect violations in social contracts (dePrince 2005). Finally, some resistance and coping strategies have been found to be risk factors for revictimization (Goodman et al. 2005; Walker 1991).

Objectives

This preliminary review points to both hypothetical and empirical indications of victim-related vulnerability and risk factors for IPV revictimization. However, most of the literature has not distinguished between revictimization by the same partner and revictimization by MP. Hence, the research questions of the present systematic review were the following:

1. What is the extent of research on female IPV revictimization by MP?
2. What does existing research say about significant differences between female victims of IPV by MP and female victims of IPV by one partner?
3. What does existing research say about possible specific victim-related risk factors for IPV by MP?

Methods

Protocol

A systematic review of the scientific literature was conducted according to the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines (Moher et al. 2009). The review protocol consists of background information, review questions, inclusion and exclusion criteria, electronic search strategy, identifying research evidence, study selection, data extraction, quality assessment, data synthesis, and dissemination. The procedure is described below. A more detailed description of the protocol can be obtained from the first author.

Eligibility Criteria

Inclusion Criteria for Study Type

Articles were included if they (a) were peer-reviewed empirical studies (not theories or discussions), (b) described victims of IPV (not perpetrators only and not dating violence/rape/assault by an acquaintance or stranger), and (c) were written in English or in Scandinavian languages. No time limitation was applied.

Inclusion Criteria for Revictimization

Studies were included if their analyses compared victims of one IPV relationship to victims of IPV by MP and were either (1) systematic reviews of empirical studies on this specific topic or (2) papers reporting individual studies that met the inclusion criteria.

Search

Full electronic search strategy used for the database Ovid MEDLINE:

Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid

MEDLINE(R) 1946 to Present. **1** domestic violence/ or spouse abuse/ or Battered Women/ or ((*sex offenses/ or *rape/ or *violence/ or *Crime Victims/ or *Adult Survivors of Child Abuse/ or (abus* or reabus* or re-abus* or violen* or assault* or victim* or revictim* or re-victim*).ti.) and (marriage/ or spouses/ or (partner* or intimate* or husband* or wife or wives or spous* or domestic* or (significant adj other*) or dating or relationship* or prerelationship*).ti.)). **2** recurrence/ or (recur* or reabus* or re-abus* or revictim* or re-victim* or repeat* or prior or past or future or later or prerelationship* or further or subsequent or history or previous or (multiple adj (intimate or partner* or relation*))).ti. or ((recurr* adj1 partner violence) or reabus* or re-abus* or revictim* or re-victim* or (previous adj partner*) or (previous adj relation*) or (previous adj ipv) or (multiple adj (intimate or partner* or relation*))).ab. **3** 1 and 2. **4** (*domestic violence/ or *spouse abuse/ or *Battered Women/ or *Adult Survivors of Child Abuse/ or *Violence/) and (revictim* or re-victim* or reabus* re-abus* or (repeat* and victimiz*)).ti. **5** 3 or 4. **6** limit 5 to (danish or english or norwegian or swedish). **7** remove duplicates from 6.

The full electronic search strategy used for the other databases can be obtained by request to the first author.

Information Sources

We conducted a systematic computer search on June 3, 2015 and an identical update search on November 29, 2016. The databases and resulting number of publications were as follows: Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) from 1946 to Present (698 publications), PsycINFO from 1806 to November Week 3, 2016 (706), Cochrane Library (bases Cochrane Reviews, Technology Assessment) (6), Web of Science (187), SveMed+ (2), NiceGuidance (UK) (1), UpToDate (3). The total was 1,603 publications. After removal of duplicates 1,190 original publications remained. After the study selection process, we conducted a hand search through the introduction part of the eligible articles for additional relevant articles.

Study Selection

References were recorded and managed in EndNote Version 6 (software). All studies were screened by title, abstract, and key words. If this step did not provide clear information that answered the eligibility questions, the full text was obtained. Both first and second author assessed full texts according to the following items: authors, year published, description of empirical study, discussion of partner violence, inclusion of separate analyses for IPV in one and more than one relationship, and whether it was a review study. Articles that were considered by consensus to meet the criteria were included in the review study.

Data Collection Process and Data Items

Each study was registered chronologically by systematically entering the following items: authors, year, aim of the study, sample, methods, statistical analyses, and results. All results pertaining to differences between women with one and those with multiple violent partners were registered. Based on a preliminary review, the categories used for registration were (1) background characteristics, including childhood trauma, lifetime victimization, and attachment style, including family-of-origin characteristics and attachment; (2) psychopathology, including personality disorders, affect dysregulation, post-traumatic stress symptoms, substance and alcohol abuse, anxiety, and depression; (3) IPV characteristics; and (4) a category of "other" characteristics.

Risk of Bias in Individual Studies

Each study was evaluated regarding design, strength of statistical analyses, degree of distinctness of definitions, validity and reliability of measurements, number of participants, and sample characteristics. Bias and study limitations were assessed at the outcome level.

Summary Measures

The studies were scrutinized for information of prevalence and for results from bivariate and multivariate variance analyses (ANOVA, MANOVA) for group differences and associations between variables (linear and logistic regression). All findings with $p < .05$ were registered as significant.

Synthesis of Results

All findings pertaining to differences between the two groups of women were classified as significant or non-significant associations. The results were separated in the discussion according to study type: Longitudinal studies report group differences found before entry into new violent relationships, whereas the cross-sectional studies report group differences between women who have experienced violence from one and from MP.

Risk of Bias Across Studies

We considered publication bias and whether some countries dominated the field and looked for cultural context and location bias across the studies. Choice of study type,

measurements, level of analyses, population, economic compensation, and group sizes were other possible risks of bias across studies. In small samples, the risk for statistical Type II errors increases. In such cases, we explored whether this risk was addressed and integrated into the interpretations and presentations of the actual findings. Finally, we analyzed studies with a retrospective cross-sectional design for the risk of recall bias.

Results

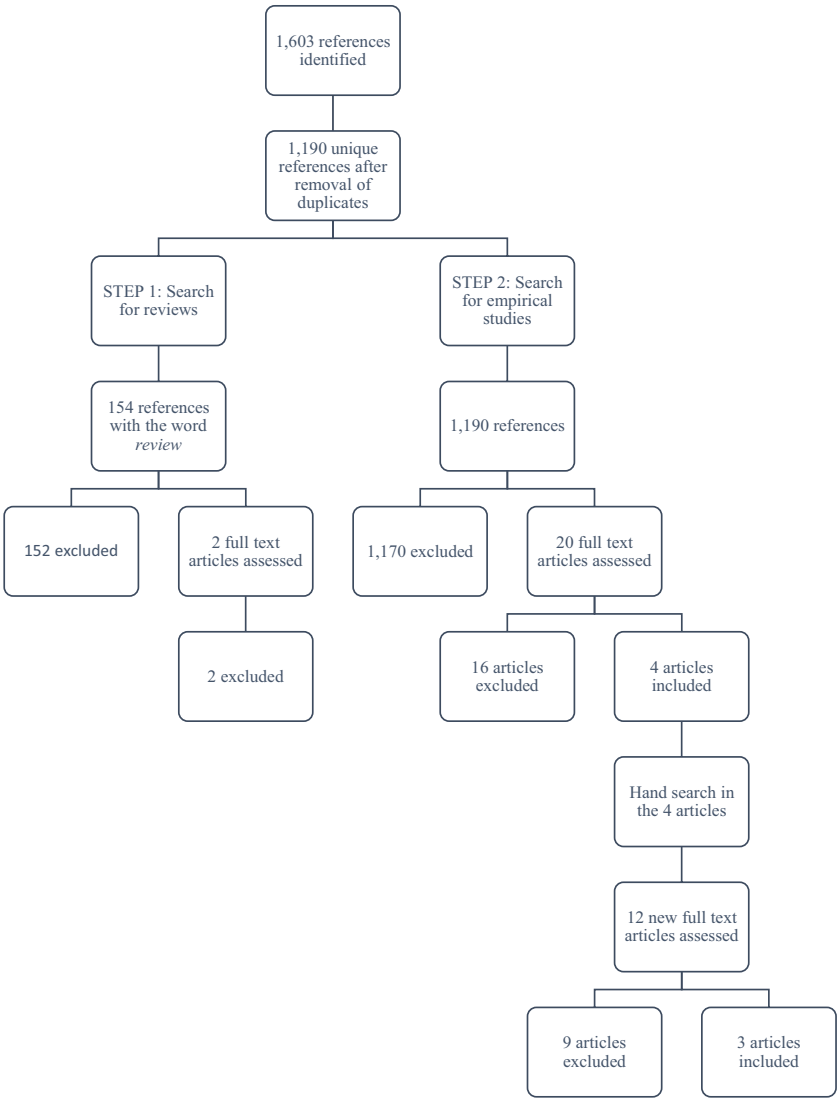
Study Selection

The process of selecting studies is presented in Flow Diagram, Fig. 1.

Among the 1190 articles retrieved by the search, 154 were digitally listed with the term *review* in the title or key words. We excluded 152 of these articles; either they were not systematic reviews or did not meet other inclusion criteria. Two systematic reviews were assessed in full text. One was excluded because it described any revictimization without specifying whether this covered IPV by one partner or by MP (Cattaneo and Goodman 2005). The other one (Kuijpers et al. 2011) examined the term *revictimization* in multiple intimate relationships and included one study which met our criteria (Cole et al. 2008). However, the Kuijpers review study was not a systematic review specifying studies that compared victims of one IPV relationship to victims of IPV by MP.

As there were no eligible systematic reviews, we proceeded to Step 2: original studies. Following the first author's initial screening, 20 full text articles were assessed. Of these 20, 18 articles reported findings from original studies, 1 paper was a review article which did not meet the criteria, and 1 was a discussion of cases with no empirical measurement provided. These 2 were excluded. Among the remaining 18

Fig. 1 Flow diagram



papers, there were 12 that focused on partner violence, and 6 on sexual assault/ rape/dating violence. Only 4 of the 12 studies included analyses that distinguished between women who experienced violence by one partner and by MP, and these 4 were included in the present study (Alexander 2009; Cole et al. 2008; Stein et al. 2016; Vatnar and Bjorkly 2008).

The introductions and reference lists of the 4 articles were hand-searched for additional relevant articles. Among 12 relevant full-text publications were 11 original studies and 1 literature review. The review was not systematic and not specific to IPV revictimization by MP. Of the 11 original studies, 10 focused on partner violence, whereas 1 focused on a variety of sexual victimizations. Concerning separate data for IPV by MP, 3 of the 10 articles met the criteria and were included in the study (Bogat et al. 2003; Coolidge and Anderson 2002; Testa et al. 2003).

In summary, Step 1 yielded no systematic reviews. Step 2 yielded four original empirical studies. A hand search resulted in three additional original studies. A total of seven publications were included in the present study.

Study Characteristics

The studies were published between 2002 and 2016 (Table 1, Summary of Reviewed Studies). Every study used quantitative analyses. Six studies used multivariate analyses (MANOVA, logistic regression analysis and linear regression analysis), and one study (Coolidge and Anderson 2002) only used a series of analysis of variance (ANOVA) (Table 1). All studies were conducted in the United States except for one which was conducted in Norway (Vatnar and Bjorkly 2008). Five studies had a cross-sectional design (Alexander 2009; Bogat et al. 2003; Coolidge and Anderson 2002; Stein et al. 2016; Vatnar and Bjorkly 2008), whereas two used a longitudinal design with a 12-month span between measurements (Cole et al. 2008; Testa et al. 2003). All eligible articles were published in English.

Sample sizes ranged from 93 (Alexander 2009) to 412 women (Cole et al. 2008) (Table 1). The populations consisted of women in a heterosexual relationship (Testa et al. 2003), women who had been involved in a romantic relationship for at least 6 weeks during a pregnancy (Bogat et al. 2003), and women who had been exposed to IPV (Stein et al. 2016) or were seeking service from police, shelters, family counseling, or educational treatment groups (Alexander 2009; Cole et al. 2008; Coolidge and Anderson 2002; Vatnar and Bjørkly 2008). Race was reported in five studies, ranging from 28% (Stein et al. 2016) to 75% White women (Testa et al. 2003). Mean age of the women ranged from 24 years (Testa et al. 2003) to 37 years (Alexander 2009). We found no reliable prevalence estimates of IPV by MP. In the victimized populations, there were from 22.9% (Vatnar and Bjørkly 2008) to 56% women with IPV by MP (Alexander 2009).

Risk of Bias Within Studies

Different types of bias emerged in common clusters of studies. Regarding violence, all studies except for one (Coolidge and Anderson 2002) applied some subscales or selected questions from the Conflict Tactics Scale (Straus 1995) or a revised version of it (Straus et al. 1996). Other selected or modified questions were drawn from the Severity of Violence Against Women Scales (SVAWS) (Bogat et al. 2003), Tolman's Psychological Maltreatment of Women Inventory (PMWI) (Cole et al. 2008), the British Crime Survey 1996 (Vatnar and Bjørkly 2008), and the National Violence Against Women Survey (Cole et al. 2008). One study included stalking explicitly (Cole et al. 2008). The Coolidge and Anderson study (2002) used a 12-item demographic questionnaire to cover both current and past history of violence (Coolidge and Anderson 2002) (Table 2). Trauma history was recorded in four studies (Alexander 2009; Cole et al. 2008; Coolidge and Anderson 2002; Vatnar and Bjørkly 2008), with the number of items ranging from less than 12 questions in one investigation (Coolidge and Anderson 2002) to 54 questions in another (Vatnar and Bjørkly 2008). None of the studies used a specific instrument to identify women with IPV by MP for sample selection. Four studies recorded retrospectively whether or not there had been violence in previous intimate partnerships (Alexander 2009; Coolidge and Anderson 2002; Vatnar and Bjørkly 2008) or the number of violent previous partners (Stein et al. 2016), and three studies used separate violence scores for separate relationships (Bogat et al. 2003; Cole et al. 2008; Testa et al. 2003).

Results of Individual Studies

For presentation of all outcomes, see Table 2.

Synthesis of Results

This systematic literature review about revictimization of IPV by MP indicated, first, that empirical research appears to be scarce, with only limited recent development. Second, there were significant differences between women with IPV in a single relationship and women with IPV by MP. Third, IPV by MP was significantly associated with childhood trauma, present drug abuse, IPV characteristics, and attachment style. Fourth, regarding PTSD and personality disorders, the results were mixed and inconclusive. Finally, depression did not appear to be a salient risk factor for subsequent violent relationships.

