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Predictors of Posttraumatic Growth, Shame, and Posttraumatic Stress Symptoms in Survivors of Intimate Partner Violence: The Roles of Social Support and Coping

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PREDICTORS OF POSTTRAUMATIC GROWTH, SHAME, AND POSTTRAUMATIC STRESS SYMPTOMS IN COLLEGE SURVIVORS OF INTIMATE PARTNER VIOLENCE: THE ROLES OF SOCIAL SUPPORT AND COPING

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Predictors of Posttraumatic Growth, Shame, and Posttraumatic Stress Symptoms in

Survivors of Intimate Partner Violence: The Roles of Social Support and Coping

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Research suggests that college students suffer higher rates of intimate partner violence (IPV) than older adults, with between 30 and 60 percent experiencing one or more violent events by their intimates (O'Hearn & Margolin, 2000). Unfortunately, IPV can result in severe psychological complications, including depression, anxiety, problems with interpersonal relationships, posttraumatic stress disorder (PTSD), and shame (Coker et al., 2002; Coker et al., 2003; Kaura & Lohman, 2007; Taylor, 2003). However, research indicates that certain religious and general coping styles and social support can serve as resilience factors, buffering victims from the negative consequences of IPV (Bosch & Schumm, 2004; Coker et al., 2002; Haden et al., 2006; Ellison & Anderson, 2001). Furthermore, there is evidence to suggest that individuals can learn from adversity and grow in the aftermath of trauma (Tedeschi & Calhoun, 2004). Unfortunately, much of the current research exploring aspects of IPV has focused primarily on the negative consequences of IPV for women (Coker, Watkins, Smith, & Brandt, 2003). There is also little research that explores the role of coping in the development of posttraumatic growth and shame for survivors of IPV. Consequently, this research project quantitatively explored the influence of IPV and the roles of social support and coping styles in the development of posttraumatic stress, shame, and posttraumatic growth for female students at The University of Montana.

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Chapter I

Introduction

Estimates show that more than half of the U.S. population will endure a traumatic event at some point in their lives (Marx & Sloan, 2003). A traumatic experience is defined by The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a threat to body integrity event that induces feelings of helplessness, horror, and fear (APA, 2000). A variety of events can be classified as traumatic, including motor vehicle accidents, natural disasters, childhood sexual and/or physical abuse, and criminal and sexual assault (Haden, Scarpa, Jones, & Ollendick, 2006; Marx & Sloan).

Intimate partner violence (IPV) is also considered a traumatic event. Intimate partner violence can include physical, sexual, emotional, and psychological abusive acts against a person that results in harm or fear of harm (Sugarman & Hotaling, 1989; Fortune, 1993). Intimate partner violence is characterized by a range of aggressive behaviors, including less severe acts such as slapping, scratching, or pushing, to more severe acts, such as punching, kicking, using a weapon, or forcing intercourse (Capaldi & Crosby, 1997). Other forms of violent behaviors can include verbal and psychological abuse, such as calling a partner names and the destruction of material goods, pets, etc. (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). For the purposes of this paper, IPV will include physically, sexually, and psychologically abusive behaviors exhibited by an individual toward his partner.

Traditionally-aged college students, between 18 and 24 years of age, experience more IPV than older adults, with between 30 and 60 percent experiencing one or more violent events by their intimates (O'Hearn & Margolin, 2000). Furthermore, it is estimated that nearly a quarter of college women will experience sexual assault (Fisher, Cullen, & Turner, 2000, as cited in Albaugh & Nauta, 2005). Although some researchers have found that both men and women are

equally likely to perpetrate IPV (Straus, Gelles, & Steinmetz, 1980; Straus & Gelles, 1986; Jouriles & O'Leary, 1985), other researchers report estimates to the contrary. For example, some researchers have identified that women are more likely to be victims of male-perpetrated IPV 85% of the time (Archer, 2000; Johnson, 2005). Others have found that women are more likely as much as 95% of the time (Pagelow, 1992). Additionally, many researchers in family violence agree that the physical consequences of IPV are more severe for women than for men (Archer, 2000; Barnett, Miller-Perrin, & Perrin, 2005; Johnson; Straus & Gelles). Due to these findings and the fact that most official reports do not contain sufficient categories for reporting same-sex IPV (Barnett et al.), this paper will focus on IPV that occurs between heterosexual couples, with men as the perpetrators.

A range of poor mental health outcomes are associated with IPV. Intimate partner violence can result in severe psychological complications, including depression, anxiety, problems with interpersonal relationships, posttraumatic stress disorder (PTSD), and shame (Coker et al., 2002; Coker et al., 2003; Kaura & Lohman, 2007; Taylor, 2003). Additionally, poorer health outcomes are related to higher rates of IPV (Coker et al., 2003). The most common mental health outcome for victims is depression (Goodkind, Gillum, Bybee, & Sullivan, 2003). Those who experience partner violence are nearly four times more likely to endorse depression than those who do not experience partner violence (Carlson, McNutt, & Choi, 2003). In addition to identifying elevated depression in survivors of IPV, Zlotnick, Johnson, and Kohn (2006) found that women were more likely to suffer from lower self-esteem and reported satisfaction in life (Zlotnick et al.). These negative mental health outcomes persisted regardless of whether or not women remained in or left their violent relationships, suggesting that partner violence can result in serious long-term negative mental health outcomes.

The next most common adverse mental health outcomes for victims of IPV are anxiety and PTSD (Cascardi, O'Leary, Lawrence, & Schlee, 1995). Research repeatedly evidences that victims of IPV experience elevated levels of anxiety (Kaura & Lohman, 2007), with studies showing that between 10% (Cascardi et al., 1995) and 25% (Carlson, McNutt, Choi, & Rose, 2002) of female IPV victims report higher anxiety. Victims of partner violence can also develop PTSD. A meta-analysis reviewing the literature on the impact of IPV on mental health found that between 30% and 85% of survivors develop PTSD (Golding, 1999).

Intimate Partner Violence and Shame

Shame is yet another negative mental health outcome for victims of IPV. Shame has always been considered an adverse consequence of abuse, which helps to perpetuate the cycle of violence (Buchbinder & Eisikovits, 2003). There is evidence to suggest that many forms of abuse can result in greater levels of shame, including physical, sexual, and emotional abuse (Taylor, 2003). Shame can further exacerbate the mental health problems of victims. Research indicates that shame is related to elevated levels of posttraumatic stress symptoms, chronic depression, and anxiety. Andrews, Brewin, Rose, and Kirk (2000) examined the correlates of shame in male and female victims of violent crime and found that shame was a significant predictor of PTSD six months following the crime. Consistent with these results, Andrews and Hunter (1997) identified that higher levels of shame were associated with chronic depression. Similar to Andrews et al., Taylor (2003) evidenced shame to be related to greater depression and trauma symptoms in female victims of IPV. Furthermore, she found that higher rates of shame were also associated with greater anxiety.

Shame is an emotion that is often confused with guilt (Tangney & Dearing, 2002). Lewis (1971) argued that the role of self is the significant difference between shame and guilt (as cited

in Tangney & Dearing). She stated, "The experience of shame is directly about the self, which is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of the experience" (p. 18, as cited in Tangney & Dearing). As one woman stated it in an earlier study:

> I think that I have internalized and really believe that there's something wrong with me. . . . It's like if someone took this really great toy off the shelf and tore it apart and pulled the leg off and pulled the eye out and then put it back on the shelf. That's just how broken and ugly . . . I feel inside. If people really knew, and people always tell me I'm so nice and I'm so easy going . . . but I always feel that if people really knew all the things inside of me, the memories and the experiences, they'd just run away screaming. It's really ugly (p. 59, Doane, 2007).

Additionally, shame is thought to be a more painful emotion than guilt, which is the reason, as some postulate, for the association between shame and poor mental health outcomes (Taylor, 2003).

Qualitative analyses reveal that victims of violence experience shame for a variety of reasons. Andrews et al. (2000) examined female and male victims of violent crime and found that 62% of them endorsed experiencing the emotion shame because they did not protect themselves. Twenty-nine percent were ashamed because others would view them as unworthy or bad as a result of the violent crime they experienced. Finally, 15% argued that they were ashamed of the emotions they experienced following the crime. Doane (2007) examined the reasons female victims of IPV provided for their experience of shame and found that women endorsed that they felt shame related to the following factors: 1) their own abusive behaviors; 2) self-disclosure; 3) inability to maintain the relationship; 4) inability to measure up to others'

expectations; 5) self-betrayal; and 6) instigation of violence. With regard to self-betrayal, 33% of women in this study endorsed that they experienced shame because they were unable to protect themselves from the violence, 25% of women stated that they felt shame because they remained in the relationship for too long, and 17% of women experienced shame because they did not somehow foresee that their partner would be abusive.

As is evidenced in the discussion above, trauma incidents can result in a variety of poor mental health outcomes. Traditionally, psychology, psychiatry, medicine, and other related disciplines have focused on the negative outcomes of traumatic events, such as distressing psychological and physical symptoms (Tedeschi & Calhoun, 2004). This focus on the negative is perhaps the result of a desire to assist those who seek the services of medical and mental health professionals (Tedeschi & Calhoun). However, professionals can only gain a biased understanding of the human experience when examining only the negative consequences of trauma and adversity (Linley & Joseph, 2004). If the study of human adversity is to be considered comprehensive, we must also contemplate and seek to understand positive changes that follow traumatic events (Linley & Joseph). Positive changes and growth have been increasingly evidenced to occur in individuals as a result of trauma (Tedeschi & Calhoun). The concept of posttraumatic growth and its processes in the lives of individuals who survive traumatic events are discussed in the following section.

Intimate Partner Violence and Posttraumatic Growth

Philosophy, media, literature, and religion have long recognized that positive changes can occur in those who survive adversity, with these disciplines and media outlining this phenomenon in texts many years before the study of growth occurred by mental health professionals (Tedeschi & Calhoun, 2004). Recent research reveals that positive growth can

occur in the aftermath of a number of negative events, including bereavement, rheumatoid arthritis, HIV infection, cancer, bone marrow transplants, heart attacks, transportation accidents, sexual assault and sexual abuse, and combat (for a review, see Tedeschi & Calhoun). This research clearly indicates that positive changes can occur as a result of struggling with adversity (Linley & Joseph, 2004). Tedeschi and Calhoun postulate that in the process of struggling with trauma a person can actually achieve a higher level of functioning.

In the current literature, a variety of terms are used to capture this concept of posttraumatic growth, including *stress-related growth, flourishing, positive by-products*, *perceived benefits*, *thriving*, and *discovery of meaning* (for a review, see Tedeschi & Calhoun, 2004). For the purposes of this research project, the term posttraumatic growth will be used. Tedeschi and Calhoun (2004) present a compelling argument as to how the term posttraumatic growth is conceptually distinct from the previous terms attempting to label the changes that can occur as a result of trauma.

First, posttraumatic growth refers to growth that follows a severe adversity, which is in contrast to the term *stress-related growth* (Tedeschi & Calhoun, 2004). Second, several of the above terms refer to an inherent or internal coping mechanism, which relies on a process. On the other hand, it is argued that posttraumatic growth is both a process and an outcome. Third, posttraumatic growth occurs because of a traumatic event that results in a significant threat to an individual's assumptions about the world. Tedeschi and Calhoun argue that posttraumatic growth can occur simultaneously with psychological distress, something that the terms *thriving* or *flourishing* do not capture.

Posttraumatic growth is also conceptually distinct from concepts that are meant to refer to individual characteristics that buffer an individual from trauma, such as resilience or protective

factors (Tedeschi & Calhoun, 2004). These concepts imply attributes or characteristics that allow individuals to cope with traumatic events. Posttraumatic growth, in contrast, refers to a change that stretches beyond resisting or not being damaged by adversity. Posttraumatic growth is unique because it refers to the process and outcome that can influence individuals to move beyond pre-trauma functioning. Specifically, posttraumatic growth defines a process and an outcome characterized by transformation or a qualitative change in previous functioning.

