2012

COPING AS A MEDIATOR BETWEEN CHILDHOOD TRAUMA AND CURRENT TRAUMA SYMPTOMS IN FEMALE SURVIVORS OF INTIMATE PARTNER VIOLENCE

Aryn Violet Ziehnert
The University of Montana

COPING AS A MEDIATOR BETWEEN CHILDHOOD TRAUMA AND CURRENT TRAUMA SYMPTOMS IN FEMALE SURVIVORS OF INTIMATE PARTNER VIOLENCE

By

ARYN VIOLET ZIEHNERT

Bachelor of Arts, Eastern Washington University, Cheney, Washington, 2010

Master's Project Prospectus

presented in partial fulfillment of the requirements
for the degree of

Master of Arts
in Psychology

The University of Montana
Missoula, MT

December 2012

Approved by:

Sandy Ross, Associate Dean of The Graduate School
Graduate School

Christine Fiore, Chair
Psychology Department

Nadine Wisniewski
Psychology Department

Danielle Wozniak
Social Work Department

Abstract

Intimate partner violence (IPV) has been estimated to affect one in four women in her lifetime (Tjaden & Thoennes, 2000), and research has found that women with previous childhood abuse experiences are more likely to enter into relationships with IPV. The purpose of the current study was to investigate differences between female IPV survivors who have and who have not experienced childhood abuse. Three hundred and ninety four women, recruited through flyers across Western Montana, participated in the original study (Fiore & Kennedy, 2000). They were interviewed on different aspects of their most recent violent relationship, their past experiences with abuse, and the social support systems they utilized. Participants also completed demographic information that included the length of their relationship, the Conflict Tactics Scale (CTS; Straus, 1979), Ways of Coping (WOC) Questionnaire (Folkman & Lazarus, 1988), and the Trauma Symptoms Checklist (TSC; Briere & Runtz, 1989). Results demonstrated that women with childhood abuse experiences report greater violence in their most recent violent relationship. Mediation analyses (Hayes & Preacher, 2011) suggested that both problem-focused and emotion-focused coping mediate the relationship between childhood abuse experiences and current trauma symptoms. The implications of these results are discussed.

Coping as a Mediator Between Childhood Trauma and Current Trauma Symptoms in Female Survivors of Intimate Partner Violence

Intimate partner violence (IPV) is defined as physical or sexual violence or psychological and emotional abuse that is directed toward a person one has been or is currently intimately involved with (Dutton, El-Khoury, Murphy, Somberg, & Bell, 2005). IPV affects people across the socioeconomic, religious, and cultural spectrum of the United States, leaving no group unsusceptible (Popescu, Drumm, Dewan, & Rusu, 2010). The cost of adult IPV in the United States has been estimated to be at least $67 billion annually (Schafer, Caetano, & Cunradi, 2004).

Findings from the National Violence Against Women (NVAW) Survey indicated that 4.8 million physical assaults and rapes are perpetrated against U.S. women in intimate partner relationships annually (Tjaden & Thoennes, 2000). Results from the NVAW Survey also indicate that nearly one in four women will experience domestic violence in their lifetime. In 1992, IPV was found to be the leading cause of injuries for women aged 15 to 44 (Novello, Rosenberg, Saltzmann, & Shosky, 1992). There has been an increased amount of research into different aspects of IPV since it was acknowledged as a national priority in 1992 (Novello et al., 1992). Some of these areas of research include women's coping strategies in response to IPV and their effectiveness (Arriaga & Capezza, 2005; Bauman, Haaga, & Dutton, 2008; Fiore & Kennedy, 2000; Kocot & Goodman, 2003; Popescu et al., 2010; Sullivan, Schroeder, Dudley, & Dixon, 2010), the childhood abuse history of female IPV victims (Becker, Stuewig, & McCloskey, 2010; Cannon, Bonomi, Anderson, Rivara, & Thompson, 2010; Popescu et al., 2010; Schafer et al., 2004; Seedat, Stein, & Forde, 2005) and the history's effect on posttraumatic stress symptoms (Becker et al., 2010; Campbell, Greeson, Bybee, & Raja, 2008; Lang, Stein, Kennedy,

& Foy, 2004; Seedat et al., 2005). These studies have found certain commonalities regarding the risk factors for IPV and the responses of female survivors of IPV. A review of the findings from these areas will be discussed in the following sections.

Childhood Victimization and IPV

Like IPV, childhood victimization is another unfortunate experience many individuals will face in the United States. Approximately 772,000 children were victims of maltreatment in 2008; of those victims, 9.1% suffered sexual abuse and 16.1% suffered physical abuse (U.S. Department of Health and Human Services, 2008). Individuals who have experienced abuse as children are at an increased risk for internalizing and externalizing behaviors, emotional problems, and relational problems, suggesting that experiencing abuse as a child is related to problems later in life (Whiting, Simmons, Havens, Smith, & Oka, 2009).

Furthermore, childhood victimization has been found to be a risk factor for later revictimization, including violence in intimate relationships. A review of the literature found that women who experience childhood victimization are two to ten times more likely to experience IPV in adulthood than women who do not experience childhood victimization (Messman-Moore & Long, 2000). The NVAW Survey found that being physically assaulted as a child by a caretaker was a risk factor for IPV in both men and women (Tjaden & Thoennes, 2000). Browne and Finkelhor (1986) found in their literature review that female victims of childhood sexual abuse were more likely to be abused by husbands than nonvictims, with upwards of 48% of child sexual abuse victims experiencing physical abuse by husbands and upwards of 60% experiencing sexual assault by husbands. These results suggest that both childhood physical abuse and childhood sexual abuse are related to an increased risk of experiencing IPV in adulthood.

In a study conducted by Whiting, Simmons, Havens, Smith, and Oka (2009), 62.7% of the participants who reported experiences of childhood physical and sexual abuse also reported experiencing IPV in their current relationships. The male and female participants who experienced IPV in their current relationship reported lower self-esteem, felt more insecure, and viewed themselves as more dependent on others compared to those who reported no IPV in their current relationship. These results suggest that not only are childhood abuse experiences related to experiencing IPV in adulthood, but that also the experiences are related to more negative psychological sequelae – such as lower self-esteem – and increased perceptions of dependency.

A study conducted by Cannon, Bonomi, Anderson, Rivara, and Thompson (2010) examined the utilization of health care services and relationship outcomes among women who had experienced childhood abuse. In their final sample, 1,434 women reported exposure to either child abuse, the witnessing of IPV before 18 years of age, or a combination of the two. They found that women who reported exposure to child abuse only were 1.59 times more likely than women who reported no exposure to child abuse to report adult IPV. In addition, they found that women with exposures to child abuse utilized significantly more health services than women with no exposures. This suggests that experiencing child abuse is related to lasting effects on women's health care utilization well into adulthood.

Childhood abuse, IPV, and Posttraumatic Stress Symptoms

Research has indicated that posttraumatic stress disorder (PTSD) is one of the most common diagnoses given to women who have suffered domestic violence (Becker et al., 2010). In order for a female to receive a PTSD diagnosis after experiencing IPV, her response to the violence must have included intense fear, helplessness, or horror (American Psychiatric Association [APA], 2000). Once the violence has occurred – or, if the violence is recurring, once

the onset of the violence has occurred – the female victim must have symptoms in three clusters: (a) reexperiencing symptoms, (b) avoidance/numbing symptoms, and (c) increased arousal symptoms. The duration of these symptoms must last for at least one month and must cause significant distress in one important area of the individual's life. Studies have estimated the population-based prevalence of PTSD for United States women to be between 1 and 12% (Golding, 1999). A review of the literature by Dutton, El-Khoury, Murphy, Somberg, and Bell (2005) found that lifetime PTSD prevalence rates increased to between 31 and 84.4% for female IPV victims, supporting the notion that IPV is associated with a higher risk in females for developing PTSD.

Studies have also found that survivors of childhood abuse are at an increased risk for PTSD. According to a literature review done by Rodriguez, Vande Kemp, and Foy (1998), there is approximately a 46% lifetime PTSD rate for survivors of childhood sexual abuse. Some authors have found even higher PTSD rates of adult survivors of childhood sexual abuse, which ranged from 72% to 100% (Boney-McCoy & Finkelhor, 1995; Nishith, Mechanic, & Resick, 2000). Other studies have found childhood physical abuse to be related to adult PTSD, but the experience of both types of childhood abuse was related to higher PTSD rates (e.g., Hetzel & McCanne, 2005).

Revictimization has been suggested to be one reason higher rates of PTSD are found in survivors of childhood abuse. Dutton and colleagues (2005) found in their literature review that PTSD rates were higher among women who had experienced victimization multiple times throughout childhood and adulthood. These rates were especially high among women who reported histories of childhood sexual abuse.

A study conducted by Becker, Stuewig, and McCloskey (2010) examined recent IPV exposure, past exposure to child abuse, and their influence on posttraumatic stress symptoms. They collected 363 women from the community and from battered women's shelters and interviewed these women on their IPV experiences, childhood victimization experiences, and their posttraumatic stress symptoms. Of these women, 193 reported being the victim of IPV in the past year. They found that women who reported physical violence were also likely to report psychological and sexual abuse from their partner, suggesting an intertwining of different forms of abuse. The results of their study also indicate that each form of abuse was associated with posttraumatic stress symptoms.

Becker and colleagues (2010) also set out to test the hypothesis that adult IPV experiences would act as a mediator between childhood abuse and posttraumatic stress symptoms. In their study, they found that adult IPV experiences mediated the relationship between childhood physical abuse and posttraumatic stress symptoms, which suggests that women who have histories of childhood physical abuse are more likely to enter violent relationships, which then relates to elevated posttraumatic stress symptoms. Becker and colleagues did not find a mediation effect of IPV experiences on childhood sexual abuse and adult PTSD. Rather, it was found that childhood sexual abuse had a direct effect on PTSD symptoms in adulthood. Overall, they found childhood victimization to be related to adult IPV experiences.

In summary, it has been found that both childhood abuse and IPV are related to posttraumatic stress symptoms later in life. Results indicate that childhood abuse has a direct effect on posttraumatic stress symptoms in adulthood, especially childhood sexual abuse. Some findings suggest, however, that the effects of childhood physical abuse on posttraumatic stress

symptoms may be mediated through the experience of IPV in adulthood. With high adult rates of PTSD in survivors of both childhood abuse and IPV, it is important to investigate what variables may impact the effects of abuse on later adult health.

Stress and Coping

People are confronted with stressors that they must make an effort to manage in everyday life. According to Folkman and Lazarus (1985), in order for people to feel stress, they must perceive a relationship between themselves and the environment as relevant and as exceeding their resources. After appraising the situation as relevant and exceeding their abilities, people then address the issue of what can be done. The cognitive and behavioral efforts people make in order to address the situation are referred to as coping techniques.

Coping techniques can be conceptualized in many different ways. One popular way coping has been delineated is by separating coping into two major functions: problem-focused and emotion-focused (Folkman & Lazarus, 1985). In problem-focused coping, people attempt to find ways to positively change the problem causing the distress. These strategies may be directed at either the self or the environment. In emotion-focused coping, people attempt to regulate the distressing emotions that arise in response to the situation without changing the actual conditions of the situation. A study conducted by Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen (1986) found that people were more likely to use problem-focused coping strategies when they perceived the situation as changeable. When people felt as though they had low control on affecting the outcome of the situation, they were more likely to use emotion-focused coping. Folkman and colleagues also found that certain emotion-focused coping strategies – such as distancing – have been associated with unsatisfactory outcomes.

Much of the research into the coping styles female IPV survivors use has focused on their use of problem-focused coping strategies and less on their use of emotion-focused coping strategies (Dutton et al., 2005). Of the research that has looked at emotion-focused coping strategies, it has been indicated that emotion-focused coping is associated with more psychological distress and less satisfaction with the strategy. In a review of the literature by Arriaga and Capezza (2005), they found that women who exhibited certain types of coping were more likely to show extreme psychological distress. More specifically, women who used emotion-focused coping strategies to reduce the negative emotions caused by the violence were more likely than women who used more problem-focused coping strategies to show signs of extreme psychological distress, such as PTSD. Arriaga and Capezza also found that women who feel trapped in the relationship are more likely to use emotion-focused coping and downplay the partner's violent behavior, which is an unhealthy form of coping.