Background Characteristics

Five studies did statistical testing of the impact of childhood exposure to abuse and lifetime victimization. Four

Table 1 Summary of reviewed studies

Authors	Purpose	Nature of sample	Method	Statistical analyses	Results
Coolidge and Anderson 2002	To examine the psychopathology and background in samples of women who had been in a single abusive relationship or in multiple abusive relationships	Women reporting multiple abusive relationships: At least one physically abusive relationship and at least one other violent or emotionally abusive relationship was reported, N = 42 Women reporting a single abusive relationship, only one physically abusive relationship, and no other history of physically or emotionally abusive relationships, N = 33 Matched normative sample group, N = 54	Cross-sectional study 12-item self-report demographic questionnaire Psychopathology was assessed by the CATI, Coolidge Axis II Inventory (Coolidge and Merwin 1992, J. Pers. Assess. 59: 223–238), a 225-item self-report inventory designed to assess psychiatric disorders and maladjustment, based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994)	Chi square analyses ANOVA Bonferroni Tukey's post hoc analyses	Women who reported multiple abusive relationships exhibited higher levels of psychopathology than women who had a single abusive relationship and the normative control group on the following factors: dependent, paranoid, and self-defeating personality disorders. Women in multiple abusive relationships with post-traumatic stress disorder (PTSD) had significantly more personality disorders than women with single abusive relationships and PTSD. Women in single abusive relationships did not exhibit more psychopathology than women in the control group with matched marital status Although childhood victimization was highly present but not significantly different between women in single abusive relationships and women in multiple relationships, it was not systematically related to PTSD scale elevations nor to multiple personality disorder diagnoses
Bogat et al. 2003	To explore whether psychosocial indicators and severity of violence could be predicted from a woman's continuity and history of IPV	205 women recruited as part of an ongoing longitudinal study examining risk and resilience factors for IPV in women and children Four final groups: (1a) women with no experience of IPV (n = 51), (2a) women who had only experienced violence with their current partner (n = 78), (3a) women who had only experienced violence with their previous partner (n = 33), and (4a) women who had experienced violence with both their current and previous partners (n = 42)	Cross-sectional study The Severity of Violence Against Women Scales (SVAWS) filled out for 3 time periods: (a) during their pregnancy with current partner, (b) the year before pregnancy with current partner, and (c) with the previous partner From the Conflict Tactics Scale (CTS): The 14-item verbal and physical aggression scales filled out for (a) during her pregnancy and (b) the year before pregnancy Beck Depression Inventory (BDI) Brief Symptom Inventory – Anxiety Scale (BSI) PTSD Scale for Battered Women Rosenberg Self Esteem Scale Dyadic Adjustment Scale (DAS) Norbeck Social Support Scale	MANOVA	Within the four group classifications, main significant differences on psychosocial outcomes and severity of IPV were between the no IPV and chronic IPV groups (IPV experiences with two partners and across three different time periods) Women who had experienced IPV with both their current and previous partner were significantly lower on the factors emotional support and relationship satisfaction and higher on anxiety, depression, PTSD, and IPV severity scores, than women who had experienced violence with only one of the partners
Testa et al. 2003	To examine evidence for effects of women's substance use on their subsequent experiences of IPV as well as for effects of IPV on women's subsequent substance use	Wave 2: 218 women reported a new heterosexual partner at some point in the preceding 12 months. Because only 16 married women reported a new partner at Wave 2, they were omitted from analyses, resulting in N = 202	Three-wave longitudinal study Follow-up mail questionnaires after 12 months Partner violence: Subscales from CTS-2 to determine whether or not (rather than frequency) a woman had experienced minor violence, severe violence, or psychological aggression from a boyfriend or dating partner in her lifetime, in the past 12 months, or from her current partner At Wave 2, the CTS-2 was assessed specific to each heterosexual partner identified Relationship satisfaction Substance use measured by a series of separate questions regarding quantity and frequency of alcohol consumption and drug use Demographics	Hierarchical logistic regressions Path analysis	Marijuana use (*OR* = 5.90, CI = 1.50–23.84) and hard drug use (*OR* = 15.57, CI = 3.03–80.08) resulted in increased odds of experiencing violence in new relationships (*OR* = 4.11, CI = 1.14–14.86). Women's heavy episodic drinking did not predict subsequent experiences of IPV in ongoing or new relationships No significant association between psychological aggression and minor physical violence at Wave 1 and violence from the new partner at Wave 2, 12 months later Significant association between severe physical violence at Wave 1 and violence from the new partner at Wave 2, 12 months later

Table 1 (continued)

Authors	Purpose	Nature of sample	Method	Statistical analyses	Results
Cole et al. 2008	To examine the prevalence of, as well as risk factors for, revictimization by a new partner	756 women who had recently obtained a protective order against a violent partner and new interview 1 year later (follow-up rate 94% ; n = 709) Of those women who reported having a new partner at T2 (N = 412), 35.2% reported abuse	Longitudinal study T1 and T2, 12 months after Questions taken from the Risk Behavior Assessment (RBA), Conflict Tactics Scales (CTS and CTS2), Tolman's Psychological Maltreatment of Women Inventory (PMWI), National Violence against Women Survey, the Diagnostic Interview Schedule (DIS), Mini International Neuropsychiatric Interview (MINI), Addiction Severity Index (ASI), the Daily Hassles Scale, and the Social Support and Social Obstruction Scale	Multivariate logistic regression	There is a subset of women who are at greater risk of experiencing abuse by future partners: Women with greater cumulative lifetime victimization (*OR* = 1.081, CI = 1.023–1.142) and those who abuse or are dependent on illicit drugs (*OR* = 2.056, CI = 1.221–3.460)
Vatnar and Bjørkly 2008	To describe three interactional aspects of IPV, including predictors of risk for IPV victimization in more than one relationship	157 help-seeking women having been exposed to IPV within the last 6 months, recruited from family counseling offices, the police, and shelters 22.9% had experienced IPV by previous partners, 66.9% had no experience of IPV in previous partnerships. 10% did not have any previous partner experience, and these were eliminated from the analyses	Cross-sectional study Structured socio-demographic and health questionnaire covering socio-demographic profile (including substance use, mental health, and self-efficacy) Semi-structured IPV questionnaire Life-time history of victimization	Univariate and multivariate logistic regression analyses	Supported main income (social security) increases the probability of IPV victimization in more than one partnership Women who had been subjected to sexual abuse by their father, mother, or a parent's intimate partner were at almost 25 times increased risk of having been an IPV victim in more than one partnership Women who had been subjected to childhood physical violence or exposed to their parents' physical IPV ran a 2.6 and 2.9 times increased risk, respectively, for IPV in more than one partnership
Alexander 2009	To compare childhood trauma histories, family-of-origin characteristics, affect dysregulation, and attachment characteristics of battered women abused in either single or multiple relationships in adulthood	93 service-seeking women in the Mid-Atlantic area, abused in either single (44%) or multiple (56%) relationships	Cross-sectional study Questionnaires and interview Current relationship violence: From the Revised Conflict Tactics Scales (CTS2), Psychological Aggression Scale, and the Physical Aggression Scale twice (first overall IPV by current partner; second, IPV by current partner within last 6 months) History of trauma in child- and adulthood: Screening questions Adult Attachment Interview (AAI) (only 67 interviews were codable) Affect dysregulation: Dissociative Experiences Scale Taxon (DES-T) Borderline Features Scale from the Personality Assessment Inventory (PAI)	Hierarchical logistic regression analysis	Women victimized multiple times were significantly more likely to have been sexually abused in childhood (Exp (β) = 1.03), to have witnessed IPV in childhood (Exp (β) = 6.44), and to have experienced parent–child role reversal (Exp (β) = 5.75). Affect dysregulation differentiated the two groups (Exp (β) = 1.02 and 1.04), but did not mediate the effect of childhood trauma. Women who were unresolved in their attachment were more likely to be victimized multiple times in adulthood

Table 1 (continued)

Authors	Purpose	Nature of sample	Method	Statistical analyses	Results
Stein et al. 2016	To identify the social and individual mechanisms that may increase risk for further exposure to IPV in the future with subsequent abusive partners	Women (with children) who had been exposed to IPV within the previous 2 years (N = 164). Participants were recruited to participate in a community-based clinical evaluation trial for women in Michigan, Ohio, Texas, and Ontario. This was a multiethnic sample. 35% reported multiple IPV relationships. Ages were 21 to 54 years (M = 33.39 years, *SD* = 7.47). Unemployment was high (58.57%). The maximum education level attained was relatively low	Cross-sectional study Structured clinical interview (1–2 h.) Demographic information: Age, ethno-racial identification, monthly household income, and education level The Revised Conflict Tactics Scale (CTS2) -- only the 39 items associated with violence victimization were included (excluding the perpetration questions) The Post-traumatic Diagnostic Scale Center for Epidemiologic Studies Depression Scale (CES-D)	Multiple (Ordinary least squares) linear regression analysis	Results of multiple regression analysis indicated that a trauma history of childhood sexual abuse (β=0.19), being held hostage (β=0.35), and torture (β=0.16) and current psychological violence (β=0.22) were associated with women's engagement with multiple violent partners. Additional findings revealed that identification as African American (β=0.22) and White (β=0.22) was associated with greater re-engagement compared with identification as Latina. Finally, current exposure to sexual violence was associated with fewer violent partners (β = -0.23) No significant difference in exposure to acts of physical violence and sexual and psychological abuse was found between women with one violent partner and women engaged with multiple violent partners No significant differences found in terms of depressive symptoms and post-traumatic stress symptoms and whether the woman had one or more than one violent intimate partner Women with exposure to current sexual violence had a lower number of violent partners Women's age, education level, income, history of non-sexual and sexual assault, current mental health problems, or current physical violence were not found to be associated with the number of violent partners

studies found a significant association (Alexander 2009; Cole et al. 2008; Stein et al. 2016; Vatnar and Bjorkly 2008), whereas one investigation did not (Coolidge and Anderson 2002) (Table 2). Women with IPV by MP had been exposed to more types of childhood violence and sexual abuse and lifetime victimization than women subjected to IPV by one partner (Table 2). One study (Alexander 2009) used the Adult Attachment Interview, and two significant associations were found with IPV by MP (Table 2).

Psychopathology

All seven studies investigated psychopathology. Post-traumatic stress symptoms were investigated in four studies. One found significant associations with women with IPV by MP (Bogat et al. 2003), and three did not (Cole et al. 2008; Coolidge and Anderson 2002; Stein et al. 2016). There were four studies with analyses of depression. One study found an association with women with IPV by MP (Bogat et al. 2003), and three did not (Cole et al. 2008; Coolidge and Anderson 2002; Stein et al. 2016). Two studies assessed anxiety. One found IPV by MP to be higher on anxiety (Bogat et al. 2003), and one investigation did not find a significant group difference (Coolidge and Anderson 2002). Two studies investigated the relationship between illicit drugs and IPV by MP, and both found a significant association (Cole et al. 2008; Testa et al. 2003). Two studies did statistical testing of the impact of alcohol, whereof one found a significant association with women with IPV by MP (Vatnar and Bjorkly 2008), and one did not (Testa et al. 2003). The impact of personality disorders was investigated in only one study (Coolidge and Anderson 2002). Women with IPV by MP scored significantly higher on three personality disorders (Table 2). Affect dysregulation as a personality feature was explored in one study (Alexander 2009), indicating differences in the initial analyses, but no significant group difference in the multivariate analysis.

IPV Characteristics

There were five investigations with measures of various IPV characteristics. Five of eight characteristics were significantly associated with IPV by MP (Table 2).

Other Characteristics

The impact of age was tested in four investigations (Table 2). Two studies found a significant association (Alexander 2009; Testa et al. 2003), and two did not (Cole et al. 2008; Coolidge and Anderson 2002). Sociodemography and quality of life are other factors that have been investigated, see Table 2. The results from testing the impact of these categories were mixed and inconclusive.

Table 2 Group differences and risk factors of intimate partner violence (IPV) by multiple partners (MP)

Hypothesized risk factors	Author, year	Findings	Significant result
Background characteristics			
a. Childhood trauma	Cole et al. 2008	Significantly more women who experienced victimization by a new partner reported emotional (t or $X^2 = 10.351$**) and sexual (t or $X^2 = 8.291$, **) abuse by a parent or guardian compared to victimized women who did not report victimization by a new partner	Yes
	Coolidge and Anderson 2002	Although childhood victimization was highly present, the factor did not significantly differ between women with a single abusive relationship and women with multiple abusive relationships	No
	Alexander 2009	Women with multiple abusive relationships were significantly more likely to report having been sexually abused as a child (X^2 (1) = 10.38**), having witnessed IPV as a child (X^2(1) = 17.23***), and more likely to report having experienced multiple forms of childhood trauma (F (1, 91) = 16.80 ***)	Yes
	Alexander 2009	History of neglect was not associated with multiple victimization in adulthood History of abuse by father and abuse by mother was not significantly related to multiple victimization in adulthood	No No
	Vatnar and Bjorkly 2008	Women who had been subjected to sexual abuse by their father, mother, or a parent's intimate partner were at almost 25 times increased risk of having been an IPV victim in more than one partnership, OR (95%CI) = 24.990 (2.048–304.997) **	Yes
	Vatnar and Bjorkly 2008	There was an increased risk for IPV in more than one partnership for women who had been subjected to childhood physical violence, OR (95%CI) = 2.564 (1,016–6.471) ** and for women who had been exposed to their parents' physical IPV, OR (95%CI) = 2.984 (1.132–7.676) **	Yes
	Vatnar and Bjorkly 2008	Exposure to parents' physical IPV increased the risk of victimization in more than one partnership significantly more than if the woman herself had been subjected to childhood physical victimization	Yes
	Vatnar and Bjorkly 2008	There seems to be a hierarchical association among sexual, physical, and psychological childhood victimization and IPV victimization in more than one partnership: If the woman had been the victim of psychological and physical childhood violence, only physical violence increased the probability of IPV victimization in more than one partnership (OR = 2.564, CI = 1.016–6.471*). If the woman had been the victim of sexual, physical, and psychological childhood violence, only sexual violence increased the probability of IPV victimization in more than one partnership (OR = 24.990, CI = 2.048–304.997 **)	Yes
	Stein et al. 2016	The women with more than one violent partner were significantly more likely to have a history of childhood sexual abuse (58.46%) than those with only one violent partner (36.69%), T/X^2 = 8.53**	Yes
b. Lifetime victimization	Cole et al. 2008	Cumulative lifetime victimization predicted partner violence by a new partner, β = 0.078, OR (CI) = 1.081 (1.023, 1.142) Wald = 7.671 **	Yes
	Stein et al. 2016	Women with more than one violent partner were significantly more likely to have had a history of non-sexual assault (60.0%) than those with only one reported violent partner (43.88%), T/X^2 = 4.60*	Yes
	Stein et al. 2016	Women with a history of being held hostage were more likely to have multiple violent partners (23.08%) than those with only one violent partner (6.47%), T/X^2 = 11.76***	Yes
	Stein et al. 2016	No group difference on torture between women with one violent partner and women with multiple partners	No
	Stein et al. 2016	No group difference on sexual assault between women with one violent partner and women with multiple partners	No
c. Family-of-origin characteristics	Alexander 2009	Women in multiple abusive relationships were more likely to have experienced parent–child role-reversal with their mothers, univariate F = 4.57*	Yes
d. Attachment	Alexander 2009	Women who were categorized on the Adult Attachment Interview with unresolved attachment regarding trauma or loss were significantly more likely to report multiple abusive relationships (X^2 = 5.30 *). In post hoc analyses, multiple abusive relationships in adulthood interacted with unresolved attachment F(1, 62) = 7.03 **	Yes

Table 2 (continued)

Hypothesized risk factors	Author, year	Findings	Significant result
Psychopathology			
a. Personality disorder	Coolidge and Anderson 2002	Compared to the single abusive relationship group and the control group, the multiple abusive relationship group scored significantly higher (sequential Bonferroni correction) on the Axis II scales borderline $F(2, 126) = 5.83$ **(multiple > norm.), dependent $F(2, 126) = 6.37$ ** (multiple > single and norm.), paranoid $F(2, 126) = 5.61$ ** (multiple > single and norm), and self-defeating $F(2, 126) = 9.55$ ***(multiple > single and norm)	Yes
	Coolidge and Anderson 2002	After Tukey's post hoc procedure ($p < .05$), women in single and in multiple abusive relationships were not significantly different in their mean numbers of personality disorders (T scores ≥ 70)	No
	Coolidge and Anderson 2002	After Tukey's post hoc procedure ($p < .05$), when PTSD symptomatology was present, women with multiple abusive relationships had significantly more personality disorders ($M = 2.8$) than women with a single abusive relationship ($M = 1.0$) (T scores > 70)	Yes
b. Affect dysregulation	Alexander 2009	Women who were multiply abused in adulthood did not report significantly more dissociative symptoms	No
	Alexander 2009	Women who were multiply abused in adulthood reported more borderline personality features, $X^2(1, N = 92) = 7.17$ **	Yes
	Alexander 2009	Given that the dependent variable of women's report of multiple IPV relationships is dichotomous, a hierarchical logistic regression analysis was used to assess the association between multiple IPV relationships and a history of both childhood trauma and affect dysregulation. The overall model was statistically significant, $X^2(7, N = 89) = 33.36$ ***, with witnessing IPV in childhood (Wald z = 10.90***) and a history of CSA (Wald z = 6.57**) predictive of a report of multiple IPV relationships in the two groups. In the final model, neither dissociation nor borderline traits differentiated the two groups. Therefore, although childhood trauma was associated with multiple abusive relationships in adulthood, this effect was not mediated by affect dysregulation	No
c. Post-traumatic stress symptoms	Coolidge and Anderson 2002	More women in multiple abusive relationships had clinically significant scores on post-traumatic stress ($X^2 = 6.29$ *), separating them from the women in the control group, but they did not differ significantly from the women with a single abusive relationship	No
	Bogat et al. 2003	Women who had experienced violence with both current and previous partners scored significantly higher on PTSD than the two groups of women who had experienced violence only with *current* partner or only with *previous* partner (mean score 31.38, statistical significance is stated in the study but no digits are referred)	Yes
	Cole et al. 2008	No significant prediction of revictimization from new partner as a function of PTSD before initiation of new relationship	No
	Stein et al. 2016	There were no significant differences in post-traumatic stress symptoms between women with one violent partner or more than one violent intimate partner	No
d. Substance abuse and alcohol	Testa et al. 2003	Marijuana use ($OR = 5.90$ *, CI = 1.50–23.84) and hard drug use ($OR = 15.57$ **, CI = 3.03–80.08) resulted in increased odds of experiencing violence from a new partner relative to women who did not use drugs	Yes
	Cole et al. 2008	Meeting criteria for illicit drug abuse/dependence in the year before Time 1 was significantly positively associated with partner violence by a new partner between Time 1 and Time 2, β = 0.721, OR (CI) = 2.056 (1.221, 3.460), Wald 7.361 **	Yes
	Testa et al. 2003	Women's heavy episodic drinking frequency did not predict violence from a new partner	No
	Vatnar and Bjorkly 2008	Current alcohol use sometimes and regular increased the risk for having had IPV in a previous relationship compared to women who did not use alcohol Woman's current alcohol use sometimes and current physical IPV was associated with IPV victimization in more than one relationship, OR (95%CI) = 2.956 (1.068–8.227) * Woman's current alcohol use regularly and current physical IPV was associated with IPV victimization in more than one relationship, OR (95%CI) = 13.666 (2.686–69.450) ** Woman's current alcohol use sometimes and current psychological IPV was associated with IPV victimization in more than one relationship, OR (95%CI) = 2.855 (1.078–7.563) * Woman's current alcohol use regularly and current psychological IPV was associated with IPV victimization in more than one relationship, OR (95%CI) = 11.637 (2.326–58.226) **	Yes

