THE IMPACT OF INTIMATE PARTNER VIOLENCE ON MENTAL HEALTH: A STUDY OF AFRICAN AMERICAN AND CAUCASIAN COLLEGE FEMALES

By

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A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of
Masters of Sciences in Human Sciences

Middle Tennessee State University

2013

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Abstract

This study examined the relationship between race and the development of mental health disorders following experiences of intimate partner violence (IPV). An existing data set was used with a questionnaire that included Post Traumatic Stress Disorder (PTSD) and depression scales as indicators of mental health. Participants included 46 African American and 46 randomly selected Caucasian female students at a large, Southeastern university who had experienced IPV (n=92). A MANOVA was used to analyze the extent to which race affected the development of PTSD and depression following IPV. The findings of the study indicated that race did not play a role in determining whether or not women were likely to develop mental health issues as a result of experiencing IPV. It is important to note that all victims of IPV regardless of race do experience some levels of PTSD and depression and would benefit from interventions that address these issues.

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Chapter I

Introduction

Intimate Partner Violence (IPV) is a reality for multiple women. The National Crime and Victimization Survey reported that annually, approximately 1.4 million women experience various types of intimate partner violence at the hands of those who swear they love them (National Crime Victimization Survey, 2012). This unfortunate statistic spreads across all races, backgrounds, cultures and nationalities (Lee, Pomeroy & Bohman, 2007). Many researchers have questioned whether there was a difference in intimate partner violence between African American and Caucasian women. They have also wondered about the propensity to develop Post Traumatic Stress Disorder (PTSD) or depression following an IPV experience. However, there is not much research on the topic of racial differences as they contribute to IPV. As a result, the small amount of research that has been presented on this topic is conflicting and does not provide definitive information. In their review of the research on this serious topic, McFarlane, Groff, Obrien and Watson (2005) iterated that

> Black women have traditionally reported intimate partner physical assault at a rate 35% higher than that of White women, and about 2.5 times the rate of women of other races in the National Crime Victimization Survey (NCVS) (Rennison & Welchans, 2000). Even though this number has dropped down to around 7% (NCVS, 2010), previous studies have produced contradictory findings as to whether race and ethnicity affect ones risk of IPV. Some studies conclude that minorities and Whites

experience equal rates of IPV (Bachman, 1994), and others conclude that minorities experience higher rates (NCVS 2010, 2011, 2012).

Classical and recent research does however conclude that both races experience Intimate Partner Violence at alarming and disheartening rates (Tjadden & Thoennes, 1999; NCVS, 2012). For example, among both races there is a significant rate of IPV that takes place regardless of socio-economic status or education level. McFarlane, Groff, Obrien and Watson (2005) stated that women who experience from IPV are subjected to various forms of violence including rape and physical assault with and without weapons.

> The NCVS detected an annual intimate partner rape rate of 0.55 per 1,000 women (Rennison & Welchans, 2000) compared to 3.2 per 1,000 women recorded by the NVAWS (Tjaden & Thoennes, 2000). Among the same sampled population, the NCVS detected an annual intimate partner physical assault rate of 4.98 (simple assaults, i.e., without a weapon) per 1,000 women and 1.2 (aggravated assaults, i.e., with a weapon) per 1,000 women as compared to the NVAWS rate of 44.2 physical assaults per 1,000 women (pg. 99).

The NCVS (2012) and the Center for Disease Control (2010) supported the ongoing trend of IPV suffered by women over the past ten years. Both of these sources report that one out of every ten women (10%) has experienced rape by an intimate partner during their life time. These statistics highlight how intimate relationships can lead to IPV experiences and how Post Traumatic Stress Disorder and Depression can potentially become health concerns among

victims (Babcock, Roseman, Green & Ross, 2008). Both of these health issues along with their treatment challenges have considerable morbidity and mortality rates (Daniels, 2005). Studies support that there are several differences between Caucasian and Black women that contribute to the success of treatment of PTSD and major depression. Several of these differences surround cultural traditions, beliefs about healthcare, education, availability of resources plus familial and spiritual support (Beeble, Bybee, Sullivan and Adams, 2009). All of these aspects are included in the various levels of social interaction that women must face every day. Accordingly, the theory that will be utilized to evaluate this research is the Social Ecological theory.

Theoretical Framework

When researching the effects of IPV on Caucasian and African American women, it is important to understand the various levels of societal influence that affect these women's propensity to develop psychological disorders after experiencing IPV. Because there are so many levels of influence affecting Intimate Partner Violence, the theoretical framework for this research must be equally versatile (Little and Kantor, 2002; Holden & Nubios, 1999). Accordingly, Dutton's Ecological Theory (2006) will be utilized to understand the possible development of psychological disorders following incidences of IPV.

The ecological theory, originally introduced by Urie Bronfenbrenner in 1979, has been identified by the National Research Council as a framework best suited to address the causes, consequences, and treatment formulations for the abused (Dutton, 2006; Little & Kantor, 2002). Belsky's adaptation of the

ecological theory (1980) targets the phenomenon of abuse and accentuates four various levels of an individual's environment that contributes to their development. These levels are the: macrosystem, exosystem, microsystem and ontogenetic levels. The macrosystem level comprises individuals' cultural values, backgrounds and belief systems. Following this level is the exosystem which comprises individuals' formal and informal societal organizations such as church, work or school, and the microsystem level which consists of the family and personal relationships. The last level, the ontogenetic level, is comprised of individual personal development such as upbringing and familial influence (Dutton, 2006). Each one of these ecological levels plays a definitive role in a woman's risk of developing Post-Traumatic Stress Disorder and/or Depression following an Intimate Partner Violence experience.

Statement of the Problem

The focal point of this study is how race may impact the levels of mental health (as defined by Post Traumatic Stress Disorder and depression) of women who have experienced IPV. A review of the literature raises questions regarding factors that may mediate or exacerbate mental health, thus highlighting the interconnectedness of these variables.

Research Question

The primary research question to be addressed is:

What differences in levels of mental health exist among African American women and Caucasian women who have been victims of intimate partner violence?

Definition of Terms

African American: An American of African, or especially of black-African descent (Merriam-Webster, 2012).

Caucasian: Of constituting, or characteristic of a race of humankind native to Europe, North Africa, and southwest Asia and classified according to physical features —used especially in referring to persons of European descent having usually light skin pigmentation (Merriam-Webster, 2012).

Depression: A state of feeling sad or dejection. A psychoneurotic or psychotic disorder marked especially by sadness, inactivity, difficulty in thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal tendencies (Merriam-Webster, 2012).

Intimate Partner: Any married or divorced partner or ex-partner. Other intimate partners that include current boyfriends with whom women maintain sexual relationships (Golding, 1999).

Intimate Partner Violence: Physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (Centers for Disease Control and Prevention, 2012).

Physical Violence: The intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or

one's body, size, or strength against another person. (Centers for Disease Control and Prevention, 2012).

Post Traumatic Stress Disorder: a psychological reaction that occurs after experiencing a highly stressing event (as wartime combat, physical violence, or a natural disaster) outside the range of normal human experience and that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event (Merriam-Webster, 2012).

Psychological Abuse: Psychological abuse has been defined as “verbal and nonverbal acts which symbolically hurt the other or the use of threats to hurt the other” (Roseman, Green & Ross, 2008; Straus, 1979).

Chapter II

Review of the Literature

Introduction

Current studies reflect that physical partner violence has been shown to have wide-ranging negative consequences, including depression anxiety, social withdrawal, suicide attempts, and posttraumatic stress disorder (PTSD) (Babcock et al, 2008). Intimate partner violence, or the chronic abuse of an individual by a current or former intimate partner, is a serious and pervasive public health concern (Center for Disease Control, 2011; Lutenbacher, Cohen & Mitzel, 2003; Scott-Tilley, Tilton & Sandal, 2010). In addition, studies indicate that women are 10 times more likely than men to be the victim of violence by intimates and that this violence is exceedingly likely to lead to the development of a mental health issue such as PTSD or depression (Center for Disease Control, 2011; Lutenbacher et al, 2003; Scott-Tilley et al, 2010). Furthermore, IPV is not exclusive to any race, culture or socioeconomic status; however, studies show that African American women are victims of IPV at higher rates than Caucasian women, yet are less likely to seek assistance outside of their family to alleviate the symptoms of PTSD and depression (Lee et al, 2007; Babcock et al, 2008; NCVS, 2010, 2011, and 2012).