Tedeschi and Calhoun (2004) postulate that the process of struggling with trauma facilitates growth. Thus, as the severity of trauma increases, so does the potential for posttraumatic growth. Growth does not occur as a direct result of trauma itself; rather, it is people's "struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs" (p. 5, Tedeschi & Calhoun).

Domains of growth vary from individual to individual; however, the outcomes of growth usually can be grouped into specific categories (Tedeschi, 1999). The following five domains of growth are captured by the posttraumatic growth inventory (PTGI): "greater appreciation of life and a changed sense of priorities; more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one's life; and spiritual development" (p. 6, Tedeschi & Calhoun, 2004).

People often report that they experience a greater appreciation for life following a trauma. For example, Tedeschi and Calhoun (2004) cite Hamilton Jordon (2000) following his struggle with cancer:

> After my first cancer, even the smallest joys in life took on a special meaning—watching a beautiful sunset, a hug from my child, a laugh with Dorothy. That feeling has not diminished with time. After my second and third cancers, the simple joys of life are

> everywhere and are boundless, as I cherish my family and friends and contemplate the rest of my life, a life I certainly do not take for granted (p. 1).

People also report a change in their relationships, often resulting in closer more intimate connections with others. Researchers argue that struggling with adversity can improve an individual's capacity for intimacy, which can in turn improve one's relationships.

In addition to these categories of growth, individuals report that they identify or recognize new possibilities in the aftermath of trauma (Tedeschi & Calhoun, 2004). Individuals can change the direction of their lives following a traumatic event, oftentimes using their own suffering to help others survive adversity. Finally, individuals report that they experience an improvement in spiritual development in the aftermath of a traumatic event. In one study assessing growth in female survivors of IPV, a woman reported the following about her spiritual development, which influenced a significant change in her self-perception:

> I guess in the relationship I, for some odd reason – I didn't think I was worth anything . . . and then later, as I got deeper into my spirituality mode, I was like, "No one deserves to be held prisoner; no one deserves to be isolated; no one deserves to . . . not be able to sleep, not be able to eat because you're in total fear" . . . as I started studying the new-age religions and stuff . . . different ideas come into your mind of well-being and self worth (p. 89 Young, 2007).

Very little research examines posttraumatic growth in survivors of IPV (Cobb, Tedeschi, Calhoun, & Cann, 2006). However, violence is often an element of those traumatic events that have been studied, such as participating in combat or being held hostage (Tedeschi, 1999). A review of the literature found only two studies that assessed posttraumatic growth specifically in survivors of IPV. Young (2007) conducted a qualitative analysis of the responses given by

female survivors of IPV and found that 71.6% of her sample described at least one instance of positive change that occurred because of their struggle with violent relationships.

Cobb et al. (2006) represents the only other study identified that assessed posttraumatic growth in survivors of IPV. These authors found that survivors of IPV exhibited higher rates of posttraumatic growth than survivors of cancer or violent crimes. Additionally, as the severity of violence increased, so did survivors' appreciation for life. The researchers found that women still in their violent relationships experienced less growth than individuals who had terminated their violent relationships. Tedeschi and Calhoun (2004) concluded that this occurred because, as is theorized, growth usually occurs in the aftermath of trauma. Growth following IPV presents a complicated picture, for suffering trauma at the hands of a trusted person can possibly hinder the path toward growth (Tedeschi, 1999). Furthermore, blame can occur after violence is committed by another, and evidence suggests that any amount of self-blame can hinder the process and outcome of posttraumatic growth (Kubany, Abueg, Kilauano, Manke, & Kaplan, 1997).

There appear to be significant differences between those individuals who experience growth, those who do not, and those who experience a combination of growth and distress (Cobb et al., 2006). Personality factors, social support, and coping behaviors are the common differences frequently discussed in the literature.

Factors that promote growth or influence risk for the development of distress can be categorized into the following: 1) pre-traumatic factors, 2) peri-traumatic factors, and 3) post-traumatic factors (Gill, 2007). Pre-traumatic factors are those attributes about an individual or her environment that influence her to be especially vulnerable to the development of pathology or posttraumatic growth prior to traumatic exposure, such as personality disorders, psychopathology, and demographic variables (e.g., gender). Peri-traumatic factors are

characterized by attributes or events that occur during the actual traumatic incident. For example, the type and severity of the traumatic event itself, dissociation during the event, and the injury from the event are all considered peri-traumatic factors. Reactions to the event by the individual or by others, including cognitive appraisal, coping strategies or social support, constitute post-traumatic factors.

Intimate Partner Violence and Social Support

As previously stated, IPV is associated with a variety of poor mental health outcomes, such as greater anxiety, depression, PTSD, and shame (see review above). Social support can serve as a protective factor in the aftermath of IPV, reducing these deleterious effects. Research indicates that possessing large social support networks is one of the few factors that can improve the likelihood that victims will exit and terminate their relationships, which reduces contact with abuse and lowers subsequent psychological distress (Bosch & Schumm, 2004). Specifically, female victims of IPV are more likely to leave their violent relationships when they are the recipients of a supportive action, such as receiving information about where to seek safety. The literature also shows that social support can be linked to negative mental health outcomes for female victims of IPV. Negative consequences for survivors of IPV can be predicted by a dearth in social support (e.g., see Brewin, Andrews, & Valentine, 2000). Additionally, not all interactions with support networks are supportive. Negative interactions with social support networks upon disclosure of abuse are linked to more psychological distress, PTSD, and shame (Doane, 2007; Ullman & Filipas, 2001).

In order to understand the possible protective or deleterious effects of social support for victims of IPV, it is important to first delineate structural and functional support. Structural support is characterized by the number of resources people can turn to in times of distress (Guay,

Billette, & Marchand, 2006). For example, victims of IPV often seek out their friends for support. Several studies have revealed that victims of IPV found friends to be the most beneficial resources in times of adversity (Fiore-Lerner & Kennedy, 2000; Geisbrecht & Sevcik, 2000; Limandri, 1989). The frequency with which an individual accesses their supportive resources refers to structural support. Structural support also indicates whether or not the supportive resources are formal or informal. Informal networks include the friends and family of victims. Formal networks, on the other hand, include individuals who are often trained to assist people, such as clergy, law enforcement, hotline workers, therapists, and victim advocates.

In contrast to structural support, functional support refers to the type of support offered, its usefulness, and its perceived quality. The different dimensions of support a victim can receive include emotional, informational, instrumental, companionship, and validation (Wills & Shinar, 2000). Emotional support includes receiving the support of someone who is willing to listen. Informational support is characterized by the receipt of information about the stressor or about other assistance for the trauma event. Tangible support, including money, clothing, housing, and transportation, characterizes instrumental support. Providing a victim of IPV with activities to take her mind off of her traumatic experience is companionship support. Finally, validation support includes the normalizing of victims' experiences of partner violence. As stated previously, these experiences with social support can be supportive or unsupportive, negative or positive, helpful or unhelpful. Research indicates that negative social interactions following disclosure can predict the severity of PTSD three months after the traumatic event (Zoellner, Foa, & Bartholomew, 1999).

In addition to differentiating between structural and functional support, it is necessary to outline the differences between perceived and received support. Victims of IPV may isolate

themselves from others because they perceive their particular circumstance as stigmatizing (Thompson et al., 2000); and, as a result, women may not access resources because they perceive them to be unavailable. On the other hand, there is evidence to suggest that many victims disclose their experience, in spite of the possibility of stigmatization. For example, in one study, 95% of female IPV victims turned to at least one confidant for support (Levendosky et al., 2004). Victims of partner violence have experienced received support when they turn to an individual or resource for support. Received support can be understood or felt as supportive or unsupportive, which can result in either positive or negative mental health outcomes for the victim.

Social Support as a Protective Factor

Supportive reactions by social support resources improve the likelihood that victims of IPV will disclose their circumstances (Coker et al., 2002; Levendosky et al., 2004). Levendosky et al. found that women were more likely to talk to someone who could empathize with their experience, which had a positive effect on their mental health outcomes. Individuals who disclosed more frequently were the recipients of more practical and emotional support. Additionally, lower levels of depression and self-esteem were associated with greater numbers of supporters. Consistent with Levendosky et al. (2004), Coker et al. (2002) found that victims of IPV experienced lower rates of depression, anxiety, and PTSD symptoms when they accessed and received support specific to the abuse. These findings emphasize that supportive interactions are necessary to reduce the deleterious effects of IPV on mental health outcomes.

In addition to identifying a relationship between better outcomes and social support, researchers examined social support as a moderator between partner violence and negative outcomes in order to identify social support's protective effect and found interesting results (Coker et al., 2002; Haden, Scarpa, Jones, & Ollendick, 2006; Ullman & Filipas, 2001). Social

support serves as a protective factor, moderating the relationship between IPV and poor mental health outcomes (Coker et al.). However, Coker et al. found that it is not enough for a woman to have a friend or family member to turn to in times of distress. Support from a resource must be perceived as supportive in order for the victim to experience reduced PTSD symptoms. For example, in a study examining college students who had experienced one or more traumatic events, Haden et al. found that social support moderated the relationship between trauma severity and PTSD. Specifically, women and men who endorsed more severe trauma experienced fewer PTSD symptoms when they were the recipients of ***supportive*** social support.

In contrast to Coker et al. (2002) and Haden et al. (2006), Thompson et al. (2000) decided to assess social support as a mediator (i.e., intervening) variable. It was hypothesized that social support could be better understood as a mediator because partner violence has a direct impact on social support, which then mediates the impact of IPV on psychological distress. Consistent with their hypothesis, higher rates of IPV were associated with less perceived social support. Additionally, lower levels of psychological distress were associated with higher rates of perceived support. Finally, they also found that perceived social support did indeed mediate the relationship between intimate partner violence and psychological distress.

Social Support as a Growth Promoting Factor

Recently, researchers are increasingly interested in assessing whether or not social support serves as a growth-promoting factor following trauma. Social support is related to greater posttraumatic growth in breast cancer patients, HIV/AIDS victims, prostrate cancer survivors, and veterans (Cadell, Hemsworth, & Regehr, 2003; Cobb et al., 2006; Maguen, Vogt, King, King, & Litz, 2006; Sheikh, 2004; Thornton & Perez, 2006). For example, one research project found that greater social support was related to posttraumatic growth in patients

struggling with HIV/AIDS (Cadell et al.). Additionally, veterans experienced higher levels of posttraumatic growth when they reported higher rates of post-deployment support from family and friends (Maguen et al.). In those struggling with heart disease, social support predicted higher levels of posttraumatic growth. Greater levels of supportive assistance clearly influence the development of posttraumatic growth following a variety of adversities. Thus, it follows that supportive interactions from social support networks will also elevate posttraumatic growth in victims of partner violence.

Social Support as a Risk Factor

As is evidenced in the review above, social support can serve as a protective factor, protecting victims from the negative mental health outcomes of IPV, and as a growth promoting factor. Research also suggests that social support can serve as a risk factor. Specifically, it is evidenced that negative responses to disclosures of sexual violence are related to greater posttraumatic stress disorder symptom severity (Ullman & Filipas, 2001). If women are blamed for the assault, treated differently after disclosure, or ignored, they are more likely to experience PTSD symptoms (Ullman & Filipas). Furthermore, Ullman & Filipas found that when a confidant attempted to distract a sexual assault victim, such as encouraging her to put the assault behind her and move on, she was more likely to experience elevated PTSD symptoms. Research also indicates that unsupportive social assistance is more influential on health outcomes than supportive social assistance. According to some, the literature on social support suggests that negative reactions to disclosure are more strongly related to poor mental health outcomes than positive reactions are to improved mental health outcomes (Newsom, Nishishiba, Morgan, & Rook, 2003).

In keeping with the results discussed above, Doane (2007) found that unsupportive assistance from religious resources was associated with higher levels of shame in survivors of IPV. Furthermore, simply accessing religious resources was associated with elevated levels of shame in the participants of this study. Similarly, in another research project, survivors of IPV who accessed *any* formal resource, such as clergy members, therapists, or advocates in a domestic violence shelter, experienced higher rates of PTSD symptoms at the first assessment (Krause et al., 2008). Accessing formal resources was also moderately associated with elevated PTSD symptoms in survivors of IPV one year following the first assessment.