Table 2 (continued)

Hypothesized risk factors	Author, year	Findings	Significant result
e. Anxiety	Bogat et al. 2003	Women who had experienced violence with both current and previous partners scored significantly higher on anxiety than women who had experienced a single violent relationship (violence only with current partner or only with previous partners), (mean score 7.26, statistical significance is stated in the study but no digits are referred)	Yes
	Coolidge and Anderson 2002	No significant difference when it came to generalized anxiety	No
f. Depression	Coolidge and Anderson 2002	Percentages of respondents meeting clinical significance for the depression scale did not differ significantly between the single and the multiple IPV group	No
	Cole et al. 2008	No significant prediction of revictimization from new partner as a function of depression before initiation of new relationship	No
	Bogat et al. 2003	Women who had experienced violence with both their current and previous partners scored significantly higher on depression than women who had only experienced violence with their *previous* partner (mean score 14.36, statistical significance is stated in the study but no digits are referred)	Yes
	Bogat et al. 2003	Women who had experienced violence with both their current and previous partners did not differ significantly on depression from women who had only experienced violence with their *current* partner	No
	Stein et al. 2016	There were no significant differences in depressive symptoms between women with one violent partner and women with more than one violent partner	No
IPV characteristics			
	Alexander 2009	No difference in frequency reports of IPV in current relationship as a function of a history of multiple abusive relationships	No
	Testa et al. 2003	No significant correlation between psychological aggression or minor physical violence at Wave 1 and violence from the new partner at Wave 2, 12 months later	No
	Testa et al. 2003	Correlation between severe physical violence at Wave 1 and violence from the new partner at Wave 2, 12 months later (0.17 *)	Yes
	Bogat et al. 2003	Women who had experienced violence with both their current and previous partners had significantly higher IPV severity score, compared to women who had experienced IPV in either current or previous relationship (mean score 45.15**)	Yes
	Cole et al. 2008	More women reporting victimization by a new partner at Time 2 reported a history of prior partner victimization - psychological abuse (*t* or $X^2 = 8.530$ *), stalking (*t* or $X^2 = 10.107$ *), physical abuse (*t* or $X^2 = 11.736$ *), and threatened/forced sex (*t* or $X^2 = 8.330$ *) - before the relationship with the DVO partner	Yes
	Cole et al. 2008	More women who had been victimized by a new partner had been stalked by the prior, DVO partner, compared to women who did not report victimization at Time 2 (*t* or $X^2 = 9.431$ *)	Yes
	Cole et al. 2008	Long involvement with a new partner (number of months) increased likelihood of experiencing victimization by the new partner (*t* or $X^2 = 49.649$ ***)	Yes
	Stein et al. 2016	There was no significant difference in current exposure to acts of physical violence, sexual IPV, and psychological IPV between women with one violent partner and those who reported engagement with multiple violent partners	No
Other characteristics			
a. Age	Alexander 2009	Women who were multiply victimized in adulthood were younger ($M = 35.06$, $SD = 9.01$) than women who were singly victimized ($M = 40.34$, $SD = 12.96$), $F(1, 91) = 5.36$ *	Yes
	Testa et al. 2003	Higher age gave lower risk for multiple IPV ($OR = 0.77$ **, CI = 0.64–0.93)	Yes
	Coolidge and Anderson 2002	The two groups did not differ on mean age	No
	Cole et al. 2008	No significant prediction of revictimization from new partner as a function of age before initiation of new relationship	No
b. Socio-demographic measures	Alexander 2009	Multiple victimization was not associated with factors such as education, income, employment status, ethnicity, relationship status, number of children, or residence in a shelter	No
	Bogat et al. 2003	There were no mean differences between the groups of women when it came to practical aid support	No
	Vatnar and Bjorkly 2008	Supported main income (social security) increases the probability of IPV victimization in more than one partnership, *OR* (95%CI) = 3.699 (1.1314–10.412)*	Yes

Table 2 (continued)

Hypothesized risk factors	Author, year	Findings	Significant result
c. Quality of life	Bogat et al. 2003	Women who had experienced violence with both current and previous partners scored significantly lower on relationship satisfaction than women who had experienced violence only with current partner or previous partner (mean score 2.81, statistical significance is stated but not referred to in the table)	Yes
	Bogat et al. 2003	Women who had experienced violence with both current and previous partners did not differ from women having only experienced violence from previous partner or women having only experienced violence from current partner on the variable self-esteem	No
	Bogat et al. 2003	Women who had experienced IPV with both their current and previous partner were significantly lower on the factor emotional support than women who had only experienced violence with a previous partner (mean score 3.03, statistical significance is stated but not referred to in the study)	Yes
	Cole et al. 2008	None of the indicators of daily stress, social support, or social obstruction was significantly associated with the victimization by a new partner	No
	Coolidge and Anderson 2002	Maladjustment was significantly higher among multiply abused women than among women with single or no abusive relationships, $F(2, 126) = 8.58$ ***	Yes

*p < .05. **p < .01. ***p < .001

Risk of Bias Across Studies

The use of a standard case definition is one key factor needed to ensure that information is collected in a systematic fashion (Centers for Disease Control and Prevention 2001). There were no explicit, uniform operational definitions of IPV, childhood trauma, the psychopathological variables, drug or alcohol use, or other variables of interest and, thus, conclusions on summarized between-study comparisons must be made cautiously. The risk of bias increased when measurement scales had been developed by the authors and had not been adequately validated before the investigations took place (Fellmeth et al. 2013).

All studies had an acceptable sample size regarding the conducted analyses (Table 2). All investigations conducted multivariate statistical testing, except for one that used ANOVA (Coolidge and Anderson 2002) and thus could be expected to produce different results than the six studies that used advanced analyses.

Two studies used a longitudinal design (Cole et al. 2008; Testa et al. 2003). It is important to emphasize that prospective designs are best fitted for identification and testing of causality and predictive risk factors. The studies of Testa et al. and Cole et al. registered which risk factors were present before the initiation of a new relationship. The other five studies were cross-sectional and tested differences between women who had already been victimized by one or by MP. With cross-sectional studies, it is not known whether the psychosocial outcomes are viewed as precursors or predictors of IPV, as consequences, or both (Bogat et al. 2003).

The data in all seven studies are self-reported and thus subject to response biases such as social desirability and recall bias. Because the reports of IPV vary in terms of recency, they may also vary in salience (Bogat et al. 2003). It is possible that more serious events were recalled with greater frequency than were less serious events. Costa et al. (2015) state that recall of childhood experiences results in a substantial rate of false negatives, measurement error, and bias that could elevate Type I errors, with higher wellbeing linked to retrospective forgetting and lower wellbeing tied to greater retrospective reporting. Hence, investigations that rely on retrospective reports of adversities may make it difficult to draw valid conclusions due to biases and the fallibility of human memory (Costa et al. 2015).

Language bias arises because studies with statistically significant results that have been conducted in non-English speaking countries may be more likely to be published in English language journals than those with non-significant results. Thus, as the present review found only studies reported in English as eligible, our analysis may be based on fewer data.

The second and third authors of this review article were co-authors of one of the included articles. This may have affected the interpretation of this study. However, the structured method of data analysis was similar for all included articles in the review, and the first author analyzed all results accordingly to mitigate against possible bias.

Discussion

Summary of Evidence

Number of Studies

The most striking finding of this review is the scarcity of research on risk of revictimization of IPV by MP specifically.

In spite of public and clinical awareness of the seriousness of this problem, it appears to have attracted limited scientific attention.

Systematic Group Differences and Risk Factors

The results of this review suggested that there were significant differences between victims of IPV by MP and victims of IPV by one partner. Several studies of IPV have found an association between childhood abuse and risk for adulthood abuse at large. The subgroup of women subjected to IPV by MP was found to have a significantly stronger tendency to have had a history of trauma (childhood emotional, physical, and sexual abuse and witnessing parents' physical abuse) than women with a single abusive relationship. This was the factor with the strongest empirical evidence in our study. Only one study failed to find this association significant; notably this was the study with the weakest methodology in terms of measurement and statistical analyses. Hence, women with childhood trauma history seem to be at risk of revictimization in multiple relationships already before their first intimate adult relationship. Trauma-related symptoms have been hypothesized to be a moderator variable between childhood trauma and revictimization, in general (Cole et al. 2008). Our study did not confirm this association for IPV by MP.

Adult attachment style has been suggested as a risk factor for IPV revictimization, such as high attachment anxiety (Zayas and Shoda 2007), the "mispairing" of partners' attachment styles (e.g., avoidant male and anxious female) (Doumas et al. 2008) and avoidant attachment style in victims with average to high levels of anger (Kuijpers et al. 2012a). In our review, unresolved attachment style was found to increase the risk of IPV by MP in one retrospective study (Alexander 2009). Role-reversal with mother also appeared to increase the risk of IPV by MP (Alexander 2009). In parent–child role reversal, "The parent tries to elicit attention or parenting from the child" (p. 81). If supported by further research, role-reversal may prove to increase risk for IPV by MP through a feeling of shame, through boundary dissolution, or through undermining a woman's awareness of her own distress (Alexander 2009). However, the current evidence regarding attachment and role reversal is still too weak, and further research is needed.

We found no empirical studies with measures of personality disorder prior to the initiation of new violent relationships and no evidence for a specific personality disorder as a predictor for IPV by MP. One study found that women who had been victimized by MP had greater clinical elevations of dependent, paranoid, and self-defeating personality disorders than women with a single violent relationship (Coolidge and Anderson 2002). However, this study was limited to univariate analyses. The two groups of revictimized women did not differ regarding the total amount of personality disorders or mean numbers of personality disorders. A hypothesis about borderline personality disorder or traits putting women at risk of IPV by MP was not clearly supported in our review. In Alexander's (2009) study, significantly more women with IPV by MP had clinically elevated levels of borderline personality traits, but the conclusion after multivariate analyses was that neither dissociation nor borderline traits differentiated the two groups (p. 84). Two studies investigated the relationship between *prior* substance abuse and *subsequent* IPV by MP (Cole et al. 2008; Testa et al. 2003). The results indicated that those who abused or were dependent upon illicit drugs were at greater risk of experiencing abuse by future partners. Regarding alcohol, the results were inconclusive. The present results on drug abuse were drawn from two longitudinal studies, and their prospective design offers methodological rigor to the findings of this association. However, this must not lead to the conclusion that this is a causal relationship. Drug users may have more frequent relationship changes, thereby increasing their potential exposure to partner violence over time. They are also involved in an illegally and socially deviant subculture that includes violent men. It is likely that drug-using women choose their partners from this riskier pool of men. Use of drugs by a woman or her partner may increase irritability and volatility, impair social interaction and ability to handle conflict, and thus increase the likelihood of violence on both sides (Testa et al. 2003).

Some characteristics of the violence in a prior relationship, such as serious violence and stalking, appear to increase the risk of IPV by MP. This is in line with findings in other research (e.g., Iverson et al. 2013; Kuijpers et al. 2012b). Due to the diversity of variables and definitions used among the studies, the results on this issue are mixed.

Limitations

We may have missed studies of interest if they are not properly registered in the data bases by the key search words we used. In addition, studies may have been overlooked if they have been published in less renowned journals, do not have the format of a scientific article, or are not published in the English or Scandinavian languages. Still, that the Kuijpers et al. (2011) review article on revictimization referred to only a single study of IPV by MP illustrates the dearth of research on this topic. The limited number of studies on risk of IPV by MP and the absence of the use of similar measurement tools in these investigations preclude making firm conclusions about risk factors. Furthermore, the suggested factors are far from establishing causal relationships. The findings in this review offer no valid evidence for a single-factor explanation or for a multifactorial trajectory of IPV by MP.

Most research still targets female victims, the main argument being that women suffer more severe consequences

(Coker et al. 2002; Hines and Douglas 2009) and seek help more frequently than male IPV victims. Consequently, this review of IPV revictimization by MP focuses on female victims. No studies pertaining to male victims were found in the search. There is no empirical evidence for generalizing to male revictimization from the current review.

Conclusions

In this systematic literature review, we found only seven studies that investigated differences between women with IPV by MP and women with a single IPV relationship. Our results indicate limited research development on IPV by MP which brings suffering to so many people. Accordingly, a vulnerable group might not achieve optimal and adequate treatment. We found some victim-related risk factors for IPV by MP and systematic differences between women who had been subjected to IPV in a single relationship and women with IPV by MP. Childhood trauma, attachment style, drug abuse, and IPV characteristics appeared to be risk factors for IPV by MP. An important message to clinicians is that there is no evidence for any specific personality disorder to be a causal factor for IPV by MP. The careful choice of intimate partner is a topic that should be shared with women having a childhood history of domestic trauma and women abusing illegal drugs. A close cooperation between services for drug abuse treatment and agencies for women subjected to IPV is recommended. Instead of treating women victimized by IPV as a uniform group, it is important to attend to women with IPV by MP as a subgroup with special needs.

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II

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IPV Characteristics, Childhood Violence, and Adversities as Risk Factors for Being Victimized in Multiple IPV Relationships

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Abstract

Empirical knowledge regarding risk factors for intimate partner violence (IPV) from multiple partners (MP) is scarce and sought by clinicians and many women themselves for the prevention of future intimate partner violence relationships (IPVRs). Quantitative data were obtained through a structured interview with a stratified sample of help-seeking women ($N = 154$) with no ($n = 48$, 0IPVR), one ($n = 55$, 1IPVR), or multiple ($n = 51$, 2IPVR) IPVRs. This study investigated the association between (a) childhood family violence, (b) other childhood adversities, (c) victimization and perpetration of IPV in the last (index) relationship, and (d) controlling sociodemographic and contextual variables, and the following dependent variables: (a) women with 1IPVR and 2IPVR compared with 0IPVR and (b) women with 1IPVR compared with 2IPVR. Multivariate logistic regression analyses indicated that, compared with nonvictimized women, IPV victimized women were nearly three times more likely to report childhood sexual abuse. They also reported a higher frequency of peer victimization and a higher likelihood of

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having an immigrant partner. In addition, the length of the index relationship was shorter for IPV victimized women. Compared with women with 1IPVR, women with IPV by MP were more likely to report childhood emotional abuse and less education, and they were less likely to be immigrants. The two groups of IPV victimized women were indistinguishable regarding characteristics of victimization and perpetration of IPV. This study indicated that there were other risk factors for IPV by MP than for IPV in general and highlighted the importance of addressing parenting and emotional care in IPV families.

Keywords
intimate partner violence, risk, multiple partners, childhood emotional abuse, sexual abuse, peer victimization.

Introduction

Intimate partner violence (IPV) is a serious, heterogenic, and complex issue associated with significant health, social, and economic costs to individuals and society (Cattaneo & Goodman, 2005; Cornelius & Resseguie, 2007; Costa et al., 2015; Mears, 2003). IPV comprises physical and sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (Breiding, 2015). An intimate partner is a person with whom one has a close personal relationship characterized by emotional connectedness, regular contact, and ongoing physical and/or sexual contact and with whom one shares identity as a couple and familiarity with each other's lives (Breiding, 2015). Worldwide, almost one third of women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner according to the World Health Organization (WHO; 2013). The National Intimate Partner and Sexual Violence Survey (Breiding, 2015) reported the following lifetime IPV experiences among women in the United States: rape (8.8%), sexual violence other than rape (15.8%), severe physical violence (22.3%), and stalking (9.2%). Nearly half of women in the United States had experienced psychological aggression by an intimate partner (Black et al., 2011). Lifetime prevalence in Norway showed that 14.4% of women had been victimized by minor physical violence from partners and 8.2% by severe physical violence (Thoresen & Hjemdal, 2014). The mental health issues associated with IPV include depression, posttraumatic stress disorder (PTSD), anxiety, self-harm, and sleep disorders; the physical health issues include poor functional health, somatic disorders, chronic disorders and chronic pain, gynecological problems, and increased risk of sexually transmitted infections (Dillon et al., 2013). Sizable

proportions of women who terminate their relationship with a violent partner become involved with a subsequent violent partner: Ranging from 22.9% (Vatnar & Bjørkly, 2008) to 56% (Alexander, 2009), women in IPV victimized female samples had prior histories of intimate partner violence relationships (IPVRs). Accordingly, it is urgent to investigate risk factors for IPV by multiple partners (MP). Empirical knowledge concerning risk factors for IPV by MP, in particular, is sought by clinicians and many women themselves for the prevention of future IPVRs. Perpetrators must be held accountable for their violence, but focusing only on the perpetrator may distract attention from a possible vulnerability in some women for being revictimized. It would be troubling to overlook the experiences of a significant percentage of victimized women who remain vulnerable to violence even after they have succeeded in leaving one violent partner (Alexander, 2009).

