Painful bonds: Identification with the aggressor and distress among IPV survivors

Abstract

Intimate partner violence (IPV) is a global health problem that often results in a variety of mental health detriments, including trauma-related distress and depressive symptoms. According to the trauma literature, IPV victims may develop strong bonds with their perpetrators – a phenomenon known as identification with the aggressor (IWA) – in order to survive the abuse. Yet, this defensive reaction may endure after the abuse has ended, and may adversely affect victims' mental health. Nevertheless, research exploring these suppositions is lacking. Filling this void, this study investigated IWA in light of current versus past IPV as well as the relations between IWA, trauma-related distress, and depressive symptoms among a convenience sample of 297 women. Of them, 68 and 229 participants reported being subjected to IPV at present or in the past, respectively. Results indicated that whereas participants who reported current IPV had elevated trauma-related distress and depressive symptoms compared to participants who reported past IPV, no differences were found in IWA levels between the groups. Identification with the aggressor was related to trauma-related distress and depressive symptoms. Furthermore, IWA had a unique contribution in explaining trauma-related distress and depressive symptoms above and beyond background characteristics and IPV features. The findings of the current study suggest that IWA may mirror the unique relational dynamics that characterize IPV, which continue to exist even after the abuse ends, and may be implicated in IPV survivors' psychological distress.

Keywords: Intimate partner violence; domestic abuse; identification with the aggressor; posttraumatic stress disorder (PTSD); depression

Introduction

Intimate partner violence (IPV), defined as physical, verbal, psychological, or sexual abuse inflicted by a romantic partner (Saltzman, Fanslow, McMahon, & Shelley, 1999), is a global public health concern that affects millions of women worldwide. Recent estimates indicate that 30% of women worldwide have suffered from IPV during their lifetimes, with rates of 40% to 60% in some regions (Aftab & Khan, 2011; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; García-Moreno et al., 2013; Meekers, Pallin, & Hutchinson, 2013). The first Israeli national survey revealed that 32% of Israeli-Arab women and 11% of women in the overall Israeli population had a history of IPV (Eisikovits, Winstok, & Fishman, 2004). Yet large-scale crises, such as the current COVID-19 pandemic, are known to escalate IPV; as such, current rates might be even higher (Mazza et al., 2020).

The ramifications of IPV are multifaceted. These consist of detrimental physical conditions (Campbell, 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Tiwari et al., 2008) and mental health difficulties, including but not limited to trauma-related distress and depression (Campbell, 2002; Dekel, Shaked, Ben-Porat, & Itzhaky, 2019; Lahav, Siegel, & Solomon, 2018; Lahav, Renshaw, & Solomon, 2019; Taft, Watkins, Stafford, Street, & Monson, 2011). Evidence has suggested that 31% to 84% of IPV survivors meet the criteria for posttraumatic stress disorder (PTSD; M. A. Dutton, 2009; Jones, Hughes, & Unterstaller, 2001; Silva, Mcfarlane, Soeken, Parker, & Reel, 1997) and that PTSD symptoms are not limited to the time of abuse, and may continue many years after separating from the abusive partners (Woods, 2000). Survivors of IPV are also vulnerable to depression. Results of meta-analysis studies suggested that IPV was related to incident depressive symptoms (Devries et al., 2013) and that women subjected to IPV were 2-3

times more likely to suffer from major depressive disorder (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012).

Evidence, however, has indicated substantial variability in trauma-related distress and depressive symptoms among IPV survivors, and revealed several factors that may be related to increased vulnerability to these detriments. Being younger, not being in a relationship, and having a low socioeconomic status (Jones et al., 2001), as well as IPV characteristics such as more recent (Bacchus, Ranganathan, Watts, & Devries, 2018; Bonomi et al., 2006; Khadra, Wehbe, Lachance Fiola, Skaff, & Nehmé, 2015), severe, and frequent IPV (Houskamp & Foy, 1991; Jones et al., 2001), are among them.

Another area that might become substantially damaged as a result of IPV, and might intensify survivors' susceptibility to psychopathology, is the victim's relational world. The recurrent abuse inflicted by the partner, who uses coercive methods of control, may not only harm the victim's sense of self in relation to others, but may also lead to pathological attachment to the abuser (Herman, 1992). This form of relations has been referred to in the trauma literature as Stockholm syndrome (Graham, 1995; Wallace, 2007), traumatic bonding (D. G. Dutton & Painter, 1981), and *identification with the aggressor* (IWA; Frankel, 2002), which is the focus of this study.

The IWA concept, which was originally developed by Ferenczi (Ferenczi, 1932, 1933), denotes a process wherein abuse victims fuse with, take on, and introject their perpetrators' experience. Though Ferenczi focused on childhood abuse, his conceptualization may also be pertinent to IPV (Frankel, 2002). One should note, however, particularly given the substantial damage of victim-blaming (Kennedy & Prock, 2018), that the concept of IWA does not imply in any way that IPV victims bear responsibility for their abuse. Rather, IWA is viewed as a normative

human phenomenon that reflects an automatic, biologically-based defensive reaction (Cantor & Price, 2007).