Some research has looked at the coping strategies used by women after leaving an abusive relationship. In a study by conducted by Fiore and Kennedy (2000), women who had been out of an abusive relationship for varying lengths of time were given the Ways of Coping Questionnaire (Folkman & Lazarus, 1988). Results indicated that women who had been out of the abusive relationship for six months or less had high utilization of both problem- and emotion-focused coping, which suggests a high demand of women's resources for women recently out of a violent relationship. Fiore and Kennedy also found that women who reported more use of emotion-focused coping strategies were more likely to report greater temptation to return to the abusive relationship. While the endorsement of problem-focused coping strategies did not predict levels of temptation, it was a predictor of increased confidence.

Other research has looked at the helpfulness ratings women attribute to the coping methods they utilize after leaving a violent relationship. In a study conducted by Bauman, Haaga, and Dutton (2008), they interviewed women from shelters, criminal court, and civil protection order intake offices and asked them about their emotion-focused coping strategies. They found that the women used a wide range of emotion-focused coping strategies to attempt to cope with their IPV experience. The strategies that were found most useful involved the use of social support, the imagery of empowerment, and problem solving. However, there was a negative correlation between the use of emotion-focused coping strategies and the women's ratings of the helpfulness of these strategies. The strategies that female IPV survivors more commonly reported using were rated as less helpful in dealing with their feelings about the abuse.

Another study looked at the coping strategies female IPV survivors use and their perceived helpfulness, focusing on women in a rural community (Riddell, Ford-Gilboe, & Leipert, 2009). Riddell and colleagues measured coping through the use of the Intimate Partner Violence Strategies Index (IPVSI; Goodman, Dutton, Weinfurt, & Cook, 2003), which measures women's use of strategies across six categories: placating, resistance, safety planning, legal, formal network, and informal network. Private strategies may be defined as those strategies utilized to provide some immediate relief without exposing the violence to others (Popescu, Drumm, Dewan, & Rusu, 2010). Public strategies may be defined as those strategies utilized that seek help both formally (e.g., turning to the police) and informally (e.g., turning to family members). Private strategies can be considered somewhat similar to a certain subset of emotion-focused coping strategies known as self-isolation. Self-isolation is hiding how bad the situation is from others. Public strategies can be conceptualized as more problem-focused than private

strategies. Riddell and colleagues found that placating – a private strategy that is more closely related to emotion-focused coping – was one of the most used strategies and yet was one of the strategies rated least helpful. Safety planning, which can be regarded as a more problem-focused strategy, was the group of strategies rated most helpful by the women. These results suggest that women are more likely to utilize strategies that hide the violent behavior from others – which is similar to the emotion-focused coping strategy of self-isolation – but are also more likely to perceive these strategies as unhelpful.

In a study conducted by Popescu, Drumm, Dewan, and Rusu (2010), 1,823 individuals completed surveys regarding their current victimization experiences, past childhood victimization experiences, and coping behaviors. These coping behaviors were categorized into four areas after factor analysis: informal help-seeking, professional help-seeking, crisis outreach, and negative coping. Informal help-seeking involved talking with individuals that were close to the individual, such as a friend or a relative. Professional help-seeking involved behaviors such as going to a support group or going to a professional counselor. Crisis outreach involved behaviors such as calling 911 or going to a shelter. Negative coping involved behaviors such as drinking alcohol, using drugs, or considering alcohol. Although not completely analogous, certain negative coping strategies are very similar to strategies defined as emotion-focused, such as trying to feel better by eating, drinking, or smoking. Popescue and colleagues found that childhood victimization and witnessing violence during childhood strongly predicted negative coping in current victims of IPV. They also found childhood physical and sexual abuse was positively correlated with all coping behaviors. This result mirrors the findings of Fiore and Kennedy (2000) in which women recently out of a violent relationship utilize many different

types of coping. Both of these results suggest that violence puts a high demand on the victims' resources.

The studies summarized here suggest that female IPV survivors may be using several forms of coping in an attempt to deal with the high demand the violence has put on their resources. However, the coping strategies the survivors use may not be what they consider most useful, and some are related to higher symptoms of psychological distress. The results of some studies on coping strategies of female IPV survivors suggest that emotion-focused coping strategies or strategies similar to emotion-focused coping are among the most utilized and are also related with higher symptoms of distress. Folkman et al. (1986) found that people were more likely to utilize emotion-focused coping strategies when they perceived the situation as unchangeable. It could be that female IPV survivors see the violence as something unchangeable and therefore are more likely to use coping strategies that focus on the emotions of the situation rather than on changing the situation itself. Thus, knowing more about how women's approach to coping operates may better inform us and guide us to improve our assistance and intervention strategies.

Mediation and Moderation. Mediation and moderation are two types of analyses that are often misunderstood. In fact, it is not uncommon to find research articles that use the terms interchangeably (Baron & Kenny, 1986). It is also not uncommon to see researchers test a variable as both a mediator and a moderator in the same article, suggesting that there is a difference between the two concepts, but also a lot of overlap. A brief discussion of the two concepts will follow, using the information provided by Baron and Kenny (1986).

A moderator is defined as the study of a third variable that affects the direction and/or strength of the relationship between an independent variable and a dependent variable (Baron &

Kenny, 1986). In analysis of variance terms, a moderator can be understood as interacting with the independent variable. As Figure 2 depicts, there are three pathways to the dependent variable: the independent variable, the moderator variable, and the interaction between the independent variable and the moderator variable. Moderation is said to have occurred when the interaction between the two is significant.

A mediator, on the other hand, is most popularly defined as a study of a third variable that acts as the mechanism through which the independent variable is able to influence the dependent variable (Baron & Kenny, 1986). In mediation, there are two pathways of the independent variable (X) to the dependent variable (Y; see Figure 1). The first pathway is the direct influence of the independent variable on the dependent variable (c'). This can be understood as the influence of the independent variable on the dependent variable, without taking the mediating variable (M) into account. The second pathway is the influence of the independent variable on the dependent variable through the mediating variable. This is known as the indirect effect (a x b). The combination of the two pathways are said to equal the total effect the independent variable has on the dependent variable. The indirect influence of the independent variable on the dependent variable is the main focus in mediation analysis.

Coping as a mediator. Baron and Kenny (1986) defined a mediator as a third variable that acts as the mechanism through which the independent variable of interest is able to influence the dependent variable of interest. In other words, they believed that mediator variables give reason as to how there are effects of the independent variable on the dependent variable.

Folkman and colleagues (1986) have argued that coping is a critical mediator between stressful person-environment relations and both their immediate and their long-term outcomes. In a study conducted by Calvete, Corral, and Estévez (2008), they set out to test coping as a

mediator between IPV and symptoms of anxiety and depression. Two hundred ninety eight women recruited from women's associations and victimization service centers were asked about their current IPV experiences and the coping methods they utilized. Calvete and colleagues utilized the Responses to Stress Questionnaire (RSQ; Connor-Smith, Compas, Wadsworth, Thomsen, & Saltzman, 2000) to assess coping responses. RSQ is a 57-item inventory that defines coping responses as either engagement coping or disengagement coping. Engagement coping can be separated into primary and secondary control responses. Primary control responses are similar to problem-focused coping strategies, as individuals are attempting to change the problem. Secondary control responses are similar to more emotion-focused coping strategies, as individuals are attempting to adapt to the problem but not change the problem itself. Disengagement coping responses are similar to emotion-focused coping strategies, as individuals are attempting to move away from the problem. Examples of disengagement coping responses are avoidance and denial. When Calvete and colleagues tested for a moderation effect of coping on the impact of IPV on distress symptoms, they consistently found that there was no moderation effect. However, when testing for a mediation effect, they found that disengagement coping – such as avoidance, negotiation, or distraction - acted as a mediator between the impact of psychological abuse and levels of distress. Women who used disengagement coping were more likely to exhibit symptoms of anxiety and depression than women who did not use disengagement coping.

Application of Childhood Victimization, IPV, Coping, and PTSD: Current Study

In summary, certain commonalities arise from the literature surrounding female survivors of IPV. Research has found that survivors of childhood victimization are at a greater risk of revictimization, including entering violent relationships in adulthood. Survivors of childhood

abuse and IPV are at an increased risk of developing symptoms of psychological distress, including posttraumatic stress symptoms. There have been studies that suggest IPV mediating the relationship between childhood abuse and posttraumatic stress symptoms. Although IPV has not been found to mediate the effects of all types of childhood abuse, it has been found to mediate the effect of childhood physical abuse.

Research has indicated that female survivors of IPV and survivors of childhood abuse attempt various different strategies in order to cope with the violence. Under the model of coping depicted by Folkman and Lazarus (1985), these strategies of coping can be either problem-focused or emotion-focused. Although many female IPV survivors report using emotion-focused coping strategies, research has found that these strategies may be associated with higher psychological distress. Furthermore, the most common emotion-focused coping strategies that women reported using were not the ones that they perceived to be the most helpful. Research has also found that problem-focused coping strategies may be associated with higher levels of confidence in women who report utilizing them.

Research suggests that women are at an increased risk for PTSD when resources are unavailable or the coping strategies they utilize are ineffective (Dutton et al., 2005). Although survivors of both childhood abuse and IPV are likely to utilize emotion-focused coping, they are still at a higher risk of developing PTSD than people who have not endured either kind of abuse. The reasons behind this may be that women who are revictimized are utilizing the same emotion-focused coping strategies in each violent situation they are in, and these coping strategies are ineffective, which puts them at an increased risk for PTSD.

The purpose of this study was to examine childhood abuse as it relates to female IPV survivors and their experience of current trauma symptoms. Women who were either currently

involved in a violent relationship at that time or had left a violent relationship were encouraged to share their experiences of the violent relationship, past experiences with violence, and current trauma symptoms in the original study conducted by Fiore and Kennedy (2000).

The hypotheses of the current study were:

(1) Types of coping women indicate on the Ways of Coping Questionnaire (WOC; Folkman & Lazarus, 1988) would act as a mediator between reported history of abuse and women's responses on the Trauma Symptom Checklist (TSC; Briere & Runtz, 1989). Specifically, it was hypothesized that emotion-focused coping strategies would mediate the relationship between women's histories of childhood abuse and their current trauma symptoms.

(2) Women who report childhood abuse – coded as childhood physical abuse only, childhood sexual abuse only, and both childhood physical and sexual abuse – would report significantly greater experiences of partner violence on the Conflict Tactics Scale partner violence subscale (CTS; Straus, 1979) than women who deny childhood abuse.

(3) Women who report childhood abuse would have stayed in the abusive relationship longer than women who deny childhood abuse.

(4) A factor analysis was conducted on women's responses on WOC to determine whether the categorization of coping into emotion-focused and problem-focused was appropriate for this sample.

Method

Participants

This study utilized archival data that were collected between 1994 and 2001 (Fiore & Kennedy, 2000). Three hundred and ninety-four adult female survivors of intimate partner

violence (IPV) were included in the original study. Women were recruited through flyers posted in various locations across Western Montana. The flyers stated the following:

> Violence in Relationships or Relationship Distress; Research volunteers needed. We are looking for women to participate in a study investigating distress. We are interested in talking with women from the community who: Are currently involved in a violent relationship and are thinking about leaving, or have left a violent relationship within the past year or more than one year ago. Participants will receive $10 for appreciation of their time. All contact will be strictly confidential.

Eligibility to participate in the study was determined through women's responses on the Conflict Tactics Scale (CTS; Straus, 1979). Women were considered eligible if they reported four or more moderate experiences of violence (e.g., hitting, pushing, shoving, biting, etc.) or at least one severe experience of violence (e.g., being beaten, raped, or threatened with a weapon). Power analyses (Faul, Erdfelder, Buchner, & Lang, 2009) revealed that a sample size of 150 provided sufficient power for the purposes of the study.

Materials

Semi-structured interview.

Each adult female survivor of IPV completed a 31-item semi-structured interview (see Appendix A). A trained interviewer conducted the semi-structured interview in order to collect descriptive data about several aspects of the most current abusive relationship. Areas addressed included the nature of the violent relationship, reasons for leaving and/or returning to the relationship, and experience of outside support. Specific follow-up questions were addressed if the women did not provide the information freely to provide consistency across interviews. Certain follow-up questions were asked if the women reported certain characteristics, such as

having children or returning to the violent relationship after leaving. Items addressing experience with violence growing up will be the focus of this study. Relevant questions included the experience of violence within the family system, outside the family system, whether the violence included sexual abuse, who perpetrated the abuse and whom it was directed toward.

Demographics questionnaire.

Women were asked to complete a 20-item demographics questionnaire (see Appendix B). The questionnaire addressed general demographic questions, including the age of the women, their education, and their occupation. The questionnaire also addressed the nature of the violent relationship, including the length of time women spent in the relationship, the geographic location where the violence occurred, and contact status with the abusive partner. The question most applicable for the purposes of this study is the length of the relationship.