Risk Factors for Revictimization of IPV

The reported childhood risk factors for IPV revictimization are, in general, psychological (Cascio et al., 2017), sexual, and physical abuse (Barrios et al., 2015; Cascio et al., 2017; Coid et al., 2001; Stroem et al., 2019) and exposure to parental abuse (Ehrensaft et al., 2003; Krishnan et al., 2001; Trickett et al., 2011). The reported violence-related risk factor for IPV revictimization of a woman is that she initiates violence toward her male partner (Dixon & Graham-Kevan, 2011; Kuijpers et al., 2012a, 2012b, 2012c). Some resistance and coping strategies have been reported as risk factors for IPV revictimization (e.g., fighting back, mutual violence, manipulation, anger, intimacy, compliance, and refusing to do what he says; Goodman et al., 2005; Iverson et al., 2013).

Risk Factors for Revictimization of IPV by MP

The vast majority of studies on IPV revictimization do not distinguish between revictimization by the same partner and revictimization by MP, which implies mixed and inaccurate results. Risk factors related to IPV by MP may not be the same as the risk factors related to recurrent violence within a cycle of a single violent relationship. A systematic literature review regarding revictimization of IPV by MP in particular indicated that IPV by MP was significantly associated with childhood domestic trauma, drug abuse, characteristics of the partner violence, and attachment style. Regarding PTSD and personality disorders, the results were mixed and inconclusive, and depression did not appear as a salient risk factor for IPV by MP (Ørke et al., 2018). With only seven published studies, empirical

research on risk for IPV revictimization by MP appeared to be scarce and had limited recent development, and the wide diversity in study designs, measurements, definitions, and variables in these studies precluded drawing firm conclusions about risk factors (Ørke et al., 2018). The review findings indicated that the vulnerability of women subjected to IPV by MP was associated with a history of childhood sexual abuse (Alexander, 2009; Cole et al., 2008; Stein et al., 2016; Vatnar & Bjørkly, 2008), in addition to emotional abuse (Cole et al., 2008), childhood domestic physical violence (Vatnar & Bjørkly, 2008), witnessing domestic IPV (Alexander, 2009; Vatnar & Bjørkly, 2008), and a history of torture and being held hostage (Stein et al., 2016). There was no evidence for one specific personality disorder typical of women at risk for IPV by MP (Ørke et al., 2018). Regarding characteristics of the partner violence, greater IPV severity (Bogat et al., 2003) and current psychological violence were associated with additional violent partners, and women with exposure to current sexual violence had a lower number of violent partners (Stein et al., 2016). Victims of IPV by MP scored higher on PTSD (Bogat et al., 2003). Long involvement with a new partner increased the likelihood of IPV revictimization by the new partner (Cole et al., 2008). Where age difference had been found between the two groups, women with IPV by MP were significantly younger than women with a single IPVR (Alexander, 2009; Testa et al., 2003). One American study reported that African American and White women had significantly more violent partners than their Latina counterparts (Stein et al., 2016).

Judging from a systematic review regarding revictimization of IPV by MP (Ørke et al., 2018), the use of a standard case definition would be one key factor needed to ensure that information is collected in a systematic fashion (German et al., 2001). Future studies could possibly benefit from more refined language that provided greater specificity in the labeling of some of the trauma history items (Stein et al., 2016). The risk of measurement bias increases when scales have been developed by authors but have not been adequately validated before investigations take place (Fellmeth et al., 2013). In this study, the abovementioned shortcomings in the existing literature were addressed.

Aims of the Study

The aims of the study were to investigate the association between women with no (0IPVR), one (1IPVR), or multiple (2IPVR) IPVRs and (a) childhood family violence and other childhood adversities and (b) IPV in the last (index) relationship. The analyses were adjusted for sociodemographic and contextual group differences. Research questions were as follows:

1. **Research Question 1:** Are women with IPVRs different from women with 0IPVR regarding childhood family violence and other childhood adversities?
2. **Research Question 2:** Are women with 2IPVR different from women with 1IPVR regarding childhood family violence and other childhood adversities?
3. **Research Question 3:** Are women with 2IPVR different from women with 1IPVR regarding characteristics of victimization and perpetration of IPV?

Method

Design and Settings

This study was part of a cross-sectional case–control study with two groups of help-seeking, IPV victimized women and a control group of help-seeking women not IPV victimized. To attain statistical power to compare subgroups, we conducted power analyses prior to the initiation of the project. One goal of the proposed study was to test the null hypothesis that the event rate is identical in the three groups (1IPVR, 2IPVR, or 0IPVR). The odds ratio (OR) for any comparison was 1.0, the log OR (β) was 0.0, and the relative risk was 1.0. Estimates for the alternate hypothesis were based on the following event rates: multiple-partner IPV = 0.50, one-partner IPV = 0.40, and no-partner IPV = 0.15. The study included a total of 120 subjects with 40 persons in each group. The alpha value was set at .05 (two tailed). For this distribution, the effect sizes were 0.50, 0.40, and 0.15, the sample size was 120, the alpha value was .05 (two tailed), and the power was 0.83. This means that 83% of studies would be expected to yield a significant effect, rejecting the null hypothesis that the OR is 1.0.

The researchers cooperated with leaders of the nationwide agencies of women's shelters, the Alternative to Violence (ATV) treatment agency, the police, and family counseling agencies in Norway to recruit participants for this study. These agencies were asked to invite all clients who met the inclusion criteria to participate in the study. The recruitment steps were as follows: (a) The initial recruitment of participants was conducted by agency personnel by presenting the study's information consent letter, either in person or by phone, to all their female users who met the inclusion criteria; (b) after receiving written consent and contact information, the researcher sought contact with those recruited to discuss aspects of their participation in the study; and (c) the participating women came to a face-to-face interview with the same researcher, a female clinical psychologist, at the local recruitment or researcher's office. To

address diversity concerns, women who were not fluent in the Norwegian language were informed that a professional interpreter could be hired for the interview. Women were included regardless of the sex of their partner. There was no economic incentive for participation, but a refund for public transport was offered. All participants were given a sheet with the answer alternatives for the questions. Timed breaks were used when needed. The researcher registered the answers by hand in the codebook. The interviews lasted approximately 2 hr.

Inclusion and Exclusion Criteria

The inclusion criteria were as follows: The participant was at least 18 years old; had made contact with police, family counseling, women's shelter, or the ATV for intimate partner–related problems; was in or had lately been in an intimate relationship that lasted at least 6 months; held either Norwegian citizenship or a residence permit; and had sufficient language fluency to understand the information letter and to make an appointment on the phone. The exclusion criterion was that the most recent IPVR ended more than 3 years ago.

Specific inclusion criteria for distinguishing the research categories were (a) women who had only experienced violence from one intimate partner within the last 3 years; (b) women who had experienced violence from an intimate partner within the last 3 years *and* in at least one previous intimate relationship; and (c) women who had currently or lately had an intimate relationship but had never been victims of IPV (control group).

All participants in the control group were recruited from family counseling offices. They shared with the study groups the characteristics of being adult women experienced with a recent intimate relationship and seeking help for intimate partner–related problems.

Dependent Variables

The women were recruited to the designated research category according to the definition of physical, psychological, and sexual violence in the information letter (Breiding, 2015). They were asked (both on the phone and, initially, in the interview) in how many adult intimate relationships they had experienced violence victimization. According to their self-reports, they were included in one of the following three research categories: 0IPVR, 1IPVR, or 2IPVR.

Procedures

Twenty-three local offices in rural as well as urban areas across Norway recruited participants for the study. Figure 1 depicts the recruitment outcomes. The total sample ($N = 154$) consisted of 36.4% ($n = 56$) recruited

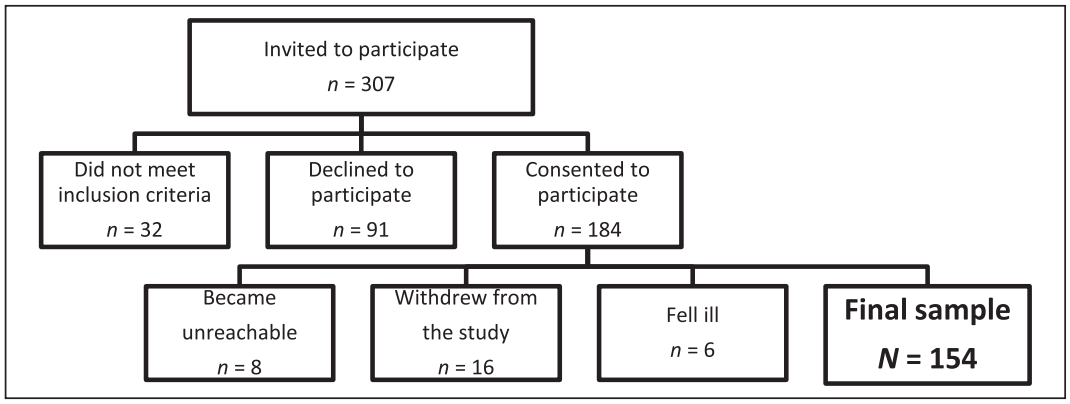

Figure 1. Recruitment process.

from family counseling offices, 35.1% ($n = 54$) from shelters, 24% ($n = 37$) from ATV, and 4.5% ($n = 7$) participants from the police. In five interviews (3.2%), a professional interpreter was hired. The 154 interviews were carried out between March 2018 and January 2019.

Subjects/Sample

The 154 women were between the ages of 20 and 69 ($M = 39.85$, $SD = 10.28$) and had a history of 1 to 13 intimate relationships ($M = 2.97$, $SD = 1.824$) (Table 1). There were women with no IPVR (31.2%, 48), women with one IPVR (35.7%, 55), and women with multiple IPVRs (33.1%, 51). Among the women with multiple IPVRs, the range was from two (62.7%, 32), three (23.5%, 12), four (7.8%, 4), and five (3.9%, 2) to six IPVRs (2%, 1). Most of the women (85.7%, 132) regarded themselves as native Norwegians, 4.5% (7) were immigrants with Norwegian citizenship, and 9.7% (15) were immigrants without Norwegian citizenship. Most women were mothers (90.3%, 139), and they had between one and six children ($M = 2.29$, $SD = 1.030$). Mean years of completed education was 14.96 years, ranging from 7 to 24 years ($SD = 3.282$). Significant sociodemographic and contextual group differences for 0IPVR, 1IPVR, and 2IPVR are listed in Table 1.

Measures

Favoring validity, reliability, and results that can be compared with other international studies, we applied the following validated questionnaires. A modified version of UngVold2015 (Mossige & Stefansen, 2016) and three parts of the Childhood Trauma Questionnaire (CTQ-SF; Bernstein et al., 2003; Dovran et al., 2013) were used to measure childhood family violence and other childhood adversities.

Table 1. Sociodemographic and Contextual Group Differences Among Women With No (0IPVR), One (1IPVR) and Multiple IPVRs (2IPVR).

Variable	0IPVR ($n = 48$) % (n)	1IPVR ($n = 55$) % (n)	2IPVR ($n = 51$) % (n)	Total ($N = 154$) % (n)	0IPVR vs. 1IPVR vs. 2IPVR p	1IPVR + 2IPVR vs. 0IPVR p	1IPVR vs. 2IPVR p
No confidants	0.0 (0)	9.3 (5)	9.8 (5)	6.5 (10)	.086	.028	.900
Immigrant	8.3 (4)	25.5 (14)	7.8 (4)	14.3 (22)	.013	.155	.016
Immigrant partner	4.2 (2)	40.0 (22)	27.5 (14)	24.7 (38)	<.001	<.001	.173
Mother	97.9 (47)	87.3 (48)	86.3 (44)	90.3 (139)	.096	.031	.879
Work/income					.001	.022	.014
Employed	77.1 (37)	50.9 (28)	41.2 (21)	55.8 (86)			
Student	6.3 (3)	12.7 (7)	3.9 (2)	7.8 (12)			
Unemployed	4.2 (2)	10.9 (6)	3.9 (2)	6.5 (10)			
Disability benefits	4.2 (2)	3.6 (2)	23.5 (12)	10.4 (16)			
Retired	2.1 (1)	0.0 (0)	2.0 (1)	1.3 (2)			
Other	2.1 (1)	9.1 (5)	3.9 (2)	5.2 (8)			
Work assessment allowance	4.2 (2)	12.7 (7)	21.6 (11)	13.0 (20)			
Language challenges	2.1 (1)	18.2 (10)	8.0 (4)	9.8 (15)	.020	.030	.125
Education (years) (M/SD)	16/2.601	15.49/3.355	13.41/3.263	14.96/3.282	<.001	<.001	.002
Length of relationship (years) (M/SD)	14.5/9.236	10.833/8.857	6.417/6.498	10.509/8.846	<.001	<.001	.003
Interpreter	0.0 (0)	9.1 (5)	0.0 (0)	3.2 (5)	.010	.126	.027

Note. The Kruskal–Wallis test was used to test for possible independent group differences for variables with nonparametric score distributions for more than two independent groups, and the Mann–Whitney U test for two independent groups. The Pearson chi-square test was used for nominal data and unrelated groups. Age, age of partner, age at the initiation of first intimate relationship, and time lapse since the last relationship were tested with nonsignificant results. IPVRs = intimate partner violence relationships.

The Revised Conflict Tactics Scale (CTS-2; Straus et al., 1996), the Psychological Maltreatment of Women Inventory (PMWI; Alsaker et al., 2011; Tolman, 1999), and the Spousal Assault Risk Assessment Guide, Version 3 (SARA-V3; Kropp & Hart, 2015) were used to measure victimization and perpetration of IPV and characteristics of IPV. With the PMWI, we added a list of mirrored questions to get a picture of violence inflicted by both parties throughout the relationship. All questionnaires had an authorized Norwegian version.

Demographic and contextual variables were drawn from UngVold2015 (Mossige & Stefansen, 2016) and Vatnar et al.'s study (Vatnar et al., 2017b) and are presented in Table 1.

In addition to the questionnaires, the following single items were developed especially for this study: "Do you have a person you can confide in?" (*Yes*/*No*); "Were there language misunderstandings during the interview?" (*No*/*slight or considerable*). The interview was prepared as a codebook with a structured assembly of the instructions and questionnaires.

Statistical Analyses

Univariate and bivariate analyses were conducted to compare the subgroups—(a) women with 1IPVR and 2IPVR (victimized) compared with those with 0IPVR (nonvictimized) and (b) women with 1IPVR compared with those with 2IPVR—and to inform the selection of variables to be included in the multivariate analysis. Multivariate logistic regression analyses were used to examine risk and protective factors associated with 1IPVR and 2IPVR. The stepwise options recommended for logistic regression for small samples were used (Altman, 1991; Pallant, 2010). In Step 1, as suggested by Altman and Pallant, initial comparisons of the two IPV groups were carried out by simple descriptive cross-tabulations with Pearson chi-square for categorical and nominal variables. For continuous variables, we used the Mann–Whitney *U* test, a nonparametric test for independent samples (Step 1, Tables 1 and 2). In the first multivariate logistic regression analyses (Step 2), variables with significant ($p \leq .05$) or trend ($p \leq .10$) group differences in bivariate analyses were adjusted for other significant differences within the same category. The following categories were analyzed in Step 2: (a) victimization and perpetration of IPV in the index relationship, (b) childhood family violence, (c) other childhood adversities, and (d) sociodemographic and contextual variables. Significant differences remaining after each of the four comparisons in Step 2 were forwarded to Step 3 (Tables 3 and 4) where we adjusted for all remaining group differences in Categories a, b, c, and d. Suitability for multivariate logistic regression analysis was investigated by the Hosmer–Lemeshow test. Cox and Snell *R* squared and Nagelkerke

Table 2. Prevalence of Childhood Family Violence and Other Childhood Adversities Among Women With No (0IPVR), One (1IPVR) and Multiple IPVRs (2IPVR).