The buffering effects of social support appear to be overwhelmed by severe levels of IPV (Carlson et al., 2002). Carlson et al. interviewed 557 female patients experiencing IPV and found that possessing multiple protective factors, such as social support, lost its buffering effect at the most severe levels of IPV. Specifically, contrary to expectation, women who experienced the most severe forms of IPV continued to be at risk for poor mental health outcomes, in spite of possessing four or five protective factors, including social support. The authors concluded that it appears that severe levels of violence overwhelm women's resources, influencing the development of negative mental health outcomes. Additionally, it has been found that unsupportive emotional assistance continues to predict distress in survivors of IPV in spite of other protective factors, such as income (Williams & Mickelson, 2007).

After considering the above literature review, it is apparent that there is evidence for the beneficial effects of social support on the mental health of victims. Most of the research focuses on the positive aspects of social support. Only recently have researchers started to examine negative reactions to disclosure, especially when considering stigmatizing situations such as partner violence. Furthermore, there are some limitations to the literature discussed above. Most

of the participants in the above literature review are from shelter populations (Guay et al., 2006). Additionally, few structural aspects of social support have been studied and the functional dimensions of support are often poorly defined.

Intimate Partner Violence and General Coping

The process of coping includes a variety of thoughts and behaviors used to manage distress during and after adversity (Lazarus & Folkman, 1984, as cited in Waldrop & Resick, 2004). The concept of coping was theoretically developed in the 1960s and 1970s with the concurrent rising interest in stress (Lazarus, 1993). Coping definitions fall into one of two broad categories: style and process. Early theorists defined coping as a personality characteristic or defense mechanism, which managed threat. Theories about an individual's style of coping eventually developed into hierarchical approaches based on developmental psychology, with theorists arguing that some defenses were healthier than others. In the late 1970s, theorists proposed a new definition of coping that focused on coping as a process that changes over time and in relation to situational factors. Lazarus contends that from a process view, coping is "ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 237). Thus, one category defines coping as stable characteristics that are relatively fixed over time and the other category defines coping as a set of responses that are dynamic and fluid, changing with situational demands. Although measures of coping may focus on one approach (style or process), both are important to consider because they account for different aspects of managing stress.

Over the years, researchers have defined a variety of coping strategies (for a review, see Waldrop & Resick, 2004). A great number of factors have emerged from the data as a result, which can result in confusion when attempting to compare results across studies. *Approach* and

avoidance coping strategies are the two most commonly discussed in the literature. *Approach coping* is viewed as an active coping strategy and is characterized by attempts to change thoughts, behaviors, or circumstances in order to manage distress following trauma (Waldrop & Resick; for a review, see Wild & Paivio, 2003). *Avoidant coping*, on the other hand, includes individuals' attempts at removing themselves from the stressor in order to reduce negative outcomes.

Cognitive and behavioral coping strategies are the second most commonly discussed in the literature. Individuals using *cognitive coping* strategies attempt to alter their thoughts and perceptions about a stressor or situation in order to manage distress (Waldrop & Resick, 2004). *Behavioral coping* strategies, on the other hand, are observable by others and include overt acts that individuals employ to manage their anxiety or psychological distress.

Many measures have been developed to assess different coping styles. Tobin (1989) developed an instrument that appears to capture the most commonly discussed constructs in the literature, problem- and emotion-focused coping hypothesized by Lazarus and approach and avoidance coping. Tobin broadly categorizes coping into engagement and disengagement approaches. Engagement coping includes efforts to manage their environment by using problem solving and cognitive restructuring, expressing emotions, and seeking social support. Individuals use these coping strategies to engage in an active interaction to manage their stressful environment. Disengagement coping, on the other hand, includes strategies such as problem avoidance, wishful thinking, social withdrawal, and self-criticism that tend to disengage individuals from their environment. Tobin argues that "feelings are not shared with others, thoughts about situations are avoided, and behaviors that might change the situation are not initiated" when individuals use this coping style (p. 4). To maintain consistency and accurately

reflect the discussion in the literature, the terms avoidance and approach coping will be used to discuss the results of various studies.

Coping style may play a significant and unique role in the lives of partner violence victims (Straight, Harper, & Arias, 2003). For example, Roth and Cohen (1986) have proposed that *approach coping* can be advantageous for victims, in that victims of partner violence may engage in strategies that remove themselves from the violent relationship (as cited in Straight et al.). Furthermore, the distress victims experience following partner violence may be significantly influenced by their individual coping style (Straight et al.).

Research indicates that the frequency and severity of partner violence and coping style can all interact to influence outcomes for victims of partner violence (for a review, see Waldrop & Resick, 2004). Some research has found that women in violent relationships tend to use *avoidant coping* strategies to manage their situation; however, as the violence escalates in frequency, they employ more *approach coping* strategies, such as seeking temporary housing at a shelter. On the other hand, victims of partner violence are more likely to employ *avoidant coping* as the severity of violence intensifies. Waldrop and Resick propose that this might be due to the unsupportive reactions provided by resources, which can increase with depictions of more severe violence. Thus, women may feel that they are unable to employ more *approach coping* strategies.

In addition to frequency and severity of partner violence, a history of family violence and beliefs about gender roles can interact to influence coping strategies employed by victims of partner violence (for a review, see Waldrop & Resick, 2004). Specifically, childhood history and perceptions about gender roles moderate the relationship between the severity of violence and the style of coping women employ. Women who were not exposed to violence during childhood

and held less traditional views of gender roles were more likely to engage in *approach coping* strategies as the severity of partner violence intensified. On the other hand, women who were exposed to violence during childhood and held more traditional views of gender roles were more likely to engage in *avoidant coping* strategies as the severity of partner violence increased.

Coping Style as a Protective Factor

Unfortunately, much of the current research focuses on the influence of partner violence and coping style on negative mental health outcomes; however, coping typically denotes something positive and appears to improve the mental health outcomes of partner violence victims (Pargament, Smith, Koenig, & Perez, 1998). For example, *approach coping* has been shown to moderate the relationship between intimate partner violence and binge drinking (Straight et al., 2003). In other words, female victims of partner violence are less likely to binge drink (i.e., five or more drinks in 2 hours) when they employ *approach coping* strategies. Furthermore, male and female victims of trauma in general who engage in *approach coping* styles, specifically in the form of interpersonal coping, experience less PTSD than those who use *avoidant coping* styles (Haden et al., 2006). Finally, individuals using *problem-focused coping* in the aftermath of trauma were more likely to experience less PTSD than those using other coping strategies (Gil, 2005).

Coping Style as a Growth Promoting Factor

The findings regarding the role of coping in posttraumatic growth are inconsistent (Wild & Paivio, 2003). On the one hand, it appears that in order to promote growth, survivors of trauma should use *approach coping* strategies. On the other hand, there is very little research examining the differential role of *avoidant coping* styles in promoting posttraumatic growth. Additionally, there is no research examining the role of coping in posttraumatic growth in

survivors of IPV. Consequently, the literature reviewed in this paper will focus on *approach coping* styles in survivors of trauma in general.

As stated previously, most of the research examining the role of coping in posttraumatic growth has identified *approach coping* as a key strategy. Most research has found that a variety of *approach coping* styles, such as emotional support, positive reframing, and planning, are associated with elevated levels of growth following adversity (e.g., see Butler et al., 2005; Kesimci et al., 2005; Park, Mills-Baxter, & Fenster, 2005). Wild and Paivio (2003) found that *approach coping* accounted for 22.2% of the variance in total posttraumatic growth scores.

The relationship between *approach coping* and growth following adversity is not as strong as the relationship between *avoidant coping* and adverse outcomes after trauma. When parceling out and examining the relationships among different subcategories of coping and different subcategories of posttraumatic growth, Butler et al. (2005) found that *active coping* was positively associated with elevated levels on the posttraumatic growth subcategory New Possibilities, but negatively associated with the posttraumatic growth subcategories Relating to Others and Spiritual Change. Furthermore, in addition to identifying a relationship between *approach coping* and growth, Park et al. (2005) found a relationship between *avoidant coping* strategies, such as venting and self-distraction, and growth in the aftermath of trauma. Thus, it is imperative that researchers examine the associations between different coping styles and different subcategories of posttraumatic growth.

Coping Style as a Risk Factor

Much of the research examining the mental health outcomes of IPV and coping style focuses on the following: depression, PTSD, and self-esteem (for a review, see Waldrop & Resick, 2004). In general, the literature suggests that elevated levels of depression are associated

with greater *avoidant coping* in women experiencing IPV. Furthermore, *avoidance coping* is associated with higher PTSD symptoms in the aftermath of trauma (for example, see Haden et al., 2006; Lee & Waters, 2003; Waldrop & Resick). Additionally, women experience lower levels of self-esteem when using *avoidant strategies* to cope with partner violence (for a review, see Waldrop & Resick). Finally, the research indicates that *avoidant coping* by female victims of IPV is also associated with negative health behaviors, such as higher rates of smoking, problematic drinking, and work limitations due to health (Straight et al., 2003). As stated previously, as the frequency of violence intensifies so does a victim's use of more *approach coping* strategies, often resulting in her seeking assistance at shelters or from friends and family. On the other hand, the research indicates that those who experience the greatest temptation to return to their violent relationship also tend to employ more *emotion-focused coping* (Fiore-Lerner & Kennedy, 2000).

As is evidenced by the above literature, the role of coping behavior in predicting mental health outcomes, such as PTSD, are sometimes inconsistent (Haden et al., 2006). It appears that there is a stronger relationship between *avoidant* types of coping strategies and negative mental health outcomes in victims of trauma. On the other hand, there are inconsistent results regarding the role of *approach* and *avoidant coping* styles and improved mental health outcome following adversity. It is possible, as Haden et al. found, that there are certain subcategories of the approach coping style that are more predictive of improved mental health outcomes.

Intimate Partner Violence and Religious Coping

Religious coping has long been understood to improve health and mental health outcomes. Improved health status is evidenced in individuals with higher levels of religiosity, often measured by behavioral indicators (e.g., daily prayer, regular church attendance, etc.) (for a

review, see Ellison & Levin, 1998). The religion-health connection is found in a variety of populations, including men and women, individuals from various ethnic and racial backgrounds, individuals from a variety of socioeconomic backgrounds, Christians and non-Christians, and Western and non-Western individuals. Researchers have found improved health outcomes in religious individuals suffering a variety of ailments, including "heart disease, hypertension and other circulatory ailments, stroke, cancer (various sites), gastrointestinal disease, as well as overall self-rated health, physical disability, and self-reported symptomatology" (p. 702, Ellison & Levin). Additionally, researchers have found improved mental health outcomes for religious individuals from diverse backgrounds and geographic locations. Spiritual well-being has been also shown to moderate the relationship between violence and mental health outcomes (Lee & Waters, 2003).

For over 35 years, religiosity has been an important topic of study in psychology and sociology (Ellison & Levin, 1998). One of the major concerns in the study of religiosity has been conceptualization and measurement. It is necessary to differentiate between behavioral indicators and functional aspects of religiosity. Behavioral indicators are characterized and measured by behaviors such as the frequency of religious attendance, prayer, financial gifts (i.e., tithes and offerings), and frequency of fasting.

Traditionally, researchers have focused on behavioral indicators to identify or measure religiosity (Ellison & Levin, 1998). The functional aspects, on the other hand, are characterized by religious coping, meaning making, and participating in religious social networks. Until recently, examination of the function of religion in the lives of religious individuals has been neglected, in part because of the difficulty in the conceptualization and measurement of religiosity. Ellison and Levin argue that researchers should shift their focus from behavioral

indicators of religiosity now that they have been "reasonably established as predictors of health" and focus on functional aspects of religion, which will be attempted in this research project.

Some argue that measures of religious coping should assess how people use their religious beliefs to understand and cope with adversity (Pargament, Smith et al., 1998). Scholars of religion have long debated the most important functions of religious coping (for a review, see Pargament et al., 2000). Pargment et al. (2000) proposes that researchers should not have to choose, for all functions are important to understand. The following five fundamental functions have been identified to operate in religious coping: 1) meaning; 2) control; 3) comfort; 4) intimacy; and 5) life transformation.

