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CHILDHOOD MALTREATMENT AND REVICTIMIZATION BY AN INTIMATE
PARTNER: THE ROLE OF AFRICULTURAL COPING FOR
AT-RISK AFRICAN AMERICAN WOMEN

by

JALIKA C. STREET

Under the Direction of Kelly M. Lewis, PhD

ABSTRACT

Intimate partner violence (IPV) is a leading cause of death and injury for women in the United States. Although African American women are one of the groups most likely to be killed by an intimate partner, there has been little research to identify factors associated with risk among this group. To address this gap in the literature, the current study investigated ecological risk factors associated with physical and psychological IPV. Next, Africultural coping was explored as a moderator hypothesized to decrease the association between childhood maltreatment (CM) one of the strongest predictors of IPV, and IPV outcomes. It was hypothesized that Africultural coping would moderate the association between the level of retrospectively reported CM and recent reports of

psychological IPV victimization, such that there would be a weaker relationship between CM and IPV for women who reported higher levels of Africultural coping. Results of multiple linear regressions indicated that higher levels of CM predicted both psychological and physical IPV, while controlling for the participants' age. Hypothesized moderators were limited in their association with IPV. Implications for research, policy, practice, and wellness promotion for African American women are discussed.

INDEX WORDS: Intimate partner violence, Childhood maltreatment, Coping, Africultural coping, African American women

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JALIKA C. STREET

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2015

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Jalika C. Street
2015

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AT-RISK AFRICAN AMERICAN WOMEN

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DEDICATION

My interest in intimate partner violence research has grown out of a combination of professional and personal experiences. As a therapist, I have gained a wealth of experience working with adults, children, and families, impacted by domestic violence and working to solve their problems in non-violent ways. These experiences have informed my research questions, which in turn have deepened my knowledge about the impact of violence on psychological health and continue to challenge me to think of new ways to disrupt and prevent the effects of violence. My family has also been significantly impacted by domestic violence. In particular, I would like to dedicate my dissertation research in loving memory of two women in my family whose lives were impacted by domestic violence: my grandmother, Ruby V. Street (1933-2014) and cousin Kyndall Danae Actkins (1986-2013) whose life was ended due to violence perpetrated by an intimate partner.

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This dissertation would not have been possible without the support of my graduate colleagues. In particular, I would like to thank the other doctoral students, past and present, of the clinical-community psychology program. A special thanks to my colleagues Karie Gaska and Bradley Goodnight for providing feedback on numerous

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1 INTRODUCTION

Intimate partner violence (IPV), physical or psychological abuse by a current or former partner, is a pervasive social problem. Estimates indicate that a third of women in the United States will experience physical IPV at least once in their lifetime (Blackman et al., 2010). IPV has been linked to numerous negative health and mental health outcomes such as injury, long-lasting trauma, and death (Garcia, Soria, & Hurwitz, 2007; Houry, Kaslow, & Thompson, 2005; Houry, Kemball, Rhodes, & Kaslow, 2006; Kaslow et al., 2002; Kaslow et al., 2000; Ramos, Carlson, & McNutt, 2004). It is estimated that one in three female homicides are committed by their intimate partner (Garcia et al., 2007).

Because IPV is such a pervasive social problem, it is important for researchers to study factors associated with risk for IPV. Researchers have found that ecological factors are essential to understanding and predicting IPV risk. In this vein, studies have identified multilayered individual, relational/familial, and sociocultural/community characteristics that interact with each other to make some women especially vulnerable to IPV. In the United States, the topography of the sociocultural environment is such that African American women are at increased risk for experiencing IPV. Illustratively, researchers have found that African American women are at especially high risk for experiencing IPV and disproportionately represent victims of homicides committed by an intimate partner (Blackman et al, 2010; Federal Bureau of Investigation, 2005). Research also indicates that ecological factors such as socioeconomic status, age, and relational/familial history (e.g. childhood maltreatment (CM); abuse or neglect as a child) are associated with increased likelihood of IPV for adult African American women. Despite the high rate and lethality of IPV for African American women, especially those who have other

ecologically-based risk factors, there has been relatively little research on factors associated with IPV among this high-risk group. Therefore, the first aim of this study was to fill this gap in the literature by exploring factors associated with high levels of IPV among at-risk African American women. These findings hold significant implications for service providers' and policy makers' ability to provide life-saving provisions for women at-risk for IPV.

While examining factors associated with IPV among women at-risk for IPV will contribute to identification and intervention efforts for these women, researchers have also increasingly recognized the value of studying factors that protect women from entering into abusive relationships and help prevent IPV from occurring before it starts (Foa, Cascardi, Zoellner, & Feeny, 2000). Forged within the unique social ecology in which African American women are positioned, Africultural coping is a group of strategies most used by African Americans to cope with stressful situations (Utsey, Bolden, Lanier, and Williams, 2007). More specifically, there is evidence that African American women use spirituality, collective coping, and cognitive/emotional debriefing to weather daily challenges. Despite the likelihood that these coping strategies are important sources of strength in dealing with stressors such as CM and IPV, Africultural coping has been absent from previous explorations of IPV outcomes for African American women. Therefore, another goal of the current study was to explore whether these coping strategies were associated with reduced levels of IPV for at-risk African American women. This study holds implications for prevention and service provisions by identifying strategies used by women to cope with and exhibit resilient outcomes despite experiences of violence.

1.1 Background

1.1.1 Intimate Partner Violence Defined

Intimate partner violence (IPV) can be defined as physical or psychological abuse in the form of threat or harm caused by a current or former partner or spouse (Saltzman, Fanslow, McMahon, & Shelley 2002). It is used as an umbrella term to describe several different forms of violence or abuse perpetrated by an intimate partner. More specifically, *physical IPV* is, “the intentional use of physical force with the potential for causing death, disability, injury, or harm” (e.g. grabbing, choking, hitting) in the context of an intimate relationship (Saltzman et al., 2002). *Psychological IPV*, also referred to as emotional abuse, is a form of IPV consisting of “trauma to the victim caused by acts, threats of acts, or coercive tactics” (Saltzman et al., 2002). Over the years, researchers have defined IPV more or less broadly. For example, definitions of IPV sometimes have further differentiated sexual violence and stalking as forms of IPV (Saltzman et al. 2002). However, because there is considerable overlap between different forms of IPV, with sexual violence perpetrated by an intimate partner and stalking rarely occurring in the absence of the more widely occurring physical and psychological IPV (Blackman et al, 2010), physical and psychological IPV were the focus of the current study. Further, the definitions of psychological and physical IPV utilized in the current study were developed and adopted by the U.S. Centers for Disease Control and Prevention, based on the collaboration of prominent researchers in the field (Saltzman et al., 2002, 1999).

Within research on IPV, both victims/survivors and perpetrators have been studied. Although violence is often perpetrated by both parties during a conflict, causing overlap between these categories, victims/survivors of IPV are studied less often (Foa et al., 2000; Kuijpers, van der Knaap, & Lodewijks, 2011; Kuijpers, Knaap, & Winkel,

2012). Research is lacking on IPV victimization and is relatively “new,” given that IPV in general has only been identified as an area of study since the 1970’s, and is “controversial” due to the perception that studying those who have experienced IPV is victim blaming, implying that those who experience IPV are responsible for the abuse (Foa et al. 2000). Although sensitivity to the safety concerns and implications of studying survivors of IPV is warranted, researchers have identified IPV victimization as a viable and understudied avenue for continued research and intervention (Foa et al. 2000; Kuijpers, 2011). Further, studying survivors of IPV and developing interventions for this group may be especially important given that this group seeks services related to the consequence of IPV at a high rate (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). Therefore, the present study focused primarily on people who are victims/survivors of IPV.

1.1.2 Prevalence of IPV

With increasing recognition of IPV as a global problem, scientists have sought to understand the scope of the problem. Epidemiological research has revealed that IPV is a pervasive social problem that affects men and women around the world, and in the United States. For instance, interviews of 24,097 women in countries around the world found that lifetime prevalence rates of IPV varied from 15% to 71% of respondents (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). According to recent national epidemiological data gathered in the United States, 35.6% of women and 28.5% of men reported rape, physical violence, and/or stalking by an intimate partner in their lifetime (Blackman et al., 2010). It is estimated that more than 10 million Americans experience IPV annually (Kessler, Molnar, Feurer, & Appelbaum, 2001). While there has been some

variation in the literature regarding rates of IPV victimization based on gender, women have consistently been found to be at highest risk for physical harm (i.e. injury, death) caused by IPV (Archer, 2000, 2004; Tjaden & Thoennes, 1998; Tjaden & Thoennes, 2000). IPV victimization rates vary not only by nationality and gender, but also by race/ethnicity. For instance, a national epidemiological study found that 41% of African American (non-Hispanic) women reported physical IPV in their lifetime as compared to rates attained for Hispanic and European American women (35% and 32% respectively) (Blackman et al., 2010). Taken together, these statistics consistently provide evidence that IPV is a pervasive problem impacting the lives of over a third of women in the United States, with considerable variation in rates based on contextual factors.

1.1.3 Health Consequences of IPV

IPV has numerous health and mental health consequences including injury, long-lasting trauma, and death. For instance, 5 million women in the United States seek medical treatment for IPV related injuries every year (National Center for Injury Prevention and Control, 2003) Further, IPV is associated with a number of other physical problems for women such as gastrointestinal disorders, sexually transmitted diseases, and gynecological/pregnancy complications (Blackman et al., 2010; Campbell, 2002) Additionally, women who have experienced IPV report significant mental health problems. Women who have experienced IPV are more likely to report depression and attempt suicide than women who do not report a history of IPV (Ramos, Carlson, & McNutt, 2004; Houry, Kemball, Rhodes, & Kaslow, 2006; Eby, 2004). Survivors of IPV also report higher rates of anxiety and post-traumatic stress disorder (PTSD), feelings of hopelessness and helplessness, dissociation, cognitive distortions, substance abuse, and

disrupted relationships with family and friends compared to women who have not experienced IPV (Houry, Kaslow, & Thompson, 2005; Houry, Kembell, Rhodes, & Kaslow, 2006; Kaslow et al., 2002; Kaslow et al., 2000). Even more alarmingly, estimates indicate that over one third of homicides of women are committed by an intimate partner (Garcia et al., 2007). Femicide, the homicide of women, is the seventh leading cause of premature death among women (Blackman et al., 2010; Campbell et al., 2003). It was estimated that over \$8.3 billion dollars was spent in a single year in healthcare costs associated with IPV in the US (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). In sum, IPV is a leading cause of injury and death for women and has been linked to numerous negative health outcomes.

1.2 Factors Associated with IPV for African American Women

Because IPV is such a pervasive and life-threatening social problem, investigators across a range of disciplines have sought to identify factors associated with IPV risk. As evidenced by the extreme variation in IPV prevalence based on nationality, ecological factors significantly contribute to IPV outcomes. These findings are consistent with ecological theory or “nested ecological” theory first applied to IPV research by Dutton in 1988. Ecology theory indicates that no single factor in isolation predicts or explains IPV (Dutton, 1988,1996; Bell & Naugle, 2008; Little & Kaufman Kantor, 2002). Instead, the richest and most accurate understanding of IPV can be developed by studying IPV within the context in which it occurs (Dutton, 1988; Bell & Naugle, 2008). These factors fall across what ecological theory describes as individual, relational/familial, and sociocultural/community realms of influence, or dynamic and interacting micro-, meso-, exo-, and macro systems within which all humans are embedded. Ecological theory has

now been internationally used by researchers to study factors associated with IPV (Garcia-Moreno et al., 2006). Although risk factors associated with IPV do not *cause* someone to experience abuse, several variables have been found to correlate with an increased likelihood of experiences of IPV. For example, variables are that primarily measured at an individual-level and have been linked to IPV outcomes include socioeconomic status (SES), employment status, drug/alcohol use, traditional sex-role ideology, anger/hostility, depression, and life-stress (Stith, Smith, Penn, Ward, & Tritt, 2004). Relational/familial variables such as number of children in the home, cohabitation with an intimate partner, history of violence in past relationships, and “victim’s” use of violence towards the perpetrator have also been explored. Finally, sociocultural variables such as national and historical context, inequality such as racism, access to employment, and the response of the judicial system have also been cited as contributing to IPV (Stith, et al., 2004; Bent-Goodley et al., 2010; West, 2004).