Variable	0IPVR ($n = 48$) % (n)	1IPVR ($n = 55$) % (n)	2IPVR ($n = 51$) % (n)	Total ($N = 154$) % (n)	0IPVR vs. 1IPVR vs. 2IPVR p	0IPVR vs. 1IPVR + 2IPVR p	1IPVR vs. 2IPVR p
Mother victimized by physical IPV	14.6 (7)	18.2 (10)	35.3 (18)	22.7 (35)	.030	.105	.046
Mother victimized by other IPV	0.0 (0)	5.5 (3)	11.8 (6)	5.8 (9)	.044	.037	.244
Father victimized by physical IPV	2.1 (1)	3.6 (2)	17.6 (9)	7.8 (12)	.006	.075	.018
Mother injured	6.3 (3)	10.9 (6)	22.0 (11)	13.1 (20)	.086	.239	.086
Mild physical violence from mother	16.7 (8)	32.7 (18)	49.0 (25)	33.1 (51)	.003	.004	.088
Psychological violence from father	41.7 (20)	52.7 (29)	76.5 (39)	57.1 (88)	.002	.009	.011
Mild physical violence from father	31.3 (15)	23.6 (13)	43.1 (22)	32.5 (50)	.098	.828	.033
Parents drug/alcohol problem	33.3 (16)	27.3 (15)	48.0 (24)	35.9 (55)	.078	.649	.028
Physical neglect (median/*SD*)	5.00/1.231	5.00/2.638	6.00/4.792	5.00/3.483	<.001	.088	<.001
Emotional neglect (median/*SD*)	7.00/4.428	8.00/4.906	12.50/6.664	9.00/5.685	.007	.039	.014
Childhood emotional abuse (median/*SD*)	6.00/4.588	7.00/5.434	13.00/6.424	7.00/6.022	<.001	.004	<.001
Childhood sexual abuse	22.9 (11)	43.6 (24)	56.0 (28)	41.2 (63)	.004	.002	.206
Childhood forced penetration	0	16.4 (9)	34.0 (17)	17.0 (26)	<.001	<.001	.037
Peer victimization	62.5 (30)	61.8 (34)	84.0 (42)	69.3 (106)	.023	.219	.011

Note. The Kruskal–Wallis test was used to test for possible independent group differences for variables with nonparametric score distributions for more than two independent groups, and the Mann–Whitney *U* test for two independent groups. The Pearson chi-square test was used for nominal data and unrelated groups. The following prevalence variables were tested with no significant results: mother victimized by IPV, father victimized by IPV, mother exposed to psychological and sexual violence from partner, father exposed to psychological, sexual, and other violence from partner or injured at home, and psychological violence from mother. IPVRs = intimate partner violence relationships; IPV = intimate partner violence.

Table 3. Multivariate Logistic Regression Analyses: Victimized ($n = 105$) Compared With Nonvictimized Women (Baseline) ($n = 48$).

Independent Variables	Adjusted Odds Ratio	95% CI	*p*
Model 1 ($N = 153$)			
Mother victimized by other IPV, prev.			n.s.
Psychological violence from mother, freq.			n.s.
Psychological violence from father, prev.			n.s.
Psychological violence from father, freq.			n.s.
Physical neglect, freq.			n.s.
Childhood sexual abuse, prev.	2.817	[1.196, 6.635]	.018
Peer victimization, freq.	1.115	[1.003, 1.238]	.044
Immigrant partner	12.533	[2.795, 56.207]	.001
Work/income status			n.s.
Education (years)			n.s.
Model 2 ($N = 153$)			
Mother victimized by other IPV, prev.			n.s.
Psychological violence from mother, freq.			n.s.
Psychological violence from father, prev.			n.s.
Psychological violence from father, freq.			n.s.
Physical neglect, freq.			n.s.
Peer victimization, freq.	1.130	[1.016, 1.256]	.024
Immigrant partner	13.146	[2.833, 60.990]	.001
Length of relationship	0.995	[0.991, 0.998]	.006
Work/income status			n.s.
Education (years)			n.s.

Note. The results were from multivariate binary logistic regression, forward stepwise (Wald). Model 1 without length of the last relationship: Cox & Snell $R^2 = .205$, Nagelkerke $R^2 = .289$, Hosmer and Lemeshow test = .937. Model 2 without sexual abuse: Cox & Snell $R^2 = .218$, Nagelkerke $R^2 = .306$, Hosmer and Lemeshow test = .216. All women who reported forced penetration in childhood (17%, 26) were victimized by IPV in adulthood. This variable was not entered in logistic regression analysis. CI = confidence interval; IPV = intimate partner violence; n.s. = nonsignificant; prev. = prevalence, freq. = frequency.

R squared were used to estimate the proportion of explained variance in the multivariate models that were tested. Values were estimated as model fit indices for the regression models (see Notes in Tables 3 and 4). Statistical analyses were performed using the statistical program package SPSS, version 25. A conventional *p* value of $<.05$ was used.

Ethical Aspects

The study was approved by the Regional Norwegian Ethics Committee. All ethical and safety recommendations from the WHO (2001) were observed. An

Table 4. Multivariate Logistic Regression Analyses ($n = 105$): Women With Multiple IPVRs ($n = 50$) Compared With Women With One IPVR (Baseline) ($n = 55$).

Independent Variable	Adjusted Odds Ratio	95% CI	*p*
Victim perpetrated minor physical assault, prev.			n.s.
Psychological violence from father, freq.			n.s.
Father victimized physical IPV, prev.			n.s.
Emotional abuse	1.140	[1.052, 1.235]	.001
Education (years)	0.859	[0.740, 0.996]	.044
Immigrant	0.130	[0.028, 0.592]	.008
Length of relationship			n.s.
Work/income			n.s.

Note. The results were from multivariate binary logistic regression, forward stepwise (Wald). Cox & Snell $R^2 = .246$, Nagelkerke $R^2 = .328$, Hosmer and Lemeshow test = .324. IPVR = intimate partner violence relationship; IPV = intimate partner violence; CI = confidence interval; prev. = prevalence; n.s. = nonsignificant; freq. = frequency.

information letter informed the participants about the study objectives and that some questions were of an intimate nature. They were assured that their participation was voluntary, that they were free to withdraw from the study at any time, that withdrawal would not affect the services they received at the recruitment office, that information would be stored confidentially, and that they were welcome to call the researcher on a given phone number. All cases were included irrespective of socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, ability, and age.

Results

Prevalence and Characteristics Among Women With 0IPVR, 1IPVR, and 2IPVR

In general, 82.2% of all participants confirmed one or more incidents of mild or severe childhood family violence. Prevalence of mother victimized by IPV was confirmed by 46.1% of the women, and that of father victimized by IPV was confirmed by 27.3%. There was no significant group difference concerning these variables. However, several bivariate group differences regarding the prevalence and frequency of childhood family violence and other childhood adversities were found. Significant prevalence variables are presented in Table 2.

Regarding the characteristics of the IPV victimization, there were no significant group differences between women with 1IPVR and 2IPVR. Women with 1IPVR or 2IPVR reported victimization of threats (84.3%), physical violence (89.1%), sexual violence (52%), severe partner violence (68.3%), violence persistency (95.1%), violence escalation (83.3%), and violence-related restriction disobedience (31.6%). The most prevalent (100%) was minor and severe psychological violence. The victimized women (1IPVR and 2IPVR) reported minor physical IPV (84.9%) and severe physical IPV (68.9%). More than half (57.5%) of the women had experienced minor and 43.4% had experienced severe sexual coercion. Women in both groups (1IPVR and 2IPVR) had experienced minor (54.7%) or severe (35.8%) injury from partners. Victimization by emotional/verbal maltreatment was reported by 98.1% of the women, and dominance/isolation by 83.7% of the women.

Regarding the women's perpetration of violence, two trends for group differences were registered: prevalence of minor physical IPV from her (40% 1IPVR and 56.9% 2IPVR, $p = .083$) and total number of minor physical IPV from her (mean rank 1IPVR 49.08, 2IPVR 58.26, $p = .097$). The victimized women reported perpetration of minor (84%) and severe psychological IPV (48.1%), severe physical assault (18.9%), minor injury (16%), severe injury (3.8%), minor or severe sexual coercion (1.9%), emotional/verbal maltreatment (17.9%), and dominance/isolation (5.8%).

Women With IPVRs Compared With Women With No IPV

The univariate analyses gave 10 variables with significant group differences or trends among women with IPVRs compared with women with no IPV regarding childhood family violence. The 10 variables were as follows: prevalence of mother victimized by other violence from partner and father victimized by physical violence from partner; frequency of mother victimized by other violence from partner; prevalence of mild and severe physical violence from mother and psychological violence from father; and frequency of psychological and mild and severe physical violence from mother and psychological violence from father. In addition, univariate analyses gave six variables with significant or trend group differences regarding other childhood adversities (physical neglect, emotional neglect, and emotional abuse; prevalence of sexual abuse and forced penetration; frequency of peer victimization; the prevalence variables with significant group differences are displayed in Table 2). Also, seven sociodemographic and contextual variables (Table 1) showed significant or trend group differences in the initial analyses. In Step 2, 11 of the differences from the initial analyses remained significant or with a trend. After controlling for all remaining group differences, the following differences between women from IPVRs and women with no IPVR

remained significant in the multivariate logistic regression models (Table 3). IPV victimized women were nearly three times more likely to report childhood sexual abuse. They also reported a higher frequency of peer victimization and a higher likelihood of having an immigrant partner (Model 1). In addition, the length of the index relationship was shorter for IPV victimized women (Model 2). All women who reported forced penetration (17%, $n = 26$) as a part of childhood sexual abuse were victimized by IPV in adulthood. Accordingly, this variable of severe childhood sexual abuse was not suitable for the multivariate logistic regression model. To attain goodness of fit, the variables were analyzed in two models (see Note in Table 3).

Women With 2IPVR Compared With Women With 1IPVR

The univariate analyses indicated two significant group differences or trends between 1IPVR and 2IPVR regarding IPV (prevalence of minor physical assault from her and total number of minor physical assaults from her). Initially, there were 12 univariate differences regarding childhood family violence (prevalence of mother victimized by physical IPV, prevalence of father victimized by physical IPV, mother injured at home; frequency of mother victimized by physical IPV, frequency of father victimized by physical IPV; prevalence of mild physical violence from mother, psychological violence from father, mild physical violence from father, and severe physical violence from father; frequency of mild physical violence from mother, psychological violence from father, and mild physical violence from father). There were seven univariate differences regarding other childhood adversities (frequency of physical neglect, emotional neglect and emotional abuse; parent's alcohol/drug use; forced penetration; prevalence and frequency of peer victimization) and five regarding sociodemographic and contextual variables (see Table 1 and 2). In Step 2, eight of these univariate differences remained significant or showed trends when adjusted for the other included variables within the same aim categories. In Step 3, after controlling for all remaining group differences in a multivariate logistic regression model, the following three variables remained explanatory for the two groups (Table 4): Women with IPV by MP were more likely to report childhood emotional abuse (frequency), had less education, and were less likely to be immigrants.

Discussion

Main Findings

Compared with nonvictimized, IPV victimized women were nearly three times more likely to report childhood sexual abuse, reported a higher

frequency of peer victimization, and had a greater likelihood of having an immigrant partner. In contrast, compared with women victimized by one partner, women with IPV by MP, in particular, had an increased likelihood of reporting childhood emotional abuse and of having less education, and they were less likely to be immigrants. Childhood family violence and characteristics of the IPV did not remain as risk factors for IPV by MP.

Childhood Emotional Abuse as a Risk Factor for IPV by MP

Cole et al. (2008) initially reported a significantly higher prevalence of childhood emotional abuse among women with IPV by MP, but this result was not sustained in multivariate analysis. Some related experiences like subjection or exposure to a parent's physical IPV (Alexander, 2009; Vatnar & Bjørkly, 2008), multiple forms of childhood trauma (Alexander, 2009), and psychological childhood victimization (Vatnar & Bjørkly, 2008) have been reported to be associated with IPV by MP. This study included both witnessing and victimization of childhood physical and psychological violence and childhood emotional abuse concurrently. This allowed for an improved understanding of explicatory factors. Although the measures of psychological violence pertained to acts, the measures of childhood emotional abuse were broader and could perhaps be understood as describing the family atmosphere. Definitions of violence include behavior, intentions, and consequences (Kropp & Hart, 2015), whereas childhood emotional abuse also encompasses humiliating or hostile behavior not included in definitions of violence.

Childhood Sexual Abuse as a Risk Factor for IPV by MP

The results of multivariate logistic regression reinforced the body of literature pointing to childhood sexual abuse as a risk factor for IPV victimization in general (e.g., Barrios et al., 2015; Coid et al., 2001; Stroem et al., 2019; Vézina & Hébert, 2007; Whitfield et al., 2003). This was also supported by the descriptive finding that every woman who had been victimized by forced penetration in childhood was later revictimized by IPV. However, in contrast to earlier findings (Alexander, 2009; Cole et al., 2008; Stein et al., 2016; Vatnar & Bjørkly, 2008), our study did not point to childhood sexual abuse as a risk factor for IPV by MP in particular.

Immigration as a Risk Factor for IPV by MP

Our study indicated that women with an immigrant partner, regardless of the partner's country of origin, ran a greater risk for IPV in general, but not for MP. An American study (Gupta et al., 2010) found that, among

immigrant men, those who were nonrecent immigrants and reported limited English-speaking ability were at the highest risk for IPV perpetration, compared with recent immigrants with high English-speaking ability. Studies have shown that immigrants were proportionally overrepresented in intimate partner homicide (IPH) statistics as both victims and perpetrators (see, for example, Campbell et al., 2007; Dobash & Dobash, 2015; Garcia & Hurwitz, 2007; Vatnar et al., 2017a), and it has been reported that the overrepresentation was attributed to social and economic disadvantage (particularly unemployment), rather than immigration and ethnicity per se (Vatnar et al., 2017a). Such information about the *partner* was not controlled for in this study.

Regarding the immigration status of the women themselves, on the other hand, our study showed an opposite pattern. Women with IPV by MP were less likely to be immigrants. An American study reported that African American and White women had significantly more violent partners than their Latina counterparts, but these results only specified ethnicity and not immigrant status (Stein et al., 2016). Another study (Alexander, 2009) failed to find any association between ethnicity and IPV by MP. In sum, this issue is not settled yet and more research is needed.

Sociodemographic Risk Factors for IPV by MP

In contrast to two studies that found no association (Alexander, 2009; Stein et al., 2016), this study found that women with IPV by MP had less education than women with 1IPVR. An association between economic hardship and economic dependency on a romantic partner and IPV exposure has been reported (Golden et al., 2013). It has been reported that actions by violent partners negatively affected the women's ability to be and stay employed (Alsaker et al., 2014). Less education may be a risk factor or a consequence of violence in multiple relationships, and our results do not show the direction of that association. There might even be an interactional association.

Victimization and Perpetration of IPV as Risk Factors for IPV by MP

Based on earlier studies, we would expect to find a higher IPV severity score (Bogat et al., 2003), less exposure to sexual IPV, and more exposure to psychological IPV (Stein et al., 2016) among women with IPV by MP. However, we found no significant group differences regarding any kind of IPV victimization in this study.

Regarding perpetration, men with a violent family background have been found to be more violent as adults (Askeland et al., 2011). It has been claimed that violence between partners is likely to have a common etiology across genders and that individuals prone to acting-out behavior had been more exposed to violence than others (Pape, 2011). Our initial findings did indicate that women with IPV by MP reported more childhood family violence. Thus, one might speculate that these women would exhibit an acting-out pattern similar to men and be at greater risk for perpetrating retaliation and escalating violence. However, our results indicated that the women with IPV by MP were not more likely to perpetrate IPV than were women with 1IPV. A gender difference has been reported from a birth cohort study where childhood maltreatment was associated with an increased risk of later delinquency for young adult males, but not for females (Abajobir et al., 2017). We have not discovered any previous study that included female perpetration of violence in the comparison of 1IPVR and 2IPVR. Earlier research has indicated that victim-perpetrated IPV was a risk factor for being revictimized (Kuijpers et al., 2012b). However, because the Kuijpers study did not differentiate between revictimization of IPV within and across relationships, it is likely that their investigation may have included recurrent violence within a cycle of a single violent relationship. In sum, this issue is not settled yet and more research is needed.

Peer Victimization as a Risk Factor for IPV

Although consequences of childhood sexual abuse have been studied extensively, concurrent childhood emotional abuse and peer victimization have received less attention in IPV risk studies. An association has been reported between the perpetration of both bullying and IPV (Corvo & Delara, 2010), but to our knowledge our study is the first to report a link between peer victimization and IPV victimization.

Limitations

Due to cultural and social differences, the findings from our sample of IPV help-seeking women do not necessarily generalize to a general community sample nor to women outside of Norway. This calls for careful interpretation of the generalizability of our findings. As in several studies of IPV help-seeking women, a significant number of the women who were invited to participate declined to do so. We have no information about these women concerning group differences. However, all the women invited were help seeking at the time and in stressful and demanding life situations that may have made it difficult for them to participate in a research project.

This investigation was based on retrospective self-reports of IPV experiences. In other studies, recall bias has been associated with underreporting of IPV (Schwartz, 2005). Because the reports of IPV vary in terms of recency, they may also vary in salience (Bogat et al., 2003). It has been claimed that retrospective questions about childhood events cannot differentiate between an actual history of severe abuse and selective recollection (Dovran et al., 2013). It is possible that more severe events were recalled with greater frequency than less severe events. Costa et al. (2015) stated that recall of childhood experiences results in a substantial rate of false negatives, measurement error, and bias that could elevate Type I errors, with higher well-being linked to retrospective forgetting and lower well-being tied to greater retrospective reporting.