Religion serves an important role in helping individuals understand and make meaning of adversity (for a review, see Pargament et al., 2000). Additionally, adversity often pushes people beyond their individual capacity to cope with stresses or to feel in control; thus, it is argued that religion offers individuals a way to seek control when they feel out of control. Religion also helps people find comfort in times of distress. Specifically, "from the religious perspective, spirituality, or the desire to connect with a force that goes beyond the individual, is the most basic function of religion" (p. 521). Intimacy can be gained through religion by beliefs that encourage offering assistance to those who are in need. Finally, major life transformations can be accomplished with the assistance of religious beliefs and values.

The concept of coping usually denotes something positive; however, as is discussed previously, coping processes can be adaptive or maladaptive and can result in positive or negative outcomes (Pargament et al., 2000). Religious coping can also be positive or negative. Subcategories of positive religious coping include "appraisal of God as benevolent, collaboration with God, seeking a connection with God, seeking support from church members, and giving

religious help to others" (p. 686, Bradley, Schwartz, & Kaslow, 2005). On the other hand, negative religious coping is characterized by the following subcategories: "appraisals of God as punishing, appraisals involving demonic forces, and expression of spiritual discontent" (p. 686, Bradley et al.).

Some suggest that positive religious coping is associated with better adjustment and improved mental health outcomes and negative religious coping is associated with poor mental health outcomes (Pargament, Smith et al., 1998). For example, research indicates that Punishing God Reappraisals, Demonic Reappraisals, Spiritual Discontent, Interpersonal Religious Discontent, and Pleading for Direct Intercession are related to greater psychological distress (Pargament, Zinnbauer et al., 1998). The subsequent discussion will review research that has examined religious coping as a protective factor, a growth-promoting factor, and a risk factor. Due to the scarcity of research examining associations between religious coping and positive mental health outcomes/posttraumatic growth in individuals struggling with IPV, the subsequent sections will incorporate research that examines both behavioral indicators and functional aspects of religious coping in survivors of trauma in general.

Religious Coping as a Protective Factor

The unique aspects of religiosity and IPV have long been neglected in the literature (Ellison & Anderson, 2001). Many have believed that religious leaders in certain organizations allow for violence against women because of the emphasis on traditional gender roles (Geisbrecht & Sevcik, 2000). However, some research indicates that religion serves as a protective factor in a number of ways (Ellison & Anderson, 2001; Geisbrecht & Sevcik, 2000; Hassouneh-Phillips, 2003). For example, it is argued that attending a religious institution is associated with a reduction in an individual's risk for experiencing IPV (Ellison & Anderson,

2001). Specifically, it is believed that the social ties found in some religious institutions might deter an individual from engaging in partner violence. Indeed, Ellison and Anderson identified that individuals in their sample were less likely to experience partner violence when they regularly attended a religious institution. They found that people who attended church once a week or more were almost 61% less likely to engage in partner violence than those who do not attend church at all.

Ellison and Anderson (2001) took their analyses one step farther and assessed whether there were some intervening variables associated with religious attendance that might decrease the rates of IPV. They examined whether or not religious involvement might reduce the risk of IPV by elevating an individual's involvement with social ties, by reducing an individual's drug and alcohol intake, and by reducing the risk of psychological problems. However, they found that there were religious effects that explained the lowered rates of IPV above and beyond these intervening variables. The authors concluded that other variables, such as specific religious coping processes, might mediate the relationship between religious attendance and reduced rates of IPV.

In addition to possibly reducing the likelihood of experiencing IPV, religiosity is also shown to reduce negative mental health outcomes in the aftermath of trauma in general and IPV in particular. In one research project, personal and public religiousness and religious coping predicted lower rates of depression in individuals struggling with adversity (Park, 2006). Furthermore, the more religious an individual was, the better adjusted they were following trauma. The author found it interesting that religious coping had more predictive power on outcome than any other variable in her study. Unfortunately, she only used four items on a subscale of religious coping. Thus, it is difficult to determine which coping style better predicted

adjustment. Finally, in a study assessing growth in female sexual assault survivors, it was found that positive changes in spirituality following the assault predicted less psychological distress (Frazier, Conlon, & Glaser, 2001).

Religious Coping as a Growth Promoting Factor

At this time, there appears to be no research examining the influence of religious coping in survivors of IPV on posttraumatic growth. However, there are a few research projects that indicate the possibility that religious coping, as measured by a variety of questionnaires, can promote posttraumatic growth in trauma survivors in general. In one study, it was found that survivors of HIV/AIDS who endorsed higher levels of spirituality, as measured by the Spiritual *Involvement and Beliefs Scale*, experienced elevated levels of posttraumatic growth (Cadell et al., 2003). Park (2006) also identified elevated levels of stress-related growth in those individuals who endorsed personal and public (intrinsic and extrinsic) religiousness and religious coping. Additionally, contrary to theoretical expectations, clergy members from a variety of religious organizations encountering adversity experienced greater posttraumatic growth when using both positive and negative religious coping styles (Proffitt, Cann, Calhoun, & Tedeschi, 2007).

Finally, in a study assessing a religious coping measure, it was found that religious coping explained between 6% and 21% of the variance of outcome scores (Pargament et al., 2000). Additionally, higher levels of stress-related growth were evidenced in individuals using all religious coping styles, except for Passive Religious Deferral and Punishing God Appraisal. Positive religious coping was also linked to an improved relationship with God.

Religious Coping as a Risk Factor

As has been addressed, researchers have typically focused on the positive influence of religious coping (Pargament et al., 2000). However, a few studies have found a link between

some religious coping styles and poor mental health and physical health adjustment. One study identified that female survivors of IPV were more likely to experience elevated PTSD symptoms when using a negative religious coping style (Bradley et al., 2005). In a sample of college students experiencing a variety of negative events, it was found that poor physical health outcomes were also associated with subcategories of negative religious coping (Pargament et al., 2000). Finally, in a study assessing growth in survivors of sexual assault, there was evidence to indicate that women who experienced negative changes in spirituality following the assault were more likely to experience elevated levels of psychological distress (Frazier et al., 2001).

As has been evidenced in the literature review above, general coping and religious coping can serve as a protective and growth promoting factor in the lives of trauma survivors. Unfortunately, the current research on general coping has focused on the negative impact of avoidance coping. Contrarily, the research on religious coping has narrowly studied the positive influence of religiosity on mental health outcomes following adversity. In order to better serve survivors of IPV, it seems important to examine both the positive and negative impact of general and religious coping styles. An additional limitation of the current literature includes a dearth in research examining the interface between religious coping and posttraumatic growth.

The present study sought to understand the unique role of social support and coping in the development of shame, posttraumatic stress symptoms, and posttraumatic growth in survivors of partner violence. Research indicates that women who are in violent relationships are at a greater risk for the development of shame (Taylor, 2003). Furthermore, the shame that women experience in violent relationships is possibly further compounded by the reactions of social support resources. Unfortunately, shame influences individuals to hide their stigmatizing situations and reduces the likelihood that victims will reach out and receive the resources

necessary to leave their violent relationships. Thus, it is necessary to consider how unsupportive reactions influence shame in IPV survivors.

As has been stated previously, the consequences of traumatic experiences are not always negative. Research indicates that individuals can learn from adversity and grow in the aftermath of trauma (Tedeschi & Calhoun, 2004). This study explored the role of partner violence in the development of posttraumatic growth.

Hypotheses

As a result of the available research, the following predictions were made:

First, it was expected that more frequent and severe violence would be positively associated with higher levels of shame and posttraumatic stress symptoms.

Second, consistent with Thompson et al.'s (2000) research, it was hypothesized that the severity of violence would be negatively associated with the supportiveness of social networks. In other words, as the severity of violence increases, the perceived supportiveness of various social resource networks would decrease.

Third, it is indicated that avoidant coping strategies are associated with higher rates of severe violence (for a review, see Waldrop & Resick, 2004). In keeping with this research, it was believed that higher rates of violence would be positively associated with higher levels of disengagement coping. The researcher also predicted that higher rates of violence would be positively related to higher rates of negative religious coping.

Fourth, given the research outlined in this paper on social support, shame, and posttraumatic stress symptoms, it was expected that unsupportive social assistance would mediate the relationship between severity of intimate partner violence and shame. Additionally,

it was hypothesized that unsupportive social support would mediate the relationship between severity of intimate partner violence and posttraumatic stress symptoms.

Fifth, considering the literature discussed in this paper regarding coping, it was hypothesized that disengagement coping and negative religious coping would mediate the relationship between severity of intimate partner violence and shame and severity of intimate partner violence and trauma symptoms.

Sixth, consistent with the research suggesting that behavioral indicators of religious coping are positively associated with posttraumatic growth it was believed that higher rates of behavioral indicators of religious coping would be associated with higher rates of positive and negative religious coping (as defined by Pargament, 2000), which would in turn mediate the relationship between behavioral indicators of religious coping and posttraumatic growth.

Seventh, it was expected that disengagement coping, negative religious coping, and unsupportive social support would predict higher scores on the Internalized Shame Scale and on the Trauma Symptom Checklist (TSC-40). Additionally, it was believed that engagement coping, positive religious coping, and supportive social support would predict higher scores on the Posttraumatic Growth Inventory.

In conclusion, it is evidenced by the above review that IPV, social support, and coping interact to influence greater risk or the possibility for growth. In spite of the abundance of research examining pathology in victims of IPV, greater risk for the development of shame has been neglected in the literature (Allen, 1995; Romito & Grassi, 2007; Straus & Ramirez, 2007). Furthermore, the study of the possibility for growth and the factors that are associated with growth in the aftermath of IPV is relatively new. This project sought to address these gaps in the

literature and explore the relationships between IPV, social support, religious and general coping styles and the development of shame, posttraumatic stress symptoms, and posttraumatic growth.

Chapter II

Methods

Inclusion Criteria

Based on their responses to the Conflict Tactic Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Appendix B), participants were eligible for participation if they reported four or more moderate experiences of violence (e.g., pushing, slapping, etc.) or one severe experience of violence (e.g., threats with a weapon, rape, or being beaten up). Additionally, due to research that suggests optimal results for outcome data post-abusive relationships (e.g., see Cobb et al., 2006), time since relationship was controlled for in this study. Participants must also have experienced violence in a heterosexual relationship, as outlined in the introduction.

Participants

Eighty-four Psychology 100 students at the University of Montana were recruited for this study. They received between 2 and 4 research credits for participation. There were four men and one female participant who did not meet criteria for the study and were excluded from data analysis, leaving a sample size of 79 participants. Participants ranged in age from 18 to 56 years old ($M = 22.28$). Previous research examining similar variables outlined in this proposal have found modest effect sizes, ranging from .14 to .39 (Brewin et al., 2000; Calhoun et al., 2000; Coker et al., 2003; Kesimci et al., 2005; and Krause et al., 2008). Consequently, the researcher hoped to identify a modest effect size of .25 in this study. A power analysis was conducted that included two covariates (childhood sexual abuse and severity of partner violence), which in previous research explains between 0.04 and 0.14 of the variance, and two predictor variables, the least of which in previous research explains 0.14 of variance, an accumulated effect size of

0.18. The power analysis revealed that a sample of at least 70 participants, with an alpha set at 0.05, will yield a power of 0.86, detecting an effect size of 0.18. To be cautious and detect an even smaller effect size, I attempted to gather data from more participants.

The racial diversity of this sample was representative of the racial diversity in Western Montana. The sample was primarily composed of Caucasian women (78.5%). The rest of the sample was composed of American Indian (10.1%); African American (2.5%); Asian American (2.5%); Hispanic American (1.3%); and multi-racial or other (3.6%). Similar percentages were identified for participants' partners' race, including the following: Caucasian (78.5%), American Indian (11.4%); African American (5.1%); Asian American (2.5%); and multi-racial or other (1.3%). One participant did not report her or her partner's racial status.

