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Encouraging Legal Help Seeking for Victims of Intimate Partner Violence: The Therapeutic Effects of the Civil Protection Order

Caroline Vaile Wright¹ and Dawn M. Johnson²

¹Department of Psychology, Saint Elizabeths Hospital, Washington, DC, USA

²Department of Psychology, University of Akron, Akron, Ohio, USA

Abstract

Civil protective orders (CPOs) are the most widely used justice system remedy for intimate partner violence (IPV), and were implemented to ensure safety and increase victim participation in the justice system. Limited data exists regarding the effectiveness of CPOs; however, theories of therapeutic jurisprudence argue that legal interventions in and of themselves can improve mental health outcomes. To test this hypothesis, we examined the effectiveness of having a CPO issued against one's abuser at improving the psychological sequelae of exposure to trauma. We used a longitudinal sample of female residents of battered women's shelters who had experienced IPV ($N = 106$; 55% African American). One-way analyses of variance using gain scores indicated that PTSD symptoms (effect size $\eta_p^2 = .16$) and incidents of sexual revictimization (effect size $\eta_p^2 = .09$) decreased from baseline to 6-months postshelter for women who had a CPO against their most recent abuser compared to women without a CPO. These results support theories of therapeutic jurisprudence, suggesting that having a CPO can improve mental health outcomes. Limitations and clinical implications of our findings are discussed, including arguing for a coordinated service system that incorporates both legal and psychological assistance to improve the mental health of victims of IPV.

Herman's (2003) seminal *Journal of Traumatic Stress* review of the mental health of crime victims made several recommendations to address the lack of systematic study of the impact of participation in the justice system for victims of intimate partner violence (IPV). In particular, she highlighted the need for more longitudinal studies investigating the long-term psychological impact of women who seek legal help compared with women who do not utilize these resources. Longitudinal studies of this nature are critical to assessing whether civil and criminal justice interventions are effective in improving mental health outcomes, such as posttraumatic stress disorder (PTSD). The current study aimed to address this gap in the literature by examining the therapeutic effects of civil justice interventions for IPV.

IPV is a significant social problem, representing the leading cause of physical injuries to women (Tjaden & Thoennes, 2000). Protective orders, a class of civil remedies that have been available in nearly every state since 1988, are the most widely used justice system remedy for IPV (Logan & Walker, 2009), and were implemented to ensure safety and

increase victim participation in the justice system (Jordan, 2004). Protective orders have jurisdiction-specific labels, often being referred to by a plethora of terms, including restraining orders, personal protective orders, no-contact orders, peace bonds, and protection from abuse orders (DeJong & Burgess-Proctor, 2006; Logan & Walker, 2009). As such, the term civil protection order (CPO) will be utilized throughout this article as an umbrella-term encompassing any civil remedy to minimize contact with an abusive partner.

Despite their availability for over two decades, limited data exist regarding the effectiveness of having a CPO (Logan & Walker, 2009), and the data that are available suggest their effectiveness is questionable at best. To complicate matters, there appears to be no clearly agreed upon method of determining whether a CPO is effective. Previous research has typically focused on three separate yet related effectiveness outcomes: (a) CPO violations including, in particular, instances of reabuse by the abuser; (b) perceptions of victims of increased safety; and (c) reduction of mental health symptoms.

To address the first, research has documented that CPO violations and instances of reabuse are quite common. Anywhere between 23%–70% of CPOs are violated (Carlson, Harris, & Holden, 1999; Tjaden & Thoennes, 2000). Specifically, Spitzberg (2002) reviewed 32 studies of restraining orders and found the average rate of violation was 40%. Further, women are more likely to experience reabuse if they have biological children with their abuser (Carlson et al., 1999), or if they have had previous experiences of being stalked by their abuser (Logan & Walker, 2009). Protective factors, fortunately, have also been identified. Most notably, in a sample of court-involved IPV victims, women who participated in an advocacy condition in which they were routinely visited by law students, reported lower levels of psychological and physical reabuse (Bell & Goodman, 2001).