There are methodological limitations to interviewing only the victims, risking over- and underreporting according to social desirability. However, the purpose of this study was to understand the experiences of the victimized and not only to capture the objective "fact." One researcher conducted all the interviews which may have increased the risk of systematic measurement error. However, reliability was strengthened by having only one interviewer, thereby avoiding low interrater reliability. The structured interview with behavior-specific questions and fixed-response options modified this risk. When investigating private and potentially traumatizing matters, one may anticipate underreporting. We consider this adjusted for by introducing the objectives of the study in an information letter, by securing confidentiality, and by pacing the interview according to the needs of the participant. One review reported that higher disclosure rates were found in studies using in-person interviews conducted by a "skilled and trained" clinician and in studies that included specific questions about the different types of IPV (Taillieu & Brownridge, 2010).

The OR of immigrant partner was high for IPV. Still, the wide confidence intervals indicate that this finding should be interpreted with caution.

Finally, the cross-sectional design has limitations concerning the measurement of the causality and temporal ordering between variables.

Conclusion

In light of the paucity of empirical studies of IPV by MP and the significant diversity in study designs, measurements, definitions, and variables, this study explored previous findings and related themes with standardized measures that can be replicated. Childhood physical domestic violence has been hypothesized to put women at risk for IPV by MP. On the contrary, one main finding in the multivariate logistic regression analysis was that childhood

emotional abuse was the major risk factor for IPV by MP in particular. However, this study supported childhood sexual abuse as a predictive factor for IPV in general. As well, to our knowledge, peer victimization as a predictive factor for IPV had not been described before. Our research extended our knowledge on immigration, indicating that women with IPV had a greater likelihood of having an immigrant partner, whereas women with IPV by MP were less likely to be immigrants.

Clinical and Policy Implications

Risk of revictimization by future partners should be discussed with all women who have been in previous violent relationships (Cole et al., 2008). As part of risk assessment for IPV among adults, screening for a history of childhood emotional abuse, childhood sexual abuse, and peer victimization is needed. Health professionals are urged to recognize that women with a history of childhood emotional abuse need special attention. Our study supported the high importance of addressing parenting beyond the termination of physical violence in IPV families. Having less education needs attention among victimized women as it constitutes a risk of IPV by MP.

Research Implications

First, future studies would benefit from a prospective, longitudinal design to allow for the exploration of characteristics that predict and prevent women's involvement with multiple violent partners. Second, childhood emotional abuse should be assessed when exploring the characteristics of women associated with IPV by MP. Third, research is needed to understand the etiology of the connection between childhood emotional abuse and risk for multiple violent relationships. Fourth, further research is needed to explore sociodemographic factors such as how being an immigrant may be associated with reduced risk of IPV by MP and the impact of education for IPV by MP. Finally, additional research is needed with more diverse samples and in different contexts.

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III

Violence Against Women (in press)

Attachment Characteristics among Women Victimized in No, One, and Multiple IPV Relationships. A Case Control Study

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Key Words

intimate partner violence (IPV), multiple partners (MP), attachment, childhood emotional abuse

Abstract

This cross-sectional study compared attachment characteristics among women victimized by intimate partner violence (IPV) in no, one, and multiple relationships (N=154). Results indicated that compared to non-victimized, victimized women had increased likelihood of higher attachment avoidance. Compared to women victimized in one relationship, women victimized in multiple relationships had higher likelihood of higher attachment anxiety scores. Adjusting for childhood adversities, childhood sexual abuse was an independent risk factor for IPV. Childhood emotional abuse mediated the association between attachment anxiety and IPV victimization in multiple relationships in particular. Attachment theory appeared useful for better understanding women's vulnerability for multiple violent relationships.

Introduction

Intimate partner violence (IPV) is a serious, heterogenic, and complex issue associated with significant health, social, and economic costs to individuals, families, and society (Cattaneo & Goodman, 2005; Cornelius & Resseguie, 2007; Costa et al., 2015; Mears, 2003; Park, 2016). IPV comprises physical and sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (Breiding, 2015). In contrast to other types of violence, IPV is commonly repetitive and tends to escalate in both frequency and severity along with the duration of the relationship (Cochran, Sellers, Wiesbrock, & Palacios, 2011). Many women who have been subjected to IPV have experienced IPV in multiple relationships. In studies of IPV victimized female samples, 22.9% to 61% of the women had prior histories of IPV relationships (Dufort, Gumpert, & Stenbacka, 2013; Vatnar & Bjorkly, 2008). However, there is limited knowledge about factors that contribute to women having repeated experiences of IPV by successive partners (Smith & Stover, 2016). Accordingly, it is urgent to investigate victim-related risk factors for IPV by multiple partners (MP).

Although a perpetrator must be held accountable for the violence, focusing on only the perpetrator may distract attention from a possible vulnerability in some women for being victimized by MP. It is important to keep in mind that risk factors do not establish a causal relationship (Park, 2016) and that a victim is not responsible for the victimization; however, identification of empirically validated victim-related risk factors may help practitioners guide victims in decision making and safety planning (Cattaneo & Goodman, 2005) and inform the prevention of future IPV relationships.

Research on IPV victimization has predominantly been conducted on female victims in heterosexual relationships, focusing on adversities and vulnerability factors that may influence the risk of revictimization. Even though rates of IPV were found to be similar between women and men (Straus, 2011), there were substantial differences in the consequences reported. Female victims were more likely to suffer more severe consequences than males were (Archer, 2000; Askeland, 2015; Caldwell, Swan, & Woodbrown, 2012; Nybergh, Taft, Enander, & Krantz, 2013; Stöckl et al., 2013; Wathen & MacMillan, 2003). Johnson and colleagues proposed specific types of IPV that were differently gendered regarding mutuality. Situational couple violence (SCV), referring to isolated violent acts commonly caused by specific conflicts, was more likely to be mutual. Intimate terrorism (IT), referring to violent coercive control over one's partner, was more likely to be perpetrated by men towards women (Johnson, 2011; Johnson & Leone, 2005). Exploring this typology and

gender, Jasinski and coworkers (2014) reported that women were not more likely than men to be the victims of IT, but female sufferers of IT were significantly more likely than male to be injured from the violence; to attempt to leave their husbands; and to report desistance (Jasinski, Blumenstein, & Morgan, 2014). Others reported that victimized women experienced more physical and emotional impairment than men did, and sought help more frequently than male IPV victims did. Victimized women also reported more fear and intimidation than men did when their partner initiated violence (Askeland, 2015; Wathen & MacMillan, 2003). Globally, the proportion of murdered women killed by a partner was six times higher than the proportion of murdered men killed by a partner (Stöckl et al., 2013). Based on this, the present study focused on female victims of IPV.

Bell and Naugle (Bell & Naugle, 2008) suggested a contextual framework for conceptualizing IPV episodes. It included distal, static and proximal antecedents; motivating factors; behavioral repertoire, discriminative stimuli; verbal rules; and IPV consequences. Expanding on an integrative model, Winstok (Winstok, 2007) proposed an interactional approach to the study of IPV. From initially addressing the parent – child relationship, attachment theory has been suggested as useful in addressing couple relationships and conflict (Cassidy & Shaver, 2016). Adult attachment style is significantly associated with fundamental components of romantic relationships, including the capacity for intimacy, partner caretaking and support, sexual behavior, conflict management, and relational aggression (Riggs, 2010). Hence, there is both a developmental and a social attachment approach in attachment theory. Within the contextual, interactional framework both were relevant to this study of victim-related risk factors for IPV by multiple partners (MP). The present study is informed by differential expressions of adult attachment among groups of IPV victimized adult women. Childhood adversities are central in attachment theory and controlled for in the statistical analyses.

Victim-Related Risk Factors for IPV

Studies on generic IPV reported anxious (Bond & Bond, 2004; Lewis et al., 2017; McClure & Parmenter, 2017; Ponti & Tani, 2019; Shechory, 2013), avoidant (Ponti & Tani, 2019; Shechory, 2013; Weiss, MacMullin, Waechter, & Wekerle, 2011; Wekerle & Wolfe, 1998), and preoccupied attachment characteristics (Henderson, Bartholomew, Trinke, & Kwong, 2005) as risk factors for IPV victimization. According to a systematic review (Velotti, Zobel, Rogier, & Tambelli, 2018), most studies on attachment and IPV victimization focused on physical or psychological IPV, and the association between specific attachment dimensions and such specific types of violence victimization was inconclusive.

Other than attachment issues, studies reported childhood risk factors for victimization of IPV. These were in particular psychological abuse/ maltreatment (Cascio et al., 2017; McClure & Parmenter, 2017; Reyome, 2010; Wekerle & Wolfe, 1998), sexual (Ørke, Bjørkly, & Vatnar, 2020) and physical abuse (e.g., Barrios et al., 2015; Cascio et al., 2017; Hetzel-Riggin & Meads, 2011), exposure to parental abuse (Ehrensaft et al., 2003; Hetzel-Riggin & Meads, 2011; Krishnan, Hilbert, Pase, & Krishnan, 2001), and peer victimization (Ørke et al., 2020).

Victimization and revictimization may not be the same. Avoidant attachment was reported as a risk factor for revictimization (Kuijpers, van der Knaap, & Winkel, 2012b). Smith and Stover (2016) reported that attachment anxiety moderated the relationship between traumatic experiences and IPV revictimization. Reported childhood risk factors for revictimization of IPV were sexual and physical abuse (Coid et al., 2001; Stroem, Aakvaag, & Wentzel-Larsen, 2019) and exposure to parental abuse (Trickett, Noll, & Putnam, 2011). Reported adult risk factors for IPV revictimization were female angry and aggressive behavior and initiation of violence (Kuijpers, van der Knaap, & Winkel, 2012a; Kuijpers et al., 2012b; Kuijpers, Van der Knaap, & Winkel, 2012c) and some resistance and coping strategies (Goodman, Dutton, Vankos, & Weinfurt, 2005; Iverson et al., 2013).

Victim-Related Risk Factors for IPV by Multiple Partners

Most studies on IPV revictimization have not distinguished between revictimization by the same partner and revictimization by subsequent partners, which implies mixed and inaccurate results (Ørke, Vatnar, & Bjørkly, 2018). Risk factors related to recurrent violence within the cycle of a single violent relationship may not be the same as the risk factors related to IPV by multiple partners (MP). A victim at risk of repeated victimization within a relationship would need other interventions than a victim at risk of revictimization by MP. Therefore, it is important to study the specifics of different forms of revictimization.

A systematic literature review (Ørke et al., 2018) regarding revictimization of IPV by MP in particular, indicated that IPV by MP was significantly associated with childhood domestic trauma, drug abuse and IPV characteristics. Attachment style as a risk factor for IPV by MP in particular was investigated in one study which reported that women who were unresolved in their attachment had increased risk of IPV by MP (Alexander, 2009). A classification of unresolved attachment regarding trauma or loss was based on the presence of uncorrected or unexplained lapses of discourse or reasoning (Alexander, 2009). Regarding PTSD and personality disorders, the results were mixed and inconclusive, and depression did not appear as a salient risk factor for IPV by MP. A recent study compared parental

psychological and physical violence and childhood emotional neglect and abuse and concluded that among these, childhood emotional abuse was a risk factor for IPV by MP (Ørke et al., 2020).

According to the reviewed literature, both attachment issues and childhood adversities were suggested as risk factors for IPV by MP. Other studies reported an association between attachment issues and childhood adversities: childhood maltreatment (physical, sexual, or emotional abuse) and neglect (disengaged and extremely insensitive parenting) were consistently found to increase the rate of children's attachment insecurity (Mikulincer & Shaver, 2016) and were associated with IPV by MP (Ørke et al., 2020). In the present study, we investigated attachment anxiety and avoidance while adjusting for significant childhood adversities. This was guided by the contextual, interactional framework and attachment theory.

Attachment Theory and Victim-Related Risk Factors for IPV and IPV by Multiple Partners

Early positive experiences of parental caregiving play a causal role in the formation of a child's stable sense of attachment security. Atypical parental behavior can influence the development of different types of attachment insecurity. These effects tend to persist over time and contribute to attachment patterns during adolescence and adulthood (Mikulincer & Shaver, 2016).

Research has shown that adult attachment style can be measured along two orthogonal dimensions: attachment anxiety and attachment-related avoidance (Brenner et al., 2019; Mikulincer & Shaver, 2016). According to Brennan et al., these two dimensions underlie virtually all self-report adult romantic attachment measures and appear crucial for capturing important individual differences in adult romantic attachment (Brennan, Clark, & Shaver, 1998). Adults with secure attachment have low scores on both attachment anxiety and attachment avoidance and subsequently are more likely to be involved in healthy and stable romantic relationships (Hazan & Shaver, 1994). Secure attachment may serve as a buffer against the negative implications of adverse life events (Bowlby, 1969). Attachment anxiety involves excessive need for approval from others, fear of interpersonal rejection or abandonment, and distress when one's partner is unavailable or unresponsive. Attachment avoidance, on the other hand, involves need for self-reliance and fear of interpersonal closeness (Cassidy & Shaver, 2016; Pedersen, Eikenæs, Urnes, Skulberg, & Wilberg, 2015).

Attachment Measurements

Adult attachment has been studied in two research traditions that apply somewhat different methodologies: the developmental approach and the social approach. Within the developmental approach, attachment styles are measured through an adult's narratives of their childhood experiences with caregivers (Bartholomew & Shaver, 1998). Within the social attachment approach, measurements of attachment styles are based on self-reports regarding qualities in current close relationships in adulthood (Pedersen et al., 2015). Some of the concepts have similar wording across measurements but are not identical (e.g., secure, preoccupied, dismissive-avoidant, and fearful-avoidant within the developmental approach and secure, anxious, and avoidant within the social approach). Different aspects of the concepts are weighted differently in the various measurements. Adult attachment style has been conceptualized and measured both in terms of types and dimensions. Mikulincer and Shaver concluded that adult attachment styles assessed with self-report measures were best characterized by dimensional measures (Mikulincer & Shaver, 2016).

As described above, studies have found an association between both attachment anxiety and attachment avoidance and IPV in general, but research regarding this association and IPV by MP is scarce, and further research is needed. In the present study, we investigated attachment differences between IPV victimized and non-victimized women and between women victimized by one and multiple partners.

The research questions were the following:

1. Are women victimized by IPV from one or multiple partners different from women with no IPV relationships regarding adult attachment characteristics, adjusting for childhood adversities and sociodemographic variables?
2. Are women victimized by IPV from one partner different from women victimized by IPV from multiple partners regarding adult attachment characteristics, adjusting for childhood adversities and sociodemographic variables?

Method

Design

This study was a part of a cross-sectional study with two groups of help-seeking, IPV victimized women and a control group of help-seeking women not IPV victimized.

Participants

Participants were recruited according to the following criteria:

- Participants were at least 18 years old.
- They had contact with police, family counseling, women's shelter, or the Alternative to Violence treatment center (ATV) for IPV or other family problems.

- They were in, or had recently been in, an intimate relationship that had lasted at least 6 months (index relationship).
- They held either Norwegian citizenship or a residence permit.
- They had sufficient language fluency to understand the information letter and to make an appointment on the phone.
- They had experienced intimate partner violence either within the last 3 years or not at all.

All participants in the control group were recruited from family counseling offices. These participants shared with the study groups the characteristics of being adult women experienced with a recent intimate relationship and seeking help for intimate partner related problems.

Twenty-three local offices in rural and urban areas across Norway recruited participants to the study. There were 307 women who were invited to participate. Among these, 32 did not meet inclusion criteria when this was controlled on the phone, and 91 declined to participate. Among the 184 who consented to participate, 8 became unreachable, 16 withdrew from the study, 6 fell ill, and 154 were included in the final sample. The total sample (N = 154) consisted of 36.4% (n =56) recruited from family counseling offices, 35.1% (n = 54) from shelters, 24% (n = 37) from ATV, and 4.5% (n = 7) participants recruited from the police. In five interviews (3.2%), a professional interpreter was hired.

The participants were between the ages of 20 and 69 (M = 39.85, SD = 10.28) and had a history of 1 to 13 intimate relationships (M = 2.97, SD = 1.824). There were women with no IPV relationships (31.2 %, n = 48), women with one (35.7%, n = 55), and women with multiple IPV relationships (33.1%, n = 51). Among the latter, the range was from two (62.7%, n = 32), three (23.5%, n = 12), four (7.8%, n = 4), five (3.9%, n = 2) to six IPV relationships (2%, n = 1). Ten participants were in an IPV relationship at the time of the interview. The index relationship had a mean duration of 10.5 years (SD = 8.9). Most women (85.7%, n = 132) were native Norwegians. There were 14.3% (n = 22) immigrants in the sample, and 24.7% (n = 38) of all the women had an immigrant partner in their index relationship. Nine of 10 women were mothers, and they had between one and six children (M = 2.29, SD = 1.030). Years of completed education ranged from 7 to 24 years, and the mean was 1 to 2 years above high school completion (SD = 3.282). More than half of the sample, (55.8%) were employed, 13% had work assessment allowance, and 10.4% received disability benefits. Significant

sociodemographic and contextual group differences among women in no, one, and multiple relationships are listed in Table 1.