Conflict Tactics Scale (CTS).

The CTS Form A (Straus, 1979) was utilized in this study as both an eligibility criterion and as a measure of the type and frequency of physical violence experienced by the female survivors of IPV (see Appendix C). The CTS Form A is a 23-item questionnaire that addresses reported violence of both the partner and the self, with responses ranging from "never" to "20+" times. Internal consistency reliability item-total correlations for women range from .52 to .91, with a mean of .76 (Straus, 1979). The current study included an additional item regarding being forced to perform sexually against one's will.

Ways of Coping Questionnaire (WOC).

The WOC (Folkman & Lazarus, 1988) measures women's reported behavioral, affective, and cognitive coping strategies to her current situation (see Appendix D). The WOC is a 66-item questionnaire that utilizes a 4-point Likert scale from 0 ("Does not apply or do not use") to 3

("Use a great deal") to identify problem-focused coping strategies and emotion-focused coping strategies. The emotion-focused coping items identify strategies that are aimed toward managing the emotional distress caused by the problem, and include six different factors: wishful thinking (e.g., "I wish that I could change what is happening or how I feel"), distancing (e.g., "I go on as if nothing happened"), emphasizing the positive (e.g., "I remind myself how much worse things could be"), self-blame (e.g., "I realize that I have brought the problem on myself"), tension-reduction (e.g., "I jog or exercise"), and self-isolation (e.g., "I keep others from knowing how bad things are"). The problem-focused coping items identify strategies that are aimed toward managing the source of the problem (e.g., "I change something so things will turn out all right"). Only 50 of the items are scored. Folkman and Lazarus (1985) reported an average coefficient alpha of .85 for problem-focused coping. For emotion-focused coping, Folkman and Lazarus (1985) reported average coefficient alphas ranging from .65 (self-isolation) to .84 (wishful thinking).

Different instructions were utilized for women who were currently in a violent relationship versus women who have left a violent relationship. For women who were currently in a violent relationship, the instructions were: "Think about what you do or think to remedy the problem or make yourself feel better about the situation. Think about the ways you deal with the situation RIGHT NOW." For women who have left a violent relationship, the instructions were: "Think about how you continue to deal with the experience."

The Trauma Symptom Checklist (TSC-33).

The TSC (Briere & Runtz, 1989) measures traumatic impact through 33 symptom items that are rated for frequency of occurrence (see Appendix E). The TSC measures the frequency of the symptoms in the previous two months on a 4-point Likert scale from 0 ("Never") to 3 ("Very

Often"). Five subscales can be produced from the TSC: anxiety (e.g., "anxiety attacks"), depression (e.g., "uncontrollable crying"), dissociation (e.g., "feelings that things are 'unreal'"), postsexual abuse trauma (e.g., "sexual overactivity"), and sleep disturbance (e.g., "restless sleep"). It should be noted that items on the postsexual abuse trauma subscale are not symptoms exclusive to sexual trauma. In the original study this study is based on (Fiore & Kennedy, 2000), the coefficient alpha for the full scale was reported at .92. Reported coefficient alphas for the subscales ranged from .70 (anxiety) to .79 (dissociation).

Procedure

Women were offered several meeting locations for further assessment once eligibility had been determined. Precautions were taken in order to maintain the safety of the women by allowing them to choose the meeting time.

All women completed the 31-item semi-structured interview in order to detail information about their experiences of the violent relationships. Interviews were audiotaped. Interviews were conducted by researchers trained in interviewing skills and were sensitive to the issues of IPV female survivors. Participants were allowed to take breaks if needed, ask questions, or address particular needs they had while being interviewed. Interviews lasted one to three hours depending on the depth of experiences and expressivity of the participant.

Following the interviews, women were given a brief standardized description of each questionnaire. Each participant was asked to complete a packet of 10 questionnaires. The 10 questionnaires, in order, were as follows: demographics questionnaire, Stages Scale, Strategies Scale, Decision Making Scale, Confidence/Temptation Scale, Ways of Coping Questionnaire, Relationship Qualities Scale, Conflict Tactics Scale, Legal/Medical Response Questionnaire, and Health Checklist. The questionnaires took approximately one hour to complete. At the end of the

interview and assessment, participants were debriefed and offered information on psychological counseling and social services. They received either $10 or eight research credits if they were in an introductory psychology course as compensation. The audiotaped interviews were then transcribed into a Word document.

Results

Demographics

Twelve women from the original sample of 394 were excluded from the analyses due to either missing or questionable data. These twelve women either did not answer the question about childhood abuse experiences or their responses to the question were not clear enough to determine which categorization of their abuse experiences was appropriate. In total, 382 women were included in the analyses. Power analyses (Faul, Erdfelder, Buchner, & Lang, 2009) conducted prior to this study revealed that a sample size of 150 would provide sufficient power for the purposes of this study. These women ranged in age from 18 to 63 years old (mean age = 31, SD = 11). The women were primarily Caucasian (89.1%), with a minority being American Indian (4.8%), Hispanic (1.5%), African-American (.5%), Asian (.5%), or other (3.3%). The majority of the women endorsed completing some college or a vocational school (63.5%); 12.4% indicated they were high school graduates, 8.4% indicated they attended some high school or obtained a GED, 7.4% indicated they were a college graduate, 3.0% indicated attending some graduate school, 4.1% indicated completing a graduate degree, and a small minority indicated completing eighth grade or less (.5%). Time since the last violent relationship ranged from 0 to 40 years, with an average of 4 years (SD = 6). The length of the violent relationship was an average of 63 months (SD = 72.5). Two hundred and sixteen women (54.8%) denied childhood abuse experiences, 65 women (16.5%) indicated experiencing CPA only, 23 women (5.8%)

indicated experiencing CSA only, and 78 women (19.8%) indicated experiencing both CPA and CSA (see Figure 3).

Partner Violence Frequency

A one-way analysis of variance (ANOVA) was conducted on the mean CTS partner violence subscale scores of women who report experiences of child abuse and women who deny experiences of child abuse. A significant main effect was found, $F(3,364)=6.106$, $p<.001$ (see Figure 4). Tukey's post-hoc pairwise comparisons revealed that women who experienced CSA only reported significantly more partner violence than women who did not experience childhood abuse, $p=.003$. The comparison between women who experienced CPA only and women who did not experience childhood abuse approached significance, $p=.062$. The comparison between women who experienced both CPA and CSA and women who did not experience abuse also approached significance, $p=.067$. See Table 1 for a summary of means on the Partner Violence Subscale across different child abuse experiences

Length of IPV Relationship

An analysis of covariance (ANCOVA) was conducted on the mean length of the violent relationship of women who report experiences of child abuse and women who deny experiences of child abuse. Age acted as a covariate in this analysis. A significant main effect for length of the violent relationship was not found, $F(3, 361)=2.019$, $p=.111$ (see Figure 5). See Table 2 for a summary of length means across different child abuse experiences.

Coping as a Mediator

Bootstrapping confidence intervals based on 10,000 samples yielding 95% confidence intervals were conducted to test for mediation, as proposed by Hayes and Preacher (2011). In each of the analyses, childhood abuse experiences acted as the independent variable (X) and

current TSC total scores acted as the dependent variable (Y; see Figure 1). Indicator coding – also known as dummy coding – was used to compare the childhood abuse experiences. Not experiencing childhood abuse was coded as 0, therefore acting as the comparison group for the mediation analyses. Experiencing CPA only was coded as 1, experiencing CSA only was coded as 2, and experiencing both CPA and CSA was coded as 3. One bootstrapping analysis utilized women's problem-focused coping subscale scores as the mediator (M in Figure 1), and one bootstrapping analysis utilized women's emotion-focused coping subscale scores as the mediator (M in Figure 1).

In addition to testing for mediation effects, the macro developed by Hayes and Preacher (2011) – entitled MEDIATE – tests for the direct effect of the independent variable on the dependent variable, the effect of the independent variable on the mediator, and the mediator on the dependent variable. Significant direct effects of childhood abuse experiences on current trauma symptoms were found for two comparisons. After adjusting for group differences in problem-focused coping subscale scores, those who experienced both CSA and CPA reported trauma symptoms that were 5.6 units higher than those who experienced no childhood abuse, p=.01. After adjusting for group differences in emotion-focused coping subscale scores, those who experienced both CSA and CPA reported trauma symptoms that were 3.7 units higher than those who experienced no childhood abuse, p=.05. Significant effects of childhood abuse experiences on the utilization of coping were found for three comparisons. Women who experienced both CSA and CPA utilized 3.1 units more problem-focused coping than women who experienced no childhood abuse, p=.02. Women who experienced CPA only utilized 3.7 units more problem-focused coping than women who experienced no childhood abuse, p=.006. Women who experienced both CSA and CPA utilized 5.4 units more emotion-focused coping

than individuals who experienced no childhood abuse, p=.01. Significant effects of coping on current trauma symptoms were found for both problem-focused coping (p<.0001) and emotion-focused coping (p<.0001). In other words, an increase in the endorsed utilization of either problem-focused or emotion-focused coping increased current trauma symptoms.

These tests are analogous to the steps for testing mediation suggested by Baron and Kenny (1986). Unlike the method suggested by Baron and Kenny (1986), it is not required that the previously mentioned tests first be significant in order to test for mediation. Preacher and Hayes (2004) argue that it is not necessary for these tests to be significant in order for mediation to occur. Studies have revealed that Baron and Kenny's (1986) method is low in power and may not test distal effects (see Shrout & Bolger, 2002).

Bootstrapping analyses revealed that both emotion-focused and problem-focused coping mediated the effect of experiencing both CSA and CPA (relative to reporting no childhood abuse experiences) on current trauma symptoms, p<.05 (See Table 3). Women who experienced both CSA and CPA were more likely to report the use of both emotion-focused and problem-focused coping strategies, which in turn increased current symptoms of trauma. Bootstrapping analyses also revealed that problem-focused coping mediated the effect of experiencing CPA only on current trauma symptoms, p<.05. Women who experienced CPA only were more likely to report the use of problem-focused coping strategies, which in turn increased current symptoms of trauma.

Factor Analysis.

A factor analysis was conducted on the WOC items after the initial tests for mediation. This analysis was conducted in order to see whether the categorization of coping into emotion-focused and problem-focused was appropriate for this sample. The factor analysis identified two

factors (see Appendix G). Factor One appears to be more of a self-focused construct, where the women are endorsing coping that is more focused on changing the self and not as focused on seeking out others to address the situation. Factor Two appears to be tapping in to the construct of catharsis, where women are endorsing coping strategies that address the negative feelings surrounding the abuse.

Bootstrapping analyses were conducted examining the two factors as mediators between previous childhood abuse experiences and current trauma symptoms. Bootstrapping analyses revealed that Factor One – "Self-Focused Coping" – mediated the effect of experiencing both CSA and CPA (relative to reporting no childhood abuse experiences) on current trauma symptoms, $p<.05$. Women who experienced both CSA and CPA were more likely to report the use of coping indicated by Factor One, which in turn increased current trauma symptoms. This finding mirrors the bootstrapping analyses conducted on problem-focused and emotion-focused coping strategies. Ultimately, the findings from the factor analysis did not extend our knowledge beyond what emotion-focused coping and problem-focused coping constructs provided to our understanding.

Discussion

This study examined the effects of childhood abuse experiences on women's IPV experiences. The prediction that women with childhood abuse experiences would encounter more frequent violence in the intimate relationship was supported in this study. However, women with child abuse experiences did not stay in the abusive relationship longer and thus the second hypothesis was not supported. Finally, the last hypothesis regarding the types of coping women endorsed utilizing in response to the violence in the relationship would act as a mediator

between their previous abuse experiences and their current trauma symptoms was supported but in an unexpected direction. Further exploration of these findings are discussed below.

This study demonstrated that women with childhood abuse experiences report more violence in the intimate relationship. Specifically, the results demonstrated that women who experienced CSA only, reported more violence in the relationship that was perpetrated toward them by their partners than women who did not experience childhood abuse. This finding lends support to the theory that early sexual abuse may alter an individual's orientation to the world and her self-concept (Browne & Finkelhor, 1986). Experiencing sexual abuse at a young age may drastically affect the way women see themselves. They may develop low self-worth, which would make them easy targets for abuse. These women may even come to believe themselves deserving of the abuse, ultimately leading them to endure more abuse.