While research on ecological predictors of IPV in the United State at large have begun to shed light on this phenomena, African American women continue to be at increased risk of death and injury due to IPV (Kessler et al., 2001; Blackman et al., 2010). For instance, although African American women account for 8% of the United States population, they account for 22% of all intimate partner homicide cases and 29% of all female victims of intimate partner homicide (Federal Bureau of Investigation, 2005). In order to better understand this disparity in outcomes for African American women, more research on within-group, ecological factors, that contribute to increased IPV risk for this group is needed (Bent-Goodley et al., 2010; Bent-Goodley, 2001; West, 2004). To address this gap in the literature, the current study examined ecological factors

associated with IPV within a population that has been chronically understudied and is at-risk for negative health consequences associated with IPV, in order to facilitate a greater understanding of these women's experiences of IPV and IPV risk. Attention was given to ecological variables that researchers have identified as understudied and potentially contributing to within-group differences in IPV outcomes among African American women.

Towards this goal, a handful of scholars who have studied IPV within the African American community have called for the need to study within-group risk and protective factors associated with IPV outcomes (Bent-Goodley, 2001, Bent-Goodley et al., 2010). Specifically, in a recent review of the literature on African American women and IPV, Goodley et al., (2010) identified a dearth of information on how historical context of slavery and oppression, life experiences, and relational/familial factors such as cohabitation, parenthood, and employment impact IPV. Therefore, this paper will first summarize the extant research on within-group variables that have been linked to IPV risk and further explore several others that warrant additional study. Then, because research on protective factors is even more lacking within this high-risk population, protective factors that support coping for this group will be discussed.

1.2.1 Individual factors and IPV risk

1.2.1.1 Socioeconomic status (SES) and IPV risk. SES is an aspect of a person's social ecology, most commonly measured at an individual level, which is crucial in understanding IPV outcomes. Although women from all socioeconomic strata experience IPV, low socioeconomic status has been commonly linked to IPV victimization (Bybee & Sullivan, 2005; Bent-Goodley et al., 2010). For example, women have been found to be at increased risk of experiencing IPV when they have limited financial resources or are

unemployed (Bybee & Sullivan, 2002; Mitchell et al., 2006; Kessler et al., 2001). Similarly, IPV has been strongly linked to housing instability. For instance, Pavao, Alvarez, Baumrind, Induni, and Kimerling, (2007) found that women who reported IPV in the last year had almost four times the odds of reporting housing instability as compared to those who did not report IPV. SES and IPV risk also continue to be linked when measured at different levels of a person's ecology (i.e. individual, relational/familial, and sociocultural/community). For example, in addition to an individual's SES predicting IPV, family income (e.g. Kessler et al., 2001; Cunradi, Caetano, Clark, & Schafer, 2000) and neighborhood poverty also have been found to significantly predict IPV. Moreover, the association between neighborhood SES and IPV has been found for African American couples to an extent greater than for other racial groups (Cunradi et al., 2000).

Low SES may both predict and maintain IPV. This is likely due to the fact that women experiencing IPV have a harder time maintaining employment than those not experiencing violence as evidenced by a longitudinal study that tracked low income women and found that those who reported IPV also had a diminished ability to maintain work (Browne, Salomon, & Bassuk, 1999). SES is not only a key ecological factor to consider in understanding women who experience IPV but it significantly impacts the way in which they cope with IPV (Goodman, Smyth, Borges, & Singer, 2009). Not surprisingly, experiencing IPV and having a low SES has been associated with poor outcomes. For instance, Carlson, McNutt, Choi, & Rose, (2002) found that experiencing economic hardship was the strongest predictor of symptoms of depression and anxiety for women with a history of IPV. In sum, researchers have found that SES is relevant to an

ecologically understanding of IPV risk with low SES being associated with higher IPV risk. As a result, it is especially pertinent to better understand what factors are associated higher levels of IPV within samples of women who identify as low income and African American to further hone-in on previously neglected risk and protective factors for IPV within this group.

1.2.1.2 Age and IPV risk. Age is another individual-level factor that may be associated with IPV outcomes for African American women. This is based on research that has found that femicide is the leading cause of premature death among African American women between the ages of 15 and 45 years (Campbell et al., 2003). Nearly half, (47%), of female survivors of IPV across racial groups report that they first experienced violence by an intimate partner between the ages of 18 to 24 years (Blackman et al., 2010). Twenty-two percent report first experiencing some form of IPV even younger, between the ages of 11 and 17 years (Blackman et al., 2010). Young adults have been found to be at higher risk for IPV as compared to people in middle adulthood. For example, Kwong et al. (2003) found that younger age was significantly associated with high levels of reported violence. Similarly, Daigneault, Hébert, and McDuff, (2009) found that younger age was a predictor of IPV for both men and women in a large, Canadian sample. This also has been found in samples of low-income, African American women. For example, Stevens et al. (2013) included age as a covariate in their model, which examined the IPV risk and found that age negatively correlated with experiences of IPV. Advanced age may again create a vulnerability to IPV and other forms of elder abuse (Turner, Spangler, & Brandl, 2010). While emerging adulthood and advanced age do not inherently make relationships more violent, access to power and resources likely

contribute to differential IPV outcomes. Based on this evidence, age appears to be a key covariate to consider when examining IPV outcomes, with younger adults being at the greatest risk.

1.2.1.3 Relational/familial factors and IPV risk: Parenthood and cohabitation.

Some researchers have cited relational/familial factors as key to capturing a full picture of IPV for African American women. Factors such as whether a woman and her partner cohabitate and/or have children have been inconsistently found to be associated with IPV (Bent-Goodley, 2001). For example, women have been found to be at increased risk of experiencing IPV when they have children with their abuser or are otherwise dependent on the abuser (Bybee & Sullivan, 2002; Mitchell et al., 2006). Based on this evidence, these factors warrant further exploration as covariates that may potentially help identify women who may be at greatest risk for IPV.

1.2.1.4 Childhood maltreatment (CM): A leading relational/familial risk factor for IPV. Early experiences of violence and neglect, or CM, is a leading relational/familial variable associated with IPV in adulthood. That is, people who survive CM; emotional, physical, or sexual abuse; or physical or emotional neglect (Bernstein et al., 2003) prior to age 18, are at higher risk to be assaulted as adults, a phenomena that has been called revictimization (Mears, 2003; Kuijpers, Van der Knaap, & Lodewijks, 2011; Desai, Arias, Thompson, & Basile, 2002). Numerous research studies have reported a link between maltreatment in childhood and more prevalent and severe levels of IPV in adulthood (Blackman et al, 2010; Stevens et al., 2013; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). In fact, CM has been found to be one of the most consistent and robust risk factors associated with experiences of IPV in adulthood (Arias,

2004; Little & Kaufman Kantor, 2002; Stith et al., 2000; Swartout, Cook, & White, 2012). For example, a meta analysis of 36 studies found that experiencing CM in childhood was significantly related to adult IPV victimization, more so than other risk factors commonly associated with IPV such as witnessing interparental violence (violence between parents) in childhood (Stith et al., 2000).

The relationship between CM and IPV has been upheld when CM has been measured either as a unitary construct (i.e. maltreatment) or as a multidimensional construct comprised of discrete forms of childhood abuse and neglect. For a discussion of the correlations between childhood physical abuse and IPV see: Swartout, Cook, and White, 2012; Tusher and Cook, 2010, childhood sexual abuse and IPV see: Tusher and Cook, 2010; Messman-Moore and Long, 2000; Swartout et al., 2012; Wind and Silvern; 1992; Daigneault et al, 2009, and childhood neglect and IPV see: Arias, 2004; Dube, Anda, Felitti, Edwards, and Williamson, 2002; Fang and Corso, 2007; Little and Kaufman Kantor, 2002. However, because different dimensions of CM frequently co-occur (Kwong et al., 2003), and it is often difficult to parse-out the unique contribution of a single form of maltreatment on the CM-IPV relationship, this paper explores CM as a unitary construct. In sum, it has been well-established that CM is a crucial interpersonal risk factor to consider in understanding IPV risk.

In summary, research has found that women, and in particular African American women, who have limited financial resources, are emerging adults, and have previously experienced CM are at increased risk for IPV. Inequalities in access to resources based on race, gender, age, and SES likely explain why African American women are disproportionately affected by IPV (Hampton, Oliver, & Magarian, 2003; West, 2004).

While these trends have been found in the literature, many African American women who meet these criteria do not enter into violent relationships in adulthood. Some researchers have attributed this to protective factors and coping. As discussed next, this is an even lesser studied, yet growing area of IPV research, central to a contextual understanding of IPV risk and resilience for African American women.

1.2.2 Protective factors: Moderating the relationship between childhood maltreatment and IPV for African American women

Researchers have begun to also explore variables that foster positive outcomes and reduce or prevent IPV victimization across racial groups. Protective factors, such as coping, have been described by researchers as a potentially powerful avenue that warrants greater examination as it relates to promoting wellness and preventing IPV (Foa et al., 2000). Variables that are protective are often synonymous with risk factors, but on the opposite end of the continuum. As Rudkin (2003) put it, “in most cases, protective factors and risk factors are two sides to the same coin” (p. 324). For example, access to tangible, interpersonal, legal, and institutional resources has been identified as protective psychological and environmental factors associated with lower levels of IPV (Foa et al., 2000). Protective factors have also been found to moderate IPV related outcomes. For example, Carlson et al. (2002) examined whether protective factors disrupted the relationship between lifetime abuse (CM and IPV) and lead to reduced symptoms of anxiety and depression. They found that hypothesized protective factors (employment, low economic hardship, self-esteem, health, and social support) moderated the relationship between lifetime abuse and anxiety/depression, indicating that these may help facilitate coping with IPV. Similarly, Perez, Johnson, and Wright, (2012) found that

a sense of empowerment attenuated (moderated) the relationship between IPV and PTSD symptoms. Thus, a handful of studies have begun to identify factors that moderate the relationship between CM, IPV, and IPV related outcomes. These factors include tangible, interpersonal, and institutional resources as well as factors generally associated with resilience such as health, optimism, flexibility, and self-esteem (Foa et al, 2000).

1.2.2.1 Coping and IPV risk reduction. Coping is “behavior that protects people from being psychologically harmed by problematic social experience” (Lazarus & Folkman, 1984; Pearlin & Schooler, 1978, p. 2). Therefore, by definition, coping is theorized to serve a protective role against stressful experiences. Coping has previously been found to moderate outcomes associated with IPV. For example, Lilly & Graham-Bermann (2010) found that emotion-focused coping moderated the relationship between IPV and PTSD. Gillum, et al., (2006) found that religious coping increased psychological well-being and decreased depression for women who experienced IPV. Although there is initial evidence that coping is a factor that is theoretically essential to understanding responses to violence, and may impact IPV outcomes, this area of research continues to be in its infancy.

1.2.2.2 Africultural coping. Just as behaviors that put people at risk for IPV, coping also takes place within a dynamic context. That is, the ways in which people cope with stress are based on their experiences and are shaped within individual, relational/familial, and sociocultural/community spheres of influence. Indeed, researchers have found that African Americans rely on unique cultural strengths and coping strategies to overcome risk and adversity which has been forged within a distinctive cultural and historical context (Utsey, Adams, & Bolden, 2000; Kuo, 2011). In contrast with deficit-

based and Eurocentric models that have historically been applied to African Americans, researchers such as Utsey et al (2000) have advocated for an Africultural approach to understanding coping used by African Americans. Also referred to as an African-centered or Afrocentric approach, an Africultural understanding of coping and health encourages practitioners to and scholars alike to recognize both historical-contextual experiences of oppression as well as resilience for people of the African diaspora (Bent-Goodley, 2005). It draws upon the “best of Africa - to develop social work approaches and patterns which support the philosophical, cultural, and historical heritage of African people throughout the world” (Graham, 1999 in Bent-Goodley, 2005). In particular, core principles such as fundamental goodness, self-knowledge, communalism, interconnectedness, spirituality, self-reliance, language and oral tradition, and thought and practice have been identified as central to an Africultural coping and resilience. The evidence for specific aspects of Africultural coping, namely spirituality, collective coping, and cognitive/emotional debriefing, which are central within scholarship on African American psychology and are predicted to be associated with resilience, will be discussed next.

1.2.2.3 Spirituality: An Africultural coping strategy. Spirituality has been described as an orienting concept and fundamental to the lives of people from the African diaspora (Belgrave & Allsion, 2006; Jones, 2004). Research has consistently demonstrated that spirituality is a strong mechanism of coping for African American women facing oppression based on the intersection of race, gender and class (Neighbors, Jackson, Bowman, & Gurin, 1983; Mattis, 2001, McAdoo, 1995; Smith, 1981). Spirituality was identified as one dimension of Africultural coping based on qualitative

and quantitative interviews regarding the ways African Americans cope (Utsey et al., 2000). Further, spirituality has been found to be an important coping mechanism for survivors of IPV (Gillum, Sullivan, & Bybee, 2006; Watlington & Murphy, 2006) and for African American survivors of IPV in particular (El-Khoury et al., 2004; Meadows, Kaslow, Thompson, & Jurkovic, 2005). For instance, El-Khoury et al. (2004) found that African American women who have experienced IPV were especially likely to use prayer as a mechanism to cope with IPV. These studies suggest that spiritually-based coping is a culturally-based factor that is likely to have an impact on the mental health outcomes of African American women who have experienced IPV. However, empirical research exploring whether spiritual well-being functions as a moderator for outcomes abused African American women is limited and thus warrants further research.