Table 1 about here

Measures

Attachment Characteristics

Among commonly used self-report measures investigating attachment in the adult relationship, the questionnaire Experiences in Close Relationships (ECR) developed by Brennan et al. was reported to have the best psychometric properties (Brennan et al., 1998; Fraley, Waller, & Brennan, 2000). Many studies confirmed high construct and criterion validity, (e.g., (Cassidy & Shaver, 2016; Mikulincer & Shaver, 2016). The Norwegian version was reported to be psychometrically adequate in a general population of 30 to 45-year-old adults (Olssøn, Sørebø, & Dahl, 2010).

The ECR, Norwegian validated version (ECR-N) (Olssøn et al., 2010) is a 36-item questionnaire comprising the following two subscales of 18 statements each: Attachment avoidance (labeled *Avoidance* in the tables: e.g., "I prefer not to show how I feel deep down") and Attachment anxiety (labeled *Anxiety* in the tables: e.g., "I worry about being abandoned"). One study reported that exploratory factor analysis of the ECR indicated five sub factors of 4 to 6 items each, comprising two different aspects of Attachment avoidance and three aspects of Attachment anxiety: Avoidance of closeness, Uncomfortable with openness, Separation frustration, Anxiety for abandonment, and Frantic desire for closeness (Five-Factor Model, ECR-FF) (Pedersen et al., 2015). Respondents were asked to indicate how they, in general, experience romantic relationships, referring not only to their most recent but also to their prior romantic relationships.

Each statement was scored on a 7-point Likert scale, from 1, *not true at all*, to 4, *neutral*, to 7, *totally true*. The measures were derived by computing the mean of the 18 items for Attachment avoidance and Attachment anxiety, and the mean of the 4 to 6 items for each of the suggested five sub factors. Within the range from 1 to 7, higher scores indicated higher levels of Attachment anxiety and Attachment avoidance (Olssøn et al., 2010). Mean score in the Norwegian normative female population was 2.55 for Avoidance and 2.75 for Anxiety (Olssøn et al., 2010). Categories of high and low Attachment anxiety and high and low Attachment avoidance were computed using the mean of the Norwegian normative female

sample (Olssøn et al., 2010) as the cutoff score, "high" being equal to or greater than cutoff. The categories were analyzed initially for descriptive purposes but not in advanced analyses, because power and precision are lost when categories rather than continuous scales are used (Brennan et al., 1998; Mikulincer & Shaver, 2016). Both subscales were reported to exhibit high internal consistency reliability (Alonso-Arbiol, Balluerka, Shaver, & Gillath, 2008).

Childhood Adversities

Our modified version of the UngVold2015 (Mossige & Stefansen, 2016) covered childhood adversities like frequency of Peer victimization (6 scaled statements) and prevalence of Childhood sexual abuse (unwanted touching, attempted or forced penetration by someone before age 16; 9 statements). Three parts of the Childhood Trauma Questionnaire (CTQ-SF) (Bernstein, Stein, Newcomb, & Walker, 2003; Dovran et al., 2013) were applied through UngVold2015: Frequency of physical neglect, emotional neglect, and emotional abuse. Childhood emotional abuse included endorsement of five scaled statements like "I thought my parents wished I never were born," "I felt someone in the family hated me"; "As I see it, I was subjected to psychological maltreatment."

Sociodemographic and Contextual Variables

The intimate relationship of interest for research (index relationship) was the most recent violent relationship for victimized participants and the most recent relationship for non-victimized participants. The following variables about this relationship, this partner, and this participant were recorded. Age, Age of partner, whether the participant considered herself and her partner as of ethnic Norwegian origin or immigrant with/ without Norwegian citizenship (Immigrant; Immigrant partner); whether the participant was a mother (Mother); years of completed education (Education); Work/income situation (Employed including sick-leave, student, unemployed, disability benefit recipient, retired, work assessment allowance, or other); whether she had anybody to confide in (No confidants); age at the initiation of first intimate relationship; time lapse since last relationship (in months); length of recent relationship (in months), (Length of relationship; transformed to years only for Table 1 to ease the reading); and whether the participant presently was in a violent relationship.

One question was developed by the current research group to test a clinical hypothesis regarding how much time the participants generally spend on considering a new partner: "I take my time when I choose a new partner". The response (Considers partner) was computed as No (*not true*) and Yes (*true* or *partly true*) and analyzed separately among the sociodemographic control variables.

In order to explore reliability aspects in the participant's answers, the following contextual variables were registered: Whether the participant and the researcher experienced some/considerable language challenges during the interview (Language challenges), and whether a professional interpreter conveyed the interview questions and answers (Interpreter).

Procedures

The researchers cooperated with leaders of the nationwide agencies of women's shelters, Alternative to Violence treatment center (ATV), the police, and with the family counselling agency in Norway to obtain participants in the study. The following procedures were followed: (1) The initial recruitment of participants was conducted by agency personnel by presenting an information letter to their female users either in person or by phone; (2) after receiving written consent and contact information, the researcher sought contact with those recruited to discuss aspects of their participation in the study, and (3) the participating women came to a face-to-face interview with the same researcher, a female clinical psychologist, at the local recruitment or researcher's office. Women who were not fluent in the Norwegian language were informed that a professional interpreter could be hired for the interview. Women were included regardless of the sex of their partner. There was no economic incentive for participation, but a refund for public transport was offered. All participants were given a sheet with the answer alternatives for the questions. Time breaks were used when needed. The researcher registered the answers by hand in the codebook. The interviews lasted approximately 2 hours.

The 154 interviews were carried out between March 2018 and January 2019.

Dependent Variables

Violent relationship or violent partner was the unit of analysis. The women were recruited to the designated research category according to the definition of physical, psychological, and sexual violence in the information letter (Breiding, 2015). They were asked (both on the phone and, initially, in the interview) in how many intimate relationships they had experienced violence victimization. According to self-report, the participants were grouped into one of the following three research categories of intimate partner violence relationships (IPVR):

- 1IPVR, women who had experienced violence from one intimate partner within the last 3 years.
- 2IPVR, women who had experienced violence from an intimate partner within the last 3 years and in at least one previous intimate relationship.

- 0IPVR, women who currently or lately had an intimate relationship but never had been victims of IPV (control group).

Statistical Analyses

Univariate and bivariate analyses were conducted to compare the subgroups -- (1) women with no IPV relationships (non-victimized) compared to women with one and multiple IPV relationships (victimized) and (2) women with one IPV relationship (1IPVR) compared to women with multiple IPV relationships (2IPVR) -- and to inform the selection of variables to be included in the multivariate analysis. Multivariate logistic regression analyses were used to examine group differences associated with victimization and with victimization in one or multiple IPV relationships.

The stepwise options recommended for logistic regression for small samples were used (Altman, 1991; Pallant, 2010). Step 1: Initial comparisons of the groups were carried out by simple descriptive cross-tabulations with Pearson chi-square for categorical and nominal variables. For continuous variables, we used t-tests for independent samples (Step 1, Tables 1 and 2). Non-parametric tests were used in case of skewed distribution. In the first multivariate logistic regression analyses (Step 2), sociodemographic and contextual variables with significant *(*$p \leq 0.05$) or trend ($p \leq 0.10$) in bivariate analyses were adjusted for other significant or trend differences within the same category. The significant or trend attachment variables from Step 1 were forwarded to Step 3 where each of them was tested in a separate multivariate logistic regression model adjusted for all remaining sociodemographic and contextual group differences from Step 2 (Model a). In Step 4, we adjusted for childhood adversities, which were found as risk factors in a previous part of this study (Ørke et al., 2020). In two extended models, we adjusted for interaction effects between the attachment factor and each of the childhood adversities. Only models with significant attachment variables are presented in the tables.

Suitability for multivariate logistic regression analysis was investigated by the Hosmer-Lemeshow test. Cox & Snell R Square and Nagelkerke R Square were used to estimate the proportion of explained variance in the multivariate models (Notes, Tables 3 and 4). Statistical analyses were performed using the statistical program package SPSS, version 25. A conventional *p*-value of <0.05 was used.

In order to attain statistical power to compare subgroups, we conducted power analyses prior to initiation of the study. The probability for the study to identify and reject the false null hypothesis (OR = 1.00) was 83%.

Ethical Aspects

The study was approved by the Regional Norwegian Ethics Committee (REK 2016/2304). All ethical and safety recommendations from the WHO were observed (WHO, 2001). An information letter informed the participants about the study objectives and that some questions were of an intimate nature. They were assured that their participation was voluntary, that they were free to withdraw from the study at any time, that withdrawal would not affect the services they received at the recruitment office, that information would be stored confidentially, and that they were welcome to call the researcher on a given phone number. All cases were included irrespective of socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, ability, and age.

Results

In the total sample, the mean score on the Attachment avoidance subscale was 3.213 (*SD* = 1.209) and on the Attachment anxiety subscale 3.577 (*SD* = 1.080), both above the Norwegian normative mean score. There were several significant differences between IPV victimized and non-victimized women, and some differences between women with IPV from one and multiple partners, regarding attachment subscales and attachment sub factors in the initial bivariate analyses (Table 2). Among the 0IPVR, 37.5% had high Attachment avoidance, while 74.1% 1IPVR and 84.0% 2IPVR had high Attachment avoidance according to the Norwegian cut-off point (Olssøn et al., 2010). High Attachment anxiety was found among 66.7% 0IPVR, 74.1% 1IPVR, and 88.0% 2IPVR, and the group difference was significant on both subscales.

Table 2 about here

Attachment Characteristics among IPV Victimized Compared to Non-Victimized Women

The bivariate analysis showed that the IPV victimized compared to non-victimized women had significantly or trend higher mean scores on both attachment subscales and on four out of the five attachment sub factors (Table 2). Eight sociodemographic and contextual variables showed significant group differences initially (Table 1). After multivariate logistic regression analysis of these eight (Step 2, not displayed in a table), the following two group differences remained with significance: Immigrant partner and Length of relationship. In Step 3, each of the six significant or trend attachment variables was tested in a separate

multivariate logistic regression model adjusted for the two significant sociodemographic variables. Three attachment variables remained significant; Attachment avoidance, Avoidance of closeness, and Uncomfortable with openness (Table 3). In Step 4, we adjusted for two childhood adversities found as risk factors in a previous part of this study: Childhood sexual abuse and Peer victimization (Ørke et al., 2020). This strengthened the model for Uncomfortable with openness (Table 3, Model 3b, Note, Cox & Snell and Nagelkerke) but not for Attachment avoidance or Avoidance of closeness. Adjusting for an interaction effect between the attachment variable and each of the two childhood adversities variables did not strengthen the models.

The strongest model showed that compared to non-victimized women, IPV victimized women had more than three times increased likelihood of having a higher score on the Attachment avoidance subscale (Table 3, Model 1). Also, they had more than two times increased likelihood of a higher score on Avoidance of closeness (Table 3, Model 2) and on Uncomfortable with openness (Table 3, Model 3a), compared to their non-victimized counterparts. Both Uncomfortable with openness and Childhood sexual abuse remained as independent risk factors for victimization (Table 3, Model 3b). Women victimized by IPV had more than 2.5 times increased likelihood of reporting Childhood sexual abuse (Table 3, Model 3b) compared to non-victimized women.

Two sociodemographic variables remained significant: having an Immigrant partner (Table 3, Model 1) and Length of recent relationship (Table 3, Model 1).

Table 3 about here

Attachment Characteristics among Women Victimized by One Compared to Victimized by Multiple Partners

The bivariate analysis showed that 1IPVR compared to 2IPVR had significant or trend different mean scores on both attachment subscales and on two out of the five attachment sub factors (Table 2). Among the sociodemographic and contextual variables, six showed significant or trend differences (Table 1). After a multivariate logistic regression analysis of the six sociodemographic and contextual variables (Step 2, not displayed in a table), the following two variables remained with significant group differences: how much time they generally spend on considering a new partner (Considers partner) and years of completed education (Education). On a theoretical basis, we wanted to adjust for all the significant and

trend control variables. In order to reduce the amount of control variables to fit the sample size, we eliminated the Interpreter variable, as this is one aspect of the Immigrant variable. In Step 3, each of the four significant or trend attachment variables was tested in a separate multivariate logistic regression model adjusted for the five remaining sociodemographic variables. Only the subscale Attachment anxiety remained significant (Table 4, Model 4a).

The main finding was that women victimized by MP had a 78 % increased likelihood of a higher Attachment anxiety score (Table 4, Model 4a). In Step 4, we adjusted for Childhood emotional abuse, which was found as a risk factor in a previous part of this study (Ørke et al., 2020). This did not strengthen the model. However, adding the interaction variable Attachment anxiety by Childhood emotional abuse strengthened the model (Note, Table 4, Model 4b, Cox & Snell and Nagelkerke). Childhood emotional abuse increased the association between Attachment anxiety and victimization by MP with a slightly increased likelihood (3.1%) (Table 4, Model 4b).

The control variable Work/income was not significant as such, apart from the subcategory Disability benefits (Table 4, Model 4b), indicating more recipients of disability benefits among women with IPV by MP. Further, victimization by MP was associated with having a shorter relationship (Table 4, Model 4b) and being native Norwegian (Table 4, Model 4b).

Table 4 about here

Discussion

Main Findings

The purpose of this study was to investigate attachment differences between IPV victimized and non-victimized women and between women victimized by one and multiple partners. We were interested in exploring whether victimization by multiple partners increased the likelihood for certain attachment characteristics, adjusting for childhood adversities and sociodemographic variables.

Non-victimized scored below the normative mean regarding Attachment avoidance, whereas both victimized groups scored above the mean. Regarding Attachment anxiety, all three groups had increased Attachment anxiety scores above the Norwegian normative mean for females. These generally elevated scores may reflect a sample of only help-seeking women. Still, the three groups had significant differences amongst them. Our results highlight

the importance of differentiating among victimized women in order to understand the vulnerability for IPV by MP and certain needs for this subgroup of women.

First, multivariate logistic regression analysis showed that compared to non-victimized, IPV victimized women had more than three times increased likelihood of a higher score on the Attachment avoidance subscale. Second, they had more than two times increased likelihood of having a higher score on both of the avoidance sub factors Avoidance of closeness and Uncomfortable with openness compared to their non-victimized counterparts. Third, Childhood sexual abuse was a significant risk factor in addition to Uncomfortable with openness. Fourth, compared to women with IPV in a single relationship, women with IPV by multiple partners had a 78 % increased likelihood of having a higher Attachment anxiety score. Finally, the association between Attachment anxiety and IPV by multiple partners was mediated by Childhood emotional abuse, but the effect size was low.

Attachment Characteristics among Victimized Women Compared to Non-Victimized Women

The present study found a higher likelihood of Attachment avoidance among victimized women compared to non-victimized. This was nuanced by higher scores on both avoidance subcategories Avoidance of closeness and Uncomfortable with openness. The importance of Attachment avoidance was reported by some earlier studies (Kuijpers et al., 2012b; Shechory, 2013; Weiss et al., 2011; Wekerle & Wolfe, 1998) but contrasted others reporting increased Attachment anxiety among victimized women (Bond & Bond, 2004; Lewis et al., 2017; McClure & Parmenter, 2017; Shechory, 2013). Earlier studies that did not distinguish between women with one or multiple partners may have missed important differences.

Attachment avoidance, meaning avoidance of closeness, uncomfortable with openness, distrust of partners, and deactivation of the attachment system (Feeney, 2016) may have preceded IPV victimization. IPV victimization contributed both to higher likelihood of reporting experiences of Childhood sexual abuse and higher scores on Uncomfortable with openness. These findings concur with previous findings that sexual abuse was associated with attachment avoidance (Brenner et al., 2019) and that childhood sexual abuse was associated with women's engagement with multiple violent partners (Stein, Grogan-Kaylor, Galano, Clark, & Graham-Bermann, 2016). A deactivating strategy associated with attachment avoidance may develop in the context of childhood sexual abuse as a way to regulate intolerable emotions, gain control over their lives, and maintain independence and a positive self-view. Velotti and coworkers (2018) suggested that avoidant individuals had typical

difficulties in seeking help because of dysfunctional beliefs about being psychologically immune to emotional threats and about others being fundamentally unavailable.

However, attachment avoidance may also be a result of IPV victimization. Due to the absence of physical safety, the woman may suppress her attachment needs and withdraw to protect herself (Slootmaeckers & Migerode, 2018).

Slootmaeckers & Migerode (2018) argued that it is not simply a question of understanding individual attachment mechanisms but also the attachment dynamics of the relationship itself. Unsafe attachment and negative interaction cycles between the partners could be seen as a context that leads to IPV (Doumas, Pearson, Elgin, & McKinley, 2008). It was argued that, in situational couple violence (SCV) the violent pursuer became aggressive in order to force engagement of the avoidant partner and maintain a desired level of proximity to the partner (Slootmaeckers & Migerode, 2018).