Theorists suggest that there are potentially boundary violations inherent in CSA that may challenge female IPV survivors' sense of control and autonomy (DiLillo, Giuffre, Tremblay, & Peterson, 2001). Many developmental psychologists describe the early years of childhood as occurring in steps, starting with seeing everything from a very self-oriented view to understanding the differences between self and others (e.g., Piaget & Inhelder, 1956). The boundaries between self and others that are learned early on become muddied and indistinct when sexual abuse occurs. Women with CSA experiences may have come to believe that they do not have control over their lives, just as they did not have control over the most intimate part of themselves. This lack of control and autonomy could lead women into relationships where they do not feel they have the power to influence the violence. Muddied boundaries from an early age may also make it hard to delineate what is physically, sexually, and emotionally appropriate and what is inappropriate in a relationship. Ultimately, CSA seems to affect the very core of an

individual, changing her belief of self and others. Revictimization is a finding that is found in regard to CSA survivors and the incidence of later sexual violence (Browne & Finkelhor, 1986). Vulnerability to physically violent relationships appears to also be a risk for women who have experienced CSA.

Two additional comparisons approached but did not reach statistical significance. Specifically, women who experienced CPA only, reported more violence in the intimate relationship than women who did not experience childhood abuse, but did not quite reach statistical significance ($p<.06$). Similarly, women who experienced both CSA and CPA reported more violence in the intimate relationship than women who did not experience childhood abuse, and again this comparison approached but did not reach statistical significance ($p<.06$). The results raise questions as to why women who reported CSA only reported significantly more violence in the relationship but women who experienced a combination of CSA and CPA did not report significantly more violence. There are a few hypotheses as to why this may have occurred. First, this may suggest that the women in this study who experienced CSA only, experienced different sexual encounters than women who experienced both CSA and CPA. Perhaps women who experienced CSA only encountered more frequent sexual abuse or more severe sexual abuse (e.g., penetration instead of fondling). Another possible hypothesis stemming from these results is that CSA only experiences alter women's perceptions in a way that combined abuse experiences do not. Studies have found that women who experience sexual abuse are likely to feel shame from the abuse (Browne & Finkelhor, 1986). Shame is an emotion that is directed toward the self, and may not be characterized by action. For those women who experienced CSA only, it may be that they are more likely to feel shame in response to the experience of IPV, which is an emotion that does not necessarily call one to action. Unfortunately, the parameters of

this study do not allow for these hypotheses to be further explored. Future research could look into the differences between CSA only experiences and those women who experience combined childhood abuse experiences.

Contrary to predictions, the current study did not demonstrate women with childhood abuse experiences staying in the IPV relationship longer than women without childhood abuse experiences. There are several possibilities as to why this result was found. One possibility is the amount of variability found in the lengths of the violent relationship. In this study, women reported being in the violent relationship for an average of 63 months, and this was found to deviate approximately 72 months on average. The amount of variability found in the length of the violent relationship would make it hard to detect an effect if one truly existed. Indeed, the observed power of the ANOVA was .518. In other words, there was 51.8% chance that the ANOVA would pick up on an effect if an effect existed. This makes it hard to determine whether the nonsignificant results were truly due to an effect not existing or due to low power to detect an effect. However, it is important to recognize the possibility that there may not actually be a difference in the length of violent relationships for women who have experienced childhood abuse and for women who have not experienced childhood abuse. The hypothesis that these differences would exist was based on the belief that women with childhood abuse experiences would be more likely to experience more violence for a longer period of time before getting out of the relationship. In fact, at least part of this hypothesis was found to be true: Women with previous childhood sexual abuse experiences were more likely to experience more violence in the relationship. Maybe the difference between women with childhood sexual abuse experiences and women without childhood abuse experiences is, indeed, the amount of violence they experience rather than how long they are experiencing this violence. Future research could

continue to look at the possibility of differences in lengths of the violent relationship for women who experienced childhood abuse and for women who did not experience childhood abuse, as this study was ultimately unable to determine whether differences exist.

Mediation analyses were also conducted on the data and demonstrated that the types of coping women reported mediated the relationship between childhood abuse experiences and current trauma symptoms. Emotion-focused and problem-focused coping were found to mediate the relationship between women who experience both CSA and CPA and current trauma symptoms. Women who experienced both CSA and CPA were more likely to report the utilization of emotion-focused and problem-focused coping strategies, which in turn was related to higher current symptoms of trauma. Problem-focused coping was also found to mediate the relationship between women who experience CPA only and current trauma symptoms. Specifically, women who experienced CPA only were more likely to report the utilization of problem-focused coping strategies, which in turn was associated with higher current trauma symptoms.

These results were somewhat surprising. The original hypothesis was that the utilization of emotion-focused coping strategies would increase current trauma symptoms for women who have experienced childhood abuse. This was found to be the case for women who have experienced both CSA and CPA. Research has demonstrated that emotion-focused coping strategies are associated with more psychological distress and less satisfaction with the strategy, and these strategies are more likely to be utilized by women who feel trapped in their violent relationship (Arriaga & Capezza, 2005). Perhaps women with both CSA and CPA experiences are more likely to feel trapped in the relationship, which may in turn lead them to choose emotion-focused coping strategies that create more psychological distress.

An unexpected finding of this study was that women with childhood abuse experiences (experiencing CPA only or experiencing both CSA and CPA) were more likely to also utilize problem-focused coping strategies, which in turn was associated with higher current trauma symptoms. Folkman et al. (1986) have found that individuals are more likely to utilize problem-focused coping strategies when they believe the situation to be changeable. Research on coping strategies utilized by female survivors of IPV has found that women who utilize more problem-focused coping strategies show fewer signs of extreme psychological distress (Arriaga & Capezza, 2005). Research has also found that problem-focused coping strategies were rated more helpful than emotion-focused coping strategies for women in violent relationships (Riddell et al., 2009). One may then deduce that the utilization of problem-focused coping strategies should be associated with lower trauma symptoms, when this was not found to be the case.

An item level analysis of the types of problem-focused coping strategies women endorsed utilizing may provide some understanding why these coping strategies are not associated with lower trauma symptoms. The first item on the WOC that represents problem-focused coping and that was endorsed by women is, "I just have to concentrate on what I have to do – the next step." Although this may seem like a good coping mechanism, it hinges on the idea that women know what the proper next step should be, when this may not be the case. Another example of a problem-focused item is, "I try to get the person responsible to change his or her mind." Like the first item, this item would seem to be a good coping mechanism. However, one could argue that it would only lead to a positive experience if the person responsible changes his or her (in this case, his) mind. If women who use this item were not able to change their significant others' minds, this type of coping would not be useful. Not only this, but it may lead to detrimental effects if trying to change the other person's mind actually leads to more violence.

Research has suggested that the use of problem-solving coping may actually put women experiencing IPV at higher levels of risk (Lewis et al., 2006). As was demonstrated by one of the items on the WOC, this may indeed be the case. There is research supporting the notion that problem-focused coping strategies may be ineffective if one has restricted resources to deal with the stressful situation (Kocot & Goodman, 2003). If this were the case, the higher trauma symptoms from greater utilization of problem-focused coping is understandable. Also of importance to note, is the authors who originally delineated between problem-focused and emotion-focused coping, also acknowledged that in and of themselves, neither emotion-focused or problem-focused coping are more effective in every situation (Folkman et al., 1986).

These results suggest that women with childhood abuse experiences are trying to cope with the trauma of IPV in any way they can. Hamby and Gray-Little (2007) have stated that research studies on the coping of female survivors of IPV tend to focus on the negative aspects of women's coping, and tend to frame it as a problem with passivity, disengagement, and avoidance coping. This study demonstrates that even more "active" forms of coping are not necessarily helping women who have multiple forms of trauma, suggesting that women's use of coping may not be the problem. Indeed, Goodman, Dutton, Vankos, and Weinfurt (2005) concluded that women's use of strategies increase in number and diversity with the increase in severity of violence. The results from this study coincide with this finding.

Nonetheless, the results also demonstrated that the emotion-focused and problem-focused strategies women identify as using do not seem to be enough to help women deal with everything that arises from IPV, especially given their personal long-term violence exposure. Since both emotion-focused strategies and problem-focused strategies are associated with higher trauma symptoms in women with child abuse histories, perhaps the long-term nature of experiencing

abuse creates feelings of powerlessness and ineffectiveness of coping, no matter the approach. van der Kolk (2005) describes long-term, developmentally adverse trauma experiences as complex trauma. Evidence suggests that complex trauma "sets the stage for unfocused responses to subsequent stress" (van der Kolk, 2005, p. 402). The diversity of the strategies utilized by these women may be indicative of unfocused responses to IPV.

These results are very important clinically. The results demonstrate that certain types of coping do mediate the response between childhood abuse experiences and current trauma symptoms. Folkman and colleagues (1986) have stated that coping is a critical mediator between stressful person-environment relations and both their immediate and their long-term outcomes. These ideas assume that coping strategies assist with management of stress. However, the results of the present study clearly demonstrate that the way to reduce negative impacts of abuse does not lie completely in providing coping strategies to women. What the results do suggest is that women are using these specific coping strategies in an attempt to manage their situations, and that these coping strategies do not seem to be addressing trauma symptomatology. Whether this is a problem inherent in the coping strategies being utilized or in the way women are utilizing cannot be determined with these data. What can be determined from these results is that women with multiple abuse experiences ranging from childhood abuse to IPV may need more than problem-focused and emotion-focused coping strategies to lower the impact of trauma.

Knowing how to best assist women who suffer from complex trauma is an important next step in developing treatments that work. Pearlman and Courtois (2005) indicate that individuals with complex trauma have difficulties identifying and modulating emotions, maintaining personal safety, and may develop distortions in views of self and ones' worth in relationships. van der Kolk (2005) indicates that treatment of complex trauma in children must focus on three

primary areas: dealing with traumatic re-enactments, establishing safety and competence, and integrating and mastering the body and mind. Under this conceptualization of treatment for complex trauma, simply applying our knowledge of coping in the general populations to victims of long-term abuse may be insufficient. Research currently being done at the Trauma Center at Justice Resource Institute by van der Kolk and colleagues is looking at integrating the body in to treatment (Justice Resource Institute, n.d.). Future research of female survivors of IPV with previous childhood abuse experiences could focus on the efficacy of the treatment model van der Kolk suggests for individuals with complex trauma.

This study also brings up the possible importance of intervening after an individual has experienced childhood abuse. The theory behind early prevention of abuse is that providing services to individuals who display certain risk factors will help stop the chain of events leading to abuse situations. Studies that have utilized prevention strategies to target families that are at-risk for child abuse and neglect have found promising results on the success of early intervention (Guterman, 1997). In Guterman's review of studies utilizing early intervention for families that are at-risk for child abuse and neglect, he found that the studies that reported few or no intervention effects point to the intervention design not matching the intervention recipients' needs. In other words, early intervention may be a useful avenue to prevent child abuse, but in order to be effective it must focus on the needs of the recipient.

Guterman (1997) focused his literature review on early intervention in order to prevent child abuse. Although preventing abuse before it starts is optimal, it is not always possible. Using his findings on early prevention strategies for families at-risk for child abuse, early prevention strategies for individuals at-risk for IPV could be a possible avenue.

Studies have found that female survivors of childhood abuse are at an increased risk for being revictimized in their intimate relationships (Messman-Moore & Long, 2000). The results from this study clearly demonstrate the negative impact childhood abuse experiences of child physical abuse and child sexual abuse have on women who have also experienced IPV. Women who have experienced childhood abuse are more likely to report greater violence in the relationship and are more likely to have higher current trauma symptoms, even though they are utilizing the coping strategies typically effective for others. Although identification and substantiation of all forms of child abuse pose challenges, early intervention where identifying effective coping or where work on boundaries and judging respectful treatment in relationships is addressed are directly addressed may prove particularly helpful.

Currently, many attachment theorists believe there is a relationship between childhood abuse, attachment patterns, and relationship violence (e.g., Lyons-Ruth & Jacobvitz, 1999). Specifically, child maltreatment has been found to be a serious risk factor for disorganized patterns of attachment, with upwards of 82% of maltreated infants displaying such patterns. Disorganized patterns of attachment are characterized by infants displaying contradictory behavior patterns toward parents, such as attaching very strongly to the parent and then suddenly pulling away or becoming distant. Pearlman and Courtois (2005) indicate that disorganized attachment styles are often found in complex trauma survivors. This disorganized pattern of attachment may make it difficult for women to recognize a healthy relationship. Lyons-Ruth and Jacobvitz (1999) indicated that women who are abused might be more likely to display unresolved and overwhelmed states of mind with respect to their violent relationship. Indeed, this may make it difficult to utilize effective coping strategies in the moment. Although this

study did not measure attachment pattern, future research might investigate the relationship between attachment pattern, approaches to coping and intimate partner violence.