Intimate Partner Violence against African American and Caucasian Women

As stated previously, it is an unfortunate reality that Intimate Partner Violence affects women from all backgrounds, races and cultures. The National Intimate Partner and Sexual Violence Survey states that almost one in five

women in the United States have been victimized by rape at some point during their lifetimes, while one in ten of women in the United State have been raped by an intimate partner during the course our their lifetimes (Center for Disease Control, 2010). The National Crime Victimization Survey (NCVS) published by the Bureau of Justice (2012) reported that there were 4,274,118 acts of violence committed by intimates (current or former spouses, boyfriends or girlfriends, other relatives, and friends/acquaintances) in 2011. These acts included rape/sexual assault, aggravated assault, and simple assault. Of that number, 1,430,952 females were victims of intimate partner violence, which is operationalized here as the perpetration of violence by intimate partners and/or friends and acquaintances. The latter can be interpreted as including casual dating relationships. These studies indicate that overall, females were more likely to be victimized by someone they knew rather than by a stranger while the opposite was true for males (i.e., 70% of reported violence vs. 30%, respectively) (NCVS, 2012). The fact that women are victimized by intimate partners more than strangers is a recurring finding in national studies (NCVS 2010, 2011, and 2012; NISVS, 2010).

Studies show that African American women, especially in the low income demographic, experience extremely high and disproportionate rates of intimate partner violence (West, 2002; Bliss, Ogley-Oliver, Jackson, Harp & Kaslow, 2008).The National Family Violence survey reports that 17% of African American wives had been victims of at least one violent act in the survey year (West, 2002). Additionally, the Violence Against Women Survey, a notable classic

reference, reflected that one quarter of the African American women surveyed had been victims of physical partner violence and 4% of these women had been stalked (Tjaden & Thoennes, 2000).

The prevalence of rape and sexual assault are also high in the African American community as evidenced by the National Intimate Partner and Sexual Violence Survey (NISVS). This survey reported that one in five African American women have experienced rape during some point in their lives (2010), and that 43.7% of African American women have experienced rape, physical violence, and/or stalking by an intimate partner during the course of their life time (Center for Disease Control, 2010).

Research regarding rates of IPV among Caucasian and African American women shows conflicting results about the differences or lack of differences between these groups. For example, there are reports that Caucasian women experience intimate partner violence at comparable rates to African American (Hamberger, Ambuel & Guse, 2007). Additionally, the National Crime Victimization Survey of 2011 stated that of the Intimate Partner Violence occurrences reported by African American women in 2010, 1% were rape/sexual assault, 5% of the incidences were aggravated assault, and 11% were simple assault. Similar numbers were reported for Caucasian women with 1% of reports comprised of rape/sexual assaults, 3% were aggravated assaults and 9% were simple assaults.

Other research suggests that Caucasian women experience rates of Intimate Partner Violence at 35% less than that of their African American counter

parts (Facts About Domestic Violence, 2010), however, these rates have dropped slightly over the past 10 years (NCVS, 2012). The NCVS reports that 6.2 out of 1,000 Caucasian women experience intimate partner violence as compared to 7.8 of 1,000 African American women (2012). Further evidence of racial differences can be found in research by the Center for Disease Control (2010) cited previously where the rates of Caucasian women reporting rape, physical violence and/or stalking by an intimate partner over the course of their lives and that of African American women are 34.6% vs. 43.7%, respectively (NISVS, 2010). The Center for Disease Control (2010) also reported that one in four Caucasian women (26%) reported experiencing attempted, threatened, or completed physical violence or nonconsensual sex by an intimate partner at least once in their lifetime and that African American women experienced rates closer to 30% (Breiding et al. 2008; Krebs, Breiding, Brown & Warner, 2011). Stalking is also an issue, as 23% of Caucasian women have reported being stalked by a current or former romantic partner (Krebs et al, 2011).

Frequent forms of intimate partner violence experienced by African American and Caucasian women include sexual abuse, dating violence, sexual assault and sexual harassment; and it is very common for these multiple forms of violence to co-occur (West 2002; NCVS, 2010). Furthermore, intimate partner violence can prove to be an ultimately deadly occurrence for African American women as homicide by intimate partners is the second leading cause of death for African American women between the ages of 20-24. However, for Caucasian women, the second leading cause of death between the ages of 20-24 is suicide

(Center for Disease Control Leading Causes of Deaths in Females, 2008). These statistics highlight an apparent difference between the prevalence rates of IPV within the African American and Caucasian communities.

According to a study conducted by the University of North Carolina, the most prominent types of Intimate Partner Violence within the Caucasian and African American communities were rape, physical assault and stalking (Prevent, 2012). African American women reported somewhat higher rates of each of these forms of IPV in comparison to Caucasian women. For example, 21.3% of Caucasian women reported physical assault compared to 25.5% of African American women, 7.7% of Caucasian women reported rape compared to 7.8 of African American women, and 4.7% of Caucasian women reported stalking compared to 5.0% of African American Women (Prevent, 2012). All of these statistics highlight the prevalence of IPV in both African American and Caucasian communities.

Social Status as a Factor

Unfortunately, classic and recent studies indicate that extensive and reliable data on the experiences and consequences of intimate partner violence among low income and African American and Caucasian women is sparse (Few, 2005; Bradley, Schwartz & Kaslow, 2005). Poverty is one of the most predominant and leading predictors of recurring IPV (Sonis & Langer, 2008) as there is an apparent relationship between socioeconomic status and rates of intimate partner violence among African American and Caucasian women. There is an excessively higher rate of IPV among low income African American and

Caucasian women in comparison to other socio-economic demographics (West, 2002; Bliss et al, 2008). Even though IPV effects women regardless of income, women with a lower annual income (below $25K) are at a three`-times higher risk of IPV than women with a higher annual income (over $50K) (Domestic Violence Resource Center, 2013). Furthermore, African American women who have received food stamps and other forms of government assistance were increasingly likely to experience physical and psychological abuse, at rates of 67% and 95% respectively (West, 2002; Bradley et al 2005).

African American and Caucasian women who fit the demographic profiles of low-income and residing in a rural area are the most frequent victims of partner violence as opposed to women residing in urban locations (West, 2002; Pruitt, 2008). Low income Caucasian women who resided in rural areas experienced Intimate Partner Violence at the same rates as their urban counterparts, however, rates of reporting for women in rural areas are lower due to higher rates of traditional patriarchal roles and lack of resources available to them (Few, 2005; Teruya, Longshore, Andersen, Arangua, Nyamathi, Leake & Gelberg, 2010).

Socio-economic status also plays a role in determining a woman's level of comfort in pursuing health care assistance following intimate partner violence. Within African American and Caucasian communities, several health care and support disparities exist between women of lower and higher economic statuses (Teruya et al., 2010; Bradley et al, 2005; West, 2002; Sonis & Lauger, 2008). African American women are frequently unable to access quality health care and

social support following intimate partner violence due to lack of adequate resources (Teruya et al., 2010; West, 2002; Pruitt, 2008).

In contrast, Caucasian women who reside in higher income areas have better access to resources such as counseling, healthcare and domestic violence shelters. These resources assisted them in decreasing the development of PTSD or Depression as Caucasian women report a dramatic decline in depression following the termination of their abusive relationships (West, 2002). Caucasian women were also more likely to be employed during instances of intimate partner violence and also less likely to be currently involved in a marriage relationship with their abusive partner (Lee et al, 2007). Accordingly, employed Caucasian women are more likely to leave abusive relationships due to lack of financial dependence on their intimate partners, where African American women, especially those residing in low-income areas, were less likely to depart or pursue resources if not employed (West, 2002). Additionally, African American women who resided in lower income rural areas were also less likely to pursue assistance following IPV as they are typically not aware of the resources available in their community and therefore do not know to access them (Few, 2005; Hamberger et al, 2007).