1.2.2.4 Collective coping: An Africultural coping strategy. Collectivism and connectedness to others have also been identified as dimensions central to the vitality of African Americans (Belgrave & Allsion, 2006; Jones, 2004). Collective coping has been established as an important part of the African-centered worldview (Belgrave & Allsion, 2006). For example, collective coping was identified as a primary coping strategy for African Americans based on qualitative and quantitative interviews regarding coping within this group (Utsey et al., 2000). Because collective coping captures how African Americans uniquely seek and use social support as a coping mechanism, it may be more culturally relevant construct to this group. This is supported by a study by Utsey and colleagues, (2007) that found that collective coping was a predictor of positive health outcomes more so than traditional measures of coping and social support.

Collective coping shares some common features with social support, a construct which has been established as a frequently cited moderator in the relationship between CM and IPV (e.g. Bybee & Sullivan, 2005; Carlson et al., 2002; Tremblay, Hébert, & Piché, 1999). Although collective coping is a construct similar to social support (Utsey et al., 2000), in the fact that it reflects the ways in which interpersonal relationships serve as a source of support, these constructs can be differentiated in several ways. For instance, collective coping emphasizes the ways that identification as a group member (i.e. as an African American) provides a sense of belonging to a community that functions as a protective factor. Collective coping is unlike social support, because social support is more likely to encompass a person's belief that he or she can be helped by the material or emotional support of a specific, indefinable person or group. Further, this form of coping was identified as the result of qualitative and quantitative research conducted exclusively with people who identified as African American. Therefore, it is possible that collective coping may serve as a protective factor for African Americans and moderate the relationship between in CM and IPV to an extent greater than social support. Despite the theoretical importance of collective coping, it has yet to be included in models of IPV resilience. Therefore, the current study aims to bridge this gap in the literature by examining collective coping as a source of resilience for African Americans who have experienced violence. In addition to spirituality and the support of others serving as vital buffers to stressors, certain cognitive/emotional processes may also help African Americans cope, as described next.

1.2.2.5 Cognitive/emotional debriefing: An Africultural coping strategy. In the wake of CM, survivors are tasked with meaning-making and emotionally processing what

has happened. The understanding they come to likely impacts their ability to cope. In keeping with the ecological theory, individuals are embedded within a sociocultural environment that shapes all aspects of their experience, including the way they cognitively process stressful experiences. As the result of a series of qualitative and quantitative studies with African American participants, Utsey and coworkers (2000) termed cognitive/emotional debriefing as a prominent coping strategy frequently utilized by African Americans that was not being captured by other conceptualizations of coping. Cognitive/emotional debriefing is “a cognitive/emotional regulation response to adversity,” where an “individual evaluates (cognitive) the level of risk and adversity in an effort to regulate emotional response to the situation.” (Utsey, Bolden, Lanier, and Williams, 2007, pg. 78). Utsey’s conceptualization was unique in that it was derived from within-group research aimed at understanding health promotion for African Americans. Further, this conceptualization focuses on specific orienting responses as helpful coping strategies for African Americans, beyond the either problem-focused or emotion-focused strategies previously explored in primarily Caucasian samples (Utsey et al., 2000). It was found to predict resilient outcomes for African American in high-risk urban environments above and beyond traditional measures of coping (Utsey et al., 2007).

Although the Africultural cognitive/emotional debriefing strategies are in some ways distinctive, they also share considerable overlap with previously validated and widely used coping frameworks (i.e. problem-focused/emotion focused coping) by Folkman and Lazarus (1988) that have previously been found to serve as a protective factor for survivors of IPV. For example, researchers have previously found that emotion-

focused coping functions as a moderator, decreasing the relationship between IPV and negative mental health outcomes such as PTSD (Lilly & Graham-Bermann, 2010).

Therefore, it was hypothesized that cognitive/emotional debriefing would serve as a protective factor and be even more culturally-valid in research with African American populations.

1.3 Justification for the Current Study

1.3.1 Study Aims

IPV is a pervasive social problem and a leading cause of death and injury for women. Nearly a third of women in the United States are affected by IPV in their lifetime. However, IPV victimization is understudied (Kuijpers, 2011) and research is needed to help illuminate why some African American women are especially vulnerable to death or injury at the hands of an intimate partner. This study aims to bridge this gap in the literature by first, investigating ecological factors associated with IPV within a sample of at-risk African American women.

While examining factors associated with high levels of IPV among at-risk groups will contribute to the ability to identify women at-risk for IPV, researchers have also noted a need to study factors that protect women from entering into abusive relationships and help prevent IPV from occurring before it starts (Foa, Cascardi, Zoellner, & Feeny, 2000). Identifying protective factors may help further this goal and has been identified as a viable area for continued research. Forged within a unique social ecology, African American women have developed coping strategies that may serve as one type of protective factor. More specifically, Africultural coping is a group of strategies used by African Americans to cope with stressful situations which includes the use of spirituality,

collective coping, and cognitive/emotional debriefing. However, Africultural coping has been absent from previous explorations of African American women and IPV outcomes despite the likelihood that these coping strategies are important sources of strength and resilience. Therefore, the second aim of the current study was to explore whether higher levels of usage of Africultural coping strategies were associated with reduced levels of IPV. Specifically, this study tested whether spirituality, collective coping, and cognitive/emotional debriefing moderate the association between CM and IPV while controlling for other ecological risk factors. Therefore, taken together, this study explored both risk and protective factors associated with levels of IPV for African American women. By learning more about IPV risk and factors that foster resiliency, this study can inform scholars, practitioners, and policy makers in their efforts to stop revictimization and end the intergenerational transmission of violence. To this effect, the following research questions and hypotheses were examined:

1.3.2 Research Questions

- 1) Do covariates (age, parenthood, and cohabitation) predict recently reported physical and psychological IPV in a sample of at-risk African American women?
- 2) Do higher levels of retrospectively reported CM predict higher levels of recent psychological and physical IPV in a sample of at-risk African American women, while controlling for significant covariates? (main effects)
- 3) Do Africultural coping factors (spirituality, collective coping, and cognitive/emotional debriefing) moderate the link between CM and IPV such that women who have higher levels of Africultural coping report adult relationships with lower levels of psychological and physical IPV? (interaction)

1.3.3 Hypotheses

1) It was predicted that all covariates (age, parenthood, and cohabitation) would be significantly associated with higher levels of recently reported psychological and physical IPV.

2) It was predicted that higher levels of retrospectively reported childhood maltreatment would predict higher levels of recent psychological and physical intimate partner violence in a sample of at-risk, low-income African American women while controlling for significant covariates. (main effect)

3) It was hypothesized that Africultural coping factors would moderate the link between levels of retrospectively reported childhood maltreatment and levels of recent psychological and physical IPV (see Figure 1) such that:

a) Higher levels of spiritual well-being would weaken the positive relationship between levels of CM and recent psychological IPV (see Figure 4).

b) Higher levels of spiritual well-being would weaken the positive relationship between levels of CM and recent physical IPV (see Figure 5).

c) Higher levels of collective coping would weaken the positive relationship between CM and levels of recent psychological IPV (see Figure 6).

d) Higher levels of collective coping would weaken the positive relationship between levels of CM and recent physical IPV (see Figure 7).

e) Cognitive/emotional debriefing would weaken the positive relationship between levels of CM and recent psychological IPV (see Figure 8).

f) Cognitive/emotional debriefing would weaken the positive relationship between levels of CM and recent physical IPV (see Figure 9).

2 METHOD

2.1 Procedure

Data were collected as a part of a series of larger, pre-intervention studies that investigated risk and protective factors in low-income, African American women. These studies took place at a large, university-affiliated, urban public health system that provides medical and psychiatric services to primarily African American residents in the Atlanta-metro region. Prior to the initiation of data collection, the studies were approved by the university institutional review board and the hospital's research oversight committee. All participants were treated in accordance with the guidelines set forth by the American Psychological Association Ethical Principles of Psychologists and Code of Conduct.

2.1.1 Sample. Participants included 473 women, ages 18-64 years who participated in pre-intervention interviews for a series of studies (named studies 4, 5, & 7). All women included in the studies self-identified as African American. Women were excluded if they did not identify themselves as Black or African American or demonstrated an inability to complete the pretreatment interview due to cognitive impairment, delirium, or acute psychosis. To be eligible for studies 4 and 7, women both endorsed a suicide attempt in the last 12 months and an experience of IPV in the last 12 months. For study 5, women were eligible if they reported a suicide attempt in the last 12 months, but excluded if they reported an experience of IPV in the last 12 months. These data sets were combined to ensure that there was a large enough sample size (increasing statistical power) in order to conduct all proposed analyses and to ensure that there is not

a problem with restriction of range as this can be especially problematic for studies that test moderation (Whisman & McClelland, 2005).

2.1.2 Recruitment and screening. Participants were recruited throughout the hospital by undergraduate and graduate volunteers of diverse racial backgrounds. Prior to recruiting participants, volunteers were trained in how to recruit by research staff and were able to first observe and practice recruitment with more experienced recruiters. There were two ways that participants were simultaneously recruited for the studies: they were either recruited by study volunteers or referred by hospital staff. In the first case, potential participants were approached by volunteers as they sat in waiting areas of the hospital for appointments. In order to be sensitive to potential safety concerns, women were not approached if they appeared to be waiting with a romantic partner and were only provided more information if they expressed an interest in learning more after the research study was initially introduced.

The initial inclusion criteria were that prospective participants must: self-identify as African American and endorse a suicide attempt in the last 12 months. For two of the three studies (studies 4 and 7), women also had to endorse an experience of IPV in the last 12 months. If a prospective participant met these criteria and expressed interest in participating in the study, a volunteer filled-out a one page initial screening form. This initial screening form reviewed the criteria for inclusion in the study and attained the potential participant's permission and contact information so they could be contacted by the research team. Secondly, hospital staff referred prospective participants (African American women who presented at the hospital with an IPV related report or a recent suicide attempt). These women were met by research volunteers who would fill-out the

one page initial screening form to assess study eligibility with them. They were then contacted by research staff or volunteers about scheduling a time to complete the full assessment battery described below.

2.1.3 Assessment. Participants who endorsed all of the initial screening criteria, were scheduled for an appointment to complete a comprehensive battery of assessment measures including, but not limited to, the measures included in this study. The measures were verbally administered to participants by trained undergraduate and graduate volunteers. Volunteer training covered information on the study protocol and administration, ethical treatment of research participants, risk assessment, and basic competencies in working with people affected by suicidal ideation and IPV. After provided informed consent, measures that screened for cognitive limitations were completed. Participants were determined ineligible and the assessment was discontinued based on the criteria of the Psychotic-symptom Screening Questionnaire, the Mini Mental State Exam (Folstein, Folstein, McHugh, & Fanjiang, 2001), and The Rapid Estimate of Adult Literacy in Medicine (MMSE \leq 24 if literate or \leq 22 if functionally illiterate in the English language) (Williams et al., 1995). Verbal administration was utilized due to the low level of functional literacy of the population. If participants' scores were above the cut-off scores, the remaining battery was administered. These assessments were conducted in a room with only the participant and research volunteer to provide privacy and took approximately three to four hours to complete. Once participants completed the assessment battery, they were debriefed and provided with \$20 incentive, two tokens for public transportation, and referrals for assistance. All potential participants were also given access to either a support group associated with the research project or a 10-week

intervention group which focused on meeting their psychiatric needs and decreasing their risk for IPV and suicide, regardless to whether they were able to complete the study.

2.2 Measures

2.2.1 Demographic Data Questionnaire (DDQ). The DDQ (Kaslow et al., 2010) assesses basic sociocultural information. The following sociocultural information was assessed via approximately 26 close-ended questions: age in years, marital status (married or cohabiting vs. unmarried or no live-in partner), parental status (parent, non-parent), employment status (employed vs. unemployed), education level (completed high school vs. less than high school), homelessness status (self-identified as homeless or not), and monthly household income.