The second outcome measure to assess effectiveness of having a CPO examines perceptions by victims of increased safety and control. Although it has received less research attention than CPO violations and reabuse, perceptions of victims can play an important role in ending the cycle of violence as we know that perceptions often drive behavior. Fischer and Rose (1995) found that IPV victims who obtained a temporary CPO reported an increased sense of control “over their activities, their bodies, and their lives” (p. 423). In a more recent study, Logan and Walker (2009) found that 78% of IPV victims subjectively perceived their protection order was effective and an additional 77% felt extremely or fairly safe after obtaining the order, despite the fact that 58% of all study participants reported experiencing a violation of the protection order, suggesting perceptions may not be in line with reality. The final effectiveness outcome, whether justice interventions can reduce mental health symptomology for IPV victims, is best examined and understood within the framework of therapeutic jurisprudence.

Therapeutic jurisprudence is a theoretical framework to address ways in which the legal system advances or impedes therapeutic goals (Hartley, 2003; Wexler, 1995; Winick, 1997). Therapeutic jurisprudence is both descriptive and prescriptive in nature, and posits that legal interventions have the potential to function in a similar manner to mental health interventions, and as such, this relationship should be factored into legal decision making (Winick, 1997). A therapeutic jurisprudence approach to addressing IPV is not a neutral,

value-free framework; instead, it seeks to promote the psychological and physical well-being of IPV victims through the law, which can include legal practices such as the awarding of protective orders (Wexler, 1995; Winick, 1997).

As a therapeutic agent, the law can bring about positive and negative therapeutic consequences (Wexler, 1995; Winick, 1997). To address the former, legal interventions can provide temporary safety, validate a victim's right to be free from personal violence, and send the message that domestic violence is criminal. Moreover, positive therapeutic effects can include informing victims of additional resources, such as mental health and social services, as well as providing help with divorce proceedings (Erez & Belknap, 1998; Simon, 1996). Finally, interventions by the justice system reinforce a victim's beliefs that the violence is not her responsibility (Simon, 1996), can enhance feelings of empowerment and liberation (Erez, 1999), and can potentially reduce mental health symptomology (Herman, 2003). Antitherapeutic effects to justice interventions can include victim blaming and disparaging attitudes from service providers and legal actors, which in turn could reinforce low self-esteem and feelings of isolation and helplessness for IPV victims (Hart, 1993; Simon, 1996).

Most previous research examining domestic violence law as a therapeutic agent has been theoretical. One notable exception is a recent empirical study by Bennett Cattaneo and Goodman (2010), who examined a longitudinal sample of 142 IPV victims recruited within the court system. They found that women who reported higher levels of court-related empowerment had greater improvements in mental health, as evidenced by reductions in depressive symptoms and increases in perceived quality of life. The finding that empowerment may act as a mechanism of change for IPV victims who use legal resources provides support for the role of therapeutic jurisprudence in domestic violence law. A critically missed piece, however, is a comparison of IPV victims who become involved in the court system to those who do not, to assess whether the act of being involved in the legal system itself, regardless of whether one finds it to be an empowering experience, can have a positive impact on psychological functioning.

The current study examined two measures of effectiveness of a CPO. First, a therapeutic jurisprudence framework was employed to assess whether civil justice interventions were associated with improvements in psychological functioning in a longitudinal sample of victims of IPV who either had obtained a CPO in response to abuse or did not. Reductions in PTSD symptomology, both at a total scale and subscale level, were examined given previous research suggesting that PTSD is one of the most common psychiatric outcomes of IPV (Pico-Alfonso et al., 2006), and that symptom clusters may play significantly different roles for IPV victims at different times (see e.g., Johnson, Palmieri, Jackson, & Hobfoll, 2007; Krause, Kaltman, Goodman, & Dutton, 2006). Given recent research by Bennett Cattaneo and Goodman (2010), the relationship of the legal system to symptoms of depression was examined as well. Second, we examined whether having a CPO was effective at reducing instances of physical, psychological, and sexual reabuse by the index relationship partner that led to their shelter stay. We hypothesized that compared to the control group, the CPO group would have greater reductions not only in PTSD and depressive symptoms, but also in rates of revictimization.