Specifically, IWA is claimed to signify a broad, automatic, and dissociation-based response that promotes survival under conditions of ongoing and overwhelming attacks that individuals cannot escape, avoid, or prevent, especially when they are attached to and dependent on the perpetrator (Frankel, 2002, 2018). This reaction consists of four intertwined components: losing one's agency and replacing it with the perpetrator's; becoming hypersensitive to the perpetrator; adopting the perpetrator's experience concerning the abuse; and identifying with the perpetrator's aggression (Lahav, Talmon, & Ginzburg, 2019).

To endure the attacks, abuse victims may react with mental subordination, losing their sense of self and undergoing the replacement of their own agency with the perpetrator's (Frankel, 2002; Mucci, 2017). Not only do they thus behave in line with the perpetrator's demands, they become mentally subordinate to their perpetrators wants/needs (Amir, 2016; Coates & Moore, 1997; Gurevich, 2016). To anticipate the attacks and decrease the hazards, victims may also become hypersensitive to the perpetrator and learn "from the inside" the perpetrator's feelings/needs. Victims may mold their own experience upon the perpetrator's experience, taking on the perpetrator's perspective concerning the abuse and internalizing the perpetrator's aggression. They may therefore view themselves, others, and the abuse from the perpetrator's perspective, feel for and understand their perpetrator, deny or rationalize the abuse, and inflict aggression both inward and outward (Lahav, Allende, Talmon, Ginzburg, & Spiegel, 2020; Lahav, Talmon, & Ginzburg, 2019). In this way, IWA consists of both *concordant and complementary identification* (Frankel, 2002): Molding their experience of *themselves* upon the perpetrators' experience of *themselves*, victims view IPV from their perpetrators' perspective and adopt their

perpetrators' aggression toward others (i.e., concordant identification). Simultaneously identifying with their perpetrators' perceptions of the "*other*," victims blame themselves for the abuse (i.e., complementary identification).

Although there may be a link between IWA and remaining in abusive relationships, IW may affect victims regardless of whether they remain in the abusive relationship. In fact, according to IWA theory, IWA becomes entrenched in the victim's mentality and continues to exist even after the abuse ends. Furthermore, although IWA aims to promote survival during the abuse, it is claimed to adversely affect survivors' well-being and to increase their risk for psychopathology (Lahav, Talmon, & Ginzburg, 2019). Specifically, survivors who are characterized by strong IWA have been argued to re-live their abuse, aim aggression inward and outward, and blame themselves for the abuse (Frankel, 2002; Van der Kolk, 1989), which, in turn, could put them at risk for psychopathology.

Whereas research on IWA among childhood abuse survivors has begun to develop (Lahav et al., 2020; Lahav, Talmon, & Ginzburg, 2019; Lahav, Talmon, Ginzburg, & Spiegel, 2019), no study to date has explored IWA in light of current or past IPV. Hence, it is unclear whether individuals who are currently or were previously subjected to IPV exhibit different levels of IWA, and whether IWA contributes to elevated psychopathology in this population. Based on IWA theory, which views IWA as a defensive reaction, one could expect IWA to be more prominent under conditions of current versus past abuse, and to contribute to elevated trauma-related distress and depressive symptoms among individuals who are currently or were previously subjected to IPV.

Research in the IPV field has revealed some trends that are consistent with IWA theory. When applying betrayal trauma theory (Freyd, 1996) to IPV, findings indicated that IPV survivors

may deny or rationalize their abuse (St. Vil, Carter, & Johnson, 2021). Additionally, studies have revealed that victims' attributions for their partners' IPV perpetration are largely similar to those of the perpetrators (Neal & Edwards, 2017), that IPV history among women is linked with more accepting attitudes concerning male aggression (Witte & Kendra, 2010), and that some IPV survivors develop strong bonds with their perpetrators, which are related to elevated distress (Ahmad, Aziz, Anjum, & Mir, 2018; D. G. Dutton & Painter, 1993). Nevertheless, these studies explored factors that may reflect one IWA component only (i.e., adopting the perpetrator's experience concerning the abuse) and did not assess the IWA phenomenon as a whole.

The current study, which investigated IWA, trauma-related distress, and depressive symptoms among women who are currently or were previously subjected to IPV, fills this knowledge gap. Given the existing theory and empirical research, three hypotheses were suggested: 1) Participants who report being currently subjected to IPV will have elevated levels of IWA, trauma-related distress, and depressive symptoms compared to participants who report being previously subjected to IPV; 2) IWA will be related to trauma-related distress and depressive symptoms, and 3) IWA will have a unique contribution in explaining trauma-related distress and depressive symptoms, above and beyond background characteristics and features of IPV status.

Methods

Participants and procedure. An online survey was conducted among a convenience sample of Israeli women. Participants were recruited through a Facebook advertisement from April 1-25, 2020. Facebook users were eligible for this study if they were female, ≥18 years old and living in Israel. The Facebook advertisement consisted of a headline, main text, and link to the survey. The survey was advertised as a study exploring the implications of stressful life events among women, and was accessible through Qualtrics, a secure web-based survey data

collection system. The survey took an average of 30 minutes to complete. It was anonymous, and no data were collected that linked participants to recruitment sources. The [masked for review] institutional review board (IRB) approved all procedures and instruments. Clicking on the link to the survey guided potential respondents to a page with information about the study's purpose, nature of the questions, and a consent form (saying that the survey was voluntary, respondents could quit at any time, and responses would be anonymous). The first page also included researcher contact information as well as that of several organizations in Israel that provide IPV support/treatment. Each participant was given the opportunity to participate in a lottery that included four $60 gift vouchers. To prevent duplicative entries to the survey, a built-in option of the Qualtrics platform ('Prevent Ballot Box Stuffing') was utilized. Additionally, to identify potential fraudulent entries resulted of bots, records attached to IP addresses that were duplicated in the data were discarded from the data.

