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Examiner 1 Overview Overall, I also suggest a more scholarly engagement with the PTSD literature. While the SASH study is still a vital resource for the epidemiology of PTSD and depression on the African continent, more current survey literature of PTSD could be cited. Can I direct the candidate to engage further with Ron Kessler's work on PTSD? I do see some references to his work but suggest engaging more with his current literature on childhood trauma and PTSD. Although data have already been published from the PhD study, I am recommending changes to be discussed to the discretion of the supervisors. I hope that these would be taken into account for the PhD thesis to cohere more substantially and be of use to future candidates who might access the thesis as a whole. Should there be further publications from the thesis, I hope that some of these comments may also assist in that endeavor. I have compiled my comments section by section:	Thank you very much for accepting to examine this work and providing helpful feedback. I have undertaken to incorporate the recommended changes and hope that this work will be useful to other scholars and PhD candidates. I appreciate the direction to other literature especially Kessler's work and will engage with it more in my post-doctoral work and future publication.	
Abstract The abstract is comprehensive and summarizes several components presented in the thesis. The abstract' sub-section background mentions that pathways from childhood trauma to mental disorders in adulthood or being a victim or a perpetrator of IPV are limited on the African continent. Might this be because the majority of studies are cross sectional and did not attempt to examine pathways as cohort studies typically would do? If yes, perhaps this could be clarified in the abstract.	I have clarified and added text to indicate that very few studies that have investigated the intersections of child abuse, mental health and violence perpetration or experience are longitudinal/ cohort studies as follows, <i>"However, pathways between childhood trauma exposures, mental ill health and men's IPV perpetration or women's IPV experiences have been little studied from population-based and even less in longitudinal studies conducted in Africa or in low and middle-income country settings"</i>	Abstract Background section Page V
In the aims and objectives sub section of the abstract, aim (d) is referred to as absence of psychopathology. Is there any particular reason why the term resilience is not used? It is used later on in the	Scholars from different fields use different measures for resilience. In this study resilience was measured as the absence of psychopathology therefore I have used the terms interchangeably. To address this	Abstract Aims and Objectives section

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abstract so it would be helpful to be consistent. I have further recommendations about the resilience component of the thesis later on and the way in which resilience has been conceptualized.	comment, I have revised text to show the link between the terms as follows, <i>“d) investigate the factors associated with resilience that was measured as absence of psychopathology among women survivors of IPV.”</i>	Page V
The methods section of the abstract has a small typo in line 5 where Study data 'was' rather than 'were' extracted. I like that confounders were sourced from the literature and mentioned very early on in the abstract.	I have revised as follows <i>“Study data were extracted and odds ratios (OR) were pooled using meta-analysis commands in STATA 15”</i> .	Abstract Methods Section Page V
There is a sentence in the results section of the abstract that I find unclear. In the second paragraph of the result, the first sentence reads 'From the secondary analysis of survey data, a higher proportion of men (62%) reported lifetime IPV perpetration compared to the reporting of IPV experiences by women (50%)'. Could this sentence be reworded slightly to reflect that both perpetration and experiences over the life time?	I have reworded text as follows, <i>“From the secondary analysis of survey data, 62% reported lifetime IPV perpetration. In contrast, 50% of women reported lifetime experience of IPV”</i> .	Abstract Results Section Page VI
I find the traumatic events to be very interesting at descriptive level. In the two paragraphs that report women and men's childhood trauma score, please try to refer to 'pathways' to PTSD and depression consistently rather than using the word path which is a bit confusing.	I have revised text as follows, <i>“Men’s childhood trauma had direct effects on perpetration of IPV and other indirect effects through pathways mediated by personal gender attitudes, other life trauma and mental ill health symptoms.”</i>	Abstract Results Section Page VII
The abstract ends mentioning social ecology. Can I suggest use of the term social capital instead?	I have revised as follows <i>“Positive social support from family and perceptions of a supportive community were shown to protect women from the potential mental ill health effects of IPV, therefore women’s resilience could be fostered through supportive responses to IPV victims at all the <u>levels of social capital</u>”</i>	Abstract Conclusion Section Page VIII
	Thanks for the feedback. I have re-written sections of the introduction for better clarity. I have elaborated that <i>“Population-based studies that are designed to focus on violence focused tend to provide higher and more accurate prevalence estimates because they often employ self-report methods</i>	Introduction 1.2Global reporting of prevalence of IPV Page 3

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	<i>and researchers are trained to sensitively deal with participants so as to enhance disclosure.”</i> I have indicated the difference of violence focused vs omnibus survey as follows, <i>“Higher prevalence of violence is reported in population-based and violence-focused surveys compared to population-based health surveys which are not violence focused, also called and omnibus surveys.</i> I have made a transition from discussing omnibus surveys and introducing the DHS surveys which are examples of national level omnibus surveys conducted in many countries as follows, <i>“Examples of omnibus health surveys are the Demographic Health Surveys (DHS) that are conducted periodically in countries. Whilst, the DHS surveys have the advantage of being large nationally representative samples, implemented by national statistical bureaus and being more acceptable as evidence to policy makers, they measure many priority health-related outcomes and the domestic violence module is not among the core modules and is administered last in the women’s questionnaires”</i> I have also revised the text to elaborate the potential for under-reporting in omnibus surveys vs violence focused surveys as follows, <i>DHS surveys because of their omnibus nature tend to report lower estimates of women’s experiences of IPV in comparison to violence focused surveys. The differences in reported estimates between omnibus and violence focused surveys also relates to researcher training that enables researchers to conduct sensitive research while minimizing participant distress or traumatization, support and debriefing given to researchers to minimize their risk to vicarious trauma associated with conducting sensitive research. These factors have been shown to enhance participant disclosures as evidenced by</i>	

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	<i>higher prevalence estimates generated from violence-focused surveys. (1, 2). Moreover, DHS surveys and other omnibus surveys, in an effort to minimize the length of questionnaires, tend to measure fewer risk factors for violence experiences or perpetration for example child abuse exposures. This limits the full consideration and study of the interplay of all necessary pertinent risk factors for violence in these surveys.</i>	
Could the finding that 40% of women in LMIC experience IPV compared to the high-income countries also be elaborated? What are the reasons for this stark difference? I feel that this statement should be elaborated as it sets the scene for the rationale for this PhD study. It is a most important rationale for the study that historically data of IPV perpetration had emerged from sub samples of men e.g. military samples.	I have elaborated that some of the reasons for varying prevalence between LMICs and HICs relate to different developmental contexts and lower positions of women. <i>“The differences in the prevalence of physical and sexual violence across countries relate to the varying extents of risk factors. For example, the higher prevalence of physical and sexual violence in LMICs relates to social norms and the lower positions occupied by women in society as determined by different development indicators including education, empowerment, wealth and gender inequality. Women in HICs and the Global North have more empowerment and access to education, financial options, information on violence and occupy better positions in society compared to women in LMICs. VAW research in HICs may avoid sectors of the population among whom the prevalence is much higher and therefore mask the true national prevalence estimates”</i>	1.2.1Global estimates of women’s experiences of IPV Page 4
Could a definition of batterer programmes be explained further? This could be helpful to a non-IPV readership.	Batterer programmes are programmes for convicted or court-referred offenders of domestic or intimate partner physical violence. The word battering is a synonym for “wife/ partner beating”. I have revised text accordingly as follows, <i>“While there is a growing body of research on men’s perpetration of IPV, the initial research began investigating court-referred male offenders who were included in programmes aimed to reduce re-offending and to protect victims, and men who were enrolled as military personnel to understand male-perpetrated IPV”</i>	1.2.2Global estimates of men’s perpetration of IPV Page 5