This literature supports the fact that socio-economic status is a contributor to the increased rates of IPV against African American women and Caucasian women who are in lower economic categories. In addition, location (rural or urban) impacts a woman's accessibility to resources that could decrease her likelihood of developing a mental disorder following Intimate Partner Violence

experiences. Ultimately, social status and rural/urban location are factors in determining the level of social support and healthcare assistance obtained by African American and Caucasian women following an encounter with Intimate Partner Violence as they both play a role in determining a victim's access to much needed resources that may contribute to ending an IPV experience (Teruya et al, 2010).

IPV, Race and Mental Health

Studies show that African American and Caucasian women who have experienced intimate partner violence were more likely to develop Post Traumatic Stress Disorder (PTSD) and depression (Bradley et al, 2005; Scott-Tilley et al, 2010; Hogue, Liddle, Becker, & Johnson-Leckrone, 2002). Research stated that:

> Although PTSD differs from major depression, it often occurs along with depression (Pico-Alfonso et al., 2006). The type of abuse—physical, sexual, or psychological—may impact the co-occurrence of PTSD and depression. Pico-Alfonso et al. (2006) found that the incidence of PTSD without depression was rare; depressive symptoms were found in 90.3% of physically/psychologically abused women with PTSD, and 89.3% of psychologically abused women with PTSD (Lutenbacher, et al, 2010).

Violence can accentuate the symptoms of mental health issues as IPV has negative influences on a woman's mental health (Babcock et al, 2008; Breiding et al, 2008; Krebs et al, 2011). Victims of IPV differ in the extent to which they exhibit PTSD symptoms, depending on the types and variations of abuse

experienced the context and availability of their social support network, and the woman's individual ability to control and adjust her own emotional responses (Babcock et al, 2008). The quality of social support proved to be a stronger indicator of the severity of PTSD symptoms more so than the type of IPV as social support is a protective factor that serves to lessen the risk of harmful mental health issues among victims of IPV (Babcock et al, 2008). Additionally, women who are able to regulate their emotional responses successfully are less likely to develop severe PTSD as they are better able to control their reaction to environmental triggers. This is due to several factors ranging from upbringing, environmental conditioning and physiological factors such as blood flow within the brain and mid-brain activity (Scott-Tilley et al, 2010; Babcock et al; Pico-Alfonso et al, 2006.)

There is evidence to suggest that the psychological and physical abusive factors of intimate partner violence are likely precursors for mental health disorders such as PTSD and Depression (Norwood & Murphy, 2012). Psychological abuse has traditionally been defined as "verbal and nonverbal acts which symbolically hurt the other, or the use of threats to hurt the other (Babcock et al, 2008). IPV has wide-ranging and vast psychological effects on victims and therefore is almost always associated with psychological abuse (Babcock et al, 2008; Scott-Tilley et al, 2010; Bradley, 2005). In fact, only one percent of women experiencing IPV reported experiencing physical abuse without concurrent psychological abuse (2008). Logically, then, there may be a link between levels of mental health and IPV.

Depression

Depression is one of the most common experiences for African American and Caucasian survivors of sexual assault and IPV (Daniels, 2005; Scott-Tilley et al, 2010). Victims of IPV are more likely to experience psychological trauma than those who have not experienced IPV because in addition to physical pain, IPV has an effect on the victim's perception of their self-worth (Zust, 2006; Daniels, 2005). Questioning self-importance and lack of self-worth can progress to depression, which can then lead to drug abuse, suicide or other serious problems (Zust, 2006; Chaung, Cattoi, McCall-Hosenfield, Camacho, Dyer & Weisman, 2012).

The severity and type of IPV is significantly correlated with the severity of depression that the victim experiences (Few, 2005). For example, West (2002) found that many women who reported numerous incidences of sexual victimization such as marital rape or childhood sexual abuse also reported depression. The depression then may then be the result of experiencing multiple incidences of sexual victimization that may then increase the difficulty that these ladies have confronting their history of IPV as an adult (Babcock et al, 2008; Chaung et al, 2012).

Although literature exists supporting the fact that African American women who experience IPV may also experience depression, much of this documentation has been in the form of self-help books and memoirs, and not in scientific research and observation (West, 2002). In popular literature works, African American women have described their mental state following Intimate

Partner Violence as “the blues”. Within these literary pieces, this term which demonstrates the “dysphoria” or depression that these women experience has been attributed to the intimate partner violence that they have experienced during the course of their lives (West, 2002). The research that has covered this phenomenon has identified obvious contributing factors, such as social support and cultural differences, associated with symptoms of depression following abusive relationships.

Post Traumatic Stress Disorder

Another mental disorder that regularly occurs as a result of IPV is Post Traumatic Stress Disorder or PTSD. Post Traumatic Stress Disorder is defined as a psychological reaction following a traumatizing event that is marked with severe anxiety and depression (Merriam Webster, 2012). It is a multifaceted, debilitating and complex disorder during which a victim of IPV is negatively affected by ongoing and pervasive thoughts of the traumatic event. Research suggests that both psychological and physical abuse is strongly related to the development of PTSD symptoms following IPV (Scott Tilley et al, 2010). Women who experience extremely disturbing emotional and psychiatric symptoms of PTSD can also be faced with physical consequences that include an impaired immune system, difficulty sleeping, blood sugar problems, obesity and other physical problems (Scott-Tilley et al, 2010; Norwood & Murphy, 2012). Additional statistics illustrate that women of both races who experience PTSD are also at risk for suicide, substance abuse, alcohol abuse and failed social relationships (Scott-Tilley et al, 2010).

Many women who are victims of IPV will experience a mental health disorder following their traumatic experiences (Scott-Tilley et al, 2010). PTSD is commonly experienced in conjunction with depression, which makes these two a frequently occurring comorbity, which means that they commonly are diagnosed together (Daniels, 2005, Bradley et al, 2005). African American and Caucasian women who experience IPV are more likely to experience PTSD than women who have not experienced IPV (Babcock et al, 2008). Much like depression, the likelihood of experiencing PTSD following IPV is related to the type of IPV experienced as well as mental, physiological and emotional factors (Scott-Tilley et al, 2010). For example, women who have been sexually assaulted, raped or threatened with weapons are more likely to develop PTSD following IPV than women who have experienced milder forms, such as verbal abuse (Babcock et al, 2008; West, 2002). Additionally, women who have a stronger support system and stronger midbrain function that can better regulate emotional responses to stimuli are better able to prevent or endure the development of PTSD following an emotionally traumatizing event such as IPV.

Even though both Caucasian and African American women commonly experience PTSD following IPV, the coping mechanisms for the disorder vary. African American women are more likely than Caucasians to seek treatment for symptoms of PTSD through religious avenues. This may be due to strict promotion of religion as a source of coping for mental health issues, if ever the mental health issues are addressed. Caucasian women are more likely to address their PTSD symptoms through clinical and psychological assistance

(Babcock et al, 2008). Typically, this behavior allows Caucasian women to receive more assistance than African American women because they find it more acceptable to access more diverse resources.

Overall, studies have shown that African American and Caucasian women who experience Intimate Partner Violence are more likely to develop mental health disorders, most likely depression and Post Traumatic Stress. The development of these mental health problems come as a result of ongoing physical abuse that occurs concurrently with psychological abuse (West, 2002; Lee et al, 2007;Tjaden & Thoennes, 2000; Bradley et al, 2005; Babcock et al, 2008). Accordingly, because of the prevalence of psychological abuse during intimate partner violence that affect these women in the various areas of their life, an ecological theoretical framework will be used to further evaluate IPV and mental health.

The Ecological Theory

The ecological theory, originally introduced by Urie Bronfenbrenner in 1979, is the most effective theory for evaluating and explaining intimate partner violence (Little & Kantor, 2002). The ecological theory is a multidimensional framework that provides a thorough approach to IPV as it indicates that intimate partner violence and thus the mental health problems that stem from IPV are not a result of one single factor but rather the result of several catalysts including the individual and their environment. The ecological theory is typically utilized to evaluate the risk factors and etiology for intimate partner violence because it also

allows for a comprehensive understanding of which aspects of an abusive environment most contribute the occurrence of IPV (Mitchell & James, 2009).