Method

Participants and Procedure

The pool of potential participants came from a sample of shelter residents recruited from two shelters within the same shelter system who all reported experiencing IPV in their most recent relationship. The study was approved by the Summa Health System Institutional Review Board. Shelter residents were provided brochures by shelter staff that included contact information for the research project. Flyers describing the study were also posted in the shelter. Then, interested participants were scheduled for an interview with trained female graduate students in psychology or counseling. The interviews consisted of both structured and semistructured interviews as well as the administration of self-report forms. Interviews were conducted at the shelter, and lasted approximately 2–3 hours for the baseline interview and 1-hour for the follow-up interviews, with every attempt being made to assure the participant's privacy and safety. In addition, participants were offered the opportunity to take breaks as needed due to the length of the interview. Participants completed follow-up assessments at the most convenient location for the women (e.g., public library, home visit). Each interviewer received extensive training from the second author, including formal training in psychopathology and assessment with an emphasis on multicultural sensitivity and gender victimization, and detailed instruction and practice of the interview protocol. Finally, interviewers received weekly formal supervision, as well as as-needed informal supervision by a licensed psychologist.

Completing a baseline interview were 147 women, and 111 women completed follow-up interviews, yielding a 75.5% retention rate. This study was part of a larger treatment study in which participants completed follow-up assessments at three time points (i.e., postshelter, 3-months, and 6-months postshelter); however, only the final posttest assessment (i.e., 6 months) was included in the current study, as we assert that women will have had ample opportunity to benefit from a CPO after 6-months leaving shelter, and may not have had sufficient time to experience such benefit at earlier time points. Limitations related to this methodology are addressed in the Discussion. Excluded from the analyses were five participants who reported that they did not have a CPO at baseline, but obtained one at a later time, resulting in 106 participants being included in the current analyses.

Of the 36 women who did not complete follow-up postshelter assessments, 33 were unable to be contacted at follow-up. One woman refused further participation with the study after completing a baseline interview. Those lost to follow-up were compared to those retained on baseline study (e.g., PTSD) and demographic variables. No significant differences were found (all p values $>.05$).

Respondents were asked at each time point whether they currently have a restraining/protective order or any other type of civil legal document to minimize contact with their abusive partner. Sixteen participants reported having an active CPO continuously for the full 6-month follow-up period, and 24 reported that their CPO either expired or was dropped between baseline and 6 months. Because of the small sample and insufficient power to compare the continuous CPO, dropped/expired CPO, and no CPO groups, participants who had a CPO at baseline but it either had expired, was dropped, or lasted the full 6 months

were combined in one group (i.e., CPO at baseline; $n = 40$) and compared to those participants without a CPO at any time-point ($n = 66$).

On average, the shelter residents were 35 years old ($SD = 8.60$; $range = 20\text{--}59$) at baseline. The majority of the sample self-identified as either African American (54.7%; $n = 58$) or Caucasian (34.0%; $n = 36$). At baseline, nearly half reported that they had never been married (42.5%; $n = 45$), and the majority had at least one child (88.7%; $n = 94$). Most residents had obtained at least a high school education/general educational development (GED; 80.2%; $n = 85$), nearly the same proportion was unemployed (76.4%; $n = 81$), and 66% of residents ($n = 70$) reported they had received some type of governmental aid at baseline. At baseline, 71.7% of participants had experienced at least one relationship prior to their most recent relationship that was physically and/or sexually abusive ($M = 1.57$; $SD = 2.06$; $range = 0\text{--}12$), the average length of the most recent abusive relationship was 63.8 months ($SD = 79.98$), and the average length of shelter stay was 60 days. Finally, 58% of participants ($n = 61$) reported receiving mental health treatment (i.e., individual, group, or family therapy) excluding self-help interventions (e.g., books, meetings, etc.) in the last 6 months since leaving the shelter.

Measures

PTSD symptoms—The Clinician Administered PTSD Scale (CAPS; Blake et al., 1995), a semistructured interview that assesses frequency and severity of PTSD symptoms, was administered at each time point. The CAPS parallels the Diagnostic and Statistical Manual of Mental Disorders (4th ed., *DSM-IV*; American Psychiatric Association, 1994) diagnostic criteria, and participants were asked about any PTSD symptoms related specifically to the IPV that led to their shelter admission. The scale was scored by summing frequency and intensity scores for each of the diagnostic items. The study used 1-month symptom status CAPS scores, and responses were provided on the standard 5-point scale. Blake et al. (1995) reported internal consistency estimates for the CAPS ranging between .73 and .85, good concurrent validity with other PTSD measures (r s between .42 and .84), and excellent interrater reliability estimates (r s between .92 to .99).