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Please correct the spelling of patriarchal on p 9 , paragraph 2	I have corrected the spelling. Thank you.	1.4.1.1Gender and social structure Page 10
On page 10- is the statement in the 3rd paragraph under political landscape about war related trauma referenced by the Jewkes and Miller references?	Yes. The references of Jewkes and that of Miller are of studies in post-conflict settings. Jewkes et al study was conducted in Bouganville after a decade of civil war that had a devastating effect on lives. The study was conducted at a time when some parts of the country were still fragile, and disarmament was incomplete therefore many social structures were still broken due to the war. Therefore, the study was able to explore the impact of trauma on mental health and intimate partner violence perpetration. Miller et al’s paper focuses on the relationship of war exposure and mental health that is mediated by daily stressors or stressful social and material conditions. The authors argue that in post-conflict settings there is need to consider both trauma-focused and psycho-social models in understanding the relationship between the political landscape and mental health	1.4.1.2Political landscape Page 11
On page 14, the paragraph headed childhood trauma could be a bit more robust. The statement 'the relationship between male perpetrated IPV and child abuse has been explained socialization theories...' could be expanded. I suggest the same for the sentence about intergenerational trauma. On page 16, please also define clinical and military samples clearly for the non PTSD reader.	I have expanded the text to elaborate the concept of socialization theory as follows, <i>The relationship of male perpetrated IPV and child abuse has been explained by socialization theories and also by trauma theories that posit that the mental ill health effects of victimisation may act as mediators to the relationship (92-94). According to the theories of socialization, boys and girls learn behaviors and attitudes considered appropriate for their sex by observing what adults in their society and settings do. According to the trauma theory, the mental effects of child abuse or witnessing marital violence as a child include depressive, post-traumatic stress disorder symptoms (PTSD) and alcohol problems (54).</i>	1.4.4.2Childhood trauma Page 15

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	I have rephrased and expanded the meaning of intergenerational-trauma as follows, <i>“This body of evidence shows pathways of intergenerational transmission of IPV in which men who have been abused or witnessed abuse in their childhood are more likely to perpetrate IPV in adulthood compared to men who were not abused. Similarly, women who were abused or witnessed abuse in childhood are more likely to perceive violence as normative and are more likely to be abuse partly because of their choice of partners that may have been skewed by their perceptions of the idealized male partner.”</i>	
I like that the study rationale suggests that male IPV as outcome is a neglected area of research. I think it could also be stated here that this study is in a community sample and that many studies of trauma in men are among the military. I suggest that the candidate also then cites some recent literature of PTSD in men. A number of these are in the military while others are in specific male dominated professionals e.g. rescue workers. I think that citing some of these recent studies could really enhance the rationale for this study.	In the rationale section, I have added text to show that few studies that have investigated the associations of IPV in community or general population samples in the following text: <i>Many of the studies that have found associations between PTSD symptoms and male perpetrated physical IPV are from samples of court-referred offenders, patients undergoing clinical treatment or participating in batterer programmes, and among military or veteran samples (19-24). Fewer studies have examined the relationships of mental health and violence perpetration from community and non-clinical samples of men from the general population (25).</i>	1.5Justification for the research Page 19
Could resilience be defined in the introduction?	I have included paragraphs in the literature review section that introduces the concept of resilience and protective factors. <i>“The processes by which or outcomes of individuals “positively adapting to adversity, overcoming highly stressful, life threatening or traumatic events and recovering or maintaining mental and overall health” is collectively termed “psychological resilience”</i>	2.8.1Psychological resilience and women’s experiences of IPV Page 29
Literature review I find the literature review to be slightly superficial given that it is a core component of the thesis’ integrating narrative. The literature review has some strengths including that it ends with the conceptual framework	The focus of the literature review is to introduce the different mental health outcomes as risk factors for violence, weigh in on the prevalence of mental ill health to make a case for the need for the investigation. The prevalence data whilst very descriptive is presented to argue and justify the study of the inter-relationships of mental	

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However, I suggest that a literature review at PhD level integrate less descriptive and prevalence information (which could easily be transferred to the introduction,) omit definitions of alcohol abuse (once again this could be moved to the introduction) and more studies of similar topics that point to the rationale of the study (already elaborated in the introduction.)	health and violence which are both large public health problems. The ordering of the thesis is that the introduction focuses on the may risk factors of violence. The literature review focuses on mental health risk factors which is central in this study.	
I suggest to also omit the section on social determinants of health in relation to mental disorders. Is this really relevant to the PhD's central questions? It would be manageable for the candidate to do this and to prevent overlap with the meta-analysis	I have maintained the two paragraphs to acknowledge social determinant as important risk factors for mental health. Omitting to mention contribution of social context to the prevalence of mental health would mean a non-holistic consideration of risk factors that should be accounted and adjusted for in analysis. Social determinants are also an important factor for violence experience/perpetration therefor their overlapping contribution is worth investigating.	2.10.1 Social risk factors for mental ill health in South Africa Page 32
I suggest that the core of the literature review is that of epidemiological studies of childhood trauma i.e. expand section 2.3.2 and make it central to the chapter. There is also a spelling error in the heading for this paragraph which must be changed. Why is childhood trauma now being referred to as child abuse? Rather be consistent in terminology. Also, as one of the findings of the study is around different domains of childhood trauma (e.g. emotional neglect is higher in women as per the abstract), could studies that examine these sorts of nuances be included in the literature review? Could studies on childhood trauma as exposure be cited in relation to alcohol abuse or depression or PTSD as outcome? Such studies would really frame the full PhD especially if their findings can be compared. What of studies that look specifically at pathways to PTSD or other psychopathologies? Could these be compared in the literature review?	I have expanded the section on childhood trauma and corrected the spelling. I have added text to clarify that in this study child abuse and trauma are used interchangeably. I have also referenced Norman et al's and Maniglio's review which showed that the long-term impacts of childhood trauma include mental ill health. As follows: <i>Childhood trauma which refers to a broad range of adverse experiences or abuse of a child that are emotionally painful or distressful, is an important risk factor for poor mental and physical effects. Negative childhood or adolescent outcomes of trauma and abuse include mood disorders, anxiety disorders and substance misuse hence first onset of mental disorders mostly occurs earlier in life (3-5). History of childhood trauma is a key risk factor for depressive and post-traumatic stress disorder symptoms (PTSD) in adulthood (6-10).</i> <i>Norman et al's 2012 review of 124 cohort, cross-sectional, and case-control studies searched from three showed statistically significant associations between child physical abuse, child emotional abuse or</i>	2.3.2 Childhood trauma abuse a risk factors for mental ill health Page 24-25