However, what exactly the revictimization link is telling us may be one of the most important questions for social science and public health professionals. Undetected child abuse may render a child helpless to typical coping strategies that this study shows are ineffective because of children's vulnerability and their powerlessness. Detected child abuse also brings with it mixed outcomes for children and their families, such as removing the child from the home and disrupting the parent-child relationship (Kobak, 1999). Ideally, intervention as soon as childhood abuse has occurred is crucial in order to reduce these negative long-term impacts.

Limitations

This study has a few limitations. First, some of the data collected for this study were collected almost 20 years ago. One may argue that the nature of women's coping with recent and past violent relationships has changed in the last 20 years, which would limit the findings of this study. Although the data from this study are aged, results from studies using more recent data do not indicate that there has been a dramatic shift in women's coping strategies. However, certain coping measures and conceptualizations have become more popular than problem-focused and emotion-focused coping recently. One more recent conceptualization of coping is engagement and disengagement coping. Nonetheless, these coping conceptualizations are similar to that of emotion-focused and problem-focused coping; in fact, the conceptualization of emotion-focused and problem-focused coping served as a stepping-stone for the conceptualization of engagement and disengagement coping. With this in mind, results from this study are still useful and can still be compared with current research. Future research could replicate this study using the most

current measures from this study, including the revised CTS, and possibly using a measure that represents the more current conceptualization of coping.

Also of importance to note, is that mediation analyses make it impossible to determine cause-effect. Therefore, one should be cautious when interpreting the results. There is the possibility that women with higher current trauma symptoms are more likely to utilize any and all types of coping available to them. In other words, there is a possibility that higher current trauma symptoms lead to higher coping strategy utilization, no matter the effectiveness of coping utilization in women with lower trauma symptoms. Unfortunately, cross-sectional studies such as this do not offer causal information. Longitudinal studies are better able to provide evidence for causal relationships. Future longitudinal studies may provide the only means of understanding more clearly how childhood experiences of abuse influences choice and utilization of coping strategies and impact trauma symptoms.

Summary

Learning what can be done to prevent women from entering into abusive situations is a crucial area of research. Unfortunately, preventing all cases of abuse is an impossible goal. So while researchers, clinicians, and society can focus on preventing all cases of abuse, focusing on preventing revictimization for those who have already experienced abuse is also an important area of research. Other research has found that women with childhood abuse experiences are more likely to experience IPV (Messman-Moore & Long, 2000). Research has also found that women who have experienced IPV in a relationship are more likely to enter into other relationships with IPV (Alexander, 2009). Both of these findings suggest that women with any abuse experiences need to be provided with opportunities and to get out of the cycle of abuse. In addition, women with any abuse experiences also need to be given strategies for dealing with the

negative experiences that can arise from abuse. This study provided evidence that the utilization of emotion-focused and problem-focused coping strategies is not enough to eliminate trauma symptoms. Researchers and clinicians need to continue to research effective strategies so that the most successful interventions can be created for this population.

References

Alexander, P. C. (2009). Childhood trauma, attachment, and abuse by multiple partners. *Psychological Trauma: Theory, Research, Practice, and Policy, 1,* 78-88. doi:10.1037/a0015254

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Arriaga, X. B., & Capezza, N. M. (2005). Targets of partner violence: The importance of understanding coping trajectories. *Journal of Interpersonal Violence, 20*, 89-99. doi:10.1177/0886260504268600

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51,* 1173-1182.

Bauman, E. M., Haaga, D. A. F., & Dutton, M. A. (2008). Coping with intimate partner violence: Battered women's use and perceived helpfulness of emotion-focused coping strategies. *Journal of Aggression, Maltreatment & Trauma, 17*(1), 23-41. doi:10.1080/10926770802250942

Becker, K. D., Stuewig, J., & McCloskey, L. A. (2010). Traumatic stress symptoms of women exposed to different forms of childhood victimization and intimate partner violence. *Journal of Interpersonal Violence, 25*, 1699-1715. doi:10.1177/0886260509354578

Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child Abuse and Neglect, 19,* 1401-1421. doi:10.1016/0145-2134(95)00104-9

Briere, J., & Runtz, M. (1989). The trauma symptom checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*, 151-162.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*(1), 66-77.

Calvete, E., Corral, S., & Estévez, A. (2008). Coping as a mediator and moderator between intimate partner violence and symptoms of anxiety and depression. *Violence Against Women, 14,* 886-904. doi:10.1177/1077801208320907

Campbell, R., Greeson, M. R., Bybee, D., & Raja, S. (2008). The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: A meditational model of posttraumatic stress disorder and physical health outcomes. *Journal of Consulting and Clinical Psychology, 76*, 194-207. doi:10.1037/0022-006X.76.2.194

Cannon, E. A., Bonomi, A. E., Anderson, M. L., & Rivara, F. P. (2010). Adult health and relationship outcomes among women with abuse experiences during childhood. *Violence and Victims, 25*, 291-305. doi:10.1891/0886-6708.25.3.291

Connor-Smith, J. K., Compas, B. E., Wadsworth, M. E., Thomsen, A. H., & Saltzman, H. (2000). Responses to stress in adolescence: Measurement of coping and involuntary responses to stress. *Journal of Consulting and Clinical Psychology, 68*, 976-992.

DiLillo, D., Giuffre, D., Tremblay, G. C., & Peterson, L. (2001). A closer look at the nature of intimate partner violence reported by women with a history of childhood sexual abuse. *Journal of Interpersonal Violence, 16,* 116-132.

Dutton, M. A., El-Khoury, M., Murphy, M., Somberg, R., & Bell, M. E. (2005). Women in intimate partner violence: Major advances and new directions. In W. M. Pinsof & J.

Lebow (Eds.), *Family psychology: The art of the science* (pp. 191-221). New York, NY: Oxford University Press.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*, 1149-1160. doi:10.3758/BRM.41.4.1149

Fiore, C. & Kennedy, L. T. (2000). Stay-leave decision making in battered women: Trauma, coping and self-efficacy. *Cognitive Therapy and Research, 24,* 215-232. doi:0147-5916/00/0400-0215

Fiore, C. & O'Shea, K. (2007). Women in violent relationships: Experiences with the legal and medical systems. In K. A. Kendall-Tackett & S. M. Giacomoni (Eds.), *Intimate partner violence* (pp. 18-1-18-25). Kingston, NJ: Civic Research Institute.

Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48,* 150-170.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*, 992-1003.

Folkman, S., & Lazarus, R. S. (1988). *Manual for the Ways of Coping Scale*. Palo Alto, CA: Consulting Psychological Press.

Golding, J. M. (1999). Intimate partner abuse as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14,* 99-132. doi:10.1023/A:1022079418229

Goodman, L., Dutton, M. A., Vankos, N., & Weinfurt, K. (2005). Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women, 11,* 311-336. doi:10.1177/1077801204273297

Guterman, N. B. (1997). Early prevention of physical child abuse and neglect: Existing evidence and future directions. *Child Maltreatment, 2,* 12-34. doi:10.1177/1077559597002001003

Hamby, S., & Gray-Little, B. (2007). Can battered women cope? A critical analysis of research on women's responses to violence. In K. A. Kendall-Tackett & S. M. Giacomoni (Eds.), *Intimate partner violence* (pp. 28-1-28-19). Kingston, NJ: Civic Research Institute.

Hayes, A. F., & Preacher, K. J. (2011). *Indirect and direct effects of a multicategorical causal agent in statistical mediation analysis*. Unpublished manuscript.

Hetzel, M. D., & McCanne, T. R. (2005). The roles of peritraumatic dissociation, child physical abuse, and child sexual abuse in the development of posttraumatic stress disorder and adult victimization. *Child Abuse and Neglect, 29*, 915-930. doi:10.1016/j.chiabu.2004.11.008

Justice Resource Institute (n.d.). Trauma center publications and products. Retrieved from http://www.traumacenter.org/products/products_landing.php

Kobak, R. (1999). The emotional dynamics of disruptions in attachment relationships. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 21-43). New York, NY: Guilford Press.

Kocot, T., & Goodman, L. (2003). The roles of coping and social support in battered women's mental health. *Violence Against Women, 9*, 323-346. doi:10.1177/1077801202250075

Lang, A. J., Stein, M. B., Kennedy, C. M., & Foy, D. W. (2004). Adult psychopathology and intimate partner violence among survivors of childhood maltreatment. *Journal of Interpersonal Violence, 19*, 1102-1118. doi:10.1177/0886260504269090

Lewis, C. S., Griffing, S., Chu, M., Jospitre, T., Sage, R. E., Madry, L., & Primm, B. J. (2006). Coping and violence exposure as predictors of psychological functioning in domestic violence survivors. *Violence Against Women, 12*, 340-354.

Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 520-554). New York, NY: Guilford Press.

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the revictimization of women: An empirical review and theoretical reformulation. *Clinical Psychology Review, 23,* 537-571. doi:10.1016/S0272-7358(02)00203-9

Nishith, P., Mechanic, M. B., & Resick, P. A. (2000). Prior interpersonal trauma: The contribution to current PTSD Symptoms in female rape victims. *Journal of Abnormal Psychology, 109,* 20-25. doi:10.1037//0021-843X.109.1.20

Novello, A. C., Rosenberg, M., Saltzman, L., & Shosky, J. (1992). From the Surgeon General, U.S. Public Health Service. *The Journal of the American Medical Association, 267*(23), 3132. doi:10.1001/jama.1992.03480230024006

Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress, 18,* 449-459. doi:10.1002/jts.20052

Piaget, J., & Inhelder, B. (1956). *The child's conception of space*. London: Routledge & Kegan Paul.

Popescu, M. L., Drumm, R., Dewan, S., & Rusu, C. (2010). Childhood victimization and its impact on coping behaviors for victims of intimate partner violence. *Journal of Family Violence, 25*, 575-585. doi:10.1007/s10896-010-9317-5

Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS procedures for estimating indirect effects in simple mediation models. Behavioral Research Methods, Instruments, and Computers, 36, 717-731.

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care for Women International, 30*, 134-159. doi:10.1080/07399330802523774

Rodriguez, N., Vande Kemp, H., & Foy, D. W. (1998). Posttraumatic stress disorder in survivors of childhood sexual and physical abuse: A critical review of the empirical research. *Journal of Child Sexual Abuse, 7*(2), 17-45. doi:10.1300/J070v07n02_02

Schafer, J., Caetano, R., & Cunradi, C. B. (2004). A path model of risk factors for intimate partner violence among couples in the United States. *Journal of Interpersonal Violence, 19*, 127-142. doi:10.1177/0886260503260244

Seedat, S., Stein, M. B., & Forde, D. R. (2005). Association between physical partner violence, posttraumatic stress, childhood trauma, and suicide attempts in a community sample of women. *Violence and Victims, 20*(1), 87-98. doi:10.1891/vivi.2005.20.1.87

Shrout, P. E., & Bolger, N. (2002). Mediation in experimental and nonexperimental studies: New procedures and recommendations. Psychological Methods, 7, 422-445. doi:10.1037//1082-989X.7.4.422

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. *Journal of Marriage and the Family, 41,* 75-88.

Sullivan, T. P., Schroeder, J. A., Dudley, D. N., & Dixon, J. M. (2010). Do differing types of victimization and coping strategies influence the type of social reactions experienced by current victims of intimate partner violence? *Violence Against Women, 16,* 638-657. doi:10.1177/1077801210370027

Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey.* Washington, DC: U.S. Department of Justice.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2008). *Child maltreatment 2008*. Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can

van der Kolk, B. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35,* 401-408.

Whiting, J. B., Simmons, L. A., Havens, J. R., Smith, D. B., & Oka, M. (2009). Intergenerational transmission of violence: The influence of self-appraisals, mental disorders and substance abuse. *Journal of Family Violence, 24*, 639-648. doi:10.1007/s10896-009-9262-3

Appendix A

Domestic Violence Interview

Interviewer _____ Location _____ ID# _____

We are studying women's experience of violent relationships and your responses, needs, and beliefs. We understand that talking about the relationship may be difficult for you. Feel free to take your time and to present information as best as you are able. Also know that you can take a break, ask questions, or let us know any particular needs and/or feelings you may experience while being interviewed.