Based on previous research demonstrating the multidimensionality of PTSD (see, e.g., Johnson et al., 2007), the current study employed a four-cluster model of PTSD symptoms. This model divides PTSD symptoms into reexperiencing, effortful avoidance, emotional numbing, and hyperarousal clusters. In the current study, the baseline CAPS scores demonstrated good reliability ($\alpha = .93$), as well as good interrater reliability ($k = .83$), which was assessed for 21 randomly selected interviews for CAP-derived PTSD diagnoses. The four subscales also demonstrated good reliability, with coefficient alphas ranging from .75 (effortful avoidance) to .87 (reexperiencing).

Depressive symptoms—The Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emory, 1979) is a 21-item scale widely used to assess depression severity. Respondents were asked about depressive symptoms (e.g., sadness, worthlessness, loss of energy) they may have experienced in the “past two weeks, including today” at baseline and 6-months. Responses are rated on the standard 4-point scale. The reliability and validity of the BDI has

been well-established (see, e.g., Beck, Steer, Ball, & Ranieri, 1996); coefficient alpha in the current sample was .89 at baseline and .94 at follow-up.

IPV severity and reabuse—The Revised Conflict Tactic Scales-Second Edition (CTS-2; Straus, Hamby, McCoy, & Sugarman, 1996) is a 32-item self-report measure assessing the severity of abuse participants experienced within the past month. Responses were provided on a 6-point Likert-type scale, ranging from 1 = *once in the past month* through 6 = *more than 20 times in the past month*. The CTS-2 was administered at baseline and 6-months postshelter. Straus et al. (1996) reported internal consistency estimates for the CTS-2 ranging between .79 to .95, and have established adequate construct and discriminant validity. In the current study $\alpha = .94$ at baseline and .90 at 6-months postshelter.

The CTS-2 was scored by summing the number of types (i.e., modes) of abusive acts participants' endorsed, which is a scoring method found to provide a valid measure of severity of violence (Regan, Bartholomew, Kwong, Trinkle, & Henderson, 2006). Continuous CTS-2 scores were used to reflect abuse severity in the last month at baseline and 6-months postshelter. CTS-2 scores were examined by type, with severity of physical, psychological, abuse with injury, and sexual coercion scores being included in analyses.

Data Analysis

To measure the effectiveness of having a CPO, that is, determining whether individuals who obtained a CPO had reductions in psychological distress (i.e., CAPS, BDI) and instances of revictimization compared to those without a CPO, 10 one-way analysis of variance (ANOVA) tests were performed using gain scores. It should be noted that violations of specific provisions of the CPO (i.e., no-contact) that did not necessarily result in a new act of abuse were not measured in the current study. Gain scores were computed by calculating the difference between the pretest (baseline) and posttest (6-months postshelter) scores on dependent variables of interest for each person, and then analyzing those differences in a one-way ANOVA using group (CPO vs. No CPO) as the independent variable. Significant main effects suggest that the change from pretest to posttest is not equal for both groups, with negative gain scores indicating that the posttest score (6 months) was less than the pretest score (baseline), which demonstrates a successful group effect.

Results

Independent samples *t* tests and Fisher exact tests for significance found no differences between the two groups in regards to demographic or relevant descriptive variables (e.g., age, race/ethnicity, education, employment status, length of shelter stay, and mental health treatment).

A one-way ANOVA using gain scores to examine change from pretest (baseline) to posttest (6-months postshelter) scores was conducted comparing women with a CPO to women without a CPO. A decrease in PTSD symptoms was greater for participants in the CPO group ($M = -41.21$, $SE = 4.04$) than for those in the control group ($M = -21.48$, $SE = 3.13$), $F(1, 105) = 19.76$, $p < .001$, $\eta_p^2 = .16$. One-way ANOVAs using gain scores were also conducted on each of the four PTSD clusters, respectively. A significant effect for

hyperarousal, $F(1, 105) = 18.55, p < .001, \eta_p^2 = .15$, was found suggesting that 6 months after leaving the shelter women with a CPO reported a greater reduction in hyperarousal symptoms ($M = -13.54, SE = 1.56$) than women without a CPO ($M = -5.05, SE = 1.21$). A significant main effect was not found for effortful avoidance, or emotional numbing symptoms. Finally, although the CPO group reported greater reductions in depression ($M = -8.87, SE = 2.01$) compared to women without a CPO ($M = -5.49, SE = 1.56$), these differences did not reach statistical significance; $F(1, 105) = 1.76; p = .187$.