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	<i>child neglect and depressive disorders, drug use, alcohol abuse, suicide attempts, STIs and risky sexual behaviours (7). Gender differences in the associations of emotional neglect and mental health outcomes included that women who were neglected were more likely to be at risk of depression, suicidality, alcohol abuse (7) while men were more at risk of depression and drug use and no association was found with suicidality and alcohol abuse (7).</i> <i>In a systematic review of fourteen reviews, including more than 270,000 subjects from 587 studies, Maniglio et al 2009 found that survivors of childhood sexual abuse are significantly at risk of a wide range of psychological disorders. and concluded that child sexual abuse should be considered as a general, nonspecific risk factor for psychopathology(6). In another systematic review of reviews, Maniglio et al 2010 searched seven databases which yielded four reviews, including about 60,000 subjects from 160 studies and found that child sexual abuse is a significant risk factor for depression (10). Chen et al 2010, in a systematic review, that yielded 37 eligible studies, 17 case-control and 20 cohort, with 3,162,318 participants found statistically significant association between sexual abuse and lifetime diagnosis of depression (OR, 2.66; 95% CI, 2.14-3.30), and posttraumatic stress disorder (OR, 2.34; 95% CI, 1.59-3.43)(11). South African studies have also found child sexual abuse to be associated with increased the risk for alcohol abuse and depression among men and women (12).</i>	
I also suggest that studies of PTSD in the military are expanded and compared in the literature review. After all, these point to the rationale of the PhD thesis.	I disagree with expanding the comparison of military samples studies in this thesis because the point has already been made that whilst previous studies have focused on these, this thesis uses general population or community sample.	
I have two more concerns that could be dealt with at the stage of literature review. First as two of the publications use SEM after logistic regression, could the literature review incorporate previous	Reviewing the existing literature on previous studies was part of the objectives of the PhD and these studies are reflected in the systematic review paper, paper 2 and paper 1. In respect of this thesis, MH	

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studies of mental health as outcome. How would these point to the rationale of this PhD study? A recent PUBMED search suggests that there are recent studies employing SEM and that these examine mental disorders as outcome. I think that attention to this also gives a framework for the two publications from this thesis that use SEM.	outcomes are considered in the context of victimisation and MH is considered as risk factors in the context of perpetration. Our premise is that we did not consider perpetrating violence as a traumatic stressor similar to other scholars in the field (13-17)	
Second, do studies of resilience in relation to mental disorders not ideally use a resilience tool (e.g. Connor Davidson Resilience Scale) rather than defining resilience as merely no psychopathology? Could studies of the definition of resilience be cited at the level of literature review that examine no mental disorder as outcome be cited? The definition of resilience is not hugely problematic in the context of the study, especially as it has been raised in the discussion of the thesis which I will elaborate on in my comments on the discussion. Therefore, I will not comment on this aspect again in my comments on the results. I think that changes suggested to the literature review could still support the conceptual framework on page 30 which is very clear and useful that there are two (one for women and one for men). I think that the conclusion of the literature review would need to be modified.	There is no consensus on definition and measurement of resilience among scholars from different fields or schools of thought. Many tools are used depending on preferred definition of resilience adopted. However, there is consensus that using multiple measures or domains for resilience is better than relying on a single measure. I have added text to provide definitions and factors for resilience in the literature review section of the thesis as follows: <i>Notwithstanding violent traumatic exposures experienced in childhood or adulthood, some exposed individuals do not report mental ill health effects. This in part relates to the severity threshold of the exposures whereby less severe or less frequent exposure may be associated with the absence or lesser mental ill health effects. The absence of mental ill health effects despite higher thresholds of abuse and trauma indicates that either these individuals did not develop symptoms or that they recovered from them quicker compared to others. The term “resilience” is used by scholars to refer to how well people sustain health and psychological well-being in a challenging environment or when exposed to adversity or stressful events (221, 251). To date the body of knowledge has mainly focused on understanding resilience in childhood, disasters and in patients using multi-disciplinary lenses including but not limited to genetics, neurobiology, developmental psychology and sociology (221). The body of knowledge supports that pathways to resilience intersect with positive adaptation facilitated by the availability of social capital counteracting the potential harmful effects of experiencing abuse and trauma (180, 219-221, 224). Positive</i>	2.11 Protective factors and psychological resilience Page 33 and 34

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	<i>adaptation requires an individual's ability to harness key supportive resources and interact with family, friends, communities or service providers around them to promote mental well-being or protect themselves against the influence of adverse risk factors (221).</i> <i>Other factors that have been associated with resilience has also been associated with genetic inheritance, personality and emotional regulation, material resources, socioeconomic position, physical environment, family or community organisation or cohesion, health behaviours and health assets (221, 252). Although resilience is mostly considered at the level of the individual, it is dependent on resilience at the family, neighbourhood, community or physical environment levels (252) For example mental health of the community may be both a protective or a risk factor for individual health. There is evidence that cohesive communities tend to have high levels of social capital, trust, reciprocity, and participation and this positively impact the mental health of individuals within them (252) On the contrary environments in which majority in the community are deprived overlapping with high unemployment and crime can present as a risk factor for individual mental health. (221)</i> In the discussion chapter, I have added text to outline the limitations in the measures of resilience used in the thesis. The use of imperfect measures for resilience has to do with the secondary design of the study and I make recommendation for future studies of resilience against abused women. This is outlined in the following text: <i>There were several constraints to our definitions and measures of resilience. We used imperfect proxy measures of social support because we relied on secondary data. While scholars in different fields agree on the concept of psychological resilience constituting aspects of response or adaptation to adverse exposures, there are contesting approaches regarding measurement so that many scales have been used. Other</i>	