A total of 983 women answered some of the survey's questionnaires, and 700 provided data regarding the study variables. Of them, only 297 (42.4%) who reported current/previous IPV were included in this sample. All participants were Jewish, with ages ranging from 18-78 (M = 43.91, SD = 13.81). Most were secular (74.8%), had a bachelor's degree or above (60.6%), were employed (55.9%), and had average or above-average incomes (50.2%). The majority defined themselves as heterosexual (87.5%) and were not in romantic relationships (56.9%).

Participants indicated various types of violence inflicted upon them by their current or previous partners: 190 (64.0%) reported physical violence, 274 (92.3%) reported verbal violence, 237 (79.8%) reported psychological violence, and 156 (52.5%) reported sexual violence. Thus, the vast majority of the sample (n = 291, 98.0%) was classified as having undergone at least two

types of violence. The average total IPV frequency score, based on the questionnaire developed by Eisikovits et al., (2004), was 0.81 (SD = 0.60).

Of the current sample, 229 (32.7%) participants reported past IPV, and 68 (9.7%) reported current IPV. Table 1 describes the background characteristics as a function of IPV status. As can be seen in the table, significant differences were found concerning age, relationship status, income, education, economic dependence upon the abusive partner, and having/not having children. Participants who reported past IPV were younger and had lower levels of economic dependence upon the abusive partner than participants who reported current IPV. A higher proportion of below-average income, and a lower proportion of currently being in a relationship, having a bachelor's degree or above, and having children, were found among participants who reported past IPV than participants who reported current IPV.

Measures

Background characteristics. Participants completed a brief demographic questionnaire that assessed age, education, income, religiosity, sexual orientation, having/not having children, and relationship status.

IPV. Participants completed a questionnaire developed by Eisikovits et al., (2004) for use in the first Israeli national survey on domestic violence. The questionnaire includes 13 items measuring different types and frequency of violence: verbal assault (e.g., cursing, insulting); psychological or emotional abuse (e.g., threatening, stalking); and physical assault (e.g., the breaking of material items, physical violence). For the purposes of this study, four items tapping sexual violence were added (e.g., forcing intercourse, coercing sexual interaction). For each of the items, participants were asked to rank the frequency of abuse on a 5-point Likert scale ranging

from 0 (*never*) to 4 (*every day*). Type of violence inflicted by the partner was indicated by scores of 1 or above on at least one item for each violence cluster. A total score of IPV frequency was calculated by averaging all 17 items.

Additionally, participants were asked to indicate 1) whether the reported violence was inflicted by current or previous partner (0 = past IPV, 1 = current IPV); 2) economic dependence on current/previous abusive partner on a 6-point scale ranging from 1 (*not true at all*) to 6 (*very much true*); 3) duration of past/current abusive relationship; and 4) time since abuse ended (in reference to past IPV). Yet given the high rates of missing data regarding duration of abusive relationship (24%), and time since past abuse (35%), these variables were not included in the current analyses.

Trauma-related distress was measured via the PCL-5 (Weathers et al., 2013). This 20-item self-report measure asked participants to indicate the extent to which they experienced intrusion, avoidance, negative alterations in cognition and mood, and hyperarousal symptoms as a result of their past/present exposure to IPV, on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). A total score was calculated by summing all 20 items. The PCL-5 demonstrates high internal consistency and test-retest reliability (Bovin et al., 2016). In this study the internal consistency reliability was excellent ($\alpha = 0.96$).

Depressive symptoms were assessed via the depression subscale of the Brief Symptom Inventory-18 (BSI-18; Derogatis, 2001) comprising six items. Participants were asked to indicate the extent to which they had been bothered by the symptom over the last two weeks, on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The BSI-18 has been found to have adequate convergent and discriminant validity and good reliability (Derogatis, 2001). In this study the internal consistency reliability for the depression subscale was excellent ($\alpha = 0.90$).

The Identification with the Aggressor Scale (IAS; Lahav et al., 2019). Levels of IWA were assessed via the IAS, a 23-item self-report questionnaire (Lahav, Talmon, & Ginzburg, 2019). The items were presented to the respondents as reflecting "possible reactions that people may experience as a result of IPV." Participants were asked to rate on an 11-point Likert-type scale, ranging from 0% (*never*) to 100% (*all the time*), the frequency with which they experienced each manifestation of IWA in regard to their abusive present or past partner. The scale comprises four subscales: adopting the perpetrator's experience concerning the abuse (9 items; e.g., "Some people feel that the point of view of their perpetrator is the right one"); identifying with the perpetrator's aggression (5 items; e.g., "Some people feel that they behave as aggressively as their perpetrator"); replacing one's agency with that of the perpetrator (5 items; e.g., "Some people do not know what they want in in the presence of their perpetrator"); and becoming hypersensitive to the perpetrator (4 items; e.g., "Some people 'read the thoughts' of their perpetrator"). The IAS has been shown to have high construct and criterion validity, and high internal reliability (Lahav, Talmon, & Ginzburg, 2019). In this study, the internal consistency ranged from 0.85 to 0.95 for the four subscales.