At the time of the study, 91.1% of participants were employed at least part-time and/or were students at the university. Around 97% of women reported that they had at least some college education. On the other hand, only 35% of their partners completed at least some college education. On average, women reported that their annual income at the time of the study was between $5,001 and $10,000 and their family's annual income was between $25,001 and $30,000. Regarding religiosity or spirituality, 31 participants (nearly 31%) reported that they were religious and 48 (60.8%) women were spiritual. Many participants who endorsed they were religious also endorsed that they were spiritual.

Every participant met inclusion criteria of violence experienced for the study, meaning that they experienced at lease four moderate incidents of violence (e.g., they were shoved or slapped) or one incident of severe violence (e.g., they were raped or beaten). Seventy-eight (98.7%) women reported that they experienced at least one incident of physical and psychological violence during their relationship. Nearly 99% of participants ($n = 78$) reported

that they were shoved, pushed, grabbed, or slapped by their partner. Seventy women (88.6%) endorsed that they were threatened with a knife or gun, punched, choked, slammed against a wall, beaten, burned, or kicked by their partner. Sixty-one women (77.2%) reported that they experienced at least one incident of mild or severe sexual violence, and sixty-six women (83.5%) endorsed that they experienced at least some minor injury from the violence. A majority of participants (74.68%, $n = 59$) endorsed that their partner's violence resulted in a sprain, bruise or cut.

The average time since relationship was between 1 and 2 years prior to the study. Eighty-two percent of participants endorsed that they were living in a town or city during the violence. Nearly 13% of participants reported that they were living in a rural location at the time of the violent relationship and four women stated that they experienced violence in both locations.

Measures

Demographic Questionnaire. The participants completed the Demographic Questionnaire (found in Appendix A), composed of general demographic questions. For example, women were asked about age, education, occupation, geographic location where the violence occurred, ethnicity of the participant and their partner at the time of the abuse, etc. Questions included on the Demographic Questionnaire pertaining to behavioral indicators of religious coping and social supports were of particular interest in this study. Weaton et al. (1997) recommended that researchers examining trauma and its consequences should first control for prior violence history (as cited in Waldrop & Resick, 2004). For example, it is believed that certain trauma experiences, such as partner violence, occur more frequently in individuals who have a history of childhood sexual and physical abuse. Thus, it was important to control for this in our study.

Consequently, we included questions on the demographic questionnaire that assessed prior childhood abuse history.

Revised Conflict Tactics Scales. Participants completed the revised Conflict Tactics Scales (CTS2), which is a self-report measure and a revision of the original conflict tactic scales. The CTS2 measured the degree to which dating, cohabiting, or married partners engaged in physical and psychological abuse toward each other (Straus et al., 1996). The CTS2 was revised to include measures of sexual coercion and physical injury from assault by a partner (see Appendix B). The CTS2 is composed of five subscales, including Negotiation, Psychological Aggression, Physical Assault, Sexual Coercion, and Injury. The CTS2 includes 78 items, with participants responding on a seven-point Likert Scale, ranging from 0, "This has never happened" to 6, "More than 20 times in the past year."

According to Straus et al. (1996), the CTS2 is scored by adding the midpoints for each of the categories chosen by the participant. For response categories 0, 1, and 2, the midpoint is the same as the response category. For response categories 3, 4, 5, and 6, the midpoints are 4, 8, 15, and 25, respectively. For the purposes of this paper, responses in category 7 were scored as 0. Straus et al. (1996) recommends that researchers measure prevalence and chronicity for physical assault, sexual coercion, and physical injury by creating two variables for each category. Total scores are typically skewed, so Straus, Hamby, and Warren (2003) recommend a weighting procedure to correct for this. For the purposes of this study, the psychological, physical, sexual, and injury subscales were recoded and summed for correlation and regression analyses.

Straus et al. (1996) report that the internal consistency reliability for the CTS2 scales ranges from .79 to .95. Additionally, preliminary research suggests that there is evidence for construct and discriminate validity. Straus et al. argue that the CTS2 is methodologically and

conceptually similar to the original CTS; thus, the abundance of evidence supporting the validity and reliability of the original measure should also be considered for the CTS2.

Internalized Shame Scale. The participants' answers to the Internalized Shame Scale (ISS; Cook, 1984) were examined for this project (please see Appendix C). The ISS includes 30 items, with participants responding on a five-point Likert Scale. For example, question 12 includes the following statement: "I am ashamed to tell people about the violence in my relationship." Participants chose a response from not at all (0) to very much (4), or not applicable. Two scales composed the ISS, a Shame Scale (24 items) and a Self-Esteem Scale (6 items). The Shame Scale is characterized by the negatively worded items on the ISS. Positively worded items on the ISS are the questions that compose the self-esteem scale (Cook, 1996). Originally, Cook desired that the self-esteem items would reduce response set. Additionally, the ISS contains two shame subscales, Failure (15 items) and Alienation (9 items).

For the purposes of this study, participants' responses for the Shame Scale were analyzed. According to Cook, high levels of shame are indicated by a total ISS score of 50 or more. Researchers have found that total scores of 60 or higher on the ISS are associated with multiple symptoms of depression (for a review, please see Cook, 1996). Cook (1994) reports that for the Shame Scale, the Internal Consistency *alpha* coefficient was .95 for large nonclinical samples and .96 for clinical samples (Cook, 1994, as cited in Taylor, 2003). Analyzing test-retest reliability revealed correlations of .84.

Trauma Symptom Checklist. The Trauma Symptom Checklist-40 (TSC-40) is a 40-item, self-report inventory designed to assess trauma symptoms (Briere & Runtz, 1989). The TSC-40 was originally designed to measure trauma that developed in survivors of childhood sexual abuse; however, research indicates that it can also be used to examine trauma that develops from

other types of adverse experiences (e.g., see Briere & Runtz, 1989; Fiore-Lerner & Kennedy, 2000; Taylor, 2003). The TSC-40 consists of a total score and six subscale scores, including the following: 1) Dissociation; 2) Anxiety; 3) Depression; 4) SATI (Sexual Abuse Trauma Index); 5) Sleep Disturbance; and 6) Sexual Problems.

In a clinical sample of individuals who experienced childhood sexual abuse, researchers identified an internal consistency *alpha* of .89 for the TSC-40 total score and an average *alpha* score of .71 for the subscales (Briere & Runtz, 1989). The internal consistency *alphas* for the subscales ranged from .66 to .75. Briere and Runtz reported that there were no gender differences identified on scores. Additionally, the measure does reasonably well at predicting those who experienced childhood sexual abuse from those who were not abused as children. In Taylor's (2003) sample, the internal consistency *alpha's* for the subscales ranged from .79 to .84. She also found an *alpha* of .95 for the total TSC-33 score.

Posttraumatic Growth Inventory. In order to assess growth following a traumatic event, researchers Tedeschi and Calhoun (1996) developed the Posttraumatic Growth Inventory (PTGI) (Appendix E). The PTGI is composed of 21 items, which are rated on a six-point Likert Scale, ranging from 0, "I did not experience this change as a result of my crisis," to 5, "I experienced this change to a very great degree as a result of my crisis." A total posttraumatic score can be derived by adding all of the individual items or scores on the five subscales can be examined. Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life comprise the five subscales of the PTGI. An example of an item on the PTGI is, "I learned a great deal about how wonderful people are."

The internal consistency *alpha* coefficient of the PTGI is .90 (Tedeschi & Calhoun, 1996). When analyzing test-retest reliability for the total score, an acceptable correlation (.71)

was identified. Internal consistency *alpha* coefficients for the subscales ranged from .67 to .85. The test-retest reliability for the individual subscales includes correlations ranging from .65 to .74.

Brief RCOPE. The Brief RCOPE, created by Pargament (2000), was used to assess participants' religious coping styles. The measure, which is both theoretically based and functionally-oriented, assesses both positive and negative religious coping strategies. The subscales that characterize the positive religious coping orientation have been associated with positive mental and physical health outcomes. Some examples of a positive religious coping item are "Sought God's love and care" and "Tried to see how God might be trying to strengthen me in this situation."

Negative religious coping, on the other hand, has been associated with primarily negative mental and physical health outcomes; however, in some cases research has found that negative religious coping styles are associated with posttraumatic growth and other positive outcomes (Pargament et al., 2000). "Felt punished by God for my lack of devotion" and "Wondered whether God had abandoned me" are examples of negative religious coping items. Responses were coded on a four-point Likert Scale, ranging from 1, "not at all," to 4, "a great deal." Higher scores on the positive or negative religious coping scales indicated a positive or negative religious coping orientation.

The Brief RCOPE was originally validated in a college sample, and a confirmatory factor analysis was conducted by examining responses from a hospitalized elderly sample (Pargament et al., 2000). For the college sample, internal consistency among the scales was moderate to high (.61-.94). For the elderly sample, internal consistency among the 17 subscales were also

moderate to high, with only three scales falling below .65. Please see Appendix F for an example of the Brief RCOPE measure.

Coping Strategies Inventory. Out of the abundance of coping measures available, Tobin et al. (1989) appear to have created the only validated measure which assesses approach, avoidance, cognitive, and behavioral coping strategies (Waldrop & Resick, 2004). The Coping Strategies Inventory (CSI) is a self-report measure that is composed of 72 items assessing the tertiary coping categories, engagement and disengagement (please see Appendix G). Participants were asked to indicate the extent to which they used particular coping strategies in response to their abusive relationships on a five-point Likert Scale. There are eight primary scales, four secondary scales, and two tertiary scales included in the CSI. The eight primary scales include Problem Solving, Cognitive Restructuring, Social Support, Express Emotions, Problem Avoidance, Wishful Thinking, Social Withdrawal, and Self-criticism. Problem Engagement, Emotion Engagement, Problem Disengagement, and Emotional Disengagement comprise the secondary scales.

A preliminary analysis supported the stability of the hierarchical model and the reliability of the scale (Tobin, Holroyd, Reynolds, & Wigal, 1989). The stability of the hierarchical model was confirmed by Tucker's coefficients ranging from .85 to .98. Additionally, internal consistency *alpha* coefficients for the primary factors ranged from .71 to .94. When analyzing test-retest reliability, the researchers found coefficients ranging from .67 to .83.

Bosch Support Measure. The Bosch Support Measure is a self-report assessment of supportive and unsupportive behaviors exhibited by resources as perceived by women experiencing partner violence (Bosch & Bergen, 2006). Participants completed up to five Bosch Support Measures, rating each of the following resources they accessed: 1) friends; 2) family; 3)

clergy; 4) medical personnel; and 5) law enforcement. The assessment includes 68 items measuring supportive and unsupportive emotional, informational, and physical support. Participants were instructed to endorse whether a resource provided a particular supportive or unsupportive response on a six-point Likert scale. For example, in response to the question, "During your abusive relationship, this person tried to placate (appease) you and tell you it was going to get better," the participant chose a response between never (1) and always (5).

Bosch and Bergen (2006) reports that reliability for the Bosch Support Measure was assessed and they found *alpha* coefficients ranging from .72 to .95. Specifically, the *alpha* coefficients for the subscales included the following: Informational Support (.77), Emotional Support (.95), Physical Support (.87), Informational Nonsupport (.72), Emotional Nonsupport (.93), and Physical Nonsupport (.86). This measure is attached in Appendix H.

Procedure

Participants who signed up on a sign-up sheet to participate in the study were called, and those who met inclusion criteria were scheduled to fill out the questionnaires. The participants read and signed the informed consent, which included information on the conditions of participation (e.g., voluntary, confidential, and anonymous), potential risk to participants (e.g., contemplating and remembering abusive acts can result in distress), and benefits to participants (e.g., providing information that adds to our understanding of violence). Once participants signed the informed consent, they were given a packet of the measures outlined in the previous section, which required 30 minutes to 1 hour to complete. Two to three research assistants and the researcher collected the data. After they completed the measures, they were given a list of resources in the community, such as the Clinical Psychology Program, and the contact numbers

of the researcher and her advisor if they needed additional information. Two research assistants entered the data from each participant into an SPSS program in order to check for accuracy.