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	<i>scholars have measured resilience at one time point therefore approaching resilience as an “outcome” of exposures preceding the time point of measurement. Other scholars advocate that resilience is a process that is constantly changing from time to time and that may manifest differently with different adverse exposure. Such scholars argue that resilience is a dynamic construct that should be measured at several time points. The salient definitions of resilience have led to different measurement approaches and consideration for multiple domains for the construct. Resilience scales have encompassed domains that include for example hardiness, developmental strength, personal or social competence, attitudes, emotional regulation and stress coping abilities. Scholars have also considered a range of protective factors for resilience that include personal attributes, family characteristics, other support systems including peers and community and material assets. There is consensus that the use of more resilience domains or constructs in measurement yields a deeper understanding of the resilience construct (18-22).</i> <i>Scholars from psychiatry have defined resilience broadly as relative resistance to adverse experiences or competent functioning despite adversity or the avoidance of psychopathology(20). In this regard scholars have measured resilience through examining psychological outcomes and mental functioning following an adverse exposure(18, 20). The absence or avoidance of psychopathology, or low levels of symptoms are viewed as a good outcome.(20) Due to the secondary nature of the study, we were limited to studying resilience at one time point as an outcome based on psychopathology. We therefore used a deficit model for resilience and defined resilience as the absence of psychopathology despite traumatic exposures including experiencing IPV. This definition is limited because it measures resilience at a single time-point and confines resilience to be an outcome of the cumulative interaction of protective and risk factors. The chosen approach misses</i>	

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	<i>out on the dynamic changes and processes of resilience that other scholars have emphasised (19). Other scholars have also argued that the approach we used is limited because pathways to resilience may not always result in the absence of psychopathology (19, 23, 24).</i>	
Methods I found the methods section to be sufficiently detailed. Strengths include that the candidate describes her contribution to the primary study on page 36, that the PTSD and depression outcome variables are defined in line with international literature, that Cronbachs alphas are presented for each of these and that the explanatory variables are well explained and linked to the conceptual framework.	Thank you.	
I have a few suggestions for minor changes to this section: First, the diagram on page 33 is not clear. The font could be clearer It is difficult to read.	The diagram used on page 33 was imported from PowerPoint. I have increased the font and reimported to the document so that a clearer diagram is presented.	Figure 3:1 Alignment of methods to research objectives Page 38
Second, why were so few databases searched for the systematic review?	The two databases were chosen because they are very large multi-disciplinary platforms that index articles from a very wide range of journals in the fields of public health, violence, trauma and mental health. PubMed has over 30 million citations going back to 1966 (25). ScienceDirect indexes articles from more than 2,500 scholarly journals and 39,000 reference books (26).Therefore the number of articles to search and screen are very high for the two journals.	3.1.1Search strategy Page 39
Third, why did study selection for the systematic review include college students? This may not be problematic at all. I just find it a bit arbitrary and would request an explanation.	Although studies of college students may not be generalisable to the whole population, they are generalisable to the student population and young people which make up a significant proportion of the whole population. Based on this consideration, we included studies of students into the systematic review.	

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Fourth on page 37, can the acronym STATSSA be accompanied by a full name?	I have revised text as follows <i>“The study’s sampling strategy and sample size calculation was done with the help of statisticians at Statistics South Africa (STATSSA).”</i>	3.2.3Study sampling Page 42
Fifth can the descriptions of the CES-D and HTQ be accompanied by citations of studies in SA that use them suggesting validity in addition to the Cronbach's Alphas?	I have cited studies that used and validated the CESD and HTQ scales as follows: <i>“Depression was measured using 20 items of the Centre for Epidemiologic Studies Depression Scale which has been used and validated in previous South African studies (CES-D) (Cronbach’s alpha = 0.942) (27-31). PTSD symptoms were measured using 30 items of the Harvard Trauma Questionnaire (Cronbach’s alpha = 0.975) which has been used and validated in previous South African studies (28, 32, 33).”</i>	3.2.8.1 Main outcomes of interest Page 45
Sixth, can more studies to support the definition of resilience in the methods to address as my concern above. At this stage, the only reference is the candidate's own paper. For a thesis, I think that there needs to be a more scholarly approach to resilience.	I have added 2 references of other work that has defined and used resilience using proxy measures of absence of psychology as follows, <i>“We restricted the data and excluded women who did not experience IPV. Using the sub-sample of victimised women we created a resilience variable by combining the depression and PTSD variables. Consistent with other studies, resilience was defined as having less than the threshold for depressive (CESD score < 16) and PTSD symptoms (PTSD score < 2.5)” among victimised women (22, 24, 34)”</i>	3.2.8.1 Main outcomes of interest Page 45
Lastly, I am assuming that the ways that the bivariate and logistic regression phases and SEM have been described in the methods (p 43-44) refer to the study as a whole.	The data analysis text presented is a summary of how bivariate and logistic regression methods are applied in the different articles. These are presented in more details in the results chapters.	
Results I realize that the systematic review is published already. I will mention that the review has a number of strengths including a robust quality appraisal and appropriate meta analytic techniques. The review builds on previous literature by sourcing studies that use regression.		
I mentioned an earlier concern about the few databases searched and the inclusion of college student sample.	The two databases were chosen because they are very large multi-disciplinary platforms that index articles from a very wide range of journals in the fields of public health, violence, trauma and mental health. PubMed has over 30 million citations going back to 1966 (25).	3.1.1 Search strategy Page 39

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	ScienceDirect indexes articles from more than 2,500 scholarly journals and 39,000 reference books (26). Therefore the number of articles to search and screen are very high for the two journals.	
Another concern that I have is that the inclusion criteria are not entirely clear to me. Were depression PTSD and alcohol abuse treated as exposures rather and IPV perpetration treated as outcome? Was regression methods a requirement for inclusion of studies? Perhaps this could be clarified in the methods section of the study.	In the systematic review, PTSD and alcohol abuse treated as exposures rather and IPV perpetration treated as outcome. Regression methods were a requirement for inclusion of studies. This is now clarified in the text as follows: <i>“The review included studies which measured physical and or sexual acts of violence reported by a man as perpetrated against his female partner as an outcome. The range of relationships could span all intimate relationship types including dating, cohabiting or marital relationships. Studies exclusively about other forms of violence other than physical and or sexual violence were not considered.”</i> <i>“The review included studies that measured alcohol abuse, depression or PTSD symptoms as risk factors for male physical or sexual IPV perpetration. To be included studied had to have determined associations using regression methods.”</i>	4.3.3.2 Outcome definitions Page 55 4.3.3.3 Mental health risk factor definitions Page 55
With regard to the first two papers that use SEM, that form the bulk of the results, appreciated that the SEM methods are well described and that they were preceded by bivariate and multinomial regression methods. There is also a robust a prior hypothesis. The detail of the SEM method will be useful to other students. Most useful is the description of latent variables and then the description of fitting the model(s) to test the relationship between latent and observed variables.	Thank you	
One concern I have is that the methods section of the thesis describes a p value of 0.2 (p 43) but in Paper 1(p 75 of the thesis a significance ≤ 0.3 is referred to).	I have revised the p-value cut off so that level of significance is at $\leq .3$	
Discussion:	Thank you for the feedback. I have considered the proposed suggestions to strengthen the discussion chapter.	