1. Please tell me about the (violent) relationship you (are/were) in:
    a. When did the violence begin?
    b. (Have you/did you) ever (left/leave)? Y N
    c. (If so, go to 2; if not, go to 3).
        b1. Temporarily or permanently? (Circle).
            _____ # of times (if temp) _____ # of times (if perm)

2. a. If you ever left your partner, where did you go?
    Friend Relative Shelter/Motel/Hotel Other N/A

b. If you left more than one time, what would you describe as the reason(s) for returning?
    Love Fear Financial Children Family
    Religion Personal beliefs Friend Peer pressure Other
    N/A

c. If you left permanently, what would you describe as the reason(s) you left for good?
    Love Fear Financial Children Family
    Religion Personal beliefs Friend Peer pressure Other
    N/A

d. If you left temporarily, what would you describe as the reason(s) you left?
    Love Fear Financial Children Family
    Religion Personal beliefs Friend Peer pressure Other
    N/A

e. Was there a turning point for you in your decision…a specific situation or realization that might have occurred? Y N
    What?

f. (Have you/did you) ever (threatened/threaten) to leave?
    Never Once Sometimes Often

g. **If the woman has children, ask:
    What role do you think your children played in your decision?

3. a. ***Only ask this question if it appears that they are still in the violent relationship.
    What would you describe as your reason(s) for staying in the relationship?
    Love Fear Financial Children Family
    Religion Personal beliefs Friend Peer pressure Other
    N/A

4. (Is there/was there) anything that (would change/would have changed) your mind about staying/leaving? Y N
If so, what?

5. Was there any violence in your family when you were growing up? Y N
Did the violence include sexual abuse? Y N
Of whom/by whom?
Any violence outside your family? Y N
Did the violence include sexual abuse? Y N
Of whom/by whom? Y N

6. Do you have anyone that you (seek/sought) support from or talk to about the relationship?
Y N

Who?
Family Friend Therapist Religious Leader
Shelter Staff Support Group Other

7. (Has your/was your) family been supportive? Y N
What have they done?

8. Have your friends been supportive? Y N
What have they done?

9. Have you sought any community support specifically in regard to your relationship?
Y N

What? (Legal, Battered Women's Shelter, Counseling, Religious, Financial, etc.)
Where?
From whom?

10. If you sought counseling, was it helpful? Y N
Why or why not?
(If not already clear, ask): How was it helpful?

11. Which of the supports have been the most helpful for you?
(Legal, Battered Women's Shelter, Counseling, Religious, Financial, Friends, Family)
Why?

12. (Is/was) there anything or anyone that interfered with you accessing community resources?
Y N
Who or what?

13. Are there any sources of support that you would not turn to again? Y N
Why?

14. Have you ever felt the need to keep the violence a secret from others? Y N
    Who?
    Why?

15. Who did you first disclose your abuse to?
    How long after the start of the violence?
    If not immediate, what kept you from telling anyone?

16. What (do you/did you) do to keep yourself safe or protect yourself?

17. **If they have not told you specifically about the nature of the physical violence (pushed, slapped, hit, kicked), ask NOW:
    Would you feel comfortable telling me exactly what was the nature of the physical violence you (experience/experienced)?
    Have you ever needed medical attention due to this violence?

18. (Do you/did you) have a limit to what behavior you would tolerate in your relationship?
    Y N
    (If yes:) What?
    Was your limit expressed to your partner? Y N
    (If yes:) When? With what consequences?

19. (Are/were) either you or your partner involved with drugs or alcohol? Y N
    (If yes:) Who?
    What role do you think they (play/played)?

20. (Are/were) either you or your partner experiencing any particular stress? Y N
    (If yes:) What?

21. **If you are unsure if she has children, ask now. If she does, ask:
    During pregnancy, was there any change in the level of violence? Y N
    How?

22. (Are/were) there specific reasons that the violence would occur? Y N
    Could you give me examples?

23. What are your feelings for your partner at the present time?

24. **If they have left their relationship, ask the following questions:
    a. Do you still have contact with your partner? Y N
    b. How much?
    c. What is it like for you?
    d. (If they have any children, add:) Do your children (does your child) still have contact with your partner? Y N
    e. How much?
    f. What is that like for them? How do they feel about it?

g. What is that like for you?

25. What do you believe would be most helpful for you in regards to this/that relationship at this time?

26. What influence do you believe this/that relationship has had on you?

27. a. Have you ever experienced a sense of shame related to this (violent) relationship?
Y N
(**If yes, continue. If not, go on to #27f).
b. To what would you credit those feelings of shame? (If she seems confused, say "What do you think was the cause of those feelings of shame?")
c. What role, if any, has shame played in your experience?
1. In leaving the relationship?
2. In seeking help from others?
3. In talking to others?
d. What (could have helped/could help) to decrease your feelings of shame?
e. Are you currently experiencing feelings of shame? Y N
(If no, go on to #27e(2)).
(1) What level on a scale of 1 to 10 (1 = no shame and 10 = complete shame)?
(2) What level of shame did you experience during the relationship on a scale from 1 to 10?
(3) (Skip this if answered no to 27e). Why do you think you are experiencing shame right now?
f. What is your definition of shame?

28. a. Have you ever experienced guilt related to this (violent relationship?) Y N
(If yes, continue. If no, go on to #28f).
b. To what would you credit these feelings of guilt? (If she seems confused, say "What do you think was the cause of these feelings of guilt?")
c. What role, if any, has guilt played in your experience?
(1) In leaving the relationship?
(2) In seeking help from others?
(3) In talking to others?
d. What (could have helped/could help) to decrease your feelings of guilt?
e. Are you currently experiencing feelings of guilt? Y N
(If no, go on to #28e(2)).
(1) What level on a scale of 1 to 10 (1 = no guilt and 10 = complete guilt)?
(2) What level of guilt did you experience during the relationship on a scale from 1 to 10?
(3) (Skip this if answered no to 27e). Why do you think you are experiencing guilt right now?
f. What is your definition of guilt?
g. In your opinion, do shame and guilt differ? Y N
If yes, how do they differ?

29. We have completed the interview.
Do you have anything that you would like to add that I did not ask about?

30. If we were to do a follow-up study on the effects of DV on children, would you be willing to participate? Y N
In your opinion, what would be the best way to recruit women and their children for that study?

31. Do you have any questions? Concerns? Y N
If yes, what questions/concerns do you have?
How are you feeling right now? How are you feeling right now?

Appendix B

Demographic Form

ID# _____

We would like some general background information about you and your partner who has been violent. If the violence occurred in a past relationship, please provide information about that partner and your relationship.

1. a. In the past, have you ever been married, lived as a couple, or dated someone who has shoved, slapped, hit, or kicked you, or physically hurt or threatened you in some other way? **Please refer to the most recent violent relationship you have been in.**
(Check one)
___ No, not in the past **(If no, talk to interviewer)**
___ Yes, was married but now separated ___ Yes, was living as a couple
___ Yes, was married but now divorced ___ Yes, dating
b. If yes, how long were you in this relationship?
_____ Years Less than a year? _____ Months_____ Not applicable
c. If yes, did you ever leave your partner who had been violent? ____ Yes ___ No
How many times did you leave your violent partner? _____
d. How long ago did this relationship end? (Check one)
_____ Less than 1 month ago _____ 1 to 2 years ago
_____ 1 month to 6 months ago _____ 2 to 3 years ago
_____ 6 months to 1 year ago _____ Over three years ago
If over three years ago, how many years ago did the relationship end? ____ Years
e. Have you been in other violent relationships in the past? _____Yes _____No
If yes, how many? _____

For the remainder of the questions, please refer to your most recent past violent relationship.

2. How long ago did the last violent incident occur? (Please fill in one blank with a number)
_____ Days ago _____ Months ago _____ Years ago

3. Where were you living at the time of the violence? (Check one)
_____ In a town/city _____ Out in the country _____ Both

4. a. Do you still have contact with your partner who has been violent? __Yes__No
b. If yes, how often do you still have contact? (Check one)
_____ Daily _____ Once every couple of months
_____ 4 to 5 days per week _____ Once every six months
_____ 2 to 3 days per week _____ Once a year
_____ Once a week _____ Once every two years
_____ Once a month _____ Less often: please specify _____

c. If yes, how would you rate your level of stress surrounding these meetings?

1	2	3	4	5
Not stressful	Somewhat stressful	Moderately stressful	Very stressful	Extremely stressful

d. If yes, how would you rate your level of fear surrounding these meetings?

1	2	3	4	5
Not fearful	Somewhat fearful	Moderately fearful	Very fearful	Extremely fearful

e. Is violence still involved? _____ Yes ____ No

f. For what reasons do you still have contact with your partner who has been violent?
_____
_____
_____

5. Your age now? _____

6. a. Your gender? (Circle one) M F
b. The gender of your partner who has been violent?(Circle one) M F

7. Your education completed? (Check one) Your partner's education? (Check one)

_____ Eighth grade or less	_____ Eighth grade or less
_____ Some high school/GED	_____ Some high school/GED
_____ High school graduate	_____ High school graduate
_____ Some college/vocational school	_____ Some college/vocational school
_____ College graduate	_____ College graduate
_____ Some graduate school	_____ Some graduate school
_____ Graduate degree	_____ Graduate degree

8. Are you currently employed? Was your partner employed?

_____ Yes, full-time	_____ Yes, full-time
_____ Yes, part-time	_____ Yes, part-time
_____ Homemaker	_____ Homemaker
_____ No, unemployed	_____ No, unemployed
_____ Student only	_____ Student only
_____ Student and employed	_____ Student and employed

9. Were you employed at the time that the violence took place? (Check one)
_____ Yes, full-time _____ Yes, part-time _____ Homemaker
_____ No, unemployed _____ Student only _____ Student and employed

10. If you were employed, what was your occupation (at the time of the violence?)
_____

11. If he was employed, what was the occupation of your partner while you were together?
_____

What is his occupation currently? _____

12. How many children did you have at the time of this relationship? _____
If any, what are their ages/genders? ___/__ ___/__ __/__ ___/___ __/__ ___/__
How many children were born out of this relationship? _____
How many lived at home during the violence? _____
How many children do you have now? _____
If any, what are their ages/genders?___/__ ___/__ __/__ ___/___ __/__ ___/__

If you do not have any children, please skip to #15.

13. If you do have children, how many are still living with you at home? _____
If any, what are their ages/genders?___/__ ___/__ ___/__ ___/___ __/___ ___/__

14. a. If you had children at the time of the violent relationship, did they see the violence between you and your partner?
_____ Yes _____ No

b. If yes, what do you think were the effects of seeing the violence for your children?
_____
_____
_____

c. If yes, have your children received any services related to the exposure to the violence?
_____ None _____ Support groups
_____ Shelter activities _____ Therapy/counseling
_____ Foster care/group home placement _____ School counseling
_____ Other: Please specify _____

d. If yes, have you talked to your children about the violence?
_____ Yes _____ No What did you tell them about the violence?

e. Do your children still have contact with your partner who has been violent?
_____ Yes _____ No

If yes, how often do they have contact? (Check one)
_____ Daily _____ Once every couple of months
_____ 4 to 5 days per week _____ Once every six months
_____ 2 to 3 days per week _____ Once a year
_____ Once a week _____ Once every two years
_____ Once a month _____ Less often: Please specify _____

15. What was <u>your own</u> annual income before taxes <u>during</u> the violent relationship you were in? (Check one)

_____ None
_____ $5,000 or less
_____ $5,001 to $10,000
_____ $10,001 to $15,000
_____ $15,001 to $20,000
_____ $20,001 to $25,000
_____ $25,001 to $30,000
_____ $30,001 to $35,000
_____ $35,001 to $40,000
_____ $40,001 to $45,000
_____ $45,001 to $50,000
_____ More than $50,000

If you do not know your annual income, how much did you make per hour?
_____

How many hours per week did you work?
_____

16. What was your annual <u>family</u> income before taxes <u>during</u> the violent relationship you were in? (Check one)

_____ None
_____ $5,001 to $10,000
_____ $15,001 to $20,000
_____ $25,001 to $30,000
_____ $35,001 to $40,000
_____ $45,001 to $50,000
_____ $5,000 or less
_____ $10,001 to $15,000
_____ $20,001 to $25,000
_____ $30,001 to $35,000
_____ $40,001 to $45,000
_____ More than $50,000

17. Who was the primary breadwinner during the violent relationship? (Check one)

_____ You _____ Your violent partner _____ Other

18. Your race? (Check one)

_____ White _____ African-American
_____ Hispanic _____ Asian
_____ American Indian _____ Other (If more than one, please list)

_____

19. The race of your partner who has been violent? (Check one)

_____ White _____ African-American
_____ Hispanic _____ Asian
_____ American Indian _____ Other (If more than one, please list)

_____

20. a. To what degree did you access each of these resources? Circle the number that best applies.