The ecological framework utilized for this study was first proposed by Belsky (1980) and later used by Dutton (2006) for the study of intimate partner violence. As stated previously, the four levels of the ecological theory consist of the macrosystem, exosystem, microsystem and ontogenetic system (Belsky, 1980; Dutton, 2006; Mitchell & James, 2009). The macrosystem level consists of an individual's cultural values and beliefs and can offer justification for whether or not a woman pursues hospitalization, shelter assistance or psychological support following intimate partner violence. The next system, the exosystem, comprises a woman's formal and informal social circles. This includes family, church, work and other circles that should provide support in assisting the woman with dealing with the intimate partner violence. The microsystem which is the area in which the abuse takes place provides the basis for the understanding of the abuse and the psychological effects that it has on the woman. Lastly, the ontogenetic level that consists of the woman's developmental history offers an understanding of intimate partner violence within the woman's cohort group, race and other factors (Little & Kantor, 2002; Mitchell & James, 2009).

The Macrosystem Level

The macrosystem level consists of the individuals' cultural beliefs, upbringing and conditioned thought processes. Regarding intimate partner violence, this level allows for the examination of ideas that may lead to the eventual abuse of individuals. One such example would be stereotypical gender

role attitudes such as the belief that men are dominant and entitled in relationships, and women are subservient to their desires and demands. This belief is evident within the woman's interactions with men over the course of her lifetime. Therefore, this level of the ecological framework can begin to explain why some women find themselves in recurring abusive relationships. For example, in many cultures, there is an expectation that a man's "duty" is to kill his wife if he suspects that she is cheating (Dutton, 2006). This belief system is ingrained into young women since birth and promotes the belief that their lives are only as valuable as their male counterparts allow (2006). This patriarchal hierarchy contributes to intimate partner violence and is not only evident in Middle Eastern and traditionally religious cultures, but also in Western cultures as well (2006). In western culture, the myth of gender equality in relationships is debunked by the reality that the dynamics of relationships reflect cultural attitudes that are still patriarchal or male dominated in nature (Lloyd & Emery, 2000). This false perception of gender equality masks the fact that intimate partner violence is used by men to force women into compliance within the relationship.

The Exosystem Level

The exosystem focuses on individuals' formal and informal social groups and circles. These can be family, friends and acquaintances, work, church and other groups that make up a person's daily interactions. This level of the ecological framework serves an important role in providing the victim of intimate partner violence with the resources and support necessary to leave the abusive

relationship and seek the help that she will need to prevent the development of mental health issues such as Post Traumatic Stress Disorder and Depression (Little & Kantor, 2002). However, a lack of social support within the exosystem can contribute to the development of mental health disorders that follow as a result of intimate partner violence (Babcock et al, 2008).

Factors at the exosystem level can also be more of a hindrance than a help to a young woman who experiences IPV. For example, if her friends and family possess limiting views of women's rights or support the abuser's actions, or if the victim of abuse is experiencing excessive stress at work, is unemployed or has a limited social support system, the victim may not immediately leave an abusive relationship (Dutton, 2006). Reasons for the victim not leaving the relationship are that she may not feel she has any viable options to the abusive relationship and may even feel that the abuse is normal and/or deserved. These beliefs are typically reinforced within the exosystem level and therefore, make it increasingly difficult for a victim of abuse to change.

African American communities are more likely to place greater value on interdependence, collective responsibility and kinship networks than middle and upper income Caucasian communities (Bradley et al, 2005) Dutton also emphasized that increased familial stress related to financial concerns contributes to higher rates of intimate partner violence as low income, unemployment and part time employment status contribute to the presence of IPV in the home (2006). Additionally, the male's peer groups and exosystem level can contribute to intimate partner violence as his family, friends and social

systems may be encouraging him to utilize violence as a means of “controlling” his girlfriend or spouse (Dutton, 2006). Without the support of resources at this level, the abused woman may be more likely to be affected by Depression, PTSD and other mental health issues (Lutenbacher, Cohen & Mitzel, 2003).

The Microsystem Level

The microsystem comprises the immediate setting in which the abuse takes place, including factors such as the relationship make up and dynamics (Lutenbacher et al, 2003). Belsky (1980) described this level as the “interaction pattern that exists in the family itself or the structural elements of that family. With regard to IPV, this level of the ecological framework looks at the types of abuse experienced such as physical, emotional, psychological and sexual abuse. Also, the microsystem allows researchers to view the dynamics of intimate partner violence that can range from severe to mild and include any variety of violent acts which includes, slapping, hitting, kicking, burning, punching, choking, shoving, beating, throwing things, locking a person out of the home, restraining and other acts designed to injure, hurt, endanger or cause physical pain (Vanderende, Yount, Dynes & Sibley, 2012; NCVS, 2012).

Power is another relationship dynamic that can be examined at this level. Violence is more likely to occur in a household or relationship where an imbalance of power exists (Dutton, 2006; Lloyd & Emery, 2000a). Lack of power in a violent relationship may result in feelings of hopelessness and helplessness (Lloyd & Emery, 2000b), and the inability to affect change, a documented condition called “learned helplessness” (Walker, 1979). Learned helplessness is

a complex psychological phenomenon that occurs when an individual submits to a violent or threatening situation after accepting that this situation is the norm for them (Walker, 1979). Victims come to perceive that they cannot predict outcomes of behavior in their abusive relationships and therefore, lack any control over their immediate environment. This may result in victims remaining in the violent situation and thus increasing their chances of developing mental health disorders such as PTSD and depression (Daniels, 2005).

The Ontogenetic Level

The ontogenetic level deals with individuals' developmental history and various aspects and attributes, such as genetic composition and environmental conditioning that shape their reaction to the stressors occurring within other levels of the ecological framework (Stith et al, 2004; Dutton, 2006; Belsky, 1980). On this level, upbringing and childhood experiences are the determinants of an individual's response to factors that are represented on the macrosystem, exosystem and microsystem levels. On the ontogenetic level, both the female's and male's experiences and reactions to stressors play a dominant role in the development of intimate partner violence within the relationship (Little & Kantor, 2002; Dutton, 2006; Mitchell & Anglin, 2009). For example, males who have witnessed intimate partner violence where their mother is abused by their father are three times more likely to exhibit this type of behavior with their intimate partners (Dutton, 2006). Additionally African American women who are abused in adulthood report substantially high rates of child sexual abuse including forced penetration, and attempted or completed oral sex, anal sex or rape during their

childhood. Many survivors of child sexual abuse (at least one incident of sexual abuse during childhood) will be re-victimized in adulthood and experience subsequent adult physical, sexual or psychological victimization (West, 2002). This research reflects how the ontogenetic level of development can adversely affect childhood survivors of abuse in adulthood.

Conclusion

According to research, around 1.4 million women are victims of IPV annually (NCVS, 2012). IPV is not exclusive to any particular race, demographic or background; however, studies reflected that African American women experience IPV at higher rates than their Caucasian counterparts (Tjaden & Thoennes, 2000; NCVS, 2012; West, 2002; Longshore et al., 2010; Bradley et al, 2005). Additional literature stated that African American and Caucasian women who experience intimate partner violence are more likely to develop mental health disorders consisting of Post-Traumatic Stress Disorder and Depression (Tjaden & Thoennes, 2000; Babcock et al, 2008; Scott-Tilley et al, 2010).

This study will examine the variables of race and mental health as evidenced by depression and Post Traumatic Stress Disorder, and the experience of Intimate Partner Violence. While there are findings that focus on the experiences and characteristics of women who generally experience IPV, few studies have specifically compared African American and Caucasian experiences of IPV and mental health. This research will provide much needed information on the link between the effects of IPV on the levels of mental health of both African American and Caucasian women.

Statement of Hypothesis

There will be a difference in the levels of mental health (indicated by depression and PTSD) between African American women who have experienced IPV and Caucasian women who have experienced IPV.

Chapter III

Methods

The study completed examined the relationship between race and depression and Post Traumatic Stress Disorder among abused African American and Caucasian women. A quantitative design was utilized to determine what influence race had on the development of a mental health disorder among female victims of Intimate Partner Violence. The hypothesis iterated that there would be a difference in the levels of mental health (indicated by depression and PTSD) between African American women who have experienced IPV and Caucasian women who have experienced IPV. Approval for this study was sought and obtained from the Institutional Review Board of Middle Tennessee State University (see Appendix A).