2.2.2 Index of Spousal Abuse (ISA). The ISA (Hudson & McIntosh, 1981, see Appendix A) assessed the presence and severity of IPV symptoms. Participants were asked to rate how often her partner has engaged in specific abusive behaviors on a 5-point Likert scale that varies from *never* to *very frequently*. The ISA was chosen because it had previously been used and demonstrated high internal validity with low income and African American samples (Campbell, Campbell, King, Parker, & Ryan, 1994; Cook et al., 2003); Tolman & Rosen, 2001).

The ISA has been divided into several different factors. The original ISA, (Hudson & McIntosh, 1981) was composed of 30 items with two subscales: ISA–Physical, (ISA-P), and ISA–Non-Physical (ISA-NP). However, an exploratory factor analysis conducted by Campbell, Campbell, King, Parker, & Ryan, (1994) examined the scale’s factor loadings with a sample of African American led them to propose a three factor model. According to their analysis, Campbell et al. (1994) reported that six items

that seemed to focus on men's behaviors that control women's behavior in their sample and suggested that this may be a construct specific to African American women.

Based on their findings using a confirmatory factor analysis, Cook, Conrad, Bender, & Kaslow, (2003) proposed a variation that has been designed to maximize internal validity and capture three related, but distinct dimensions of abuse: (a) psychological abuse, (b) physical abuse, and (c) controlling behavior. For the current study, the 4 items that best loaded onto the physical abuse subscale (e.g. "*My partner punches me with his/her fists*") and the 11 items that compose the psychological abuse subscales (e.g. "*My partner insults or shames me in front of other people*") were used to assess physical and psychological IPV. The subscales as proposed by (Tolman, 1999) were not used because there is evidence of increased validity when items are loaded onto physical/psychological abuse factors in this manner with a similar sample (Cook et al., 2003). In the current study, this measure demonstrated solid internal consistency and reliability, psychological IPV Cronbach's $\alpha = .93$, physical IPV Cronbach's $\alpha = .89$). The items that assessed sexual IPV were not included in the current investigation based on concerns regarding the scale's validity (see Cook et al., 2003). The subscale that assessed controlling behavior was also not included as it was not a primary outcome of interest.

2.2.3 Childhood Trauma Questionnaire (CTQ). The 28 item, CTQ, (short-form) (see Appendix B) was used to assess childhood maltreatment: physical, sexual, and emotional abuse, as well as physical and emotional neglect (Bernstein et al., 2003). Participants responded to questions on a 5-point Likert scale which ranged from *never true* to *very often true*. Sample items include: "*People in my family hit me so hard that it left me with bruises*" (Physical abuse), and "*Someone tried to touch me in a sexual way*

or tried to make me touch them” (Sexual abuse). Because different forms of abuse have been previously found to be highly correlated, only the composite measure of childhood abuse was used in order to reduce multicollinearity (Carlson et al., 2002). Research has demonstrated that the scale has good construct and content validity. That is, test–retest reliability has been reported to range from .79 to .86 (Bernstein et al., 2003; Bernstein & Fink, 1998; Kaslow et al., 2002; Thompson, Kaslow, Short, & Wyckoff, 2002). In the current study this measure continued to have high internal consistency and reliability, Cronbach’s $\alpha = .90$).

2.2.4 Spiritual Well-Being Scale (SWBS). The 20 item SWBS (see Appendix C) was administered to assess the participants’ use of spirituality as a coping strategy. Participants rated items on a 6-point Likert scale ranging from *strongly agree to strongly disagree*, with higher scores indicating greater levels of spiritual well-being (Paloutzian & Ellison, 1982, 1991). The test–retest reliabilities and internal consistency of this scale are good, and content and construct validity have been established (Bufford, Paloutzian, & Ellison, 1991). For the current study, the composite measure was calculated as described by Paloutzian and Ellison (1982; 1991). This scale demonstrated strong reliability Cronbach’s $\alpha = .90$. Although the scales has two sub-scales, these were not used because the total score demonstrated the highest reliability. This choice also helped reduce potential multicollinearity of the two subscales and retain enough statistical power for all analyses.

2.2.5 Africultural Coping Systems Inventory (ACS). The 30-item ACSI (see Appendix D) assessed coping strategies frequently endorsed by participants. These coping strategies have been found to be consistent with an African-centered conceptual

framework (Utsey et al., 2000). Participants were asked to recall how they responded to “a stressful situation that occurred in the past week or so” and choose answers from a 4-point Likert scale (ranging from 0= *did not use*, 1= *used a little*, 2= *used a lot*, and 3= *used a great deal* so that a higher score indicates greater reliance on a coping strategy. Coping strategies in two out of the four domains cognitive/emotional debriefing and the collective coping subscales were included in the current study. As proposed by the inventory’s developers, the cognitive/emotional debriefing scale was composed of 11 items (e.g. “*Sought out people that would make me laugh*”), and collective coping was composed of 8 items (e.g. “*Thought of all the struggles Black people have had to endure, which gave you strength to deal with the situation*”). The scale had previously been reported to have adequate internal consistency cognitive/emotional debriefing (Cronbach’s $\alpha = .79$), collective coping (Cronbach’s $\alpha = .78$) (Utsey et al., 2000). This was also the case in the current sample: cognitive/emotional debriefing Cronbach’s $\alpha = .78$; collective coping Cronbach’s $\alpha = .82$. The other two scales were not included because the scale either had low reliability or was significantly correlated with other variables included in the study (i.e. SWBS), increasing the potential for multicollinearity.

3 RESULTS

3.1 Preliminary Data Analyses

3.1.1 Power analysis. A power analysis was conducted to ensure that there was sufficient statistical power for all proposed analyses using G* Power 3.1: software for correlation and multiple liner regression analyses (Faul, Erdfelder, Buchner, & Lang,

2009; Faul, Erdfelder, Lang, & Buchner, 2007). The analysis revealed that the sample was adequately sized to conduct all planned analyses (see Table 4).

3.1.2 Merging data sets. Data sets 4, 5, and 7 were combined in SPSS18 in order to create one, larger sample. To determine whether there were significant differences between the three data sets on the ISA (physical and psychological IPV), descriptive statistics and ANOVA were run and the three groups were compared. As anticipated, there was a significant difference between the data sets in terms of scores on the ISA (psychological IPV $F(2, 422) = 25.51$ $p < .001$; and physical IPV $F(2, 423) = 18.52$, $p < .001$). This was expected given endorsement of a history of recent IPV was an exclusionary criteria for study 5, but not studies 4 and 7. Otherwise, the samples were demographically comparable and the average group scores on variables of interest (e.g. CTQ) were not significantly different.

3.1.3 Missing data. Next, the data were visually inspected to identify any potential outliers and erroneous values (e.g. values entered outside of the range of their corresponding scale). Most scales of interest were consistently administered to participants, across all three data sets. However, the ACSI was only administered in data set 7. Therefore, the ACSI (collective coping, cognitive/emotional debriefing scales) had approximately one third of the number of participants as compared to the other measures. Otherwise, there were only a small number of missing values. Because it was determined that there was no apparent pattern to the values that were missing and there was sufficient sample size, missing values were not anticipated to significantly skew results.

3.1.4 Erroneous values. If a data entry error was identified, and the value fell outside of the range of possible responses for a given scale, this value was recoded as

missing. There were only three such values that seem to be erroneous on the ACSI and two values on the ISA that were recoded as missing because they were outside the range of possible responses.

3.1.5 Outliers. One participant response was identified as an outlier on the outcome variable (Index of Spouse Abuse – psychological IPV). This case was reviewed and it was determined that the value was a true outlier, within the scale range and not just a data entry error. Therefore, this case was retained in the data set but a transformation (as described below) was performed in order to decrease the amount that the scale was skewed by this value.

3.1.6 Assumption checks. Next, the assumptions of multiple linear regression (that variables are normally distribution, non-multicollinear, and there is homogeneity of variance) were checked as described below.

3.1.6.1 Normal distribution. Data were examined to determine whether or not they met the assumption of normal distribution. In order to do this, frequency distribution tables of the composite scales of interest were created and visually inspected. Two variables were skewed slightly more than would be ideal for variables used in regression analyses. Therefore, these two variables (ISA psychological IPV, physical IPV) were transformed in order to improve the normality of their distribution by taking their square root. This improved the level of skewing on this scale, bringing it within acceptable limits as described by Tabachnick and Fidell (2007).

3.1.6.2 Multicollinearity. Next, the bivariate correlations were run to assess whether the assumption of multicollinearity was violated. If independent variables are highly correlated, demonstrating significant overlap, this can cause problems in the

accuracy of coefficient estimates. Results indicated that, in accordance with the most commonly used cut-off point, all Pearson's correlation coefficients were lower than .80 (see Table 3). Variance inflation factors (VIF) were also less than 10, in accordance for recommended levels (Stevens, 2009). This indicated that none of the independent variables or covariates were highly correlated at a level that would indicate multicollinearity. To further reduce any multicollinearity and make coefficients more interpretable, scale scores were also mean centered for all future analyses.

3.1.6.3 Homogeneity of variance. To check whether the assumption of homogeneity of variance was violated, scatter plots of the residuals were visually inspected. Visual inspection showed that the assumption of homogeneity of variance was not violated as the residuals were evenly distributed at all levels of the outcome variable (i.e. ISA: psychological IPV, physical IPV).

3.2 Descriptive Statistics

Next, descriptive statistics were calculated. For demographic characteristics of the sample see Table 1, for all scale scores (see Table 2) and intercorrelations (see Table 3). In general, the most women who participated in the study were between the ages of 20-40 years old. Women self-identified as having limited financial resources, with the majority being unemployed, and approximately half indicating they were homeless. Most women had either not completed high school or high school was their highest level of educational achievement.

3.3 Hypothesis Testing

3.3.1.1 Hypothesis 1 model: IPV covariates. To test the first research question, hypothesized covariates that were measured as continuous variables (age) were entered

into a correlation analysis with psychological and physical IPV as outcomes.

Subsequently, t-tests were conducted to determine whether or not there were significant differences in level of psychological and physical IPV based on dichotomous factors (covariates included: parenthood, i.e. whether participants identified as a parent, and whether they were currently cohabitating with a romantic partner).

3.3.1.2 Hypothesis 1 results. Results indicated that levels of recently reported IPV did not differ at a statistically significant level based on whether women identified themselves as a parent or as currently cohabitating with a romantic partner. Therefore, these hypothesized covariates were not included in further analyses. Participants' age was associated with psychological IPV but not physical IPV. However, participant age was retained as a covariate in all subsequent models based on a-priori hypotheses.

3.3.1.3 Hypothesis 2 models: CM, psychological IPV, physical IPV. In order to test the second hypotheses, two separate multiple linear regressions were run. In the first step of both models, age was entered as a covariate. In the second step, the CTQ (total score) was entered as the predictor variable. In the first model (2a) psychological IPV was included as the outcome variable, and physical IPV was entered as the outcome variable in the second model (2b). Next, the hypotheses and their coinciding results are described.

3.3.1.4 Hypothesis 2 results. 2a) The first stepwise linear regression analysis tested the research question that higher levels of retrospectively reported CM predicted recent experiences of psychological IPV, while controlling for participant age. In this model, both age and retrospectively reported levels of CM were significantly associated with higher levels of recent experiences of psychological IPV, $F = 13.81$, $R^2 = .07$,

$p < .001$ for the full model. As hypothesized, higher levels of CM significantly predicted higher levels of recent psychological IPV.

2b) A second linear regression was conducted to determine whether higher levels of retrospectively reported CM predicted recent experiences of physical IPV, while controlling for participants' age. In this model, age was not significant associated with higher levels of retrospectively reported CM. However, the full model, with retrospectively reported CM entered in the second step, was statistically significant and was associated with higher levels of recent experiences of physical IPV, $F = 6.32$, R Square = .03, $p < .01$. Therefore, as hypothesized, CM significantly predicted higher levels of recent physical IPV.

3.3.1.5 Hypothesis 3 models: Spirituality, collective coping, cognitive-emotional debriefing moderators. The third research question examined whether Africultural coping moderated the link between levels of retrospectively reported CM and levels of recent psychological and physical IPV, while controlling for participant age (see Figure 1), In order to answer this research questions, six independent multiple moderated linear regression analyses (3a-3f) were run to test for significant main and moderating effects. To test the interactions described under hypothesis three, the three Africultural coping factors (collective coping, cognitive/emotional debriefing, and spiritual well-being), and interaction terms, were entered into regression models with psychological and physical IPV tested separately as outcome variables (see Figure 2-9).