One-way ANOVAs using gain scores was also conducted on four measures of revictimization: physical assault, injury, psychological abuse, and sexual coercion. A significant effect for sexual reabuse, $F(1, 105) = 10.45, p = .002, \eta_p^2 = .09$, was found suggesting that 6 months after leaving the shelter women with a CPO reported a fewer instances of sexual reabuse ($M = -3.51, SE = 0.39$) than women without a CPO ($M = -1.94, SE = 0.30$). A significant main effect was not found for physical assault, injury, or psychological reabuse incidents.

Discussion

Grounded in the theoretical framework of therapeutic jurisprudence, which asserts that legal interventions in and of themselves can act as a therapeutic agent for victims of IPV (Wexler, 1995; Winick, 1997), the current study found that indeed, civil legal interventions may bring about positive therapeutic outcomes similar to traditional mental health interventions. Most notably, our results suggest that IPV victims who filed and obtained a protective order against their abuser reported significant reductions in PTSD symptomology when compared to women who did not use this legal resource. Specifically, civil legal interventions were most effective at reducing IPV victim's PTSD symptoms related to the hyperarousal cluster. It would appear that knowing that one has an order of protection against an abuser may increase a woman's sense of security, thereby diminishing her fear response. Similar to the Bennett Cattaneo and Goodman (2010) study, we also found decreases in depressive symptomology; however, these reductions failed to reach statistical significance when comparing the two groups. Finally, women who obtained a CPO in response to their abuse reported experiencing significantly fewer instances of sexual reabuse 6 months after leaving shelter.

Studying PTSD in the context of domestic violence is critically important as previous studies have found that PTSD symptoms can effect perceptions of risk for revictimization (Bennett Cattaneo, 2007), and even compromise future safety for IPV victims (Krause et al., 2006). Such research provides additional support that rates of revictimization and reductions in IPV-related PTSD symptoms are separate yet related effectiveness outcomes when evaluating the impact of a CPO. To elaborate further, Messman-Moore and Long (2003) provided a detailed critique regarding the relationship between PTSD symptom clusters and revictimization for female trauma victims. These authors assert that both reexperiencing and emotional numbing symptoms may increase a trauma victim's vulnerability to revictimization by interfering with her ability to recognize and react to dangerous situations. Of particular interest in the current study is the role of hyperarousal symptoms of PTSD. Messman-Moore and Long assert that although a moderate level of hypervigilance may

create a heightened sense of awareness in victims, “continual arousal symptoms may actually desensitize the survivor to real threat and decrease the likelihood that she will respond to perceived danger,” leading to an “inability to accurately assess risk” (p. 545).

Based on the previous research, as well the work by Messman-Moore and Long, it would be logical to conclude that the reduction of hyperarousal symptoms for IPV victims with a CPO would make them less likely to be revictimized by their abuser. This appeared to hold true for instances of sexual reabuse. Unfortunately, however, there was no difference in reabuse rates for the three other types of abuse: physical assault, psychological abuse, and abuse resulting in injury. These findings suggest that current research is still lacking, and that it may be the perception of safety, a third proposed measure of CPO effectiveness, which is also important for women who use civil legal interventions, a topic that will be further explored below.

As stated previously, the aim of justice interventions for IPV, including the implementation of protective orders, are to ensure safety and empower victims to gain some control in managing conflict. Although having a CPO in the current sample did not appear to ensure physical safety beyond sexual coercion, one can infer that this type of legal intervention was effective at providing women with at least some perceived sense of safety and control, enough that trauma-related symptomology improved. This suggests there is value for IPV victims when hyperarousal symptoms improve; however, additional interventions are needed to decrease the other PTSD clusters and the likelihood of other types of reabuse. Therefore, the question remains of what can be done by the justice system, and by mental health and legal professionals in particular, to both promote and improve legal interventions to bring in line these perceived benefits with more tangible benefits.