Participants

This study used an extant data set of questionnaires distributed to 408 female students in the Psychology Subject Pool, Human Sciences, Health and Human Performance and University 1010 classes at Middle Tennessee State University. For the purpose of this study, a subsample was drawn from the original data that included African American and Caucasian subjects who had experienced intimate partner violence. This included physical, emotional, and/or sexual abuse as reported on the Abuse Behavior Inventory (ABI). The original sample contained those who responded that they had “rarely” experienced any physical violence including sexual abuse and/or emotional abuse to “very frequently” experiencing these actions. Subjects who responded to the

questionnaire stating that they were only threatened with weapons were removed from the sample as the focus of the original, as well as this study, was on females who experienced IPV rather than the threat of abuse. A sample of 181 female respondents, or 44.4% of the original sample was selected for the purpose of the original study. As this study evaluated the patterns of mental health disorders among African American and Caucasian women who have experienced IPV, a subset of 166 respondents comprised of 121 Caucasian and 46 African American women was used. Due to the significant difference in the number of Caucasian and African American women who experienced IPV, a random sample of 46 Caucasian women was selected for analysis. This makes a total number of 92 women in the subsample for this study.

Demographics

This study evaluated a sample of 92 females who were college students at Middle Tennessee State University. All participants had experienced IPV with equal numbers of African American (n=46) and Caucasian (n=46) women ranging in age from 18-54 with the mean age being 21.7. The most frequently reported age for African American participants was age 19 (30.4%), and for Caucasian participants it was 20 (26.1%). Additionally, because the study took place on a college campus, academic class of participants was also noted. Of the sub-sample in this study, 39.1% of African American participants (n=18) and 32.6% (n=15) of Caucasian participants were freshman, 19.6% (n=9) of African American and 23.9% (n=11) of Caucasian participants were sophomores, 13.0% (n=6) of African Americans and 17.4% (n=8) Caucasian participants were

Juniors, 26.1% (n=12) of African Americans and 19.6% (n=9) of Caucasian participants were seniors and 2.2% (n=1) of African American participants and 6.5% (n=3) of Caucasian participants were graduate students.

Regarding children, 84.8% (n=78) of the women in this study did not have children. These women, (n=37) 80.4% of African American participants did not have children and 89.1% (n=41) of Caucasian participants did not have children. Of those who did have children, 13.0% (n=6) of African American participants and 2.2% (n=1) of Caucasian participants had one child; 4.3% (n=2) of African American and Caucasian participants had two children; and 2.2% (n=1) of African American participants and 4.3% (n=2) of Caucasian Participants had three children. Additionally, participants were asked about their relationship status. Approximately half or 50.5% (n=46) of all participants were single. Within race, 57.8% (n=26) of African American participants and 43.5% (n=20) of Caucasian participants were single; 40% (n=18) of African American and 41.1% (n=19) of Caucasian participants reported having a boyfriend or a partner; 2.2% (n=1) of African American participants and 10.9% (n=5) of Caucasian participants were married; and 0% (n=0) of African American and 4.3% (2) of Caucasian participants were divorced.

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Measurements and Instruments

A questionnaire packet containing a consent form (see Appendix B), demographic questions and inquiries relating to intimate partner violence, perceived social support, posttraumatic stress disorder and depression (see Appendix C) was developed. All used in this and the original study are easily available; therefore permission was not required for their use.

Intimate Partner Violence. The Abusive Behavior Inventory (ABI, Shepard and Campbell, 1992) is a 30 item self -report scale that utilizes a five-point Likert scale to answer how often specific behaviors occur that ranges from 1 (never) to 5 (very frequently). This scale measured the frequency of intimate partner

violence. The psychological subscale included the questions: 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 15, 16, 17,19, 22 and 23. The physical subscale included questions 6, 7, 14, 18, 20, 21, 24, 25, 26, 27, 28, 29, and 30. In order to accurately score this instrument, valid scores were added up for each subscale. The psychological abuse scores were divided by 17 and the physical abuse scores by 13 in order to attain a score that reflected the mean frequency of these behaviors. Additionally, sexual abuse was evaluated using 18, 26, 28 and 28 of the physical abuse subscales.

The ABI scale has been documented to have good internal consistency and reliability with a range of alpha coefficients from .79 to .92 for a group of males and females in abusive relationships (Males M= 35.9; Female M= 32.9) and non-abusive relationships (Male M=40; Female M- 37.3) (Shephard & Campbell, 1992). Furthermore, alphas of .80 for middle school students and .90 for high school students have been reported (Holt & Espelage, 2005).

Mental Health Disorders. Two instruments were used to measure mental disorders were the PTSD Checklist-Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993) and the Center for Epidemiologic Studies Depression scale (CES-D; Radloff, 1977).

The PCL-C is a 17-item self-report scale that uses a five-item Likert scale that asks how often items have been a problem in the last month. Answers range from 1 (Not at all) to 5 (Extremely). The total sum of the scores range from 17 to 85, with the higher scores representing the presence of more PTSD symptoms. The purpose of the PCL-C was to measure reoccurring symptoms written in a

way so that they could generally apply to any traumatic event. The scale has been documented to have a test-retest reliability of .96 and an internal consistency of .97 (Weathers et al., 1993). Furthermore Lee et al, (2007) reported that the Cronbach's alpha was .94 for Caucasians and .91 for Asians. Convergent validity, which is a type of construct validity that signifies that this scale correlates well with similar scales, was substantiated by a correlation of .85 between another stress scale (the Mississippi Scale) and the PCL-C (Weathers et al., 1993).

The Center for Epidemiologic Studies Depression scale (CES-D; Radloff, 1977) is a measure of level of depression. The CES-D is a 20-item short self-report scale that utilizes a four-point Likert scale that ranges from 0 (Rarely or none of the time) to 3 (Most or all of the time) in response to how often one had specific feelings within the last month. This scale was used to measure depressive symptoms and the total sum of the scores ranges from 0 to 60. The higher scores indicated the presence of more depressive symptoms.

The CES-D measured the general population for depression symptoms that are also among clinical diagnoses. The scale has been reported to have a strong discriminate validity (i.e., a type of construct validity that indicates non-correlation between unrelated scales) between patient and general population. Like the PCL-C, the CES-D is documented to have a good internal consistency of .85 for general population and .90 for clinical patients (Radloff, 1977; Lee et al, 2007). Additionally, the CES-D reports Cronbach's alphas of .93 for Caucasian subjects and .86 for Asian subjects.

Procedure

The original study was a cross-sectional design comprised of a self-administered paper-and- pencil survey packet. Participants took approximately 25 minutes to complete the survey. The surveys were distributed at locations identified by the research investigator and in classrooms. Students were given the questionnaire packet and made aware of the voluntary nature of participation and anonymity. The students were provided with a written consent form that was signed if they agreed to take part in the study. These forms were gathered together and stored separately from the survey responses of the participants. The students were instructed not to place their names on the questionnaire packet in order to maintain anonymity. Due to the sensitive and delicate nature of the study, students were given the chance to end participation in the study at any time. A resource list of several agencies was included at the end of the survey that could be contacted for further assistance in the event that anyone experienced distress following participation in the study (See Appendix B).

Data Analysis

Descriptive statistics such as percentages and means were used to evaluate the demographic information of age, race, relationship status and mental health status as well. Data was utilized using SPSS 20 to address the following research question: what differences in levels of mental health exist among African American women and Caucasian women who have experienced intimate partner violence. Multivariate analysis of variance (MANOVA), which tests the mean difference between groups based on the dependent variables

was used to analyze the hypothesis that states that there will be a difference in the levels of mental health (indicated by depression and PTSD) between African American women who have experienced IPV and Caucasian women who have experienced IPV. The categorical, independent variable (IV) was race. The two variables composing mental health, PTSD and depression, were the continuous, dependent variables (DV).

CHAPTER IV

Results

In the present study, support was sought for the hypothesis stating that there will be a difference in the levels of mental health (indicated by depression and PTSD) between African American women who have experienced IPV and Caucasian women who have experienced IPV.