3.3.1.6 Hypothesis 3 results. 3a) To test the hypothesis that higher levels of spiritual well-being would weaken the positive relationship between levels of CM and recent psychological IPV, the control variable age was entered in the first step, second

(CM) as the predictor variable, next spiritual well-being, and finally the interaction term (product of CM and spiritual well-being) were entered in four steps of a regression model. In this model, there were three significant main effects. The third model which included age, CM, and spiritual well-being was the best fit for the data, accounting for the most variance in psychological IPV, $F(3, 360) = 9.59$, $R^2 = .07$, $p < .001$. The addition of the interaction in the fourth step did not significantly improve the model, indicating that there was no interaction between spiritual well-being and CM in predicting recent psychological IPV, while controlling for age despite what was hypothesized.

3b) This hypothesis was also tested with physical IPV as an outcome. This time, participant age was entered into the first step of the regression as a covariate, CM and spiritual well-being were entered next as predictor variables, and finally the interaction term (product of CM and spiritual well-being) was entered in the fourth step of the regression model. In this model, there was only one main effect. Retrospectively reported CM predicted recently reported physical IPV $F(3,362) = 4.97$, $R^2 = .03$, $p < .01$. However, neither the second step that included the spiritual well-being nor the third step that included the interaction term, were a significant improvement over the first step. Therefore, the hypothesis that higher levels of spiritual well-being significantly would weaken the positive relationship between levels of CM and recent physical IPV, while controlling for age, was not supported.

3c) To test the hypothesis that higher levels of collective coping would weaken the positive relationship between CM and levels of recent psychological IPV, the covariate (age), the predictor variable (childhood maltreatment), moderator (collective

coping), and interaction term (product of CM and collective coping) were entered in four steps of a regression model. The first two steps of the model were statically significant. Participant age and retrospectively reported CM were associated with recent psychological IPV, $F(2, 106) = 5.23$, $R^2 = .09$, $p < .01$. However, the addition of collective coping and the interaction term did not significantly improve the model indicating that collective coping did moderate this relationship as predicted. See Table 4 for regression coefficients and 95% confidence intervals.

3d) This hypothesis was also tested with physical IPV as an outcome. This time, only participant age was associated with physical IPV. No other factors entered (CM, collective coping, interaction term) significantly improved the model $F(4, 104) = 2.37$, $R^2 = .06$, $p > .05$. Therefore, the hypothesis that higher levels of collective coping would significantly weaken the positive relationship between levels of CM and recent physical IPV was not supported.

3e) To test the hypothesis that cognitive/emotional debriefing would weaken the positive relationship between levels of CM and recent psychological IPV the covariate (age), the predictor variable (childhood maltreatment), moderator (cognitive/emotional debriefing), and interaction term (product of CM and collective coping) were entered in four steps in a regression model. Results indicated that there was a main effect of age, CM, and cognitive/emotional debriefing $F(3, 105) = 5.53$, $R^2 = .14$, $p < .01$. The inclusion of the interaction term did not significantly improve the model, indicating that the relationship between CM and psychological IPV did not depend on levels of cognitive/emotional debriefing, while controlling for age.

3f) This hypothesis was also tested with physical IPV as an outcome. Again there were significant main effects of participant age, CM, and cognitive/emotional debriefing, $F(3, 105) = 3.67$, $R^2 = .10$, $p < .05$. However the fourth model was not a significant improvement over the prior three. Therefore, the hypothesis that higher levels of cognitive emotional debriefing would significantly weaken the positive relationship between levels of CM and recent physical IPV, while controlling for age, was not supported.

4 DISCUSSION

In the United States, African American women are one of the groups most likely to experience IPV and suffer its most lethal consequence. For instance, African American women have been found to be at especially high risk for experiencing IPV and disproportionately represent victims of homicides committed by an intimate partner. Despite the serious consequences associated with IPV for African American women, there has been relatively little research on risk factors for IPV within this group. Researchers have successfully used ecological theory to help delineate the multiple factors associated with IPV. Therefore, using ecological theory, the first aim of this study was to explore individual, relational/familial, and sociocultural/community risk factors associated with IPV for African American women.

4.1 Demographic Covariates and IPV Risk for African American Women.

First, based on the extant literature, individual-level covariates that were believed to be associated with African American women's experiences of IPV were examined. Analyses revealed that participants' age was a significant, but relatively weak, predictor of higher levels of psychological, but not physical IPV. While it was hypothesized that age would

be negatively correlated with IPV; the reverse was found. There was a small, positive correlation between age and psychological IPV. That is, IPV risk increased with participant age with older adult women being more likely to report psychological IPV within the last year as compared to women younger in age.

These results indicate that interventions for psychological IPV may benefit assessing the age, and corresponding developmental needs, of the women for whom they are designed. For instance, women in middle adulthood may be more likely to be responsible for the economic and social welfare of the family, making it even more difficult to leave an abusive relationship. Age is therefore a piece of a women's identity and context in which the relational violence is occurring which is critical to understanding to best aiding prevention and intervention efforts. Failure to do so may create significant barriers for women accessing help.

Levels of IPV did not differ at a statistically significant level based on whether or not women identified themselves as parents. In other words, women who indicated they were parents at the time of the study were no more or less likely to report physical or psychological IPV than those who were not parents. There may be several reasons for this finding. First, the differences in IPV based on parenthood may already be accounted for by other variables included in the model. For example, holding the status of a parent is increasingly likely for older participants. Because age was already included in the model, it is unlikely that the addition of parental status would increase the predictive accuracy of the model. Further, it is plausible that there may be ways that status as a parent might serve as both as a risk and protective factor for IPV. For example parenthood may increase the level of stress on intimate partners or may conversely

encourage parents to defuse a dispute before it escalates. The relationship between parental status and IPV would also likely depend on such factors as the number of children, their age, whether the child/children live in the home with the couple, whether they are the biological children of the perpetrator, and level of familial/community support. Further examination of this null finding could help illuminate which, if any, of these initial explanations holds true.

Results also indicated that a woman's cohabitating with her partner was not associated with IPV risk within this sample. These results suggest that women who reported living with an intimate partner at the time of the study were no more likely to report IPV than those who did not. Therefore this factor seems to have no ability to help identify women at risk for experiencing IPV. Again, these results should be interpreted with some caution as there may have been some overlap between this variable and others already included in the model, diminishing the ability to detect an effect. Further, it is vital to note that, parenthood status and cohabitation may not always be a significant covariate for research purposes, it still may be extremely important to take this into consideration at intake and during treatment for safety planning purposes (e.g. to alert clinicians not call a woman's home if she has disclosed living with an abusive partner).

4.2 Continued need to examine CM and IPV in tandem. Beyond covariates, CM, categorized within the relational/familial realm of influence according to ecological theory, consistently had the largest effect size of the variables examined in this study. In line with prior examinations of IPV risk, maltreatment experienced by participants in childhood (CM) was associated with higher levels of both psychological and physical

IPV. Africultural coping was hypothesized to serve a protective role and moderate the relationship between CM and IPV.

These findings highlight the importance of health and mental healthcare settings including experiences of CM in the screening/assessment of women who have potentially experienced IPV. Based on these findings, a history of reported CM should alert healthcare providers in these settings to the need for additional screening for recent or ongoing IPV. Further, agencies that provide services for women affected by IPV should be prepared with training, staff, and resources dedicated to the identification and treatment of childhood trauma. Researchers such as Little & Kaufman (2002) have made practical suggestions for what information should be gathered as a part of such assignments. In terms of prevention, these findings suggest that early, evidence-based interventions which provide support for children and families that have been reported for maltreatment, may help prevent future IPV and other negative health outcomes for survivors of maltreatment.

4.2.1 Africultural coping.

There was a main effect of spirituality on psychological IPV scores such that higher levels of spirituality well-being were associated with lower levels of abuse. The current study provided additional evidence that spirituality may be used as a positive coping strategy used by African American women associated with lower IPV risk. More research is needed to more fully explore the ways in which African American women may enlist their spirituality to cope with IPV. Measured as spirituality as a broad construct, however, this accounted for relatively little variance in IPV scores. Further

exploration of specific spiritual coping behaviors women use therefore may help further illuminate how spirituality is used by women to prevent discord in intimate relationships.

However, two other dimensions of Africultural coping assessed, collective coping and cognitive-emotional debriefing were not significantly associated with physical or psychological IPV. Therefore, overall, there was limited support for these hypotheses. Collective coping and cognitive emotional debriefing may function as a moderator in other models i.e. may attenuate the relationship between IPV and PTSD or other health consequences. The lack of significant association between other aspects of Africultural coping may have been due to lack of specificity (based on characteristics of the sample or specific relational violence outcome). A more nuanced approach, for example examining IPV coping or gaining qualitative data to assess whether and how Africultural coping relates to relational stress and IPV could help illuminate this further. More research is needed to test these hypotheses.

There were differences in the association between covariates, predictors, and IPV outcomes based on the type of IPV measured. In general, the strongest effects were found for psychological IPV as opposed to physical IPV. This is consistent with prior research, such as a study conducted by Coker, Davis, Arias, Desai, Sanderson, Brandt, & Smith (2002) that found that higher psychological IPV scores were more strongly associated with health outcomes (i.e. poor health, depressive symptoms, substance use, chronic disease, chronic mental illness, and injury) than physical IPV scores. These findings continue to demonstrate the importance of examining the impact of psychological IPV on health outcomes. Further research is needed to better understand the full ramifications of this form of abuse. Researchers should further investigate whether response bias, such as

fear, stigma, or shame about reporting physical abuse prevent people from disclosing physical IPV.

4.3 Implications for Policy

This study holds critical implications, not only for understanding factors associated with IPV, but also helps practitioners and policy makers' alike hone-in on areas to target for policy, prevention, and intervention. IPV is not only a devastating social problem but a costly one overburdening the healthcare, judicial, and correctional systems and costing tax-payers billions of dollars each year. For instance, according to estimates, the US spent over \$8.3 billion dollars in a single year on medical expenses associated with IPV (Max et al, 2004). IPV also negatively impacts the workforce through its association with increased absenteeism, tardiness, and work-place distraction (Reeves, & O'Leary-Kelly, 2007).

Women in this study who reported higher levels of IPV, also had multiple stressors and risk factors for IPV such as poverty, unemployment, and homelessness. The literature has also consistently indicated that these risk factors are associated with CM, which was linked to higher levels of IPV. Therefore, these findings indicate that policies which successfully reduce economic poverty (i.e. low SES, low high-school completion, unemployment, homelessness) are likely to decrease IPV risk. Policies which work to reduce economic poverty may be especially relevant given the consistent relationship between SES and IPV. By investing on poverty alleviation on the front-end, we may be able to save federal and state governments billions on IPV related healthcare, law-enforcement, and the judicial costs down the line.

This research also continued to find strong linkages between CM and IPV. This is consistent with the research literature which has found strong connections between exposure to traumatic childhood experiences such as CM, IPV adulthood, and a host of related poor health outcomes. Therefore, local and national funding is needed for continued research and implementation of effective violence prevention/intervention strategies as well as emergency services provisions and healthcare initiatives for women and families impacted by violence. Research and programming to prevent and intervene in cases of reported CM thusly also has the potential to prevent future costs associated with IPV by intervening early and helping prevent the intergenerational transmission of CM and IPV.

4.4 Implications for Practice

4.4.1 Screening and referrals for mothers and children experiencing IPV.

This research highlights several insights for practitioners. First of all, there are often missed opportunities in connecting women and children affected by IPV with potentially life-saving services. The problem in-part lies in the fact that this women and children experiencing violence are never identified as needing help, even when they enter treatment settings such as hospitals, doctors' offices, child welfare agencies, and mental health clinics. Some researchers have argued that universal screening for IPV would help address this problem (Todahl, Walters, 2011). However, an initial randomized control trial in a healthcare setting found that universal screening did not significantly improve IPV-related outcomes (Moracco, & Cole, 2009). However, when a women has indicated that IPV may be a presenting concern, or there other factors that are indicating IPV risk, further assessment is recommended. Further, because of the frequent co-occurrence of

CM and IPV, researchers such as Little and Kaufman (2002) have argued that is important for IPV and CM to be assessed in tandem—when children are present in the home of a women who is identified as having an abusive partner, or conversely, that a mother's relationship status and presences of abuse is assessed when a child is identified as recently being maltreated. Little and Kaufman (2002) made practical suggestions specific questions which can be asked when assessing for violence (CM and IPV) in the home and better trying to understand the needs of both the mother and her children.