Covariates. Given that not being in a relationship and being economically dependent upon current/previous abusive partner have been associated with intensified distress among IPV survivors (e.g., Jones et al., 2001) – a trend that was also found in this study, so that both were significantly correlated with trauma-related distress and depressive symptoms (p_s<.05)- these background characteristics were treated as covariates in the present analyses.

Analytic Strategy

To explore trauma-related distress, depressive symptoms, and IWA as a function of IPV status, one-way analyses of covariance (ANCOVAs) were conducted, comparing participants who

reported past IPV, and participants who reported current IPV in these outcomes, while controlling for relationship status and economic dependence upon the abusive partner. To explore the associations between IWA scores, on the one hand, and trauma-related distress and depressive symptoms, on the other, Pearson correlation analyses were conducted. Lastly, to explore the unique contribution of IWA in explaining trauma-related distress and depressive symptoms above and beyond background characteristics (relationship status and economic dependence upon the abusive partner), IPV status (past versus current IPV), and frequency of IPV, two hierarchical regressions were conducted for trauma-related distress and depressive symptoms. The analyses included three blocks: background characteristics (first block); IPV status and frequency (second block), IWA total score (third block).

RESULTS

IWA and Frequency of IPV

For the entire sample, the average frequency of IPV total score was 0.81±0.60 and ranged between 0.60 and 4.00. Frequency of IPV total score was significantly related to IWA total score ($r=.22$, $p<.001$) - the higher the frequency of IPV, the higher the IWA score. Exploring the relations between frequency of IPV and IWA, according to violence type, indicated that higher frequency of both psychological and sexual violence was related to higher IWA ($r=.22$, $p<.001$; $r=.27$, $p<.001$, respectively). Frequency of verbal violence was related to one IWA subscale - replacing one's agency with the perpetrator's – the higher the frequency of verbal violence, the higher the levels of replacing one's agency with the perpetrator's ($r=.22$, $p<.001$). Frequency of physical violence was unrelated to IWA ($r=.02$, $p=.70$).

IWA, trauma-related distress, and depressive symptoms as a function of IPV status

As can be seen in Table 2, significant differences in trauma-related distress and depressive symptoms were found between the groups. Participants who reported current IPV had elevated trauma-related distress and depressive symptoms compared to participants who reported past IPV, $F(2, 694)= 8.87$, $p < .01$; $F(2, 694)= 14.78$, $p < .001$, respectively. Yet there were non-significant differences between the groups in IWA scores, so that the groups exhibited similar levels in adopting the perpetrator's experience, identifying with the perpetrator's aggression, replacing one's agency with the perpetrator's, becoming hypersensitive to the perpetrator, and the IWA total score. Supplementary ANOVAs comparing the groups in outcomes without adjusting for covariates revealed the same trends.

Associations between IWA, trauma-related distress, and depressive symptoms

As can be seen in Table 3, IWA was significantly related to trauma-related distress and depressive symptoms. The higher the scores in adopting the perpetrator's experience, identifying with the perpetrator's aggression, replacing one's agency with the perpetrator's, becoming hypersensitive to the perpetrator, and the IWA total score, the higher the levels of trauma-related distress ($r=.35$, $p<.001$; $r=.35$, $p<.001$; $r=.40$, $p<.001$; $r=.31$, $p<.001$; $r=.42$, $p<.001$, respectively) and depressive symptoms ($r=.28$, $p<.001$; $r=.28$, $p<.001$; $r=.26$, $p<.001$; $r=.20$, $p<.001$; $r=.30$, $p<.001$, respectively).

The contribution of IWA in explaining trauma-related distress and depressive symptoms

Hierarchical regressions explained 27.4% and 17.1% of the variance of trauma-related distress and depressive symptoms, respectively, and were significant, $F(5, 291) = 22.00$, $p < .001$, $F(5, 291) = 12.01$, $p < .001$. Furthermore, as can be seen in Table 4, IWA had a unique effect in explaining trauma-related distress and depressive symptoms ($\beta = 0.34$, $p < .001$; $\beta = 0.26$, $p <$

.001, respectively). A higher IWA total score was associated with trauma-related distress and depressive symptoms above and beyond the effects of relationship status, economic dependence upon the abusive partner, IPV status, and IPV frequency.

Discussion

For individuals subjected to IPV, intimate relationships do not offer feelings of safety and security, but rather put them in a "state of captivity," wherein they are at the mercy of their abusive partners (Herman, 1992). This repeated exposure to threat and abuse may lead not only to long-lasting physical and mental detriments (Campbell, 2002), but could also modify survivors' relational world, as reflected in the formation of strong bonds with their perpetrators.