A general linear multivariate analysis of variance (MANOVA) was conducted with posttraumatic stress disorder (PTSD) and depression making up the dependent variable of mental health with the independent variable being race. Preliminary assumptions testing were conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity. One violation was found in the Levene's Test of Equality of Error Variances as the depression value was .049 which is less than the acceptable .05 level. Therefore, a Bonferroni correction was computed to set a more conservative alpha level (p=.025).

Results of the analysis indicated that there was no statistically significant difference between African American and Caucasian women who experienced IPV on the combined dependent variables, F (2, 89)= 1.13; p= .33; Wilks' Lambda = .98; partial eta squared = .03. When the results for the dependent variables were considered separately, neither PTSD nor depression reached statistical significance, using a Bronferroni adjusted alpha level of .025.

For PTSD, F (1, 90) = 1.94, p = .17; partial eta squared = .02. The PTSD mean scores for African American were lower (M = 38.89, SD = 15.06) than those for Caucasian females (M = 43.37, SD = 15.52).

For Depression, F (1, 90) = 2.08, p = .152, partial eta squared = .02. The mean scores indicated that African American females had lower scores on depression (M = 37.76, SD = 11.24) with Caucasian females having slightly higher scores on depression (M = 41.57, SD = 13.91).

Chapter V

Discussion

The purpose of this study was to analyze the relationship between race and the mental health of women who have experienced IPV. The hypothesis indicated that there would be a difference in the levels of mental health (indicated by depression and PTSD) between African American and Caucasian women who have experienced IPV. The ecological theory will be used to explain the effects of IPV on mental health as it is a versatile and multi-faceted approach. This chapter will examine the findings of this study as well as limitations and suggestions for other research and interventions.

A MANOVA was conducted in order to examine the relationship between race and the development of PTSD and depression among a sample of college women who experienced abuse. Results of the study revealed that the research hypothesis was not supported. There was no statistically significant difference between Caucasian and African American women who experienced IPV and the subsequent levels of PTSD and depression. The results of this research are consistent with literature that indicate both African American and Caucasian women experience PTSD and depression following IPV at similar levels (Lutenbacher et al, 2010; Scott-Tilley et al, 2010; West, 2002; Few, 2005).

Both African American and Caucasian women in this study reported symptoms of PTSD and depression. For the PTSD (PLC-C), scores ranged from 17-85, and for the depression scale, scores ranged from 0-60. Results of the study showed that African American women had a mean score of 38.89 for

PTSD and 37.76 for depression, while Caucasian women had a mean score of 43.37 for PTSD and 41.57 for depression. These scores show that even though there was no significant difference between the two groups Caucasian women had higher scores for PTSD and depression than African American women. However, both groups averaged within the mid-range for PTSD and in the low ranges for depression, which does not indicate high rates of mental health issues.

The lower rates of PTSD and depression in the sample could be explained by the age of the women who participated in the study. The range of ages for the participants was 18-54 with a mean of 21.7. Sixty-eight or 74% of the participants were 21 years of age or younger. Accordingly, the ontogenetic level of the ecological model could help to explain the low to mid-range mental health scores as it might be assumed that because of their age, the participants in the study had limited life experiences. If true, they may not have an accumulation of stressors that, in addition to IPV, would lead to higher levels of mental health issues. In comparison, previous studies of mental health symptoms and IPV considered the factors of age and outside stresses and the mean ages of those samples were considerably higher. Bradley, Schwartz & Kaslow's (2005) sample averaged 34.6 years of age, and; Kujiper, Van Der Knapp, Winkel, Pemberton & Baldry's (2010) participants' average age was 37. In each of these studies, the documented rates of PTSD and depression were also considerably higher than documented in this study.

It is also important to look at the microsystem level of the ecological theory because it represents the direct environment or relationship in which the abuse took place (Stith et all, 2004). Because of the young age of the sample, it is possible that these women have not been exposed to abuse long enough to develop more serious symptoms of PTSD and depression. Again, the fact that much of the empirical findings have been based on subjects who were older than those in this study leads to the speculation that they (the older subjects) may have been in the abusive relationship longer, leading to the development of more severe symptoms of PTSD and depression.

Further explanations for the lack of findings can also be examined at the microsystem level by looking at the relationship status and parental status of the subjects. The findings from this research showed that the majority of the sample was single, with no children. Fifty percent of the women in this study were single and 41% had a boyfriend. Only 7% were married and 2% were divorced. This might account for the lack of findings, as literature has indicated that IPV and the stress of managing a long term relationship could result in symptoms of PTSD and depression (Zust, 2006). When the issue of parenthood is examined, once again previous findings show that raising children within an abusive marital atmosphere leads to higher levels of PTSD and depression (Kujiper et al, 2010). Since 85% of this sample of college females did not have children, this could also help to explain the pattern of moderate levels of PTSD and lower levels of depression when compared to research with older samples. It may be that younger females have fewer symptoms of PTSD and depression than older

females regardless of experiences with IPV (Babcock et al, 2008; Kujiper et al, 2010).

Although social support was not a variable analyzed within this study, the impact of formal and informal social groups might be a source of explanation for the findings of this research. Research has shown that Caucasian compared to African American women are less likely to rely on religious or informal help following an IPV experience and more likely to seek the help of formal support such as health care professionals (Scott-Tilley et al, 2010). Additionally, even though this study found no significant difference between the mental health levels of the two races, Caucasian women reported somewhat higher rates of PTSD and depression symptoms than African American women. It is possible that this could be accredited to the differences in cultural perceptions of mental illness. As stated previously, the African American culture tends to rely on religious assistance rather than formal sources of assistance. It is possible, then, that such informal types of assistance may not help victims of IPV to be able to identify or understand the possible symptoms of PTSD and depression, and thus these particular mental health symptoms may be ignored (West, 2002).

Limitations

Limitations for this research include the fact that most of the women in the sample were 21 years of age or younger. Because of the young age of the women, it was difficult to find a balanced perspective regarding the development of PTSD and depression and also the results of the study cannot be extrapolated to the general public. Furthermore, this sample cannot be generalized to the

overall population including individuals who are not in college. Women who have completed college may be better able to identify and utilize mental health resources through employment and education experiences than women who are still in college or have not attended college (Beeble & Salem, 2009). Accordingly, because the sample was limited to a large regional college campus in the Southeast, it did not allow for a comprehensive depiction of life experiences, socio-economic status and cultural demographics that may or may not contribute to the development of PTSD and depression in abused women.

Another limitation is that this study used an extent data set. An extent data set does not allow for the consideration of several other variables that could have contributed to PTSD and depression. Finally, all subjects were college students who were predominantly single or dating and did not have children. Perhaps because of these factors, no significance was found for mental health issues among this sample of women who experienced IPV.

Implications for Research

Future research on this topic should examine women from additional cultural and racial backgrounds in order to provide a well-balanced demographical representation. Additionally, comparing samples of women who are and who are not college students would allow for a more diverse sample that would test the impact of IPV and long term relationships and children. Future research should also evaluate other areas of mental health that include multiple personality disorder, dissociative identity disorder, depersonalization disorder, dissociative amnesia and dissociative fugue. These disorders affect a limited

group of women and thus can identify even more specific and profound ways that IPV triggers predisposed genetic tendencies towards the development of mental health issues.

Implications for Interventions

The findings for this study have critical implications for the development of interventions that address IPV and the mental health issues that can result from it. By taking an ecological theory perspective, it becomes evident that IPV is not caused by one single factor but by several (Little and Kantor, 2002). Although no significant differences were found, the presence of PTSD and depression symptoms in this sample supports the connection between IPV and mental health issues. Women who experience IPV are more likely to develop PTSD or depression than others regardless of race (Lutenbacher et al, 2010; Few, 2005). Therefore, it is very important to African American and Caucasian women of all ages on the potentially damaging consequences of IPV and on the best ways to safely leave a violent relationship. With this information, these women will be better able to avoid and/or cope with the mental health issues that result from abuse (West, 2002).