Additionally, practitioners working with adult survivors of IPV or children who have been maltreated (past and current) should, at a minimum, know their region's ethical and legal mandated reporting requirements and be prepared at an individual and agency level to knowledgeably handle cases of suspected abuse (i.e. knowing when, where, and how to contact the appropriate local authorities). Because persons experiencing abuse have often had the experience of being out of control, it is often recommended that reporting be done collaboratively rather than solely by clinicians. Mandated reporting is most readily thought of with children, but persons with disabilities and the elderly can also require clinicians help clients seek safety, which may be the case for adult clients experiencing IPV.

Women who are experiencing IPV often have a variety of needs (e.g. legal, housing and shelter, food, financial). It is not uncommon for clinicians/organizations that specialize in addressing the needs of those impacted by IPV find themselves wanting to expand their services addressing CM and other forms of interpersonal trauma given the likelihood that related issues will come-up over the course of treatment. Programs and practitioners who conceptualize and treat violence as a family problem (rather than only

having services for a single presenting problem or population (e.g. children, women, men) may be able to provide multiple services for under one roof, reducing the need for multiple agency involvement. However, it is unlikely that any one individual clinician, program, or agency will be able to effectively address all the needs of an individual or family presenting with IPV – especially given the complexity and high level of need of many of these families. Therefore it is often important to form strong collaborative working relationships and partnerships between community organizations which can help people access the multiple resources they may require.

4.4.2 Trauma-Informed Care

Given the high prevalence of histories of CM in women who present for IPV, clinicians' and agencies working with this population should also have a focus on trauma-informed care as to minimize policies and practices that are inadvertently disempowering and re-traumatizing. Trauma-informed care can be defined as “a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” (Hopper, Bassuk, & Olivet, 2010; p. 82). This is a flexible concept that therefore can be further modified to meet the needs of the specific cultural group and population for which it is intended. For example, the current study found that African Americans who had a greater sense of spiritual-wellbeing were less likely to report recent physical or psychological IPV. This adds the growing body of literature that documents the mental-health benefits of spirituality for African American women. It is thusly recommended that aspects of spiritual be integrated into interventions for African Americans as a culturally-relevant competent with a growing evidence-base.

In this case, IPV organizations may benefit from partnerships with local churches, mosques, affiliated individuals (e.g. pastors, chaplains, imams) may help provide increased visibility for IPV interventions, while also providing access to church resources, and clientele in a de-stigmatized setting. A continued focus and integration of such strengths into the practice setting is likely to be beneficial and well received, although like any intervention needs to be thoughtfully tailored to the meet the needs of specific the individual, family, or setting.

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APPENDICES

Appendix A

Table 1

<i>Demographic Characteristics of the Sample</i>	
Variable	Value
Mean age (<i>SD</i>)	35.60 (10.15)
Marital Status (%)	
Single/Never Married	38.6
Partnered, Not living together	11.7
Partnered, Living together, Not married	17
Married	5.9
Divorced, Separated, or Widowed	2.5
Sex of Current Partner (%)	
Male	73.7
Female	7.6
Not reported	19.1
Have Kids (%)	78.2
Monthly household income (%)	
< \$250	36.2
\$250 - \$499	12.9
\$500 - \$999	25.4
\$1,000 - 2,000	13.7
> \$2,000	11.8
Unemployed (%)	86.9
Homeless (%)	54
Education (%)	
Less than 12 th grade	40.9
High school diploma or equivalent	34.4
Some college or technical school	17.0
Completed college or technical school	7.7

Appendix B

Table 2

Psychometric Properties of Major Study Variables

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Range	
				Potential	Actual
Childhood Maltreatment	473	2.72	0.70	1 – 5	1.32 – 4.5
Africultural Coping					
Collective Coping	114	1.55	0.21	0 – 3	0.0 – 3.0
Cognitive-Emotional Debriefing	114	1.58	0.58	0 – 3	0.0 – 3.0
Spirituality	415	4.12	0.88	1 – 6	1.40 – 6.0
Psychological IPV	425	3.06	1.22	1 – 5	1.00 – 5.0
Physical IPV	426	2.84	1.40	1 – 5	1.00 – 5.0

Appendix C

Table 3

Correlations Among Major Study Variables

Variable	1	2	3	4	5	6	7	<i>n</i>
1. Age	–	-.05	-.19*	-.25**	.03	.11*	.08	426
2. Childhood Maltreatment		–	-.24*	-.07	-.11*	.22**	.14*	473
3. Collective Coping			–	.67**	.41**	-.03	.02	114
4. Cognitive-Emotional Debriefing				–	.21*	.15	.13	114
5. Spirituality					–	-.12*	-.08	415
6. Psychological IPV						–	.82**	425
7. Physical IPV							–	426

* $p < .05$, ** $p < .01$

Appendix D

Table 4

Regression Coefficients and Confidence Intervals,

Model	Unstandardized Coefficients		<i>p</i>	<i>n</i>	95.0% Confidence Interval for B	
	B	Standard Error			Lower Bound	Upper Bound
Model 3a						
Age	.04*	.01	.01	362	.01	.03
CM	.35*	.09	.00	361	.17	.53
Spirituality	-.01*	.00	.02	359	-.02	-.00
Model 3b						
Age	.01	.01	.13	363	-.01	.03
CM	.30*	.11	.01	362	.09	.51
Model 3c						
Age	.02*	.01	.02	107	.01	.04
CM	.32*	.14	.02	106	.05	.58
Model 3d						
Age	.03*	.01	.03	107	.00	.05
Model 3e						
Age	.03*	.01	.01	107	.01	.05
CM	.34*	.13	.01	106	.07	.60
Cognitive/Emotional Debriefing	.04*	.02	.02	105	.01	.08
Model 3f						
Age	.03*	.01	.01	107	.01	.06
CM	.28	.16	.08	106	-.04	.60
Cognitive/Emotional Debriefing	.05*	.02	.04	105	.00	.09

**p* < .05

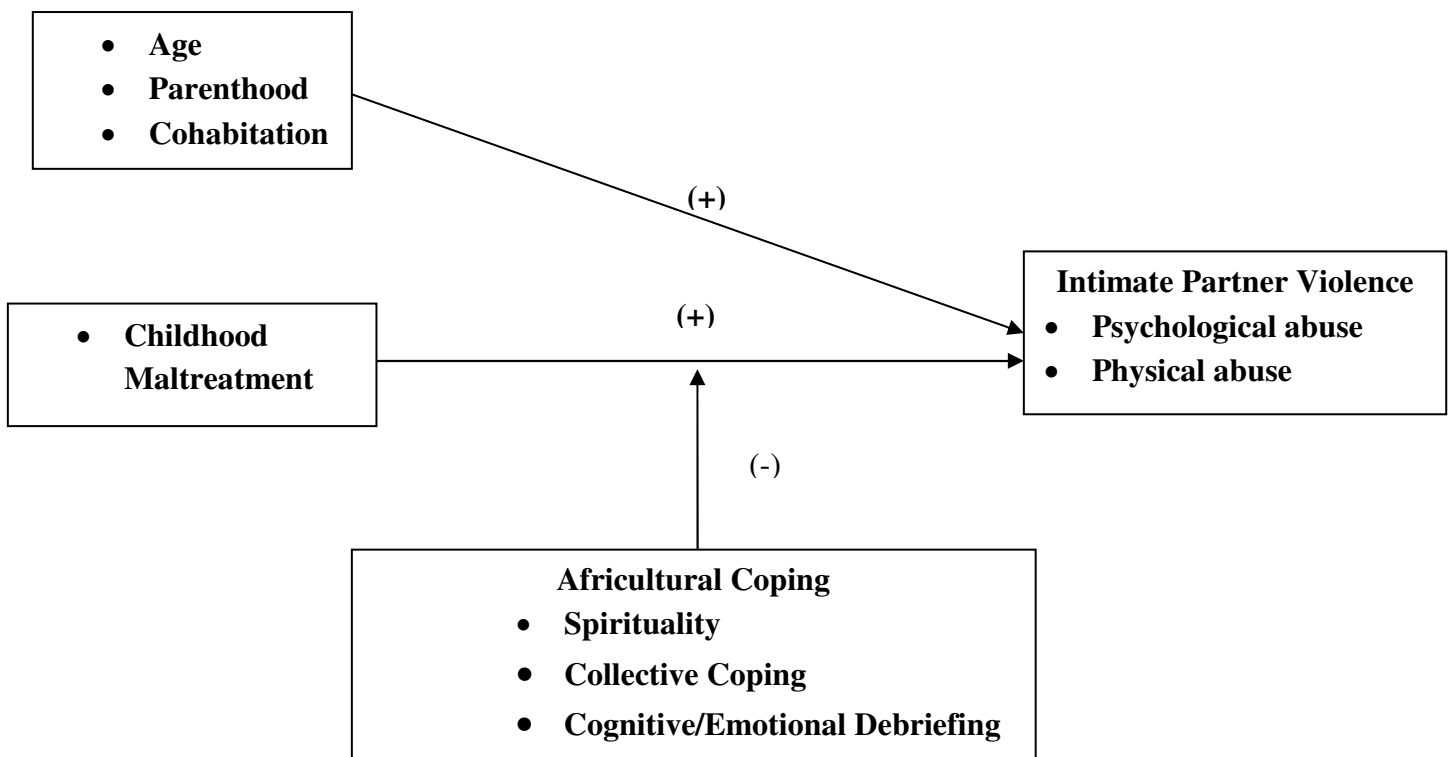
Appendix E

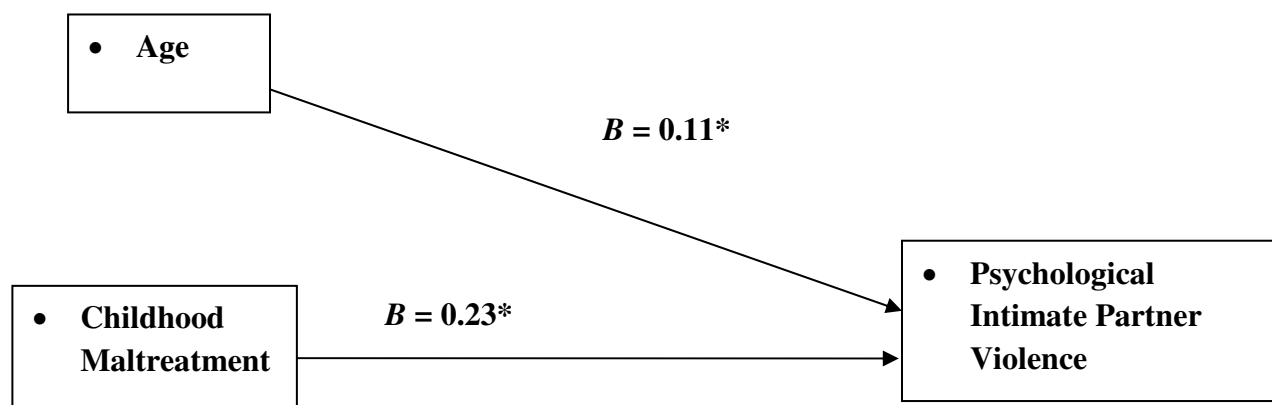
Table 5

Post Hoc Test: Correlations between Childhood Maltreatment Types & Psychological IPV & Physical IPV

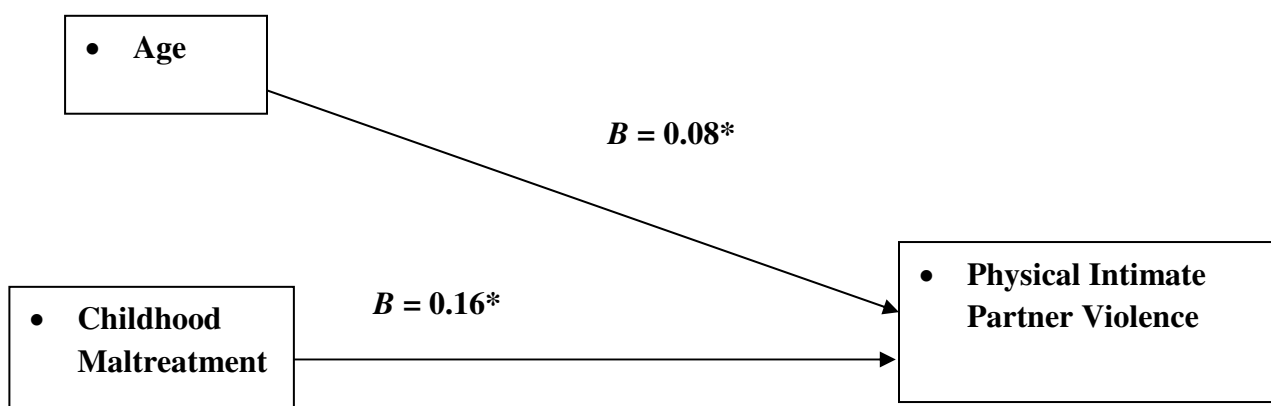
Variable	1	2	3	4	5	6	7
1. Childhood Emotional Abuse	–	.66**	.06	.31	.56**	.18**	.13**
2. Childhood Physical Abuse		–	.09	.34**	.52**	.12*	.12*
3. Childhood Emotional Neglect			–	.42**	.01	.10*	.05
4. Childhood Physical Neglect				–	.24**	.20**	.14**
5. Childhood Sexual Abuse					–	.11*	.06
6. Psychological IPV						–	.82**
7. Physical IPV							–