Theoreticians, clinicians, and researchers in the IPV field have long viewed victims' affiliative attachment to their perpetrators as a substantial aspect of IPV that may be implicated in the deep and enduring repercussions of this type of trauma (e.g., Dutton & Painter, 1981; Graham, 1995; Wallace, 2007). Nevertheless, to date the unique concept of IWA has been investigated only in childhood abuse survivors. This study, which explored IWA in the aftermath of IPV, thus reflects an important step in illuminating this phenomenon.

The present findings indicated that frequency of IPV, and frequency of psychological and sexual violence in particular, were related to higher IWA. These findings are aligned with the IWA theory (e.g., Frankel, 2002) which views IWA as a defensive reaction, and suggest that victims' reliance on IWA, as a way to survive IPV, may be especially prominent under conditions when the attacks inflicted by the partner are recurrent and involve psychological or sexual violence.

The current analyses revealed that participants who reported current IPV had elevated trauma-related distress and depressive symptoms, compared to participants who reported past

IPV. These findings are consistent with former findings indicating elevated PTSD and depression among women subjected to IPV (e.g., Beydoun et al., 2012; Devries et al., 2013; Jones et al., 2001; Khadra et al., 2015) and signify the negative implications of IPV for individuals' mental health. Being currently subjected to IPV exposes one to ongoing threats and injuries and may thus result in elevated psychopathology.

Surprisingly, exploring IWA as a function of IPV status revealed non-significant differences between participants who reported current versus past IPV. These findings may insinuate that although IWA reflects an involuntary response that promotes victims' survival under conditions of repeated assault inflicted by the perpetrator, it could become entrenched in victims' mentality (Lahav, Talmon, & Ginzburg, 2019) and may persist not only after the abuse ends but could also be resistant to change, at least to some degree. Yet given the cross-sectional design of this study and the lack of data regarding additional IPV features that may shape IWA, such as relationship duration, the offered explanation is speculative only, and future longitudinal research incorporating various IPV features is needed.

Although bonding with the aggressor may be essential for surviving the abuse (e.g,. Frankel, 2002), it may also have maladaptive facets, as implied by the current results. Identification with the aggressor was associated with elevated trauma-related distress and depressive symptoms, and had a unique contribution in explaining these outcomes in women who reported current/previous IPV, above and beyond background characteristics and IPV features. The current results are consistent with previous evidence indicating associations between IWA and negative outcomes among childhood abuse survivors, such as guilt, dissociation, self-injurious behavior, re-victimization, and PTSD symptoms (Lahav et al., 2020;

Lahav, Talmon, & Ginzburg, 2019; Lahav, Talmon, Ginzburg, et al., 2019), and suggest that the adverse qualities of IWA might also be applicable under conditions of past or present IPV.

Several processes entailed in the IWA phenomenon may contribute to elevated trauma-related distress and depressive symptoms among individuals subjected to current/previous IPV. Individuals characterized by strong IWA may view the violent acts inflicted by their partners from their partners' point of view, and thus may deny or minimize the abuse, or feel responsible and blameworthy for it (Frankel, 2002). They may lose contact with their own feelings/wants/needs, and become highly submissive (Frankel, 2018). Additionally, via taking on their abusive partners' aggression, they may direct aggression inward and be susceptible to self-destructive behaviors. These processes, in turn, may preclude their acknowledging the abuse or seeking help, may intensify their re-living the trauma, and may hinder their ability to reprocess the abuse. As such, these individuals may become particularly vulnerable to trauma-related distress and depressive symptoms.

Alternatively, the current findings may reflect the impact of women's distress on their IWA levels. According to this explanation, intrusive re-experiencing of the trauma, as part of trauma-related distress, and elevated self-blame, as part of both trauma-related distress and depressive symptoms (5th ed., DSM–5; American Psychiatric Association, 2013), may shape women's patterns of relating to their abusive partners, leading to an increased sense of agency loss, hypersensitivity toward their partners, identification with their partners' aggression, and adoption of their partners' view regarding the abuse. The cross-sectional design of this study does not allow for any of the alternatives to be ruled out. Furthermore, a reciprocal relation between IWA and distress might exist, so that IWA, on the one hand, and trauma-related distress

and depressive symptoms, on the other, may shape one another over time. Future longitudinal studies are needed to explore this prospect.

The current findings should be considered in view of the study's limitations. First, it was based on self-report data which may be subject to response biases (Lehrner & Allen, 2014). Despite the relatively large sample size, the possible implications of using convenience sampling should also be taken into account. Furthermore, the fact that this study was conducted among Israeli Jewish women only limits its generalizability. Lastly, the study's cross-sectional design precludes conclusions regarding the directionality of relations between the study variables as well as regarding change in IWA over time. Thus, longitudinal studies exploring the associations between IWA, trauma-related distress, and depressive symptoms among clinical samples of IPV survivors with varied cultural backgrounds are needed.

Notwithstanding these limitations, the current investigation denotes a step forward in the understanding of the complex and strong bonds often formed between IPV victims and their abusive partners. The present findings suggest that individuals who currently or previously were subjected to IPV may take on their perpetrators' perspective, identify with their perpetrators' aggression, become highly attuned to their perpetrators' experience, and undergo the replacement of their agency with that of their perpetrators. These manifestations of IWA may be particularly noticeable in IPV survivors as compared to survivors of other types of interpersonal trauma (being taken hostage by a stranger), given that the trauma of IPV occurs within a romantic and perhaps longstanding relationship with the aggressor.