Domestic violence shelters, nurses, teachers, pastors, family and friends can encourage women who are involved in abusive relationships to seek help as soon as possible. Early intervention with young women can assist abused women in finding the help they need soon enough to prevent the development of PTSD and depression symptoms. Additionally, it is important to provide these young women with an understanding of the symptoms of PTSD and depression

so that they can pinpoint particular areas in their life where these mental health issues are evident and therefore seek help. It will take a collective effort from all members of the community to protect women from IPV and the mental health issues that result from it.

Conclusion

In conclusion, this study did not find high levels of mental health issues or discernible differences in psychological health within a college aged sample of African American and Caucasian women who had experienced IPV. It is known that IPV and mental health are interconnected due to the increased emotional and psychological trauma that victims of IPV experience. It would seem logical then that all women, regardless of race, should be thoroughly educated on the risks of IPV and the symptoms of PTSD and depression. The knowledge and information gained from this and future research can better equip women with the tools they need to understand the mental health issues of PTSD and depression that result from IPV.

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APPENDICES

Appendix A

Institutional Review Board Authorization Document

MIDDLE TENNESSEE STATE UNIVERSITY

February 26, 2013

Nichole Terry, Beth Emery
Department of Human Sciences
nmt2g@mtmail.mtsu.edu, Beth.Emery@mtsu.edu

Protocol Title: "The Impact of Intimate Partner Violence on Mental Health: A Study of African American and Caucasian College Females"

Protocol Number: 13-240

Dear Investigator(s),

The exemption is pursuant to 45 CFR 46.101(b) (4). This is because the research being conducted involves the collection and study of existing data, documents and records that is being recorded by the investigator in a manner that subjects cannot be identified, directly or through identifiers linked to the subjects

You will need to submit an end-of-project report to the Compliance Office upon completion of your research. Complete research means that you have finished collecting data and you are ready to submit your thesis and/or publish your findings. Should you not finish your research within the three (3) year period, you must submit a Progress Report and request a continuation prior to the expiration date. Please allow time for review and requested revisions. Your study expires on **February 26, 2016.**

Any change to the protocol must be submitted to the IRB before implementing this change. According to MTSU Policy, a researcher is defined as anyone who works with data or has contact with participants. Anyone meeting this definition needs to be listed on the protocol and needs to provide a certificate of training to the Office of Compliance. **If you add researchers to an approved project, please forward an updated list of researchers and their certificates of training to the Office of Compliance before they begin to work on the project.** Once your research is completed, please send us a copy of the final report questionnaire to the Office of Compliance. This form can be located at www.mtsu.edu/irb on the forms page.

Also, all research materials must be retained by the PI or **faculty advisor (if the PI is a student)** for at least three (3) years after study completion. Should you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Andrew W. Jones

Compliance Office
615-494-8918
Compliance@mtsu.edu

Appendix B

Questionnaire Packet

Debriefing Material

Psychology Pool Description: All women who may have experienced stressful situations

The purpose of this study is to examine the relationship between social support, mental health, and stressful situations.

The current study will consist of questions about demographic information, stressful situations, posttraumatic stress disorder, depression, and social support. It should take approximately 25 minutes to complete.

Risks for participation in this study are minimal. You may experience some distress as a result of reliving and disclosing sensitive and/or painful information. However, n the present study, these risks can be minimized by contacting someone from the list of agencies provided at the end of the survey. You may also withdraw from the study at any time without explanation, prejudice or penalty.

Benefits to participating in this present study include the opportunity to disclose information about stressful situations by completing specified surveys. As a result of this study, you may experience a sense of relief and empowerment in that you will be helping others by sharing your experiences.

Oral Description of Study for Classroom Participants

I will be conducting a study for my thesis looking at social support, mental health, and stressful situations. I am looking for females who are at least 18 years of age to participate in my study, who may or may not have experienced intimate partner violence in a heterosexual relationship.

The study will be a self-administered paper and pencil questionnaire packet consisting of questions about demographic information, stressful situations, post traumatic stress disorder, depression and social support that will take approximately 25 minutes to complete. By participating in this survey, you will help us to better understand issues related to mental health and social support as well as stressful situations.

This is an opportunity to disclose information about stressful situations that may ultimately give you a sense of relief and empowerment and that will help others. It is also possible to experience some distress as a result of reliving and minimized by contacting someone from the list of various agencies provided for additional help if any distress is experienced. You may also withdraw from study participation without explanation, prejudice or penalty.

Contact information:
Primary Investigator: Antranette Stringer
Faculty: Dr. Beth Emery
Office: Ellington Human Science Annex, Rm # 121
Number: 615-89-2468

Principal Investigator: Antranette Stringer
Study Title: Stressful situations: The effects of social support on mental health
Institution: Human Science

Name of participant: _____ Age: _____

The following information is provided to inform you about the research project and your participation in it. Please read this form carefully and feel free to ask any questions you may have about this study and the information given below. You will be given an opportunity to ask questions, and your questions will be answered. Also, you will be given a copy of this consent form.

Your participation in this research study is voluntary. You are also free to withdraw from this study at any time. In the event new information becomes available that may affect the risks or benefits associated with this research study or your willingness to participate in it, you will be notified so that you can make an informed decision whether or not to continue your participation in this study.

For additional information about giving consent or your rights as a participant in this study, please feel free to contact Leigh Gostowski at the Office of Compliance at (615) 494-8918.

1. **Purpose of the study:**
   The purpose of this study is to examine social support, mental health, and stressful situations.

2. **Description of procedures to be followed and approximate duration of the study:**
   I understand that this study is an anonymous paper-and-pencil survey consisting of a questionnaire packet that includes questions about demographic information, social support, posttraumatic stress disorder, depression, and stressful situations. It should take approximately 25 minutes to complete.

3. **Expected costs:**
   I understand that there are no expected financial costs involved in participating in this study.

4. **Description of the discomforts, inconveniences, and/or risks that can be reasonably expected as a result of participation in this study:**
   I understand that risk for participation in this study is possible distress as a result of reliving and disclosing sensitive and/or painful information. However, this risk can be minimized by contacting someone from the list of various agencies provided for additional help if any distress is experienced.

5. **Unforeseeable risks:**
   There are no unforeseeable risks.

6. **Compensation in case of study-related injury:**
   There will be no compensation in the case of study related injury.

7. **Anticipated benefits from this study:**

Benefits to participating in this present study include the opportunity to disclose information about stressful situations by completing specified surveys. As a result of this study, you may experience a sense of relief and empowerment in that you will be helping others by sharing your experiences.

8. **Alternative treatments available:**

Not applicable

9. **Compensation for participation:**

I understand that there is no expected financial compensation involved in participating in this study.

10. **Circumstances under which the Principal Investigator may withdraw you from study participation:**

I may be withdrawn from study participation if I am unable to complete the surveys provided in the study because of any distress.

11. **What happens if you choose to withdraw from study participation:**

I may withdraw from the study at any time without explanation, prejudice or penalty.

12. **Contact Information.**

If you should have any questions about this research study or possibly injury, please feel free to contact Antranette Stringer at (706) 399-0653 or my Faculty Advisor, Dr. Beth Emery at (615) 898-2468

13. **Confidentiality.**

All efforts, within reason, will be made to keep the personal information in your research record private but total privacy cannot be promised. Your information may be shared with MTSU or the government, such as the Middle Tennessee State University Institutional Review Board, Federal Government Office for Human Research Protections, if you or someone else is in danger or if we are required to do so by law. In order to further protect your confidentiality, your consent form will be separated from the survey data when you hand in the completed survey. It will be stored separately from the data in a secure location.

STATEMENT BY PERSON AGREEING TO PARTICIPATE IN THIS STUDY

I have read this informed consent document and the material contained in it has been explained to me verbally. I understand each part of the document, all my questions have been answered, and I freely and voluntarily choose to participate in this study.

I have read this informed consent document for this study and understand my rights as a research participant. Further, I understand that information I provide is only intended for research purposes and is not intended to establish a patient/psychologist relationship between me and the researchers/university or to be used for diagnostic purposes. A list of referral counseling services was provided to me. Should I become distressed at any time while participating in this study and feel the need that I need psychiatric/medical or other emotional assistance, I will contact one of the referral counseling services.