Attachment Characteristics among Women Victimized by One Compared to Victimized by Multiple Partners

Higher Attachment anxiety among women with IPV by MP involves excessive need for approval, fear of abandonment, and distress and hurt in the face of conflict (Feeney, 2016). Our result deviated from Alexander's finding (Alexander, 2009) of unresolved attachment style. The reason for the divergent findings may be that these two studies applied measurements from two different approaches wherein the attachment concepts are not operationalized in the same way.

While some studies have reported increased attachment anxiety among IPV victimized in general (Bond & Bond, 2004; Lewis et al., 2017; McClure & Parmenter, 2017; Shechory, 2013), the contribution from the present study was that increased Attachment anxiety characterized women victimized by multiple partners in particular.

A statistically significant interaction variable of Attachment anxiety by Childhood emotional abuse increased the likelihood for IPV by MP, suggesting that experiences of Childhood emotional abuse increased the association between higher Attachment anxiety score and victimization by MP. This was supported by Valdez and colleagues, who reported a childhood emotional trauma trajectory associated with a desire for intimacy, fear of loneliness, IPV, and deficits in navigating interpersonal relationships (Valdez, Lim, & Lilly, 2013). Having grown up with humiliating and invalidating caregiving, this group of women with increased attachment anxiety may view adult relationships as opportunities for acceptance. A propensity to seek closeness and ingratiate themselves with their partners

(Downey & Feldman, 1996) may prevent their recognition of a partner's early risk behaviors, putting themselves at risk for further maltreatment (Hocking, Simons, & Surette, 2016).

Compared to non-victimized, victimized women had higher Attachment avoidance scores. Compared to 1IPVR, women with IPV by MP had higher Attachment anxiety scores. To speculate, our findings indicated that compared to non-victimized, women with IPV by MP may possibly display a mixed attachment strategy with higher scores on both Avoidance and Anxiety dimensions than non-victimized do. This might have an especially destructive effect, possibly trapping the women in a cycle of conflict-riddled attempts to meet personal needs while trying to avoid rejection and mishandling (Mikulincer & Shaver, 2016).

It has been hypothesized that high levels of attachment anxiety among victims of IPV may make it more difficult to leave an abusive relationship (Mikulincer & Shaver, 2016; Park, 2016). As described initially, attachment anxiety involves excessive need for approval from others, fear of interpersonal rejection or abandonment, and distress when one's partner is unavailable or unresponsive (Cassidy & Shaver, 2016; Pedersen, Eikenæs, Urnes, Skulberg, & Wilberg, 2015). In the present study, there was no measure of the act of leaving, but of relationship length. The results showed that the group of women with IPV by MP in particular exhibited the highest levels of Attachment anxiety and reported shorter relationships. Higher levels of Attachment anxiety seemed, in this case, to contribute to a higher likelihood of engaging in short, destructive relationships rather than long relationships. Including the result that victimized women in general had more than three times increased likelihood of higher score on Attachment avoidance (Table 3), may inform this finding. Attachment avoidance involves need for self-reliance, and fear of interpersonal closeness (Cassidy & Shaver, 2016; Pedersen et al., 2015). Shorter, destructive relationships among women with IPV by MP may follow a combination of high levels of both attachment anxiety and attachment avoidance in this group.

The increased attachment scores could have preceded IPV due to childhood trauma or they could have been reinforced by the current IPV (Alexander, 2009). Slootmaeckers and Migerode (2018) suggested a pattern of situational couple violence, which had its origins in a negative interaction cycle of clinging and withdrawal. Violence was seen as an attempt to regulate distance from the continuous contact-seeking of the clinging partner (Slootmaeckers & Migerode, 2018). While yearning for contact, the clinging partner was pushed aside and may in turn seek even more comfort, connection and proximity. Due to their heightened sense of insecurity, the clinging partners became increasingly overwhelmed by powerlessness and separation anxiety (Slootmaeckers & Migerode, 2018). Doumas and coworkers (2008), too,

reported that the "mispairing" of an avoidant male partner with an anxious female partner was associated with both male and female violence. However, when controlling for partner violence, the relationship between attachment and violence was significant for males only (Doumas et al., 2008).

A recent longitudinal study reported that attachment anxiety was associated with increased risk for experiencing physical assault, while attachment avoidance was unrelated to subsequent IPV victimization (Sandberg, Valdez, Engle, & Menghrajani, 2019). To measure causality one must have a prospective design. Therefore, our results do not provide causality between attachment avoidance and IPV or between attachment anxiety and IPV by MP in particular.

Most research on adult attachment was based on the assumption that working models are relatively general and trait-like. Recent research, however, suggested that people develop attachment representations that are relationship-specific, leading people to hold distinct working models in different relationships (Fraley, Heffernan, Vicary, & Brumbaugh, 2011). Slootmaeckers and Migerode (2018) argued that the attachment pattern in a given romantic relationship is the result of attachment disposition (childhood), past romantic attachment, and contemporary interaction and experience with this partner. Dispositional attachment and situational attachment interact (Slootmaeckers & Migerode, 2018).

A person's position on the Anxiety and Avoidance dimensions can move across different, temporarily separated assessments, partly due to contextual factors, partly due to normal measurement error, and partly due to real change over time (Mikulincer & Shaver, 2016).

In addition to applying the frequently used subscales Attachment avoidance and Attachment anxiety, this study explored the application of five sub factors (Pedersen et al., 2015). Comparing victimized to non-victimized, the strongest model showed that the sub factor Uncomfortable with openness and Childhood sexual abuse were separate risk factors for IPV. Adding Childhood sexual abuse did not contribute to substantial changes of the odds ratio (OR) value for Uncomfortable with openness (Table 3, Model 3b). Except for this, we found that the application of the five sub factors did not add substantially to the results.

Limitations

Some young participants may be early in their victimization "career" and would later in life appear in the IPV by MP group, and this may blur group differences.

Discussing results regarding attachment is complicated due to research traditions applying different methodologies. The concepts of attachment anxiety and avoidance are not

operationalized in the same way in the developmental and the social approach. There are more measures than constructs, and the measures do not necessarily correspond with each other or with any particular understanding of the construct (Mikulincer & Shaver, 2016). Furthermore, studies regarding categories of attachment styles may give a different picture than studies of scores along attachment scales.

As found in several studies of help-seeking women after IPV, a considerable amount of the invited women declined to participate. We have no information regarding these women concerning group differences. Therefore an analysis of the representativeness of the studied sample was not possible. We may have missed women who declined participation due to health problems, social distress or other difficulties. The experiences of these women might have differed from those of the included women. Another important limitation is that the present study only included information about help-seeking women. They may differ from those who are not help-seeking women in several aspects (Dufort, 2013). Thus, findings from this study of help-seeking women do not necessarily generalize to all help-seeking victims, to victimized women who do not seek help, to community samples, or to women outside of Norway, due to cultural, social and societal differences. Cultural context is important in understanding IPV risk markers (Mallory et al., 2016). This calls for careful interpretation of the generalizability of our findings.

Some of the ORs were high. Still, wide confidence intervals regarding Immigrant partner and Disability benefits indicate that these findings should be interpreted with caution.

Finally, the cross-sectional design has limitations concerning any assumptions of causality and temporal ordering of variables.

Clinical Implications

The results suggested that women victimized by multiple partners had specific attachment issues; high on avoidance and high on anxiety. Accordingly, all IPV victimized women would not benefit from the same treatment. Victimized women should be assessed regarding attachment anxiety and avoidance, and childhood sexual and emotional abuse. Women at increased risk might benefit better from long term intervention. They should be invited step-by-step to talk about these topics in therapy and might be guided toward an increased awareness of how attachment issues have affected their relationship (Velotti et al., 2018). Therapy should target fears of rejection and excessive need of approval in relation to the choice of a new partner. Clinicians might help developing skills, so that when attachment anxiety or avoidance is triggered, clients are less likely to react automatically and more likely to respond consciously and constructively in ways that do not compromise their dignity and

well-being (Park, 2016). Improved insight in these therapy topics may inform the women to engage in the prevention of future IPV relationships.

Focusing on the discrepancy between partners' needs for intimacy and distance within the couple has been suggested as a strategy for treating intimate partner violence (Doumas et al., 2008). Emotionally Focused Therapy (EFT) emphasizes emotions and attachment (Johnson, 2007). Based on EFT, it was argued that negative interaction cycles may be discussed with couples suffering from situational couple violence (SCV), but not intimate terrorism (IT), when ethics and safety allow (Slootmaeckers & Migerode, 2018). However, it is important to keep in mind that very few risk factors establish a causal relationship (Park, 2016).

Research Implications

More research is needed in order to investigate the interaction between increased attachment anxiety and IPV by MP: the temporal order of the variables is yet to be described, as well as whether increased attachment anxiety is possibly disturbing the initial process of partner choice or the dynamics within the relationship. Speculations regarding a combination of increased attachment anxiety and avoidance among women with IPV by MP would require further empirical investigation. Moreover, differentiating between Johnson’s types of violence (M. P. Johnson, 2008) may help nuance the association between attachment style and risk of IPV revictimization by multiple partners.

Conclusion

In this study, we found differences in attachment characteristics both between women victimized by one and multiple partners, and between victimized and non-victimized women. The results supported the relevance of attachment theory for understanding IPV victims. Both attachment anxiety and attachment avoidance appeared influential in IPV by MP. The findings suggested that interventions should especially reach multiply victimized women with high attachment anxiety before initiation of future intimate relationships.

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Table 1

Sociodemograpic and Contextual Group Differences among Women with No (0IPVR), One (1IPVR), and Multiple IPV Relationships (2IPVR)

Variable	0IPVR (*n* = 48)	1IPVR (*n* = 55)	2IPVR (*n* = 51)	Total (*N* = 154)	1IPVR + 2IPVR vs. 0IPVR	1IPVR vs. 2IPVR
	% (*n*)	% (*n*)	% (*n*)	% (*n*)	*p*	*p*
Immigrant	8.3 (4)	25.5 (14)	7.8 (4)	14.3 (22)	.155	.016
Immigrant partner	4.2 (2)	40.0 (22)	27.5(14)	24.7 (38)	<.001	.173
Work/income					.022	.014
Employed	77.1 (37)	50.9 (28)	41.2 (21)	55.8 (86)		
Student	6.3 (3)	12.7 (7)	3.9 (2)	7.8 (12)		
Unemployed	4.2 (2)	10.9 (6)	3.9 (2)	6.5 (10)		
Disability benefits	4.2 (2)	3.6 (2)	23.5 (12)	10.4 (16)		
Retired	2.1 (1)	0.0 (0)	2.0 (1)	1.3(2)		
Other	2.1 (1)	9.1 (5)	3.9 (2)	5.2 (8)		
Work assessment allowance	4.2 (2)	12.7 (7)	21.6 (11)	13.0 (20)		
Mother	97.9 (47)	87.3 (48)	86.3 (44)	90.3 (139)	.031	.879
No confidants	0.0 (0)	9.3 (5)	9.8 (5)	6.5 (10)	.028	.900
Considers partner	87.5 (42)	81.8 (45)	52.9 (27)	74.0 (114)	.010	.001
Language challenges	2.1 (1)	18.2 (10)	8.0 (4)	9.8 (15)	.030	.125
Interpreter	0.0 (0)	9.1 (5)	0.0 (0)	3.2 (5)	.126	.027
Education (yrs.) (Mean/*SD*)	16/2.60	15.49/3.36	13.41/3.26	14.96/3.28	<.001	.002
Length of relationship (yrs.) (Mean/*SD*)	14.48/9.24	10.83/8.86	6.42/6.50	10.51/8.85	<.001	.003

Note. The Mann-Whitney U test was used to test for possible group differences for variables with nonparametric score distributions for two independent groups. The Pearson chi-square test was used for nominal data and unrelated groups. Age, age of partner, age at the initiation of first intimate relationship, time lapse since last relationship, and whether the victimized was presently in a violent relationship were tested with non-significant results.

Table 2

Mean Scores of Attachment Characteristics among Women with No (0IPVR), One (1IPVR), and Multiple IPV Relationships (2IPVR), Measured by Experiences in Close Relationship

Variable	0IPVR (*n* = 48) Mean, *SD*	1IPVR (*n* = 54) Mean, *SD*	2IPVR (*n* = 50) Mean, *SD*	TOTAL (*N* =152) Mean, *SD*	0IPVR vs. 1IPVR+ 2IPVR *p*	1IPVR vs. 2IPVR *p*
Anxiety	3.32, 1.09	3.49, 1.10	3.92, 0.97	3.58, 1.08	.048	.041
Avoidance	2.46, 0.89	3.37, 1.14	3.77, 1.21	3.21, 1.21	<.001	.086
Avoidance of closeness	2.37, 1.03	3.20, 1.24	3.70, 1.40	3.10, 1.34	<.001	.059
Uncomfortable with openness	2.33, 1.04	3.18, 1.31	3.59, 1.47	3.04, 1.38	<.001	.137
Separation frustration	3.72, 1.25	3.76, 1.18	3.89, 1.11	3.79, 1.18	.631	.553
Anxiety for abandonment	3.26, 1.68	3.44, 1.61	4.16, 1.60	3.62, 1.67	.071	.025
Frantic desire for closeness	2.85, 1.30	3.18, 1.25	3.56, 1.16	3.20, 1.26	.024	.118

Note. Independent samples t-test. Range 1 – 7.

Table 3

Victimized (n = 105) Compared to Nonvictimized Women (baseline) (n = 48). Multivariate Logistic Regression Analyses

Independent variables	Adj. odds ratio (OR)	95% CI	*p*
Model 1 (*n* = 152)			
Avoidance	3.352	2.036 - 5.517	<.001
Immigrant partner	18.568	3.578 - 96.373	<.001
Length of relationship	.993	.989 - .997	<.001
Model 2 (*n* = 152)			
Avoidance of closeness	2.214	1.525- 3.213	<.001
Immigrant partner	13.502	2.794 - 65.257	.001
Length of relationship	.994	.990 - .998	.003
Model 3a (*n* = 151)			
Uncomfortable with openness	2.700	1.741- 4.188	<.001
Immigrant partner	20.502	3.977- 105.684	<.001
Length of relationship	.992	.988 - .996	<.001
Model 3b (*n* = 151)			
Uncomfortable with openness	2.656	1.697- 4.157	<.001
Childhood sexual abuse, prev.	2.784	1.071- 7.236	.036
Immigrant partner	22.494	4.215- 120.025	<.001
Length of relationship	.993	.989 - .997	.001
Peer victimization, freq.			ns

Note. Multivariate Logistic Regression, Forward stepwise (Wald). Prev. = prevalence, freq. = frequency. CI = Confidence Interval.

Model 1 Cox & Snell R Square = .347, Nagelkerke R Square = .486, Hosmer and Lemeshow Test = .856.

Model 2 Cox & Snell R Square = .294, Nagelkerke R Square = .412, Hosmer and Lemeshow Test = .966.

Model 3a Cox & Snell R Square = .324, Nagelkerke R Square = .454, Hosmer and Lemeshow Test = .212.

Model 3b Cox & Snell R Square = .344, Nagelkerke R Square = .483, Hosmer and Lemeshow Test = .149.

Table 4

Women with Multiple IPV Relationships (n = 50) Compared to Women with One IPV Relationship (baseline) (n = 54). Multivariate Logistic Regression Analyses

Independent variable	Adj. odds ratio (OR)	95% CI	*p*
Model 4a (*n* = 104)			
Anxiety	1.776	1.085 - 2.909	.022
Work/income			
Employed (baseline)			ns
Student			ns
Unemployed			ns
Disability Benefits	17.578	1.943 - 159.055	.011
Retired			¤
Other			ns
Work assessment allowance			ns
Length of relationship	.987	.980 - .994	<.001
Immigrant	.136	.027 - .694	.016
Education			ns
Considers partner			ns
Model 4b (*n* = 104)			
Anxiety			ns
Childhood emotional abuse			ns
Anxiety*Childhood emotional abuse	1.031	1.010 - 1.053	.004
Work/income			
Employed (baseline)			ns
Student			ns
Unemployed			ns
Disability Benefits	13.551	1.603 - 114.558	.017
Retired			¤
Other			ns
Work assessment allowance			ns
Length of relationship	.990	.983 - .997	.004
Immigrant	.114	.020 - .649	.014

Note. Multivariate logistic regression, Forward stepwise (Wald). Prev. = prevalence, freq. = frequency. OR = odds ratio. CI = Confidence Interval.

¤There were no retired in the 1IPVR group and one in each of the other two groups.

*Statistical interaction between anxiety and emotional abuse.

Model 4a Cox & Snell R Square = .348, Nagelkerke R Square = .465, Hosmer and Lemeshow Test = .549.

Model 4b Cox & Snell R Square = .375, Nagelkerke R Square = .501, Hosmer and Lemeshow Test = .416.

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