Nevertheless, although IWA may help one endure repeated exposure to danger during the abuse, it may be implicated in IPV survivors' mental health detriments. Thus, appropriately applied, the present findings imply that individuals who currently or previously were subjected to

IPV might benefit from clinical interventions that aim to weaken the bonds to their violent partners. The current knowledge in this regard, however, is sparse. Specifically, although IWA has been addressed in psychoanalytic psychotherapies for abuse survivors (e.g., Frankel, 2002, 2018), their effectiveness has not been investigated. Furthermore, though there are evidence-based therapies for IPV survivors, such as cognitive processing therapy (Iverson, Resick, Suvak, Walling, & Taft, 2011), no research has evaluated their effects in altering IWA. Hence, future clinical studies investigating the effectiveness of interventions in modifying IWA are needed to promote treatment for IPV survivors who strongly identify with their perpetrators.

References

Aftab, S., & Khan, A. (2011). Women surviving under the menace of domestic violence. *Medical Channel*, *17*(2), 8–12.

Ahmad, A., Aziz, M., Anjum, G., & Mir, F. V. (2018). Intimate Partner Violence and Psychological Distress: Mediating Role of Stockholm Syndrome. *Pakistan Journal of Psychological Research*, *33*.

American Psychiatric Association, 2013. Diagnostic and Statistical Manual of Mental Health Disorders, 5th ed. (DSM-5). American Psychiatric Association, Washington, DC.

Amir, D. (2016). Hermetic narratives and false analysis: A unique variant of the mechanism of identification with the aggressor. *The Psychoanalytic Review*, *103*(4), 539–549.

Bacchus, L. J., Ranganathan, M., Watts, C., & Devries, K. (2018). Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. *BMJ Open*, *8*(7), e019995.

Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: a systematic review and meta-analysis. *Social Science & Medicine*, *75*(6), 959–975.

Bonomi, A. E., Thompson, R. S., Anderson, M., Reid, R. J., Carrell, D., Dimer, J. A., & Rivara, F. P. (2006). Intimate partner violence and women's physical, mental, and social functioning. *American Journal of Preventive Medicine*, *30*(6), 458–466.

Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2016). Psychometric properties of the PTSD checklist for diagnostic and statistical manual of mental disorders–fifth edition (PCL-5) in veterans. *Psychological Assessment*, *28*(11), 1379–1391. https://doi.org/http://dx.doi.org/10.1037/pas0000254

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331–1336.

Coates, S. W., & Moore, M. S. (1997). The complexity of early trauma: Representation and transformation. *Psychoanalytic Inquiry*, *17*(3), 286–311.

Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine*, *9*(5), 451–457.

Dekel, R., Shaked, O. Z., Ben-Porat, A., & Itzhaky, H. (2019). Posttraumatic stress disorder upon admission to shelters among female victims of domestic violence: an ecological model of trauma. *Violence and Victims*, *34*(2), 329–345.

Derogatis, L. R. (2001). *BSI 18, Brief Symptom Inventory 18: Administration, scoring and procedures manual*. NCS Pearson, Incorporated.

Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., … Watts, C. H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS Med*, *10*(5), e1001439.

Dutton, D. G., & Painter, S. (1993). Emotional attachments in abusive relationships: A test of traumatic bonding theory. *Violence and Victims*, *8*(2), 105–120.

Dutton, D. G., & Painter, S. L. (1981). Traumatic bonding: The development of emotional attachments in battered women and other relationships of intermittent abuse. *Victimology: An International Journal*, *6*(1–4), 139–155.

Dutton, M. A. (2009). Pathways linking intimate partner violence and posttraumatic disorder. *Trauma, Violence, & Abuse*, *10*(3), 211–224.

Eisikovits, Z., Winstok, Z., & Fishman, G. (2004). The first Israeli national survey on domestic violence. *Violence against Women*, *10*(7), 729–748.

Ferenczi, S. (1932). *The clinical diary of Sandor Ferenczi (J. Dupont, Ed.; M. Balint & NZ Jackson, Trans.)*. Cambridge, MA: Harvard University Press.

Ferenczi, S. (1933). Confusion of tongues between adults and the child (E. Mosbacher, Trans.). In M. Balint (Ed.), *Final contributions to the problems and methods of psycho-analysis*. London, England: Karnac Books.

Frankel, J. (2002). Exploring Ferenczi's concept of identification with the aggressor: Its role in trauma, everyday life, and the therapeutic relationship. *Psychoanalytic Dialogues*, *12*(1), 101–139.

Frankel, J. (2018). Psychological enslavement through identification with the aggressor. In A. Dimitrijevic, G. Cassullo, & J. Frankel (Eds.), *Ferenczi's influence on contemporary psychoanalytic traditions* (pp. 134–139). Routledge.

Freyd, J. J. (1996). *Betrayal Trauma: The Logic of Forgetting Childhood Abuse*. Cambridge, MA: Harvard University Press.

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*(9543), 1260–1269.