Chapter III

Results

Statistical Analyses Conducted

First, descriptive statistics and frequencies were obtained for demographic variables within the entire sample to develop a better understanding of the population studied. Second, descriptive statistics, including mean, standard deviation, and range were calculated for each variable used in analyses (see Table 1). Third, zero-order correlations were computed to determine how demographic characteristics, severity of violence, coping styles, and received support were associated with posttraumatic stress symptoms, shame, and posttraumatic growth. Demographic variables significantly related with outcome variables and that could potentially influence findings were included as covariates in regression analyses. Fourth, hierarchical regression analyses were conducted to determine the degree to which coping styles and social support contributed to the prediction of posttraumatic stress symptoms, shame, and posttraumatic growth above and beyond partner violence. Fifth, hierarchical regression analyses were conducted in three stages to test for mediating variables, as described by Baron and Kenny (1986). When conditions for partial mediation were met, Sobel's test for indirect effect was used to confirm partial mediation.

Descriptive Information for Primary Variables

Intimate Partner Violence. Only five women were currently in the violent relationship at the time of the study, with seventy-three women (92%) reporting that their relationship ended over 1 month prior to the study. Fifty-three women (67%) reported that they left the relationship over 1 year prior to the study. Two women (2.5%) reported that they were married, but separated, 6 women (7.6%) reported that they were married, but divorced, 19 women (24.1%)

stated that they were living as a couple, and 51 women (64.6%) endorsed that they were dating their partners during the violence.

The CTS-2 was used to assess IPV experienced by women. Using a Likert scale with items from 0 (never) to 6 (20 or more times), which indicated the frequency of violent acts during a 12-month period, the mean frequency of minor violence was 35.68 (SD = 14.64). The mean frequency of severe violence was 21.11 (SD = 16.70) and the total frequency of violence was 56.80 (SD = 29.83). The following percentages of women reported the various forms of severe violence on the CTS: punched with a fist 55.7% (n = 44), beaten 49.37% (n = 39), threatened with a weapon 18.99% (n = 15), sought medical attention 35.44% (n = 28), and forced to participate in sexual activity 49.36% (n = 39). These percentages of severe violence are lower than those reported in other studies assessing for violence experienced by women in the community (Fiore Lerner & Kennedy, 2000; Kemp, 1995; Jacobson et al., 1994).

History of Abuse. Women reported their history of abuse with 24.1% of women endorsing that they had experienced childhood sexual abuse and around 34.2% of women endorsing that they had experienced childhood physical abuse.

Trauma Symptoms. Using the TSC-40, the level of current trauma symptoms was assessed. Participants reported a mean total TSC-40 score of 44.31 (SD = 18.09), which is higher than those reported by Higgins and McCabe (1994) found in a sample of adult women who experienced childhood sexual abuse (M = 31.09, SD = 18.41)

Shame. The ISS was used to assess current shame experienced by participants. The average total shame score on the ISS was 48.92 (SD = 21.90), which is approaching high levels of shame (a total score of 50 or more) according to Cook (1984).

Posttraumatic Growth. Participants reported an average total posttraumatic growth score of 59.20 (SD = 24.124), which was assessed by the Posttraumatic Growth Inventory (PTGI), which is lower than that reported by Cobb et al. (2006) in a sample of victims of IPV (M = 68.08, SD = 24.95) and higher than that reported by Peltzer (2000) in a sample of violent crime survivors (M = 40.3, SD = 20.30). (90.26)

Coping Styles. The CSI was used to assess engagement and disengagement coping styles that were used to deal with their violent relationships. Participants' average total scores for engagement coping was 46.71 (SD = 10.24) and disengagement coping was 54.11 (SD = 13.16). To determine religious coping style, the researcher used the Brief RCOPE and found that the mean total scores for positive religious coping was 14.05 (SD = 6.77) and negative religious coping was 11.12 (SD = 4.64). These scores are higher than scores reported by Hills et al. (2005) in a sample of adults struggling with distress (Positive Religious Coping, M = 11.3, SD = 7.7 and Negative Religious Coping, M = 3.2, SD = 4.3).

Social Support. Women were asked to rate the extent to which they accessed various resources and to rate the extent to which these resources were supportive. The following percentages of participants endorsed that they accessed the following resources: friends 87.3% (n = 69); family 74.6% (n = 59); legal assistance 39.2% (n = 31); law enforcement 40.5% (n = 32); counselor 55.6% (n = 44); shelter 17.7% (n = 14); support groups 20.2% (n = 16); religious resources 40.5% (n = 32); financial assistance 31.6% (n = 25); medical assistance 34.1% (n = 27); vocational services 18.9% (n = 15); crisis hotlines 24% (n = 19); and neighbors 30.3% (n = 24).

Of those who accessed resources, the following percentages of respondents found them at least somewhat supportive: friends 79.7% (n = 55); family 71.1% (n = 42); legal assistance

38.7% (n = 12); law enforcement 46.8% (n = 15); counselor 56.8% (n = 25); shelter 14.2% (n = 2); support groups 12.5% (n = 2); religious resources 56.2% (n = 18); financial assistance 28% (n = 7); medical assistance 33.3% (n = 9); vocational assistance 13.3% (n = 2); crisis hotlines 21% (n = 4); and neighbors 37.5% (n = 9).

Relationships Between Demographic and Outcome Variables

The relationship between demographic variables (such as age and income) and outcome variables (trauma symptoms, shame, and posttraumatic growth) was investigated using Pearson product-moment correlation coefficients (see Table 2). Only those relationships that were significant will be discussed. There was a small, negative correlation between time since relationship and trauma symptoms, r = -.249, n = 77, p < .05, with greater time since relationship associated with lower levels of trauma symptoms. A small, positive relationship between time since relationship and posttraumatic growth was identified, r = .225, n = 78, p < .05, with greater time since relationship associated with higher levels of posttraumatic growth. Surprisingly, there was a small, positive correlation between childhood sexual abuse and posttraumatic growth, r = .261, n = 78, p < .05, with experience of childhood sexual abuse associated with higher levels of posttraumatic growth. Moderate, positive correlations were identified between childhood physical abuse and trauma symptoms and childhood physical abuse and shame, r = .377, n = 78, p < .01 and r = .325, n = 78, p < .01, respectively, with the experience of childhood physical abuse associated with higher trauma symptoms and higher shame scores. As a result, time since relationship, childhood physical abuse, and childhood sexual abuse, were used as control variables in subsequent regression analyses.

Predicted Relationships between Variables of Interest

Trauma Symptoms. The relationships between total violence experienced, coping styles, and social support and trauma symptoms were investigated using Pearson product-moment correlation coefficients. As was predicted, there was a modest, positive correlation between total violence experienced and trauma symptoms, $r = .281$, $n = 78$, $p < .05$, with higher rates of violence associated with higher trauma symptoms (see Table 4). Also, there was a strong, positive correlation between disengagement coping and trauma symptoms, $r = .462$, $n = 78$, $p < .01$ (see Table 5). In contrast to the researcher's prediction, negative religious coping was not significantly related to trauma symptoms, $r = .185$, $n = 76$, $p < .110$. Also, a relationship between total supportiveness of resources and trauma symptoms was not identified (see Table 6). As a result, correlations between the supportiveness of each resource and trauma symptoms were conducted, and a small, negative relationship between the supportiveness of family and trauma symptoms was identified, $r = -.279$, $n = 78$, $p < .05$.

Shame. Pearson product-moment correlations were conducted to investigate the relationships between violence experienced, coping styles, and social support. In contrast to the hypothesis, a significant relationship between total violence experienced and shame was not identified. Because of this, correlation analyses between subcategories of violence and shame were conducted (see Table 4). These results revealed a small, positive correlation between total psychological violence experienced and shame, $r = .236$, $n = 78$, $p < .05$, with higher levels of psychological violence associated with higher total shame scores. As predicted, a small, positive relationship between negative religious coping and shame was identified, $r = .234$, $n = 78$, $p < .05$, with higher levels of negative religious coping correlated with higher levels of shame (see Table 5). There was also a large, positive correlation between disengagement coping and shame,

$r = .523$, $n = 78$, $p < .01$, confirming the hypothesis that higher levels of disengagement would be associated with higher levels of shame. Interestingly, a small, negative relationship between engagement coping and shame was found, $r = -.276$, $n = 78$, $p < .05$, with higher levels of engagement coping associated with lower total shame scores. As a result, engagement coping will be included in subsequent regression analyses.

Posttraumatic Growth. Zero-order correlations were conducted between violence experienced, coping styles, social support and posttraumatic growth. Correlation analyses revealed that there was a modest, positive correlation between total violence experienced and posttraumatic growth, $r = .329$, $n = 79$, $p < .01$ (see Table 4), with higher posttraumatic growth associated with greater total violence. Furthermore, as was predicted, a small, positive correlation between engagement coping and posttraumatic growth was found, $r = .268$, $n = 79$, $p < .05$, with higher levels of approach coping associated with higher levels of posttraumatic growth (see Table 5). In contrast to the hypotheses stated in this project, total supportiveness of resources was not associated with posttraumatic growth (see Table 6). As a result, correlation analyses between the supportiveness of each resource and posttraumatic growth were conducted and revealed the following positive relationships. There was a modest, positive relationship between the supportiveness of religious resources and posttraumatic growth, $r = .338$, $n = 79$, $p < .01$ and a small, positive relationship between the supportiveness of neighbors and posttraumatic growth, $r = .258$, $n = 79$, $p < .05$. Thus, the higher the supportiveness of religious resources and neighbors, the higher the posttraumatic growth.

Coping Styles. To examine the relationships between violence experienced, social support, and coping styles, zero-order correlations were conducted. In keeping with the literature and confirming the researcher's hypothesis, a modest, positive relationship between total

violence experienced and disengagement coping was found, $r = .381$, $n = 79$, $p < .01$, with higher levels of total violence associated with higher levels of disengaged coping (see Table 7). Surprisingly, a modest, positive relationship was found between mild violence and engagement coping, $r = .308$, $n = 79$, $p < .01$, with higher rates of mild violence associated with higher levels of engagement coping used. There was a modest, positive correlation between total violence experienced and negative religious coping, $r = .418$, $n = 77$, $p < .01$, with higher rates of total violence associated with higher negative religious coping. In addition to this, there was a large, positive correlation between positive religious coping and the behavioral religious indicators assessed for in the demographic interview, $r = .539$, $n = 35$, $p < .01$, confirming the hypothesis that positive religious coping would be positively associated with behavioral religious indicators. On the other hand, negative religious coping was not associated with the behavioral religious indicators, which is in contrast to the hypothesis.

Social Support. In contrast to the predictions outlined in this project, total violence experienced was not correlated with total supportiveness of resources. Because of this, a series of zero-order correlations were conducted to identify relationships between the various subcategories of violence experienced and the supportiveness of each resource. Refer to Table 8 to examine significant relationships.

Regression Analyses for Predicted Outcome Variables

Trauma Symptoms. Hierarchical multiple regression was used to identify the relative contribution of disengagement coping and supportiveness of family to predict levels of trauma symptoms, after controlling for the influence of time since relationship, childhood physical abuse, and violence experienced. Only variables that were significantly related were included in these analyses (see Table 9). Preliminary analyses were conducted to ensure no violations of

assumptions of normality, linearity, multicollinearity and homoscedasticity. In Step 1, time since relationship, childhood physical abuse, and total violence experienced were entered, which explained 26.2% of the variance in trauma symptoms. Disengagement coping and supportiveness of family were entered in Step 2, with the model as a whole explaining 36% of the variance in trauma symptoms, $F(5, 71) = 8.01$, $p < .001$. The predictor variables explained an additional 10% of the variance, after controlling for time since relationship and childhood physical abuse, $\Delta R^2 = .098$, F change $(2, 71) = 5.46$, $p < .001$. In the final model, time since relationship, childhood physical abuse, and disengagement coping were the only statistically significant variables, with disengagement coping recording a higher beta value ($\beta = .305$, $p < .01$) than childhood physical abuse ($\beta = .249$, $p < .05$) and time since relationship ($\beta = -.211$, $p < .05$).