_____ _____

Date Signature of patient/volunteer

Consent obtained by:

_____ _____

Date Signature

_____

Printed Name and Title

NOTE: All resources are in Murfreesboro unless indicated otherwise.

MENTAL HEALTH PROFESSIONAL RESOURCES

MTSU Counseling Services	898-2670 (KUC 329)

VIOLENCE & ABUSE

Sexual Assault Center (Nashville)	259-9055 1-800-879-1999 (24 hr. hotline)
First Call for Help (Murfreesboro)	907-1114
Life Management Center (Nashville)	269-0803
Domestic Violence Hotline	356-6767 (serving Nashville area)
Exchange Club Family Center for the Prevention of Child Abuse (Murfreesboro)	890-4673
Murfreesboro Domestic Violence Program	896-2012 or 896-7377
YWCA Domestic Violence Program (Nash.)	(615) 242-1199 or 1-800-334-2648
Domestic Violence Prog./Sexual Aggression	896-9542
Hope House- Maury County	(931) 381-8580
Miriam's Place (Nashville)	292-3500
Prevention Child Abuse TN	383-0994

Appendix C

Survey

Part I. Demographic Information

1. Age: ☐

2. Classification:
   1 Freshman
   2 Sophomore
   3 Junior
   4 Senior
   5 Graduate

3. Race/Ethnicity:
   1 African American or Black
   2 American Indian or Alaska Native
   3 Asian
   4 Native Hawaiian or other Pacific Islander
   5 Hispanic/Latino
   6 White/Caucasian

4. Number of Children:
   0
   1
   2
   3
   4
   5 or more

5. Relationship Status:
   1 Single
   2 Partner (Boyfriend)
   3 Married
   4 Divorced

Part II. Circle the number that best represents your closest estimate of how often each of the behaviors happened in your relationship with your partner or former partner.

1 Never; 2 Rarely; 3 Occasionally; 4 Frequently; 5 Very frequently

6. Called you a name and/or criticized you.	1	2	3	4	5
7. Tried to keep you from doing something you wanted to do (e.g., going out with friends, going to meetings).	1	2	3	4	5
8. Gave you angry stares or looks.	1	2	3	4	5
9. Prevented you from having money for your own use.	1	2	3	4	5
10. Ended a discussion with you and made the decision himself.	1	2	3	4	5
11. Threatened to hit or throw something at you.	1	2	3	4	5
12. Pushed, grabbed, or shoved you.	1	2	3	4	5
13. Put down your family and friends.	1	2	3	4	5
14. Accused you of paying more attention to someone/something else.	1	2	3	4	5
15. Put you on an allowance.	1	2	3	4	5
16. Used your children to threaten you (e.g., told you that you would lose custody, said he would leave town with the children).	1	2	3	4	5
17. Became very upset with you because dinner / housework, was not done when he wanted it or the way he thought it should be.	1	2	3	4	5
18. Said things to scare you (e.g., told you something "bad" would happen, threatened to commit suicide).	1	2	3	4	5
19. Slapped, hit, or punched you.	1	2	3	4	5
20. Made you do something humiliating or degrading (e.g., beg for forgiveness, ask for permission to use the car or to do something).	1	2	3	4	5

21. Checked up on you (e.g., listened to your phone calls, checked the mileage on your car, called you repeatedly at work).	1	2	3	4	5
22. Drove recklessly when you were in the car.	1	2	3	4	5
23. Pressured you to have sex in a way you didn't want.	1	2	3	4	5
24. Refused to do housework or child care.	1	2	3	4	5
25. Threatened you with a knife, gun, or other weapon.	1	2	3	4	5
26. Spanked you.	1	2	3	4	5
27. Told you that you were a bad parent.	1	2	3	4	5
28. Stopped /tried to stop you from going to work/school.	1	2	3	4	5
29. Threw, hit, kicked, or smashed something.	1	2	3	4	5
30. Kicked you.	1	2	3	4	5
31. Physically forced you to have sex.	1	2	3	4	5
32. Threw you around.	1	2	3	4	5
33. Physically attacked the sexual parts of your body.	1	2	3	4	5
34. Choked or strangled you.	1	2	3	4	5
35. Used a knife, gun, or other weapon against you.	1	2	3	4	5

Part III. We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

1 Very Strongly Disagree; 2 Strongly Disagree; 3 Mildly Disagree; 4 Neutral; 5 Mildly Agree; 6 Strongly Agree; 7 Very Strongly Agree

36.	There is a special person who is around when I am in need.	1 2 3 4 5 6 7
37.	There is a special person with whom I can share my joys and sorrows.	1 2 3 4 5 6 7
38.	My family really tries to help me.	1 2 3 4 5 6 7
39.	I get the emotional help and support I need from my family.	1 2 3 4 5 6 7
40.	I have a special person who is a real source of comfort to me.	1 2 3 4 5 6 7
41.	My friends really try to help me.	1 2 3 4 5 6 7
42.	I can count on my friends when things go wrong.	1 2 3 4 5 6 7
43.	I can talk about my problems with my family.	1 2 3 4 5 6 7
44.	I have friends with whom I can share my joys and sorrows.	1 2 3 4 5 6 7
45.	There is a special person in my life who cares about my feelings.	1 2 3 4 5 6 7
46.	My family is willing to help me make decisions.	1 2 3 4 5 6 7
47.	I can talk about my problems with my friends.	1 2 3 4 5 6 7

Part IV. Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully. Circle the response that indicates how much you have been bothered by that problem in the past month.

1 Not at all; 2 A little bit; 3 Moderately; 4 Quite a bit; 5 Extemely

48. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience?

1 2 3 4 5

49. Repeated, disturbing *dreams* of a stressful experience?

1 2 3 4 5

50. Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?

1 2 3 4 5

51. Feeling *very upset* when *something reminded you* of a stressful experience?

1 2 3 4 5

52. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience?

1 2 3 4 5

53. Avoiding *thinking about* or *talking about* a stressful experience or avoiding *having feelings* related to it?

1 2 3 4 5

54. Avoiding *activities* or *situations* because *they reminded you* of a stressful experience?

1 2 3 4 5

55. Trouble *remembering important parts* of a stressful experience?

1 2 3 4 5

56. *Loss of interest* in activities that you used to enjoy?

1 2 3 4 5

57. Feeling *distant* or *cut off* from other people?

1 2 3 4 5

58. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?

1 2 3 4 5

59. Feeling as if your *future* will somehow be *cut short*?

1 2 3 4 5

60. Trouble *falling* or *staying asleep*?

1 2 3 4 5

61. Feeling *irritable* or having *angry outbursts*?

1 2 3 4 5

62. Having *difficulty concentrating*?

1 2 3 4 5

63. Being *"super-alert"* or watchful or on guard?

1 2 3 4 5

64. Feeling *jumpy* or easily startled?

1 2 3 4 5

Part V. Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this in the past month.

1 Rarely or none of the time (less than1 day/ per week)
2 Some or a little of the time (1-2 days/ per week)
3 Occasionally or a moderate amount of time (3-4 days/ per week)
4 Most or all of the time (5-7 days/ per week)

65. I was bothered by things that usually don't bother me.
1 2 3 4

66. I did not feel like eating; my appetite was poor.
1 2 3 4

67. I felt that I could not shake off the blues even with help from my family or friends.
1 2 3 4

68. I felt I was just as good as other people.
1 2 3 4

69. I had trouble keeping my mind on what I was doing.
1 2 3 4

70. I felt depressed.
1 2 3 4

71. I felt that everything I did was an effort.
1 2 3 4

72. I felt hopeful about the future.
1 2 3 4

73. I thought my life had been a failure.
1 2 3 4

74. I felt fearful.
1 2 3 4

75. My sleep was restless.
1 2 3 4

76. I was happy.
1 2 3 4

77. I talked less than usual.
1 2 3 4

78. I felt lonely.
1 2 3 4

79. People were unfriendly.
1 2 3 4

80. I enjoyed life.
1 2 3 4

81. I had crying spells.
1 2 3 4

82. I felt sad.
1 2 3 4

83. I felt that people dislike me.
1 2 3 4

84. I could not get "going."
1 2 3 4