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Like the introduction and literature review, this chapter is also integral to coherence of the thesis. I think that the chapter achieves its goals in that it reflects on the results sufficiently. I have a few concerns which if addressed could strengthen the overall coherence of the thesis and ultimately be a useful resource to PhD candidates		
On p 120, there is a discussion of women and men's reports of IPV, one of the findings of the study. The sentence that states that this is consistent with previous studies should then congruently cite a number of studies. Citing only the Jewkes et al Plos Medicine study is not sufficient to infer that this is a similar finding to previous studies. Perhaps there are others that have different findings? Such comparison the discussion is really important. I have the same suggestion for the interrogation of the women's finding on p 121 paragraph 2.	I have added text to elaborate that women's statistics relate to violent experiences and men's reports relate to violence perpetration. Jewkes et al references data from many countries or in the UN Multi-Country study that used similar measurement and analysis therefore is a justifiable comparison to the present study. <i>These findings are consistent with those of the UN Multi-country study, which uniquely measured both women's violence experiences and men's perpetration in the same countries using the WHO domestic violence questionnaires similarly used in this thesis , which compared women's and men's reports to find higher reporting of lifetime IPV perpetration by men compared to reporting of experiences by women (35)</i>	8.1 Comparison of women's and men's reports of IPV Page 127
On page 123, the discussion of childhood trauma is adequate and I am pleased to see engagement with the different domains of the CTQ. On page 137, several studies have been cited to support the finding that accumulative traumas are associated with psychopathology. Has the finding described at the bottom of page 137 of the relationship between sexual abuse and emotional neglect and IPV perpetration among men emerged in previous studies? I think if the outcome of IPV perpetration among men has not been examined before, studies of specific experiences of childhood trauma in relation to other outcomes could be cited and compared. This would really enrich this aspect of the discussion. The section of the relationship between PTSD and IPV perpetration among men (p 139) is well written and carefully considered.	The relationship of child abuse including sexual abuse and IPV perpetration has been investigated before. In the literature review section, I have referenced some studies that have research this and the text is as below: <i>“There is evidence that life stress or trauma and mental ill health symptoms may mediate the experience of childhood physical, sexual, emotional abuse, neglect or witnessing mother or female caregiver abuse with women's adult experiences of IPV and men's perpetration of IPV (36-47). This body of evidence shows pathways of IPV from one generation to the next in which men who have been abused or witnessed abuse in their childhood are more likely to perpetrate IPV in adulthood compared to men who were not abused.”</i>	1.4.4.2 Childhood trauma Page 15

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I think that the limitations section could be improved by considering the limitations of the CTQ including self- report and possibility of recall bias. This is mentioned on page 144 but as a superficial explanation. There are some citations to support recall bias in relation to reporting of childhood trauma. The CTQ also does not always capture severity of trauma but perhaps this was dealt with in this study by keeping the score continuous. This could also be mentioned as a means of dealing with limitations if relevant.	I have added text to consider limitations of the CTQ as follows: <i>“It is notable, that the study used the childhood trauma questionnaire, which is a retrospective tool administered in adulthood and renders itself inherent to participant recall bias which may have minimised the occurrence of violence. The tool also measures frequency of items and does not capture severity. The use of a continuous score for items was intended to provide a proxy for a severity based on frequency. It is therefore possible that the impact of childhood trauma on adulthood variables may in fact be greater than the findings from this study. The effect of this limitation would be to bias the association towards the null.</i>	8.11Limitations Page 152
Was there perhaps a limitation in interpreting if the life events preceded the onset of PTSD or IPV perpetration?	The limitations in the timing and occurrence of life events and mental PTSD has been included in text as follows: <i>Our analysis was based on cross-sectional data therefore we will never definitely know which came first between the life trauma events and the MH symptoms. However, in our hypothesis we assumed that life events preceded violence perpetration in line with trauma theories.</i>	8.11Limitations Page 153
Could more detail be given to the limitation around resilience presented on page 144? While I like that the candidate mentions that resiliencies contested in the literature, I am unclear what is meant by 'dynamic changes and processes' of resilience. Perhaps if several scholars are discussing this, several citations need to be mentioned. Also, please be clear on what factors were available to investigate in relation to resilience? the measure was created by the candidate, presumably there was guidance from literature as to what factors would be important? There is some literature cited in the paper on resilience. Perhaps these could be emphasized in the limitations section?	In the discussion chapter, I have added text to outline the limitations to the measures of resilience used in the thesis. The use of imperfect measures for resilience has to do with the secondary design of the study and I make recommendation for future studies of resilience against abused women. This is outlined in the following text: <i>There were several constraints to our definitions and measures of resilience. We used imperfect proxy measures of social support because we relied on secondary data. While scholars in different fields agree on the concept of psychological resilience constituting aspects of response or adaptation to adverse exposures, there are contesting approaches regarding measurement so that many scales have been used. Some scholars have measured resilience at one time point therefore approaching resilience as an “outcome” of exposures preceding the time point of measurement. Other scholars advocate that resilience is a</i>	8.11Limitations Page 153-4

Examiner comments	Candidate response/correction	Reference section and page
	<i>process that is constantly changing from time to time and that may manifest differently with different adverse exposure. Such scholar's argue that resilience is a dynamic construct that should be measured at several time points. The salient definitions of resilience have led to different measurement approaches and consideration for multiple domains for the construct. Resilience scales have encompassed domains that include for example hardiness, developmental strength, personal or social competence, attitudes, emotional regulation and stress coping abilities. Scholars have also considered a range of protective factors for resilience that include personal attributes, family characteristics, other support systems including peers and community and material assets. There is consensus that the use of more resilience domains or constructs in measurement yields a deeper understanding of the resilience construct (18-22).</i> <i>Scholars from psychiatry have defined resilience broadly as relative resistance to adverse experiences or competent functioning despite adversity or the avoidance of psychopathology(20). In this regard scholars have measured resilience through examining psychological outcomes and mental functioning following an adverse exposure(18, 20). The absence or avoidance of psychopathology, or low levels of symptoms are viewed as a good outcome.(20) Due to the secondary nature of the study, we were limited to studying resilience at one time point as an outcome based on psychopathology. We therefore used a deficit model for resilience and defined resilience as the absence of psychopathology despite traumatic exposures including experiencing IPV. This definition is limited because it measures resilience at a single time-point and confines resilience to be an outcome of the cumulative interaction of protective and risk factors. The chosen approach misses out on the dynamic changes and processes of resilience that other scholars have emphasised (19). Other scholars have also argued that</i>	