*p<.05, **p<.01

Appendix F**Figure 1:** General Conceptual Model – Africultural Coping Moderating the Relationship between Childhood Maltreatment and Intimate Partner Violence

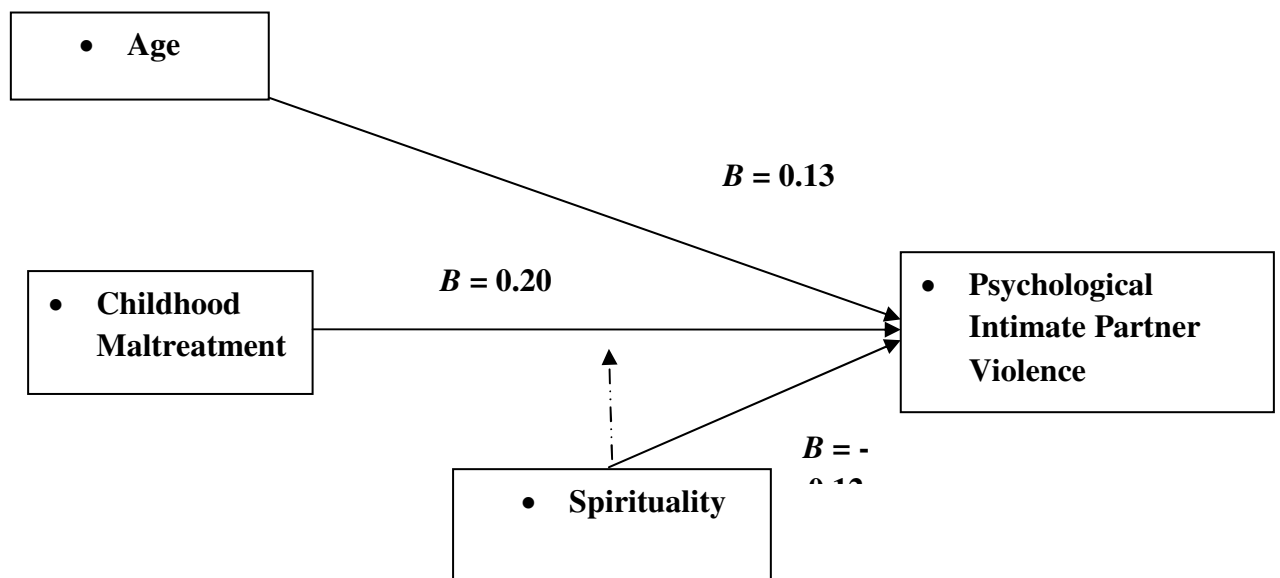
Appendix G**Figure 2:** Covariates, Childhood Maltreatment, and Psychological Intimate Partner Violence, Hypothesis 2a

Values = Standardized Beta, * = $p < .05$

Appendix H**Figure 3:** Covariates, Childhood Maltreatment, and Physical Intimate Partner Violence, Hypothesis 2b

Appendix I

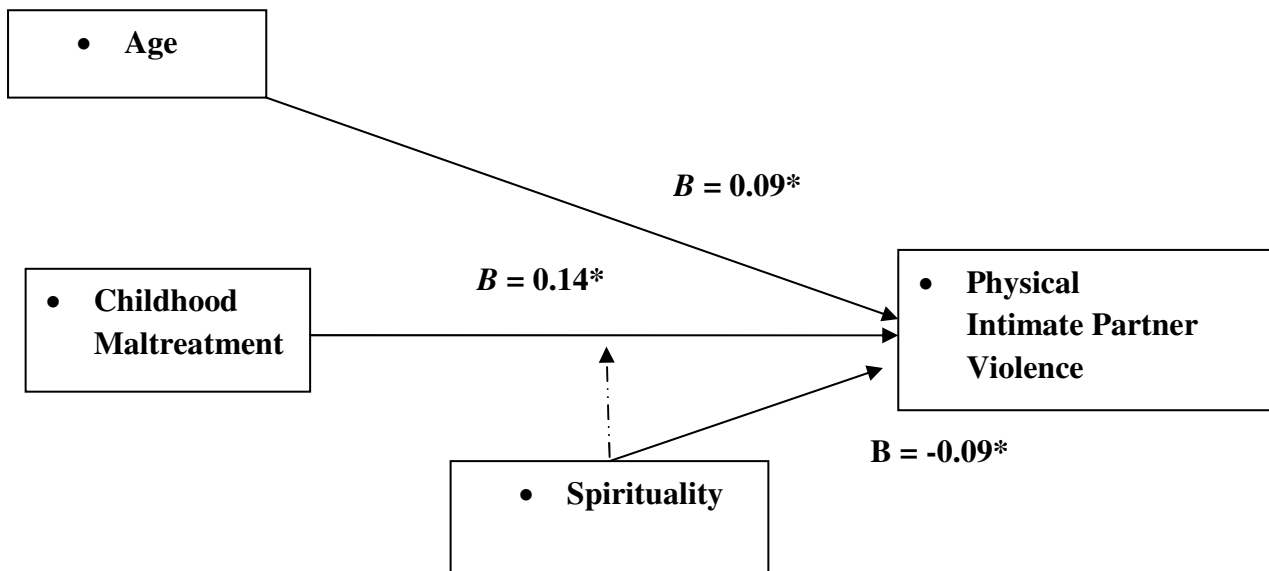
Figure 4: Spiritual Well-being Moderating the Relationship between Childhood Maltreatment and Psychological Intimate Partner Violence with Age control, Hypothesis 3a



Values = Standardized Beta

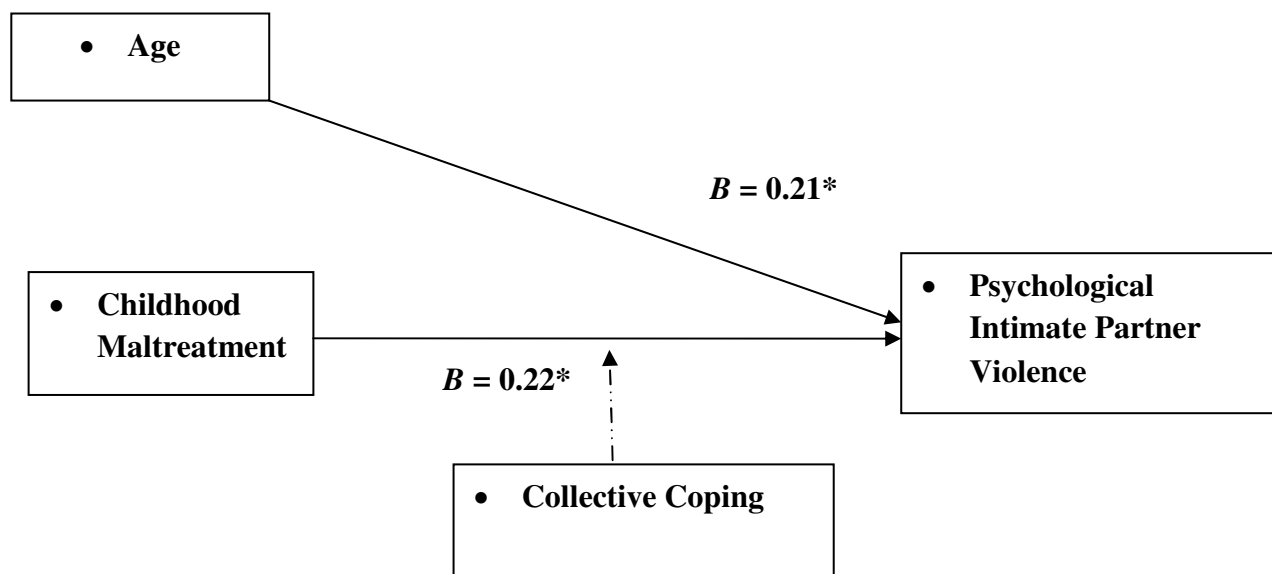
-----> = Non-Significant, $p > .05$

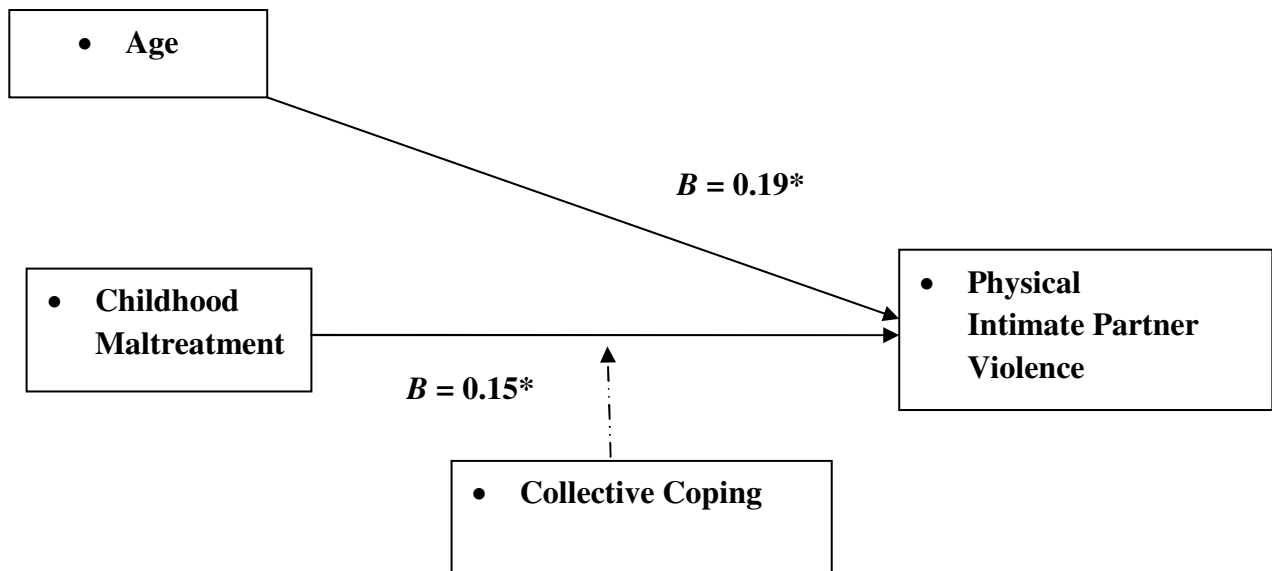
————> = Significant, $p < .05$

Appendix J**Figure 5:** Spiritual Well-being Moderating the Relationship between Childhood Maltreatment and Physical Intimate Partner Violence with Age control, Hypothesis 3b

Appendix K

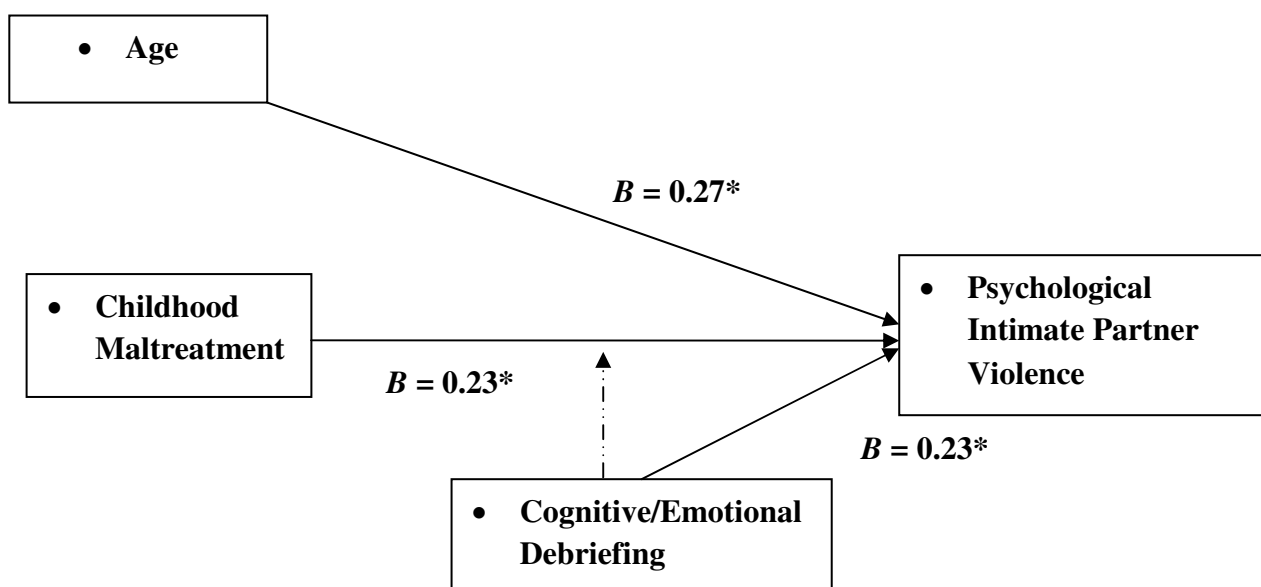
Figure 6: Collective Coping Moderating the Relationship between Childhood Maltreatment and Psychological Intimate Partner Violence with Age control, Hypothesis 3c