It would appear that one avenue towards improving the mental health of IPV victims is through the development of a coordinated service system, that incorporates at a minimum both legal and psychological assistance, with the mutually shared goal of increasing therapeutic outcomes and decreasing antitherapeutic consequences (e.g., victim blaming, helplessness) inherent in the traditionally adversarial legal process. One established way this can be accomplished is through the use of advocates (Bell & Goodman, 2001; Herman, 2003), a previously discussed protective factor for psychological and physical reabuse. Additional ways a coordinated legal and mental health service system could enhance therapeutic outcomes is by offering concurrent mental health treatment. One such intervention is Helping to Overcome PTSD through Empowerment (HOPE; Johnson, Zlotnick, & Perez, 2011), a CBT-based individual therapy protocol specifically developed for IPV, which has been shown to effectively reduce PTSD symptoms in battered women in shelters, and could readily be modified for use with women concurrently involved in the justice system. Certainly, working solely with IPV-victims is insufficient to end the cycle of abuse that occurs; however, the finding that legal interventions can improve abused women’s lives is an exciting and hopeful first step.

We acknowledge several limitations to the current study. Most substantially, using a sample of sheltered battered women, whom by default are engaging in help-seeking behaviors, may demonstrate distinctly different levels of our variables of interest, which limits the

generalizability of our results to battered women who do not seek shelter. Moreover, there is, unfortunately, no way to rule out the influence of constructs not included in the study, particularly the role of personality factors such as resilience and self-efficacy, and the quality or helpfulness of legal responses (e.g., whether an abuser who violated a CPO was arrested). We also acknowledge limitations related to not using the most recent version of the BDI (see Beck et al., 1996, for discussion). In addition, we were not able to confirm the veracity of women's self-reports regarding their CPO status, or whether women in our sample obtained the CPO of their own initiative.

Finally, there were limitations related to the small sample size and nonrandomized method design, limiting the types of analyses that are possible. Although traditionally researchers have used analysis of covariance (ANCOVA) in the analysis of pretest-posttest designs, numerous articles (see, e.g., Miller & Chapman, 2001) have outlined the inappropriateness of such analyses for nonrandomized groups. Although such articles suggest the use of gain scores as an alternative method in the measurement of change, gain scores also have important limitations. Most notably, they have been criticized "because of the (generally false) assertion that the difference between scores is much less reliable than the scores themselves" (Dimitrov & Rumrill, 2003, p. 161). Consistent with arguments asserted by Fitzmaurice, Laird, and Ware (2004) and Van Breukelen (2006), we, however, believe that gain score analysis is the most appropriate methodology given our research question: How do groups, on average, differ in gains following intervention? That being said, using a pretest-posttest analysis prevented inclusion of additional time points (i.e., 3-months postshelter) available in our longitudinal dataset, which also limits our results.

Strengths of this research, however, include its use of a longitudinal sample of battered women in shelters, and quantitative research design utilizing standardized clinical interviews and empirically supported measures. Further, previous research examining the impact of legal interventions for victims has been unable to incorporate the use of a control group (Parsons & Bergin, 2010), whereas the current study was able to compare IPV victims who engaged in legal resources to those who did not.

The current study is an important first step in providing empirical support for promoting the use of legal interventions as a means of improving psychological outcomes for victims of IPV; however, several factors still need to be addressed. For example, it may be that therapeutic benefits are less derived from actual legal outcomes (i.e., whether an abuser is sent to jail), but instead from the legal process itself, as suggested by the theory of procedural justice. When applied to situations of IPV, procedural justice theories suggest that if crime victims view legal procedures as fair, then outcomes will be viewed as just, even if the outcome is not personally favorable (Wayte, Samra, Robbennolt, Heuer, & Koch, 2002). Therefore, future research needs to investigate the quality of an IPV victim's encounters with the legal system, and in particular improving victim satisfaction with the justice response (see, e.g., Byrne, Kilpatrick, Howley, & Beatty, 1999, for a discussion of victim dissatisfaction). Similarly, however, future studies also need to examine the importance of enforcing the conditions of the CPO and associated consequences to the abuser for violations, particularly as it relates to revictimization. Finally, future research should also seek to explore the other potential mechanisms of change (e.g., the role of

personal empowerment) that could help explain why legal interventions in and of themselves improve mental health outcomes.

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