Examiner comments	Candidate response/correction	Reference section and page
	<i>the approach we used is limited because pathways to resilience may not always result in the absence of psychopathology (19, 23, 24).</i>	
Recommendations- I suggest that empirical epidemiological studies including RCT that focus on PTSD or childhood trauma are suggested for this section? What about recommending studies that measure resilience through validated tools given that the definition of resilience was raised as a limitation.	I have recommended the use of validated tools for measuring resilience in future studies. <i>The work showing resilience as a potential pathway to prevention is novel and needs to be explored further in longitudinal larger scale studies, that use more accurate clinical diagnoses of mental ill health symptoms, better measures of social support and explore several resilience domains through validated tools in addition to the lack of psychopathology.</i>	9.5Future research Page 162
Further/future papers- When examining a PhD I usually recommend possibilities for further analyses or publications given that the candidate has an excellent track record. One possibility is to look at different outcomes through a logistic regression model. For example, another hypothesis could link childhood trauma to any of the psychopathologies already examined or look at comorbid psychopathologies versus one psychopathology. There is also merit in examining cumulative traumas (e.g. childhood trauma and life events) in relation to psychopathology for another paper during the candidate's post-doctoral period.	Thank you for these helpful suggestions. I will consider them in my post-doctoral work.	
Examiner 2		
Overview: This doctoral thesis by published work examines the pathways between childhood trauma (CT), mental ill health and men's perpetration and female experiences of intimate partner violence (IPV). Rates of IPV in South Africa are high relative to many other contexts and identifying ways to reduce IPV prevalence is a critical public health and social justice imperative. While the existing literature has established relationships between CT and IPV, and between mental ill health and IPV, the inter- relationship between these three factors has not been well elaborated. By examining the mediating role of mental ill health in the relationship between CT and IPV, the thesis makes a substantial and novel contribution to the	Feedback is noted and appreciated.	

Examiner comments	Candidate response/correction	Reference section and page
literature. Not only does it yield new knowledge, but it is able to translate this into innovative recommendations for addressing both the incidence of IPV in South Africa and elsewhere, and methodological recommendations for the way in which IPV is researched. The thesis includes four journal articles, three of which have been published in international peer- reviewed journals in the health field. One article was in press at the time of thesis submission (journal unspecified). Three of the articles report on secondary data analysis from a household survey in Gauteng and one is a systematic review and meta-analysis. Overall the dissertation is of a very high quality. While the candidate did not herself develop the research design for the household survey, the dissertation demonstrates the candidate's mastery of a number of methodological and analytic competencies, including systematic review methodology, meta-analysis, and structural equation modelling. My comments on the specific chapters follow.		
Introduction and literature review These chapters would have been enhanced by the development of a clear argument for why the candidate's research is vital. Although the candidate indicates that there is "limited" research on mental ill health as a mediator of the relationship between CT and IPV in general populations in LMICs (pg. 17), this conclusion is not supported by a careful mapping of this literature. The nature and extent of this "limited" literature remains unclear. For example, the references cited on page 14 for the mediation role of mental ill health in the CT-IPV relationship do not actually examine this mediation relationship, in LMICS or anywhere else. It would have been valuable to position the doctoral study more carefully within the existing knowledge base. The candidate should clarify whether any previous research has specifically examined mental ill health as a	The limited nature of studies investigating associations mental ill health and IPV perpetration among men from the general population has been well demonstrated by the findings of the systematic review that was conducted as part of this doctoral work. In referenced studies with women samples, mediation is not well investigated because of the limited use of regression analysis without further analysis of inter-relationships of variables. This point is made in the thesis as follows: <i>“Likewise, among women, child abuse history, mental ill-health and IPV experience not only intersect but female victims of child abuse are more likely to report mental ill health and experience IPV (37, 39, 42, 44, 48-54). Mental ill health is both an established effect of child abuse and</i>	1.5 Justification for the research Page 19

Examiner comments	Candidate response/correction	Reference section and page
mediator of the association between CT and IPV perpetration or experience. If so, where has this research been conducted and what is still unknown? This will enable the candidate to make a stronger case for the novelty of her own research.	<i>IPV. Other research has shown that mental ill health is a risk factor for IPV. Therefore, women with mental ill health maybe at increased risk for repeated or on-going IPV. Nonetheless, limited research has been conducted to explore the complex pathways between child abuse, mental ill health and IPV among women from the general population in LMICs."</i>	
Towards the end of the Literature Review chapter a conceptual framework for the dissertation is presented in the form of two figures. These clearly map the relationships that will be tested in the dissertation, but they would have been enhanced by more discussion and explanation of the hypothesised relationships. There was room for more conceptual and theoretical development here, beyond just recognising that research has not yet really examined the role of mental ill health as a mediating factor, and that the relationships are likely to be "more complex" than reported in previous research. The nature of the complex direct and indirect pathways of interest should be narratively explained, rather than just presented in a figure.	I have enhanced this section by narratively explaining the hypothesised relationships as follows: <i>"Notwithstanding, social support has been identified among the protective factors may which have protective effects confer resilience, abate and protect women from the mental ill health effects of abuse and potentially reduce further victimisation. Based on these assumptions, we hypothesised that the relationships of the said variables are more complex than is oftenly described by scholars in the field. Figure 2:1 presents the conceptual framework that guided our inquiry of the inter-relationships of variables using data collected from a representative sample of women. We hypothesised that violent exposures including child abuse, intimate partner violence and other life traumatic events would increase risk for mental ill health and this in turn would increase risk for further victimisation by partners. Child abuse overlaps with family violence and would be associated with developing inequitable gender beliefs. Poor socio-economic status which overlaps with greater prevalence of family violence would also be associated with inequitable gender beliefs. Through patterns social learning, justification of the use of violence, intergenerational transmission and unaddressed mental ill health, women exposed to child abuse would be more likely to experience intimate partner violence. Informal and social support factors would be protective to mental health and would make women more resilient and less likely to experience further victimisation."</i>	2.112.12 Conceptual frameworks for the study Page 34-35

Examiner comments	Candidate response/correction	Reference section and page
	<i>"We hypothesised that men's inequitable gender beliefs would be associated with lower socio-economic status and experiences of family violence including childhood abuse. Experiences of childhood abuse, traumatic events and poor socio-economic status would increase risk for mental ill health. Mental ill health would increase men's use of violence against female partners."</i>	
Methods: The Method chapter provides a detailed description of the methodologies employed in both the systematic review/meta-analysis and the household survey. The systematic review and meta-analysis followed appropriate methodological guidelines, while the household survey employed a robust survey methodology with a large sample.		
There are a few minor comments on this chapter, which is otherwise very comprehensive: 1) For the systematic review, I would have been interested to know more about the selection of databases to search: why only these two, and why these two in particular?	The two databases were chosen because they are very large multi-disciplinary platforms that index articles from a very wide range of journals in the fields of public health, violence, trauma and mental health. PubMed has over 30 million citations going back to 1966 (25). ScienceDirect indexes articles from more than 2,500 scholarly journals and 39,000 reference books (26). Therefore the number of articles to search and screen are very high for the two journals.	3.1.1 Search strategy Page 39
2) Survey instruments are well described, but - perhaps more emphasis could have been given here to the fact that the survey instruments were not chosen to answer the specific research questions of this dissertation and were therefore not necessarily the most valid forms of assessment of the variables of interest to the candidate - a common limitation of secondary data analysis. - In particular, women's perceptions of community attitudes towards gender relations does not seem like a good proxy for perceived community support. Women may view their community to hold	Thank you for noting and raising limitations of the thesis that is associated with the use of secondary data. I have added this limitation following the description of social support measures as follows, <i>"It must be noted that the social support measures used here were limited due to the secondary nature of the study. We relied on data already collected for the primary study to develop these measures which although not the gold standard, provide good proxy measures which are helpful to gain insights and fill an important knowledge gap about support and utilisation of services by women victims of IPV."</i>	3.2.8.2.5 Social support and help-seeking Page 48