Shame. Hierarchical multiple regression was used to identify the relative contribution of disengagement coping, engagement coping, and negative religious coping in predicting levels of shame above and beyond the covariates childhood physical abuse and psychological violence (see Table 10). Once again, assumptions were not violated, as indicated by preliminary analyses. Only those variables that were significantly related to the outcome variable were included in the regression analysis. Childhood physical abuse and psychological violence were entered at Step 1, explaining 14% of the variance in shame scores. The total variance explained by the model as a whole after disengagement coping, engagement coping, and negative religious coping were entered in Step 2 was 43%, $F(5, 70) = 10.55$, $p < .001$. These predictor variables explained an additional 29% of the variance in shame, after controlling for childhood physical abuse and psychological violence, $\Delta R^2 = .286$, F change $(3, 70) = 11.70$, $p < .001$. In the final model, childhood physical abuse, disengagement coping, and engagement coping were the only variables that reached statistical significance, with disengagement coping recording a higher beta

value (β = .387, p < .001) than engagement coping (β = -.314, p < .001) and childhood physical abuse (β = .222, p < .05).

Posttraumatic Growth. Hierarchical multiple regression was used to identify the relative contribution of engagement coping, clergy supportiveness, and neighbor supportiveness to predict levels of posttraumatic growth, after controlling for the influence of time since relationship, childhood sexual abuse, and violence experienced (see Table 11). Once again, assumptions were not violated, as indicated by preliminary analyses. In Step 1, time since relationship, childhood sexual abuse, and total violence experienced were entered, which explained 19% of the variance in posttraumatic growth scores. After entry of the second set of variables in Step 2, the total variance explained for the model as a whole was 34%, $F(6, 70) = 6.11$, p < .001. Engagement coping, supportiveness of neighbors, and supportiveness of clergy explained an additional 15.5% of the variance, after controlling for the influence of time since relationship, childhood sexual abuse, and total violence experienced, $\Delta R^2 = .155$, F change (3, 70) = 5.50, p < .001. Supportiveness of clergy, engagement coping, and childhood sexual abuse were the only variables that reached statistical significance in the final model, with supportiveness of clergy recording the highest beta, β = .315, p < .01.

Tests for Mediation

Baron and Kenny's (1986) recommendations for mediation analysis were followed to explore social support and coping styles as mediators of violence experienced and mental health outcomes (e.g., shame, trauma symptoms, and posttraumatic growth). When a partial mediated relationship was identified, Sobel's test for indirect effect was used to confirm partial mediation. The steps of mediation will be explained in detail for the first test.

Intimate Partner Violence, Disengagement Coping, and Trauma Symptoms. For a summary of the following steps, please refer to Table 13. Step one: In the first step, the predictor variable (total violence experienced) must be significantly associated with the outcome variable (posttraumatic stress symptoms). A hierarchical regression analysis was conducted to identify a relationship between violence experienced and trauma symptoms, while controlling for childhood physical abuse and time since relationship. There was a statistically significant relationship between these two variables, $B = .538$, $p < .001$ (identified as Path c in Figure 1).

Step two: Total violence experienced must be significantly associated with the mediator (disengagement coping), according to Baron and Kenny (1986). A standard regression analysis was conducted and there was a statistically significant, positive correlation between total violence experienced and disengagement coping, $B = .524$, $p < .001$ (identified as Path a in Figure 1).

Step three: The potential mediating variable (disengagement coping) must be significantly related to the outcome variable (posttraumatic stress symptoms) and the relationship between the predictor variable (total violence experienced) and the outcome variable (trauma symptoms) must significantly drop or become insignificant in the final step to suggest mediation. A hierarchical regression analysis was performed, with trauma symptoms regressed on total violence experienced and disengagement coping, while controlling for time since relationship and childhood physical abuse. There was a statistically significant positive relationship between disengagement coping and trauma symptoms, $B = .452$, $p < .003$ (identified as Path b in Figure 1) and the relationship between total violence experienced and trauma symptoms was no longer significant when avoidant coping was added to the equation, $B = .301$, $p < .133$ (identified as Path c' in Figure 1).

Because these results suggested a partial mediation, Sobel's *z* test was used to test for indirect effects or, more specifically, to examine if the regression coefficient for the predictor variable (violence experienced) in Step three was smaller than the regression coefficient for the predictor variable in Step one, and it was ($z = 2.36$, $p < 0.05$). The Sobel *z* test indicated a significant reduction in the regression coefficient between violence experienced and posttraumatic stress symptoms from Step One to Step Three, supporting the hypothesis that disengagement coping mediates the relationship between violence experienced and trauma symptoms.

Intimate Partner Violence, Negative Religious Coping, and Trauma Symptoms. Step one: A hierarchical regression analysis was conducted to identify a relationship between violence experienced and trauma symptoms, while controlling for childhood physical abuse and time since relationship (see Table 14). There was a statistically significant relationship between these two variables, $B = .538$, $p < .001$.

Step two: A standard regression analysis was conducted to examine whether or not total violence experienced was significantly correlated with negative religious coping, and there was a statistically significant, positive correlation between these two variables, $B = .203$, $p < .001$.

Step three: A hierarchical regression analysis was performed, with trauma symptoms regressed on total violence experienced and negative religious coping, while controlling for time since relationship and childhood physical abuse. There was not a statistically significant positive relationship between negative religious coping and trauma symptoms, $B = .417$, *n.s.* Therefore, the researcher was unable to identify a mediating effect.

Intimate Partner Violence, Social Support, and Trauma Symptoms. Step One: A hierarchical regression analysis was conducted to identify a relationship between violence

experienced and trauma symptoms, while controlling for childhood physical abuse and time since relationship. There was a statistically significant relationship between these two variables, $B = .538$, $p < .001$.

Step Two: A standard regression analysis was performed to examine if total violence experienced predicted supportive family (as the only variable significantly associated with trauma symptoms and violence), and it did not. Therefore, a mediator could not be identified.

Mediators for Shame. Step One: A hierarchical regression analysis was performed to identify whether or not psychological violence (as the only violence variable that was found to be significantly related to shame in previous analyses) significantly predicted shame symptoms when controlling for childhood physical abuse, and it did not. Therefore, the researcher was unable to assess social support or coping styles as possible mediators between psychological violence and shame symptoms.

Religious Behavioral Indicators, Religious Coping, and Posttraumatic Growth. Step One: A hierarchical regression analysis was conducted to explore whether or not behavioral religious indicators was significantly related to posttraumatic growth, controlling for time since relationship and childhood sexual abuse, and no significant relationships were found. An analysis to assess for mediation could not be conducted as a result.

Exploratory Analyses

Trauma Symptoms, Including Shame as a Predictor. Hierarchical multiple regression was used to identify the relative contribution of disengagement coping, supportiveness of family, and shame to predict levels of trauma symptoms, after controlling for the influence of time since relationship, childhood physical abuse, and violence experienced. Only variables that were significantly related were included in these analyses (see Table 12). Preliminary analyses were

conducted to ensure no violations of normality, linearity, multicollinearity and homoscedasticity. In Step 1, time since relationship, childhood physical abuse, and total violence experienced were entered, which explained 26.2% of the variance in trauma symptoms. Disengagement coping, supportiveness of family, and shame were entered in Step 2, with the model as a whole explaining 50% of the variance in trauma symptoms, $F(6, 70) = 11.70$, $p < .001$. The predictor variables explained an additional 23.8% of the variance, after controlling for time since relationship and childhood physical abuse, $\Delta R^2 = .238$, F change $(3, 70) = 11.13$, $p < .001$. In the final model, time since relationship, total violence, and shame were the only statistically significant variables, with shame recording a higher beta value ($\beta = .460$, $p < .001$) than total violence ($\beta = .193$, $p < .05$) and time since relationship ($\beta = -.169$, $p < .058$). In contrast to the previous analysis, disengagement coping was no longer significant.

Chapter IV

Discussion

For over twenty years, intimate partner violence (IPV) has been considered a major public health concern, resulting in a variety of negative outcomes for women (Coker et al., 2002; Coker et al., 2003; Fals-Stewart & Leonard, 2005; Kaura & Lohman, 2007; Taylor, 2003). There is evidence to suggest that survivors of IPV are also able to grow in the aftermath of trauma, although most of the research focuses on the negative outcomes of IPV (Bosch & Schumm, 2004; Coker et al., 2002; Haden et al., 2006; Ellison & Anderson, 2001; Tedeschi & Calhoun, 2004). This study explored how social support and coping contributed to shame, trauma, and posttraumatic growth following IPV.

The hypothesis that the severity of IPV would be positively correlated with trauma symptoms was confirmed by the results in this study, supporting previous findings discussed in the literature (for a review, see Golding, 1999). In contrast to predictions, the severity of IPV was not correlated with shame symptoms, which conflicts with earlier studies (Andrews, Brewin, Rose, & Kirk, 2000; Taylor, 2003). There is the possibility that women in this sample placed increasing amounts of blame on their partners as the severity of violence increased (Waldrop & Resick, 2004). Consequently, women experiencing more frequent and severe violence may have been able to argue to themselves that the violence is not their fault, which would lower the amount of shame they experienced about their role in the violent relationship.

Upon closer scrutiny, it was found that there was a positive relationship between psychological violence and levels of shame, which is in keeping with the previously cited research. On the other hand, many survivors of IPV report that the psychological violence they experience is more damaging than the physical violence they experience (Arias & Pape, 1999).

This finding suggests that support resources should not minimize the consequence of psychological abuse.

As predicted, the severity of IPV was positively correlated with posttraumatic growth. These results are consistent with previous findings and suggest that survivors of IPV are able to grow from their experiences with violence (Cobb, Tedeschi, & Calhoun, 2006). Women in this sample on average reported lower levels of posttraumatic growth than women seeking refuge from IPV at a shelter (e.g., see Cobb et al., 2006), but slightly higher than that reported by survivors of violent crime (Peltzer, 2000). Tedeschi and Calhoun (2006) propose that the process of struggling with trauma facilitates growth, and that greater amounts of adversity should result in greater amounts of growth. Comparatively, women in this sample experienced moderate levels of violence, which would result in moderate levels of growth according to Tedeschi and Calhoun's theory.

Time since relationship was a significant predictor of posttraumatic growth, with greater time since relationship positively correlated with higher levels of posttraumatic growth. These findings are in keeping with Tedeschi and Calhoun's theory that growth occurs after the resolution of the traumatic incident; however, these results must be interpreted with caution, as women leave and return to their violent relationships numerous times (Tan, Basta, Sullivan, & Davidson, 1995) and thus may not be completely free from the threat of violence (Cobb et al., 2006). Ultimately, though, the findings suggest that similar to individuals struggling with a variety of other major crises, survivors of IPV are capable of experiencing posttraumatic growth.

This study sought to assess the relationship between the severity of violence and total social support. It was hypothesized that the severity of IPV would be negatively associated with supportive interactions with resources. This hypothesis was not supported, which is inconsistent

with previous research that has found a negative relationship between the severity of violence and supportive interactions with resources (Thompson et al., 2000). One possible explanation for the discrepancy in this study's findings and previous research is that the women in this study experienced moderate levels of violence, with over 64.6% of women reporting that they were in a dating relationship when they experienced the violence. Thus, it may be inferred that violence experienced in dating relationships may be perceived as less severe and may not impact support networks in the same manner as more severe and chronic violence. The proportion of women seeking support from the various resources is generally less in this study than in other studies (Fiore, & Legerski, 2006) and this may also reflect less chronicity or less perceived need for support. Alternatively, it could represent greater shame and felt need to keep the violence from others.

Additional analyses revealed that there was a positive relationship between subcategories of violence and subcategories of social support instead of a negative relationship. In other words, greater levels of certain types of violence, such as sexual assault, was related to more supportive interactions with certain types of social support, such as crisis hotlines. One explanation could be that women experiencing sexual assault are more likely to call a crisis hotline and, subsequently, experience a supportive interaction. Another notable finding is that a majority of women (at least 87.3%) in this sample accessed some form of support, with the most accessed resources including friends, family, counselors, law enforcement, and religious resources. Furthermore, the majority of women found these resources to be at least somewhat supportive. These findings are hopeful and possibly indicate that the social attitude about IPV is changing and support resources are providing more helpful assistance to young women experiencing violence.