1 = Not at all
2 = Very little
3 = Somewhat
4 = Often
5 = Very much

Friends?	1	2	3	4	5
Family?	1	2	3	4	5
Legal services?	1	2	3	4	5
Police?	1	2	3	4	5
Counseling/therapy?	1	2	3	4	5
Shelter (BWS)?	1	2	3	4	5
Support groups?	1	2	3	4	5
Church?	1	2	3	4	5
Financial?	1	2	3	4	5
Medical?	1	2	3	4	5
Vocational/ job-related help?	1	2	3	4	5
Crisis helpline?	1	2	3	4	5
Neighbor?	1	2	3	4	5

b. How helpful were each of these resources? Circle N/A if you did not seek services from these resources. Circle the number that best applies.

1 = Not at all
2 = Very little
3 = Somewhat
4 = Often
5 = Very much

Friends?	1	2	3	4	5	N/A
Family?	1	2	3	4	5	N/A
Legal services?	1	2	3	4	5	N/A
Police?	1	2	3	4	5	N/A
Counseling/therapy?	1	2	3	4	5	N/A
Shelter (BWS)?	1	2	3	4	5	N/A
Support groups?	1	2	3	4	5	N/A
Church?	1	2	3	4	5	N/A
Financial?	1	2	3	4	5	N/A
Medical?	1	2	3	4	5	N/A
Vocational/ job-related help?	1	2	3	4	5	N/A
Crisis helpline?	1	2	3	4	5	N/A
Neighbor?	1	2	3	4	5	N/A

c. If you did not access some or all of these supports, please tell us any helpful information about why you did not.

_____

_____

_____

_____

Thank you.

Appendix C

Conflict Tactics Scale

ID #_____

No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reasons. They also use different ways of trying to settle their differences. Please read the list below of some things you and your spouse/partner might have done when you argued.

Please circle the number of times you or your partner did the following during any one year of your relationship. Circle "Ever?" if it did not happen during the past year but happened at any time prior to or after the year you are describing.

1. Discussed the issue calmly.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

2. Got information to back up (your/his/her) side of things.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

3. Brought in or tried to bring in someone to help settle things.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

4. Argued heatedly, but short of yelling.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

5. Insulted, yelled, or swore at each other.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

6. Sulked and/or refused to talk about it.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

7. Stomped out of the room or house (or yard).
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

8. Cried.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

9. Did or said something to spite the other one.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

10. Threatened to hit or throw something at the other one.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

11. Threw or smashed or hit or kicked something.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

12. Threw something at the other one.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

13. Pushed, grabbed, or shoved the other one.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

14. Slapped the other one.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

15. Kicked, bit, or hit with a fit.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

16. Hit or tried to hit with something.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

17. Beat up the other one.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

18. Threatened with a knife or gun.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

19. Used a knife or gun.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

20. Forced the other one to perform sexually against his or her will.

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

21. Other: _____

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

22. Other: _____

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

23. Other: _____

YOU:	Never	1	2	3-5	6-10	11-20	20+	Ever?
PARTNER:	Never	1	2	3-5	6-10	11-20	20+	Ever?

Thank you.

Appendix D

Ways of Coping Questionnaire

ID # _____

Listed below are a variety of thoughts, feelings, and behaviors of women who have experienced violence in a relationship. Please think about each of them and whether you use them to deal with your experience.

If you are in a violent relationship now, think about what you do or think to remedy the problem or make yourself feel better about the situation. Think about the ways you deal with the situation RIGHT NOW. If you have left a violent relationship, think about how you continue to deal with the experience.

Please think about how often you use each strategy RIGHT NOW, and circle one number from "0" (Does not apply or do not use) to "3" (Use a great deal).

Does not apply or do not use	**Use somewhat**	**Use quite a bit**	**Use a great deal**
0	**1**	**2**	**3**

1.	I just concentrate on what I have to do next – the next step.	0	1	2	3
2.	I try to analyze the problem in order to understand it better.	0	1	2	3
3.	I turn to work or another activity to take my mind off things.	0	1	2	3
4.	I feel that time will make a difference – the only thing is to wait.	0	1	2	3
5.	I bargain or compromise to get something positive from the situation.	0	1	2	3
6.	I do something that I don't think will work, but at least I am doing something.	0	1	2	3
7.	I try to get the person responsible to change his or her mind.	0	1	2	3
8.	I talk to someone to find out more about the situation.	0	1	2	3
9.	I criticize or lecture myself.	0	1	2	3
10.	I try not to burn my bridges, but leave things open somewhat.	0	1	2	3
11.	I hope for a miracle.	0	1	2	3

12.	I go along with fate; sometimes I just have bad luck.	0	1	2	3
13.	I go on as if nothing happened.	0	1	2	3
14.	I try to keep my feelings to myself.	0	1	2	3
15.	I look for the silver lining, so to speak; I try to look on the bright side of things.	0	1	2	3
16.	I sleep more than usual.	0	1	2	3
17.	I express anger to the person(s) who caused the problem.	0	1	2	3
18.	I accept sympathy and understanding from someone.	0	1	2	3
19.	I tell myself things that help me feel better.	0	1	2	3
20.	I am inspired to do something creative about the problem.	0	1	2	3
21.	I try to forget the whole thing.	0	1	2	3
22.	I get professional help.	0	1	2	3
23.	I seek to change or grow as a person.	0	1	2	3
24.	I wait to see what will happen before doing anything.	0	1	2	3
25.	I apologize or do something to make up.	0	1	2	3
26.	I make a plan or action and follow it.	0	1	2	3
27.	I accept the next best thing to what I want.	0	1	2	3
28.	I let my feelings out somehow.	0	1	2	3
29.	I realize that I have brought the problem on myself.	0	1	2	3
30.	I seek to come out of the experience better than I went in.	0	1	2	3
31.	I talk to someone who can do something concrete about the problem.	0	1	2	3
32.	I try to get away from it for a while by resting or taking a vacation.	0	1	2	3

33.	I try to make myself feel better by eating, drinking, smoking, or using drugs or medications, etc.	0	1	2	3
34.	I take big chance or do something very risky to solve the problem.	0	1	2	3
35.	I try not to act too hastily or follow my first hunch.	0	1	2	3
36.	I find new faith.	0	1	2	3
37.	I maintain my pride and keep a stiff upper lip.	0	1	2	3
38.	I seek to rediscover what is important in life.	0	1	2	3
39.	I change something so things will turn out all right.	0	1	2	3
40.	I generally avoid being with people.	0	1	2	3
41.	I don't let it get to me; I refuse to think too much about it.	0	1	2	3
42.	I ask advice from a relative or friend I respect.	0	1	2	3
43.	I keep others from knowing how bad things are.	0	1	2	3
44.	I make light of the situation; I refuse to get too serious about it.	0	1	2	3
45.	I talk to someone about how I am feeling.	0	1	2	3
46.	I stand my ground and fight for what I want.	0	1	2	3
47.	I take it out on other people.	0	1	2	3
48.	I draw on my past experiences; I was in a similar situation before.	0	1	2	3
49.	I know what has to be done, so I double my efforts to make things work.	0	1	2	3
50.	I refuse to believe that it has happened.	0	1	2	3
51.	I promise myself that things will be different next time.	0	1	2	3
52.	I have come up with a couple of different solutions to the problem.	0	1	2	3

53.	I accept the situation, since nothing can be done.	0	1	2	3
54.	I try to keep my feelings about the problem from interfering with other things.	0	1	2	3
55.	I wish that I could change what is happening or how I feel.	0	1	2	3
56.	I change something about myself.	0	1	2	3
57.	I daydream or imagine a better time or place than the one I am in.	0	1	2	3
58.	I wish the situation would go away or somehow be over with.	0	1	2	3
59.	I have fantasies or wishes about how things might turn out.	0	1	2	3
60.	I pray.	0	1	2	3
61.	I prepare myself for the worst.	0	1	2	3
62.	I go over in my mind what I will say or do.	0	1	2	3
63.	I think about how a person I admire would handle this situation and use that as a model.	0	1	2	3
64.	I try to see things from the other person's point of view.	0	1	2	3
65.	I remind myself how much worse things could be.	0	1	2	3
66.	I jog or exercise.	0	1	2	3

Thank you.

Appendix E

Trauma-Symptom Checklist (TSC-33)

ID #_____

How often have you experienced each of the following in the last two months? Please circle the appropriate number.

Never **0**	**Occasionally** **1**	**Fairly Often** **2**	**Very Often** **3**

1.	Insomnia (trouble getting to sleep)	0	1	2	3
2.	Restless sleep	0	1	2	3
3.	Nightmares	0	1	2	3
4.	Waking up early in the morning and can't get back to sleep	0	1	2	3
5.	Weight loss (without dieting)	0	1	2	3
6.	Feeling isolated from others	0	1	2	3
7.	Loneliness	0	1	2	3
8.	Low sex drive	0	1	2	3
9.	Sadness	0	1	2	3
10.	"Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
11.	"Spacing out" (going away in your mind)	0	1	2	3
12.	Headaches	0	1	2	3
13.	Stomach problems	0	1	2	3
14.	Uncontrollable crying	0	1	2	3
15.	Anxiety attacks	0	1	2	3
16.	Trouble controlling temper	0	1	2	3
17.	Trouble getting along with others	0	1	2	3
18.	Dizziness	0	1	2	3
19.	Passing out	0	1	2	3
20.	Desire to physically hurt yourself	0	1	2	3
21.	Desire to physically hurt others	0	1	2	3
22.	Sexual problems	0	1	2	3
23.	Sexual overactivity	0	1	2	3
24.	Fear of men	0	1	2	3
25.	Fear of women	0	1	2	3
26.	Unnecessary or over-frequent washing	0	1	2	3
27.	Feeling of inferiority	0	1	2	3
28.	Feelings of guilt	0	1	2	3
29.	Feelings that things are "unreal"	0	1	2	3
30.	Memory problems	0	1	2	3
31.	Feelings that you are not always in your body	0	1	2	3

32. Feeling tense at all times	0	1	2	3
33. Having trouble breathing	0	1	2	3

Appendix G

Factor Analysis on WOC items

Rotated Factor Matrix[a]

	Factor		
	1	2	3
I just concentrate on what I have to do-the next step		.484	
I try to analyze the problem in order to understand it better		.472	
I turn to work or another activity to take my mind of things		.428	.307
I feel that time will make a difference-the only thing is to wait		.319	
I bargain or compromise...positive from the situation	.345	.334	
I do something that I...I am doing something	.457		
I try to get the person responsible to change his or her mind	.461		
I talk to someone to find out more about the situation		.522	
I criticize or lecture myself	.605		
I try not to burn bridges, but leave things open somewhat	.510		
I hope for a miracle	.615		
I go along with fate; sometimes I just have bad luck	.516		
I go on as if nothing happened	.366		.539
I try to keep my feelings to myself	.438		.553

I look for the silver lining...the bright side of things		.435	.390
I sleep more than usual	.445		
I express anger to the person(s) who caused the problems			
I acccept sympathy and understanding from someone		.577	
I tell myself things that help me feel better		.665	
I am inspired to do something creative about the problem		.627	
I try to forget the whole thing			.592
I get professional help		.440	
I seek to change or grow as a person		.620	
I wait to see what will happen before I do anything	.617		
I apoligize or do something to make up	.719		
I make a plan of action and follow it		.650	
I accept the next best thing to what I want	.602		
I let my feelings out somehow		.554	
I realize that I have brought the problem on myself	.576		
I seek to come out of the experience better than I went in		.568	
I talk to someone who can do something concrete about the problem		.528	
I try to get away from it for awhile by resting or taking a vacation	.387	.366	