Examiner comments	Candidate response/correction	Reference section and page
attitudes supportive of IPV, while also themselves holding such views - in such cases, the community would not necessarily be perceived as unsupportive of the participant. Much depends on the alignment of participants' attitudes with the perceived attitudes of their community. As perceived community support was used as a key predictor of resilience, this measure could have been more carefully problematised.	We have highlighted that future research using better measures of social support is necessary to better understand resilience among victimised women is necessary as follows, <i>"The work showing resilience as a potential pathway to prevention is novel and needs to be explored further in longitudinal larger scale studies, that use more accurate clinical diagnoses of mental ill health symptoms, better measures of social support and explore several resilience domains in addition to the lack of psychopathology. Research studies will do well to measure and quantify the impact of protective factors including social support and pathways to resilience so that these are fostered in interventions for reducing women and girls' risk to further victimisation."</i>	9.5 Future research Page 162
3) The previously established reliability and validity of the instruments in the South African context could also have been briefly discussed, though the lack of local cut-offs is acknowledged in the discussion of study limitations later on.	I have cited studies that used and validated the CESD and HTQ scales as follows: <i>"Depression was measured using 20 items of the Centre for Epidemiologic Studies Depression Scale which has been used and validated in previous South African studies (CES-D) (Cronbach's alpha = 0.942) (27-31). PTSD symptoms were measured using 30 items of the Harvard Trauma Questionnaire (Cronbach's alpha = 0.975) which has been used and validated in previous South African studies (28, 32, 33)."</i> I have also highlighted the lack of consensus on cut off scores for scales as a limitation that warrants consideration as follows: <i>"While the mental health scales used are validated in these settings, and our tests found them highly reliable, the lack of consensus on cut off points by scholars posed a challenge. We had to rely on cut-off points used by scholars from published work and this could be problematic if there is possibility of publication bias based on reporting of the mental health scales."</i>	3.2.8.1 Main outcomes of interest Page 45 8.11 Limitations Page 153
Publications Chapter 4 presents Paper 1, a systematic review and meta-analysis of the associations between alcohol abuse, depression and PTSD	Thank you for the feedback on the systematic review and meta-analysis.	

Examiner comments	Candidate response/correction	Reference section and page
with male perpetration of IPV. As noted above, the appropriate methodologies were used and the candidate demonstrates mastery of these methods and of the reporting standards for systematic reviews and meta-analyses. The inclusion of only population level studies, and the inclusion of studies adjusting for multiple disorders, are notable strengths of this paper. The paper demonstrates the limitations of existing research and builds a strong rationale for Paper 2.		
Paper 2 examines pathways between CT, mental ill health and IPV perpetration amongst male participants in the household survey. Hypotheses are clearly stated and systematically examined using appropriate data analysis techniques. The exploration of specific common mental disorders as mediators of the CT-IPV is a strength of this paper. The finding that PTSD, but not depression or alcohol abuse, partially mediates the CT-IPV relationship is a substantial contribution to the knowledge base. It elaborates on the victim-perpetrator framework in a way that is critical for prevention and intervention planning. The exceptionally high rates of reported CT amongst men in this population-based sample is also an important contribution to the local knowledge base, which has likely under-reported this prevalence using different methodologies.	Thank you for your insights and validating this paper that focused on structural pathways to men's use of violence against intimate partners.	
Paper 3 examines the mediating role of mental ill health in the relationship between CT and women's experiences of IPV. Again, clear hypotheses are stated and systematically examined using path analysis. As with Paper 2, the examination of specific forms of mental ill health is a strength of this paper. PTSD, depression and binge drinking were all found to play a mediating role and, further, a bi-directional relationship between mental ill health and IPV experiences was established. These findings elucidate the complexity of the inter-relationships between CT, mental ill health, and IPV experiences among women. Again, the very high reported	Thank you for affirming the contribution that this paper makes to field.	

Examiner comments	Candidate response/correction	Reference section and page
prevalence of CT among women in this sample, compared with other population level studies in South Africa, demonstrates the value of the survey methodology used in this study.		
Paper 4 reports on social support factors that are associated with resilience (defined here as an absence of mental ill health) amongst women in the sample who had experienced IPV. The development of a rationale for this study was rather weaker than for the previous three papers. • Social support is already well-established as a factor associated with better mental health outcomes in trauma survivors, and more could have been done to motivate for how this study contributes novel knowledge (for example, just how limited is the literature on this topic from Africa and other LMIC settings? • What forms of social support have and have not been examined previously?). Social support was operationalized as family support, perceptions of whether community attitudes were supportive, service utilisation, ease of finding money in an emergency, alcohol consumption, and knowing someone else who has been abused. These are arguably imperfect measures of social support, constrained by the existing data set from the household survey. However, the candidate gives solid explanations for how these variables provide useful information on social support.	Thank you for your insights. The use of imperfect measures for social support in this article are limitations that are associated with the use of secondary data. The primary study did not have a focus on social support and most of the variables used in the secondary study are implied as proxies that can provide some information in a context were research on social support and resilience among women victims of abuse in LMICs is emergent. I have highlighted these limitations and considerations for future research including social support in different sections as follows, Methods: <i>“It must be noted that the social support measures used here were limited due to the secondary nature of the study. We relied on data already collected for the primary study to develop these measures which although not the gold standard, provide good proxy measures which are helpful to gain insights and fill an important knowledge gap about support and utilisation of services by women victims of IPV.”</i> Paper 4: <i>“Other social support measures could also be used in addition to longitudinal research which may be more appropriate in investigating a phenomenon such as resilience that is not static and can change in response to different life stressors over time.”</i> <i>“Further prospective research on social support and other protective factors is necessary using bigger samples and longitudinal design to inform context-specific and targeted interventions that work.”</i> Limitations: <i>“There were several constraints to our measures of social support and resilience analysis. We used imperfect proxy measures of social support because we relied on secondary data.”</i>	3.2.8.2.5 Social support and help-seeking Page 48 7.5 Discussion Page 124 9.5 Future research Page 162