García-Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C., & Abrahams, N. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: Worth Health Organization*. Geneva, Switzerland: Worth Health Organization.

Graham, D. L. R. (1995). *Loving to survive: Sexual terror, men's violence, and women's lives* (Vol. 3). New York: New York University Press.

Gurevich, H. (2016). Orpha, orphic functions, and the orphic analyst: Winnicott's "regression to dependence" in the language of Ferenczi. *The American Journal of Psychoanalysis*, *76*(4), 322–340.

Herman, J. L. (1992). *Trauma and recovery*. New York: Harper Perennial.

Houskamp, B. M., & Foy, D. W. (1991). The assessment of posttraumatic stress disorder in battered women. *Journal of Interpersonal Violence*, *6*(3), 367–375.

Iverson, K. M., Resick, P. A., Suvak, M. K., Walling, S., & Taft, C. T. (2011). Intimate partner violence exposure predicts PTSD treatment engagement and outcome in cognitive processing therapy. *Behavior therapy*, *42*(2), 236-248. https://doi.org/10.1016/j.beth.2010.06.003

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-traumatic stress disorder (PTSD) in victims of domestic violence: A review of the research. *Trauma, Violence, & Abuse*, *2*(2),

99–119.

Kennedy, A. C., & Prock, K. A. (2018). “I still feel like I am not normal”: A review of the role of stigma and stigmatization among female survivors of child sexual abuse, sexual assault, and intimate partner violence. *Trauma, Violence, & Abuse, 19*(5), 512–527.

Khadra, C., Wehbe, N., Lachance Fiola, J., Skaff, W., & Nehmé, M. (2015). Symptoms of post-traumatic stress disorder among battered women in Lebanon: An exploratory study. *Journal of Interpersonal Violence*, *30*(2), 295–313.

Lahav, Y., Siegel, A., & Solomon, Z. (2018). Twofold trauma exposure – the dual function of attachment avoidance. *Attachment and Human Development*, *20*(5), 514–531. https://doi.org/10.1080/14616734.2018.1448998

Lahav, Yael, Allende, S., Talmon, A., Ginzburg, K., & Spiegel, D. (2020). Identification with the aggressor and inward and outward aggression in abuse survivors. *Journal of Interpersonal Violence*, 1–24. https://doi.org/10.1177/0886260520938516

Lahav, Yael, Renshaw, K. D., & Solomon, Z. (2019). Domestic Abuse and Forgiveness among Military Spouses. *Journal of Aggression, Maltreatment and Trauma*, *28*(2), 243–260. https://doi.org/10.1080/10926771.2018.1531335

Lahav, Yael, Talmon, A., & Ginzburg, K. (2019). Knowing the Abuser Inside and Out: The Development and Psychometric Evaluation of the Identification With the Aggressor Scale. *Journal of Interpersonal Violence*, 088626051987230. https://doi.org/10.1177/0886260519872306

Lahav, Yael, Talmon, A., Ginzburg, K., & Spiegel, D. (2019). Reenacting Past Abuse–Identification with the Aggressor and Sexual Revictimization. *Journal of Trauma and Dissociation*, *20*(4), 378–391. https://doi.org/10.1080/15299732.2019.1572046

Lehrner, A., & Allen, N. E. (2014). Construct validity of the Conflict Tactics Scales: A mixed-method investigation of women's intimate partner violence. *Psychology of Violence*, *4*(4), 477.

Mazza, C., Ricci, E., Biondi, S., Colasanti, M., Ferracuti, S., Napoli, C., & Roma, P. (2020). A nationwide survey of psychological distress among italian people during the COVID-19 pandemic: Immediate psychological responses and associated factors. *International Journal of Environmental Research and Public Health*, *17*(9), 3165.

Meekers, D., Pallin, S. C., & Hutchinson, P. (2013). Intimate partner violence and mental health in Bolivia. *BMC Women's Health*, *13*(1), 1–6.

Mucci, C. (2017). Ferenczi's revolutionary therapeutic approach. *The American Journal of Psychoanalysis*, *77*(3), 239–254.

Neal, A. M., & Edwards, K. M. (2017). Perpetrators' and victims' attributions for IPV: A critical review of the literature. *Trauma, Violence, & Abuse*, *18*(3), 239–267.

Saltzman, L. E., Fanslow, J. L., McMahon, P. M., & Shelley, G. A. (1999). Intimate partner violence surveillance: Uniform definitions and recommended data elements, Version 1.0. *Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.*

Silva, C., Mcfarlane, J., Soeken, K., Parker, B., & Reel, S. (1997). Symptoms of post-traumatic stress disorder in abused women in a primary care setting. *Journal of Women's Health*, *6*(5), 543–552.

St. Vil, N. M., Carter, T., & Johnson, S. (2021). Betrayal trauma and barriers to forming new intimate relationships among survivors of intimate partner violence. *Journal of Interpersonal Violence*, *36*(7–8), NP3495–NP3509.

Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., & Monson, C. M. (2011). Posttraumatic stress disorder and intimate relationship problems: a meta-analysis. *Journal of Consulting and Clinical Psychology*, *79*(1), 22–33.