Appendix L**Figure 7:** Collective Coping Moderating the Relationship between Childhood Maltreatment and Physical Intimate Partner Violence with Age control, Hypothesis 3d

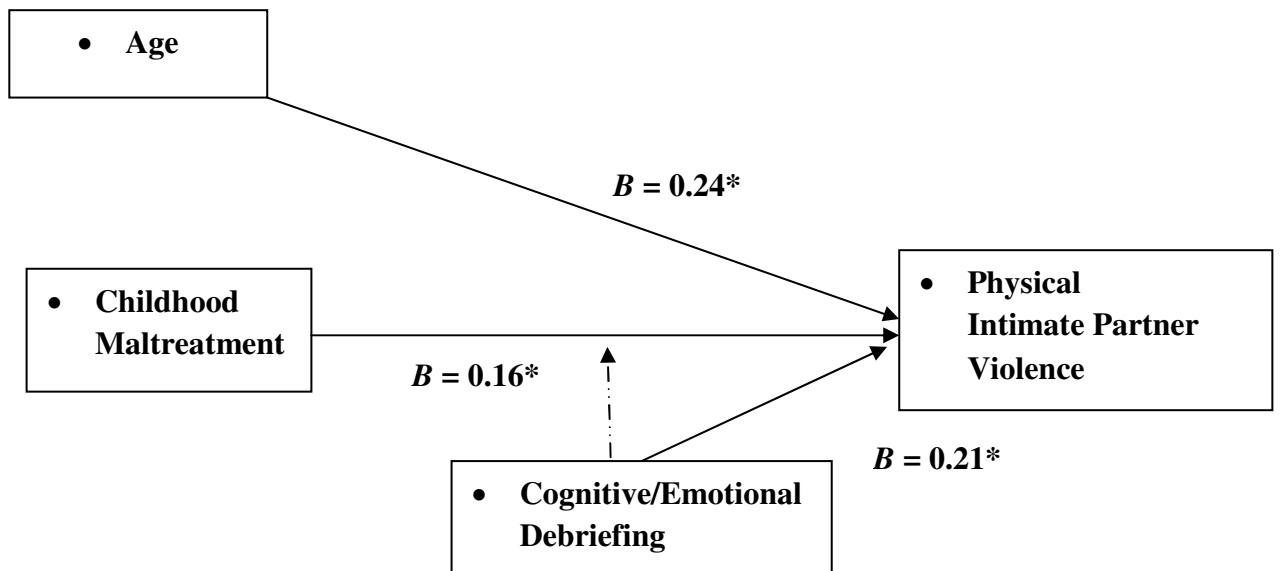
Appendix M

Figure 8: Cognitive/Emotional Debriefing Moderating the Relationship between Childhood Maltreatment and Psychological Intimate Partner Violence with Age control, Hypothesis 3e



Appendix N

Figure 9: Cognitive/Emotional Debriefing Moderating the Relationship between Childhood Maltreatment and Physical Intimate Partner Violence with Age control, Hypothesis 3f



Appendix O

INDEX OF SPOUSE ABUSE (ISA)

Please answer questions for: _____ Current Partner
 _____ Partner within last year

This questionnaire is designed to measure the degree of abuse you have experienced in your relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

- | | |
|---|-----------------|
| 1 | Never |
| 2 | Rarely |
| 3 | Occasionally |
| 4 | Frequently |
| 5 | Very Frequently |

- _____ 1. My partner belittles me (makes me feel unimportant or small).
- _____ 2. My partner demands obedience to his/her whims (demands that I do everything that he or she says).
- _____ 3. My partner becomes surly (rude, mean) and angry if I tell him/her that he/she is drinking too much.
- _____ 4. My partner makes me perform sex acts that I do not enjoy or like.
- _____ 5. My partner becomes very upset if dinner, housework or laundry is not done when he/she thinks it should be.
- _____ 6. My partner is jealous and suspicious of my friends.
- _____ 7. My partner punches me with his/her fists.
- _____ 8. My partner tells me I am ugly and unattractive.
- _____ 9. My partner tells me I really couldn't manage or take care of myself without him/her.
- _____ 10. My partner acts like I am his/her personal servant.
- _____ 11. My partner insults or shames me in front of others.
- _____ 12. My partner becomes very angry if I disagree with his/her point of view.
- _____ 13. My partner threatens me with a weapon.
- _____ 14. My partner is stingy in giving me enough money to run our home.
- _____ 15. My partner belittles me intellectually (makes me feel like I'm not smart).
- _____ 16. My partner demands that I stay home to take care of the children.
- _____ 17. My partner beats me so badly that I must seek (get) medical help.
- _____ 18. My partner feels that I should not work or go to school.
- _____ 19. My partner is not a kind person.
- _____ 20. My partner does not want me to socialize (get together) with my friends.
- _____ 21. My partner demands sex whether I want it or not.
- _____ 22. My partner screams and yells at me.
- _____ 23. My partner slaps me around my face and head.

- _____ 24. My partner becomes abusive (is mean or mistreats me) when he/she drinks.
- _____ 25. My partner orders me around.
- _____ 26. My partner has no respect for my feelings.
- _____ 27. My partner acts like a bully towards me.
- _____ 28. My partner frightens me.
- _____ 29. My partner treats me like a dunce (like I'm stupid).
- _____ 30. My partner acts like he/she would like to kill me.
- _____ 27. My partner acts like a bully towards me.
- _____ 28. My partner frightens me.
- _____ 29. My partner treats me like a dunce (like I'm stupid).
- _____ 30. My partner acts like he/she would like to kill me.

Appendix P

Childhood Trauma Questionnaire (CTQ) (Short Form)

Directions: These questions ask about some of your experiences growing up as a child and a teenager. For each question, circle the number that best describes how you feel. Although some of these questions are of a personal nature, please try to answer as honestly as you can. Your answers will be kept confidential.

1 = Never True

2 = Rarely True

3 = Sometimes True

4 = Often Untrue

5 = Very Often True

When I was growing up, . . .

- 1. I didn't have enough to eat.
- 2. I knew that there was someone to take care of me and protect me. (R)
- 3. People in my family called me things like "stupid", "lazy", or "ugly".
- 4. My parents were too drunk or high to take care of the family.
- 5. There was someone in my family who helped me feel important or special. (R)

When I was growing up, . . .

- 6. I had to wear dirty clothes.
- 7. I felt loved. (R)
- 8. I thought that my parents wished I had never been born.
- 9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.
- 10. There was nothing I wanted to change about my family.

When I was growing up, . . .

- 11. People in my family hit me so hard that it left me with bruises or marks.
- 12. I was punished with a belt, a board, a cord (or some other hard object).
- 13. People in my family looked out for each other. (R)
- 14. People in my family said hurtful or insulting things to me.
- 15. I believe that I was physically abused.

- 1 = Never True**
2 = Rarely True
3 = Sometimes True
4 = Often Untrue
5 = Very Often True

When I was growing up, . . .

- ___16. I had the perfect childhood.
___17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.
___18. Someone in my family hated me.
___19. People in my family felt close to each other. (R)
___20. Someone tried to touch me in a sexual way or tried to make me touch them.

When I was growing up, . . .

- ___21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.
___22. I had the best family in the world.
___23. Someone tried to make me do sexual things or watch sexual things.
___24. Someone molested me (took advantage of me sexually).
___25. I believe that I was emotionally abused.

When I was growing up, . . .

- ___26. There was someone to take me to the doctor if I needed it. (R)
___27. I believe that I was sexually abused.
___28. My family was a source of strength and support. (R)

Appendix Q

SPIRITUAL WELL-BEING SCALE (SWBS)

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience.

- 1 = Strongly Agree
 2 = Moderately Agree
 3 = Agree
 4 = Disagree
 5 = Moderately Disagree
 6 = Strongly Disagree

- | | |
|-------------|--|
| 1 2 3 4 5 6 | 1. I don't find much satisfaction in private prayer with God. |
| 1 2 3 4 5 6 | 2. I don't know who I am, where I came from, or, where I am going. |
| 1 2 3 4 5 6 | 3. I believe that God loves me and cares about me. |
| 1 2 3 4 5 6 | 4. I feel that life is a positive experience. |
| 1 2 3 4 5 6 | 5. I believe that God is impersonal and not interested in my daily situations. |
| 1 2 3 4 5 6 | 6. I feel unsettled about my future. |
| 1 2 3 4 5 6 | 7. I have a personally meaningful relationship with God. |
| 1 2 3 4 5 6 | 8. I feel very fulfilled and satisfied with life. |
| 1 2 3 4 5 6 | 9. I don't get much personal strength and support from my God. |
| 1 2 3 4 5 6 | 10. I feel a sense of well-being about the direction my life is headed in. |
| 1 2 3 4 5 6 | 11. I believe that God is concerned (cares) about my problems. |
| 1 2 3 4 5 6 | 12. I don't enjoy much about my life. |
| 1 2 3 4 5 6 | 13. I don't have a personally satisfying relationship with God. |
| 1 2 3 4 5 6 | 14. I feel good about my future. |
| 1 2 3 4 5 6 | 15. My relationship with God helps me not to feel lonely. |
| 1 2 3 4 5 6 | 16. I feel that life is full of conflict (problems) and unhappiness. |
| 1 2 3 4 5 6 | 17. I feel most fulfilled when I am in close communication with God. |
| 1 2 3 4 5 6 | 18. Life doesn't have much meaning. |
| 1 2 3 4 5 6 | 19. My relationship with God contributes to my sense of well-being. |
| 1 2 3 4 5 6 | 20. I believe there is some real purpose for my life. |

Appendix R**Africultural Coping Systems Inventory**

0 = do not use

1 = use a little

2 = use a lot

3 = use a great deal

- _____ 1. Prayed that things would work themselves out.
- _____ 2. Got a group of family or friends together to help with the problem.
- _____ 3. Shared your feelings with a friend or family member.
- _____ 4. Remembered what a parent (or other relative) once said about dealing with these kinds of situations.
- _____ 5. Tried to forget about the situation.
- _____ 6. Went to church (or other religious meeting) to get help from the group.
- _____ 7. Thought of all the struggles Black people have had to endure, which gave you strength to deal with the situation.
- _____ 8. To keep from thinking about the situation, you found other things to keep you busy.
- _____ 9. Sought advice about how to handle the situation from an older person in your family or community.
- _____ 10. Read a scripture from the Bible (or similar book) for comfort and/or guidance.
- _____ 11. Asked for suggestions on how to deal with the situation during a meeting of your organization or club.
- _____ 12. Tried to convince yourself that it was not bad.
- _____ 13. Asked someone to pray for you.
- _____ 14. Spent more time than usual doing group activities.
- _____ 15. Hoped that things would get better with time.

- _____ 16. Read passage from daily meditation book.
- _____ 17. Spent more time than usual doing things with friends and family.
- _____ 18. Tried to remove yourself from the situation.
- _____ 19. Sought out people you thought would make you laugh.
- _____ 20. Got dressed up in my best clothing.
- _____ 21. Asked for blessings from a spiritual or religious person.
- _____ 22. Helped others with their problems.
- _____ 23. Lit a candle for strength or guidance in dealing with the problem.
- _____ 24. Sought emotional support from family and friends.
- _____ 25. Burned incense for strength or guidance in dealing with the problem.
- _____ 26. Attended a social event (dance, party, movie) to reduce stress caused by the situation.
- _____ 27. Sung a song to yourself to help reduce the stress.
- _____ 28. Used a cross or other object for its special powers in dealing with the problem.
- _____ 29. Found yourself watching more comedy shows on television.
- _____ 30. Left matters in God's hands.