Examiner comments	Candidate response/correction	Reference section and page
	<i>“Notwithstanding, our study focused on a concept that is scantily studied in our settings and laid a foundation on which future research can be designed including measurement of more risk or protective factors and consideration of different resilient domains and scales as well as longitudinal designs to increase understanding of the concept at different timepoints. Importantly our findings indicate potential for social support in conferring resilience and acting to prevent women’s further revictimisation. This warrants further study in our setting.”</i>	
Overall this was the weakest paper of the four with regard to making a novel contribution to the knowledge base, but it is nevertheless able to offer some recommendations for enhancing resilience amongst women who have experienced IPV in the South African context. In this paper it seemed that the social support variables were missing from Table 7.2, despite being referred to in the table description just above it - I was unclear on what this table was meant to summarise.	Thanks for highlighting the weakness of the paper and also the omission of an important data table. I have presented Table 7.2 in the text.	Table 7.2 Factors associated with resilience among abused women. Page 122
Discussion: Chapter 8 provides a very comprehensive and systematic discussion of the findings across the four papers, providing a clear summary and careful interpretations of all the findings, along with consideration of their relationship to previous literature. Here there is more conceptual/theoretical engagement with processes of mediation in the CT-IPV relationship. The reasons why PTSD may mediate the CT-IV perpetration relationship among men are thoroughly discussed, although the role of PTSD in mediating CT and women's experiences of violence warrants further consideration. It seems unlikely that this could entirely be accounted for by just one symptom of PTSD (emotional numbing), as suggested on pg. 137? Perhaps the need for further research to unpack this could be acknowledged here.	Thank you for the feedback. I note the suggestion to further study PTSD’s role in increasing violent experiences of women. As discussed in the thesis <i>“Pathways from mental ill health to women’s victimisation have been explained in literature and attributed to the interaction of PTSD’s emotional numbing symptoms and the affective symptoms of depression.”</i> In consideration to your suggestion, I have added to the text the need for further research on this mediating role that has been found in my research as follows, <i>“Further research may be necessary to elucidate the mediating role of the interactions of PTSD and affective symptoms in increasing women’s risk for violent experiences in our settings.”</i>	8.8.3 Mental ill health Page 145

Examiner comments	Candidate response/correction	Reference section and page
Recommendations: Later in this chapter, limitations of the study are appropriately acknowledged and discussed. The next chapter then offers recommendations for IPV prevention and intervention based on the study findings. A broad range of strategies at different levels are considered, though it would have been useful to see more focused recommendations about how PTSD, as the key mediating mental health variable in IPV perpetration and experience, can be effectively addressed. CETA offers one model, but there is a well-established broader evidence base for treating PTSD with short-term therapies	Thank you for all the feedback on the thesis. I have added a section in the recommendations chapter that focuses on treatments for PTSD as follows: <i>9.3 Treatments for PTSD and co-morbid conditions</i> <i>Consistent with extant literature, we found in this work that PTSD symptoms among men and women were associated with childhood and other life traumas and that these symptoms were co-morbid with depressive symptoms and alcohol abuse. The comorbidity of symptoms implies the need for multimodal and sequential treatments that address both PTSD and comorbid symptoms at different developmental levels i.e childhood and adulthood. Intervening with children is important because as demonstrated in this work and in literature childhood trauma contributes to later development of PTSD. There is also evidence that earlier intervention has better outcomes compared to later intervention for PTSD patients. Effective early trauma-focused interventions to reduce PTSD symptoms or enrich the therapeutic process among children include individual counselling, short-term cognitive behavioral therapy (CBT), pharmacotherapy, psychodynamic therapy, school-based treatment, child-parent psychotherapy and creative arts therapies(55). Early provision of CBTs can reduce both PTSD and associated symptoms especially depression and prevent chronic PTSD among trauma survivors. Exposure therapy, a form of CBT involves education about common reactions to trauma followed by repeated revisiting, recounting, and processing the traumatic events, has been found effective among adults whose PTSD was associated with child sexual abuse or adult sexual or physical abuse(55, 56). Re-experiencing or confronting the trauma as opposed to avoiding, affords individuals opportunity to have corrective experiences for fear structures induced on the memory through traumatic exposure which is important for recovery (56). Chronic PTSD may lead to difficulty in social functioning therefore interventions which emphasize functional</i>	9.3 Treatments for PTSD 159-161

Examiner comments	Candidate response/correction	Reference section and page
	<i>improvement including case management, psycho-social rehabilitation, couples and family therapy are more effective compared to individual psychotherapy and pharmacotherapy(55).</i> <i>Combinations of individual, group, and family psychotherapies, that have components of behavioural or cognitive-behavioural orientation, for a range of mental health and behavioural disorders have been effective in reducing mental ill health symptoms in children and adolescents (57) However different factors must be considered in decisions for combination treatments based on the desired treatment outcomes. For example psychosocial treatments are requisite if individuals have functional problems and pharmacotherapies become a priority when individuals have complex or severe comorbid-symptoms for example in the case of major depression (55, 57).</i>	
Examiner 3		
This is an excellent piece of scholarship and I congratulate the Candidate on a thorough and interesting piece of work that makes an important contribution to the field of violence against women and violence against children. As she rightly points out, and demonstrated through the systematic review and meta-analysis, there is not enough research currently that address the relationship between child abuse, trauma, mental ill health, including PTSD and alcohol bingeing and the experience or perpetration of Intimate Partner Violence. This thesis helps to fill that gap, first through the systematic review of literature and meta-analysis in Paper One, as well as through the other three papers. Papers Two and Three use Structural Equation Modelling to test hypothesized pathways between child trauma, PTSD, and either the perpetration of IPV among men, or experiencing IPV among women. Paper Two shows that there are multiple pathways by which child trauma affects the	Thank you very much for taking time to review and provide positive feedback for this work.	

Examiner comments	Candidate response/correction	Reference section and page
likelihood of perpetrating IPV, both directly, and mediated through PTSD. Paper Three shows how mental ill health is both a result of child trauma and increases the risk of experiencing IPV among women, while at the same time it is also a result of recent IPV. Both of these papers have important implications for policy and programs; in particular, by highlighting the importance of programs to reduce child abuse (for example, through parenting programs), as well as to help youth and adults to heal from traumatic childhood experiences as a strategy for IPV prevention. Paper Four explores factors that increase the psychological resilience of women who have experienced IPV. Resilience is defined in this paper as being under the cut off threshold for PTSD and depression. The paper found that having supportive family and social networks were significantly associated with resilience. This paper makes an important contribution to the field, by highlighting ways that health programs, and in particular, mental health programs can contribute to women's healing from IPV, by promoting greater access to formal services, and through activities that increase women's social support and networks. Although focusing primarily on the pathways to IPV between child trauma and mental ill health, the thesis also points out the important role played by restrictive gender attitudes in increasing the risk of IPV. The thesis is well written and well-argued, and shows an excellent grasp of relevant literature and theoretical concepts, as well as analytical skills. I believe that, through this thesis, the Candidate has made a significant contribution to knowledge in the fields of violence against women and children, and is therefore worthy of receiving the title of Doctor of Philosophy. Well done!		

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