Tiwari, A., Chan, K. L., Fong, D., Leung, W.-C., Brownridge, D. A., Lam, H., … Chan, A. (2008). The impact of psychological abuse by an intimate partner on the mental health of pregnant women. *BJOG: An International Journal of Obstetrics & Gynaecology*, *115*(3), 377–384.

Van der Kolk, B. A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics of North America*, *12*(2), 389–411.

Wallace, P. (2007). How can she still love him? Domestic violence and the Stockholm Syndrome. *Community Practitioner*, *80*(10), 32–35.

Weathers, F., Litz, B., Keane, T., Palmieri, T., Marx, B. P., & Schnurr, P. (2013). *The ptsd checklist for dsm-5 (pcl-5).* Scale available from the NationalCenter for PTSD at www.ptsd.va.gov.

Witte, T. H., & Kendra, R. (2010). Risk recognition and intimate partner violence. *Journal of Interpersonal Violence*, *25*(12), 2199–2216.

Woods, S. J. (2000). Prevalence and patterns of posttraumatic stress disorder in abused and postabused women. *Issues in Mental Health Nursing*, *21*(3), 309–324.

Table 1: Characteristics of the study groups (n=297)

	Past IPV (n=229)	Current IPV (n=68)	*t* or X^2
Age (M, SD)	42.97 (14.13)	47.07 (12.56)	-2.34*
Income (below-average: n,%)	125 (54.6)	23 (33.8)	9.04**
Relationship status (not in a relationship: n,%)	69 (30.8)	59 (86.8)	66.35***
Education (bachelor's degree and above: n,%)	115 (54.0)	45 (70.3)	4.85*
Religiosity (religious: n,%)	47 (20.5)	13 (19.1)	1.00
Sexual orientation (heterosexual: n,%)	200 (87.3)	60 (88.2)	1.29
Economic dependence upon the partner (M, SD)	1.52 (1.24)	2.93 (1.84)	-5.90***
Having/not having children (having children: n,%)	141 (61.6)	54 (79.4)	7.40**

Note. IPV = Intimate partner violence. M= mean, SD= standard deviation, n= number. * $p<0.05$ **$p<0.01$ ***$p<0.001$

Table 2. Means, SDs, and Univariate F Results of Trauma-related distress, depression symptoms, and IAS scores as a function of IPV status (n=297)

	Past IPV (n=229)		Current IPV (n=68)		$F(2, 694)$	η^2_p
Variable	*M*	SD	*M*	SD		
Adopting the perpetrator's experience	30.28	23.70	32.47	20.38	0.19	.00
Identifying with the perpetrator's aggression	23.90	26.99	28.06	25.07	0.74	.00
Replacing one's agency with that of the perpetrator	38.24	27.82	40.94	25.64	0.02	.00
Becoming hypersensitive to the perpetrator	35.69	27.84	40.63	25.08	0.84	.00
IWA total score	31.56	22.45	34.77	18.95	0.42	.00
Trauma-related distress	23.59	19.28	26.69	18.30	8.87**	.03
Depression	1.22	1.08	1.60	1.03	14.78***	.04

Note. IPV = Intimate partner violence; IWA = Identification with the aggressor. The analyses controlled for relationship status and economic dependence upon the abusive partner. * $p<0.05$ ** $p<0.01$ *** $p<0.001$

Table 3. Correlations between identification with the aggressor, trauma-related distress, and depression symptoms among participants who reported past/current IPV (n=297)

Note. IWA = Identification with the aggressor. *** p < .01. **** p < .001*

Measure	1	2	3	4	5	6	7
1. Adopting the perpetrator's experience	-						
2. Identifying with the perpetrator's aggression	.71***	-					
3. Replacing one's agency with that of the perpetrator	.73***	.49***	-				
4. Becoming hypersensitive to the perpetrator	.66***	.49***	.56***	-			
5. IWA total score	.95***	.80***	.83***	.78***	-		
6. Trauma-related distress	.35***	.35***	.40***	.31***	.42***	-	
7. Depression	.28***	.28***	.26***	.20***	.30***	.66***	-
***M* (*SD*)**	30.78 (22.97)	24.85 (26.77)	38.86 (27.32)	36.82 (27.27)	32.30 (21.71)	24.99 (19.20)	1.30 (1.08)

Table 4. Regression standardized coefficients for trauma-related distress and depression symptoms among participants who reported current/past IPV (n=297).

		Trauma-related distress		Depression symptoms	
		β	*R^2 Change*	*β*	*R^2 Change*
Step 1					
	Relationship status	-.14*	.03	-.18**	.04
	Economic dependence upon the partner	.16**		.14*	
Step 2					
	Relationship status	-.17**	.13	-.26***	.07
	Economic dependence upon the partner	.06		.05	
	IPV status	.20**		.26***	
	Frequency of IPV total score	.33***		.16**	
Step 3					
	Relationship status	-.15**	.11	-.24***	.06
	Economic dependence upon the partner	.02		.02	
	IPV status	.18**		.25***	
	Frequency of IPV total score	.26***		.10	
	IWA total score	.34***		.26***	

Note. IWA = Identification with the aggressor. Relationship values: 0 = not in a relationship, 1 = in a relationship. IPV status values: 0 = past IPV, 1 = current IPV. ** $p < .01$. *** $p < .001$