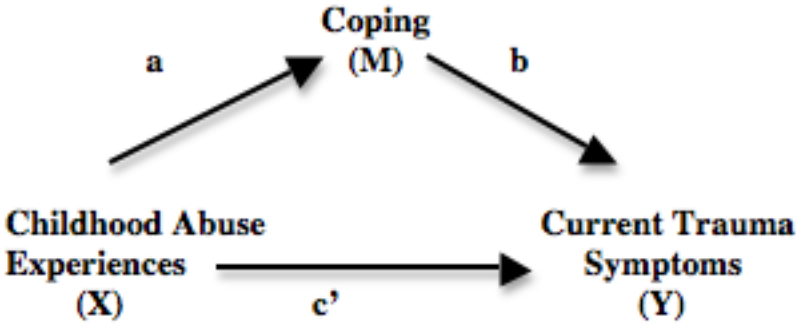
I try to make myself feel...using drugs or medication etc.	.521		
I take big chances or do something very risky to solve the problem	.473		
I try not to act hastily or follow my first hunch		.395	
I find new faith		.530	
I maintain my pride and keep a stif upper lip		.355	.435
I seek to rediscover what is important in my life		.685	
I change something so things will turn out all right		.472	
I generally avoid being with people	.537		
I don't let it get to me; I refuse to think too much about it			.568
I ask advice from a relative or friend I respect		.550	
I keep others from knowing how bad things are	.482		.421
I make light of the situation; I refuse to get too serious about it			.398
I talk to someone about how I am feeling		.605	-.340
I stand my ground and fight for what I want		.493	
I take it out on other people	.401		
I draw on my past experiences; I was in a similar situation before			
I know what has to be done...to make things work		.460	
I refuse to believe that it has happened	.500		

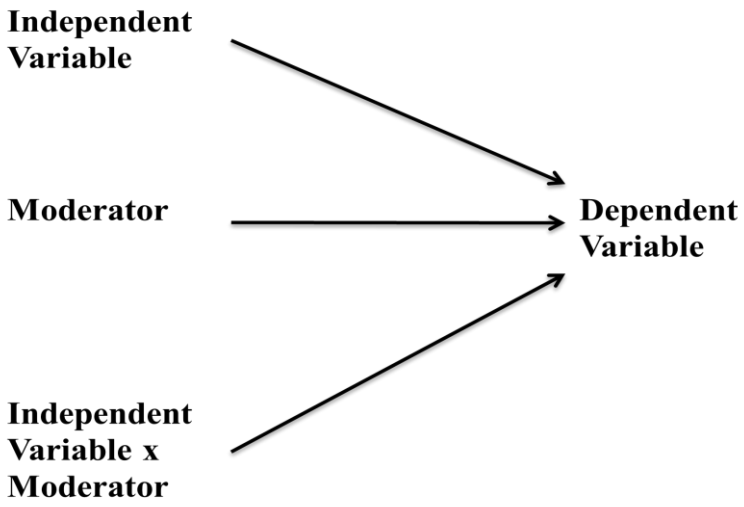
I promise myself that things will be different next time	.476		
I have to come up with a couple of different solutions to the problem	.306	.417	
I accept the situation, since nothing can be done	.302		
I try to keep my feelings about the problem from interfering with other things		.353	.343
I wish that I could change what is happening or how I feel	.703		
I change something about myself	.417	.389	
I daydream or imagine a better place than the one I am in	.635		
I wish the situation would go away or somehow be over with	.677		
I have fantasies or wishes about how things might turn out	.695		
I pray		.355	
I prepare myself for the worst	.514		
I go over in my mind what I will say or do	.458	.391	
I think about how a person that I admire...use that as a model		.487	
I try to see things from the other person's point of view	.301	.459	
I remind myself how much worse things could be	.457		
I jog or exercise		.343	

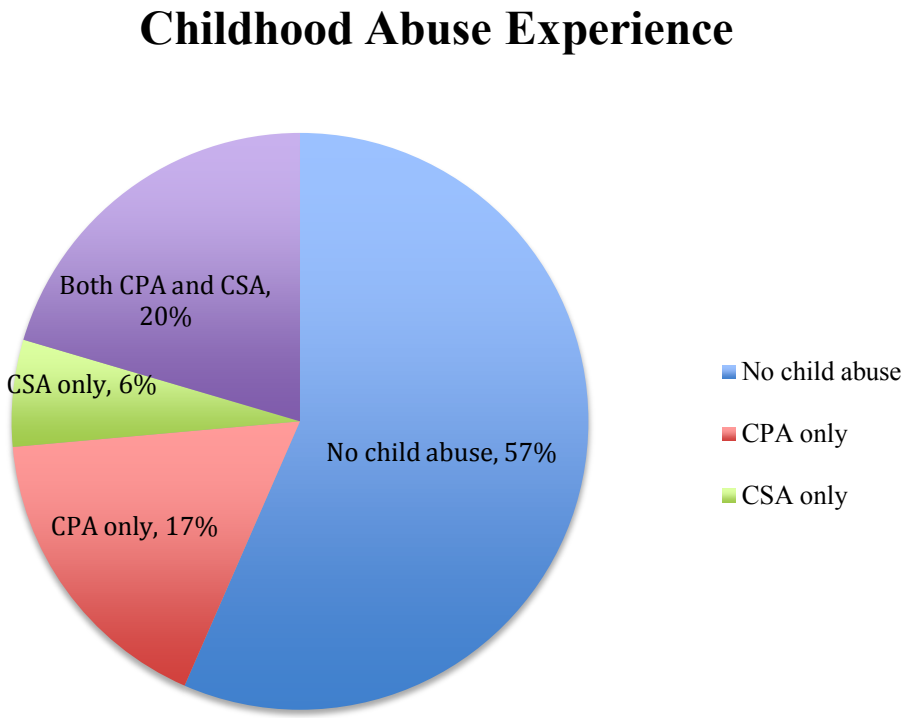
Extraction Method: Principal Axis Factoring.

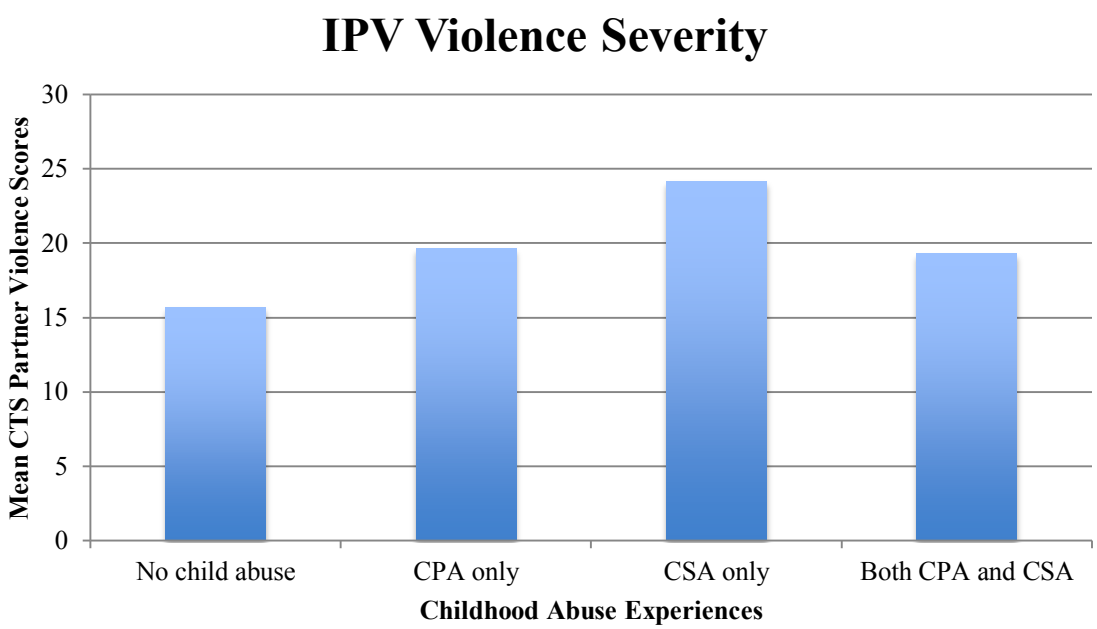
Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 6 iterations.


Coping
(M)
a
b
Childhood Abuse
Experiences
(X)
c'
Current Trauma
Symptoms
(Y)


Independent Variable
Moderator
Dependent Variable
Independent Variable x Moderator


Childhood Abuse Experience
Both CPA and CSA, 20%
CSA only, 6%
No child abuse, 57%
CPA only, 17%
No child abuse
CPA only
CSA only


IPV Violence Severity
Mean CTS Partner Violence Scores
30
25
20
15
10
5
0
No child abuse
CPA only
CSA only
Both CPA and CSA
Childhood Abuse Experiences

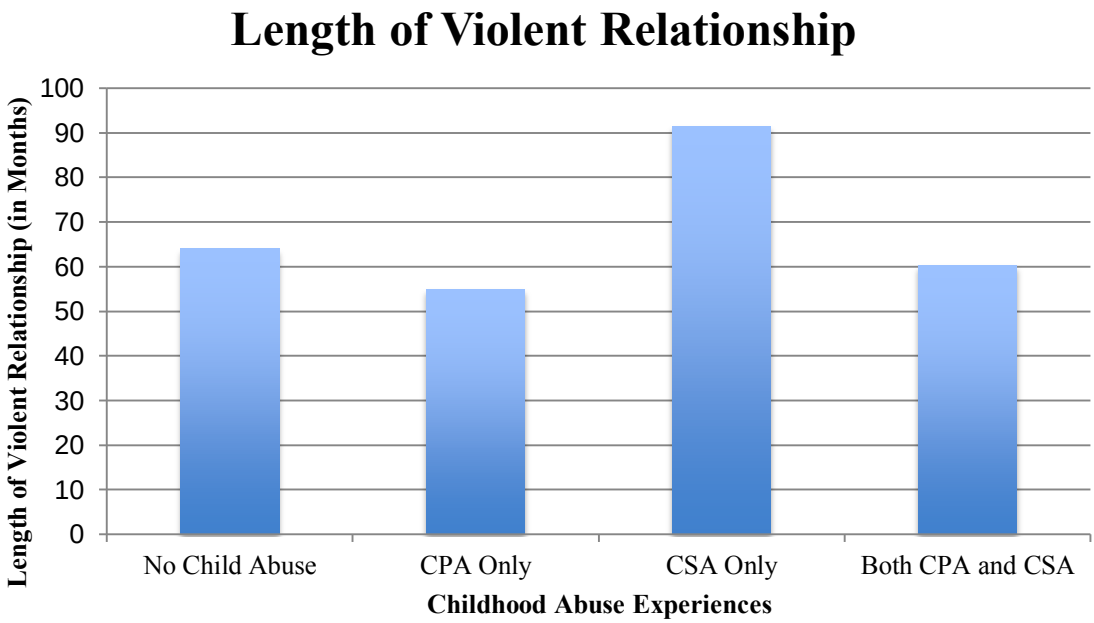

Length of Violent Relationship
Length of Violent Relationship (in Months)
100
90
80
70
60
50
40
30
20
10
0
No Child Abuse
CPA Only
CSA Only
Both CPA and CSA
Childhood Abuse Experiences

Table 1

Summary of Partner Violence Subscale Scores for Different Childhood Abuse Experiences

	No Child Abuse	CPA Only	CSA Only	Both CPA and CSA	Total
Mean	15.66	19.62	24.17	19.31	17.59
Std. Deviation	10.76	11.47	13.23	11.58	11.43
Minimum	0	0	0	0	0
Maximum	42	42	41	41	42

Table 2

Summary of Mean Length of Abuse (in months) for Different Childhood Abuse Experiences

	No Child Abuse	CPA Only	CSA Only	Both CPA and CSA	Total
Mean	57.92	57.60	89.73	74.99	63.24
Std. Deviation	68.14	63.15	90.13	83.82	72.58
Minimum	1	3	0	2	0
Maximum	468	396	264	420	468

Table 3

Summary of Bootstrapping Results

	Emotion-Focused Coping				Problem-Focused Coping			
CA Category	Effect	SE	LLCI	ULCI	Effect	SE	LLCI	ULCI
CPA Only	1.3216	1.2383	-1.1421	3.6922	1.5760*	.6575	.4188	2.9797
CSA Only	.3499	2.1630	-3.9773	4.4692	-.0703	.8920	-1.8642	1.7024
Both CPA and CSA	3.2376*	1.1557	.9167	5.5145	1.3111*	.5685	.3235	2.5320

Note: Indicator Coding was utilized, with No Child Abuse used as the comparison group for each analysis.
*$p<.05$; N=10000 Bootstrapping resamples; LLCI = Lower limit confidence interval; ULCI = Upper limit confidence interval for $\alpha=0.05$

Figure Captions

Figure 1. Mediation model, where a = the effect of the independent variable (X) on the mediator (M), b = the effect of the mediator (M) on the dependent variable (Y), a x b = the indirect effect of X on Y through M, and c' = the direct effect of X on Y.

Figure 2. Moderation model.

Figure 3. Experiences of childhood abuse reported by the women.

Figure 4. Mean CTS partner violence subscale scores differentiated by women's childhood abuse experiences.

Figure 5. Mean length of violent relationship compared by women's childhood abuse experiences.