In addition to assessing the relationship between social support and mental health outcomes, a goal of this research was to assess the relationship between the severity of violence and coping styles. The results in this study confirmed the hypothesis that the severity of IPV would be positively associated with disengagement coping and negative religious coping styles. These findings suggest that women experiencing greater levels of IPV are using more disengagement coping and negative religious coping styles. At higher levels of violence, victims of IPV appear to be isolating from friends, avoiding problems and distressing memories of the violence, and criticizing themselves (Tobin et al., 1989). A possible explanation for this finding may be that abused women are more likely to use disengagement coping strategies because their partner reacted negatively to more engagement coping strategies (Waldrop and Resick, 2004). For example, women may have experienced more violence if they reached out to their friends and family for help, which may have in turn incited jealousy in their partners who then may have reacted with violence. Another explanation is that at higher levels of violence, disengagement coping is what serves women better emotionally given the danger and difficulty achieving safety, just as psychological numbing may be evident in posttraumatic stress disorder.

Religious coping assists individuals in gaining a sense of meaning and purpose in the aftermath of trauma (Pargament, 1998) Furthermore, religious coping can assist people in experiencing comfort, safety, and personal control in stressful times. At higher levels of violence, survivors of IPV appear to be exhibiting spiritual discontent and the belief that God is punishing them. Furthermore, these women are endorsing that they are feeling dissatisfied with religious support systems in reaction to the severity of violence. There is the possibility that when more engagement and positive religious coping strategies did not result in desired outcomes to stop the violence, women engaged in more avoidant and/or negative religious

coping strategies. Walker (1979) explains this finding by suggesting that women experience learned helplessness when their more active (or engagement) coping strategies do not result in desired outcomes (as cited in Waldrop & Resick).

The research indicates that experiences prior to violent relationships also may influence coping styles. For example, in one study, women exposed to violence during childhood and who held more traditional views of gender roles were more likely to engage in avoidant (or disengagement) coping strategies as the chronicity of violence increased (for a review, see Waldrop & Resick). This same finding may influence women in this sample, as nearly 34% of women experienced childhood physical abuse and 23% of women experienced childhood sexual abuse. Thus, in addition to assisting women with their current experience of violence, intervention may need to also target past experience of abuse.

Results in this study indicated that disengagement coping and engagement coping were the most significant predictors of shame, explaining close to 30% of the variance in shame scores above and beyond violence history. When considered together, negative religious coping was no longer significant in relation to these other variables. The result of this analysis indicates that general coping styles explain more variance in shame symptoms, which is inconsistent with previous research that has found religious and non-religious coping styles and social support to all be significant predictors of shame symptoms (Bradley et al., 2005; Frazier et al., 2001). This study also found that disengagement coping was the most potent predictor of trauma scores, explaining nearly 10% of trauma scores above and beyond violence history. These results confirmed the hypothesis that disengagement coping would significantly predict higher trauma symptoms.

In accord with other research (Gill, 2005; Haden et al., 2006), findings in this study suggest that disengagement coping predicts shame and trauma symptoms. Thus, it is possible to infer that coping strategies that disengage survivors from their environment, problems, and others influences higher trauma and shame. On the other hand, one could argue that IPV victim's cognitive and interpersonal resources are overwhelmed by their shame or trauma symptoms, which in turn impair their ability to engage in active efforts to manage both problem- and emotion-focused aspects of their stressful situations. Interestingly, negative religious coping was no longer a significant predictor in relation to disengagement coping, in spite of the fact that this coping style was a significant correlate of shame. Possibly, disengagement coping is related to negative religious coping, which better explains the development of shame symptoms.

Engagement coping significantly predicted lower levels of shame. These results can be interpreted to mean that individuals who reach out to social support, problem solve, and express their emotions experience lower levels of shame. This may suggest an inherent coping style that existed prior to the violent relationship, which results in a more positive outcome. However, it is also possible that their partners at lower levels of violence do not prevent IPV victims from using engagement coping strategies. Indeed, it was found that minor violence was positively associated with engagement coping strategies, which seems to support this interpretation.

Regarding trauma symptoms in particular, an exploratory analysis revealed that when total shame was added in the hierarchical regression, disengagement coping was no longer a significant predictor of trauma symptoms. Shame scores were the most potent predictor of trauma, explaining 24% of the variance in trauma symptoms, with the model as a whole explaining 50% of the variance. These results are consistent with previous research (Andrews, Brewin, Rose, and Kirk, 2000), and this finding suggests that higher levels of shame are

associated with higher levels of disengagement coping, which in turn are associated with higher levels of trauma symptoms. Thus, it may be that shame is mediating the relationship between disengagement coping and trauma symptoms. Given the strength of this variable, it would be integral that interventions consider the powerful role of shame in both coping styles and ultimately the presence of trauma symptoms.

As explained earlier, violent partners may prevent women from using more engagement coping strategies, influencing the use of disengagement coping. Unfortunately, this coping style is characterized by strategies that isolate the victim from social support, inhibits problem solving, and fosters self-criticism. Survivors of IPV immobilized by this coping style appear to exhibit greater self-blame, which in turn influences higher trauma symptoms. Research indicates that IPV survivors attribute their shame to the following factors: their own abusive behaviors, self-disclosure of the violence they experienced, inability to maintain the relationship, inability to measure up to others' expectations, self-betrayal, and instigation of violence (Doane, 2007). These feelings of self-blame contribute to trauma symptoms, which more than likely influence more disengagement coping and feelings of shame, perpetuating a cyclical loop between violence, disengagement coping, shame, and trauma symptoms. To better understand the complexity of this relationship, a path analysis with a larger sample of women might further delineate the complexity of these variables.

Results in this study suggest that certain strategies, such as disengagement coping, place people at greater risk for developing shame and trauma symptoms. Thus, therapists should target these coping styles when working with survivors of IPV, which may assist in the reduction of shame and trauma symptoms. Furthermore, women may need to process their experience of

shame and supportive resources may need to gently point out that the perpetrator of violence is ultimately responsible for his/her own actions.

The hypothesis that supportive social support, positive religious coping, and engagement coping would significantly predict posttraumatic growth was partially confirmed by the results of an additional hierarchical regression analysis. Supportive interactions with religious resources and engagement coping significantly predicted posttraumatic growth in the second step, explaining 16% of the variance in growth scores above and beyond abuse history and time since relationship. These results suggest that supportive interactions with religious resources and engagement coping assist women in coping with violence and assist in promoting growth in the aftermath of their relationships, with supportive interactions with religious resources as the most potent predictor. Perhaps, IPV survivors were able to find meaning in their violent relationship, gain more meaningful relationships with others, and foster their spiritual development when they reached out to religious resources and were given supportive assistance.

Surprisingly, religious coping was no longer significant in the second step of this analysis, which contradicts previous findings that religious coping is a significant predictor, sometimes above and beyond other predictors, of posttraumatic growth (Frazier et al., 2001; Park, 2006). These results suggest that religious coping is conceptually distinct from receiving supportive assistance from religious resources. Although accessing religious resources may be a characteristic of religious coping strategies, the opposite may not be true; i.e., an aspect of religious coping is seeking social support from religious resources, but one may access religious resources without fully using religious coping styles. Ultimately, these findings are difficult to interpret given the difference in these findings compared to results reported in previous studies.

The findings regarding the role of coping in posttraumatic growth are contradictory (Wild & Paivio, 2003). Some research has found that approach coping (engagement coping) alone is a significant predictor of posttraumatic growth, whereas other research has identified that avoidance coping (disengagement coping) is positively correlated with posttraumatic growth. The findings in this study suggest that engagement coping alone was positively associated with posttraumatic growth, implying that individuals who use higher levels of engagement coping experience greater amounts of growth in the aftermath of violent relationships. These results indicate that reaching out to others, expressing their emotions, and using active problem-solving strategies facilitate the growth process following IPV relationships. Women who use engagement coping strategies are able to reflect back on the violent relationship with the understanding that they may have learned something. Furthermore, they report an increased appreciation in life and in their own strengths. Intervention should focus on affirming IPV victim's efforts to actively manage their stressful environment and statements of benefit found in the violent relationship to promote growth.

Research repeatedly demonstrates that unsupportive interactions with resources are linked to negative mental health outcomes (Doane, 2007, Ullman & Filipas, 2001, Zoellner et al., 1999). Thompson et al. (2000) suggested that researchers should assess for the mediating effects of *received* support in the relationship between IPV and trauma symptoms. Consequently, it was hypothesized in this study that unsupportive interactions with resources would mediate the relationship between severity of IPV and trauma symptoms and IPV and shame. Although there was a statistically significant relationship between IPV and trauma symptoms, a significant relationship was not found between IPV and unsupportive interactions with family members (as the only variable significantly associated with trauma symptoms and violence), violating one of

three conditions that must be met in order to identify a mediating effect. These results conflict with Thompson et al.'s study, which found that *perceived* unsupportive social assistance mediated the relationship between abuse and distress. Thus, it is possible that perceived and received social support are distinct constructs that influence different outcomes.

Findings in this study suggest that disengagement coping partially mediates the relationship between IPV and trauma symptoms. These results suggest that there are mechanisms specific to both disengagement coping and violence that influence the development of trauma symptoms. Thus, both the trauma of IPV relationships and disengagement coping style explain the negative outcome of trauma symptoms. These findings indicate that moderate levels of violence influence negative mental health outcomes in college-aged survivors of IPV. Although some may consider dating violence a less severe form of family violence, these results indicate that there is a psychological cost to women who experience dating violence. Violence alone did not entirely explain the presence of trauma symptoms, though. Disengagement coping in response to violence may indeed explain more in the development of trauma. Survivors of IPV, who disengage themselves from the problem, environment, and relationships, whether this style is an inherent personality characteristic or a learned response to an abusive relationship, are at greater risk for the development of trauma symptoms. This suggests that there may be ways to address coping style as an intervention that could ease the development of trauma symptoms.

In contrast to predictions, negative religious coping did not mediate the relationship between IPV and trauma symptoms, in spite of significant relationships between all three variables. When religious coping was entered with IPV in the final regression, the relationship between IPV and trauma did not significantly reduce or become insignificant. These results contradict Bradley et al.'s (2005) findings that religious coping partially mediated the

relationship between IPV and PTSD. However, the results did suggest that violence independently affects religious coping style and that religious coping style independently impacts the development of trauma. Violence may overwhelm women's resources and change their worldview about self, others, and even God. Unfortunately, this changed worldview impacts the development of PTSD. This finding suggests that intervention should also target the changes in women's perceptions about others and the world. At the minimum, survivors should be supported through this process.

Finally, it was hypothesized that positive and/or negative religious coping would mediate the relationship between behavioral indicators of religious coping and posttraumatic growth; however, we found that both behavioral indicators of religious coping and positive/negative religious coping were not correlated to posttraumatic growth, nor did they significantly predict total growth scores. These results suggest that religious coping was not needed to promote growth in the aftermath of trauma for women in this study. However, only thirty-six women (45.5%) endorsed that they prayed and attended religious services (behavioral indicators of religious coping), and it may be that this sample size was not large enough to identify a significant relationship.

One of the most notable findings in this study was the lack of relationships between total social support and trauma, shame, and posttraumatic growth. Because research repeatedly demonstrates that supportive interactions with resources are correlated with positive outcomes and unsupportive interactions with resources are correlated with negative mental health outcomes, these findings are especially surprising and difficult to interpret. A possible explanation for these findings is that unsupportive interactions are not occurring as often or carry the same weight with women who experience moderate levels of dating violence during their

adolescent years. Perhaps, their family environments (as some of them may have been living with their families of origin during the relationship) were supportive enough or their interactions with their family members carried more weight than other relationships. Indeed, analyses of subcategories of support systems found that unsupportive interactions with family members was the *only* resource related to higher trauma symptoms, indicating at least the following. First, survivors were highly likely to turn to family members for support during or after the violent relationship. Second, when supportive family members did not respond in a way that met victims' needs or assumptions, they experienced higher trauma symptoms.

Limitations

There are several methodological limitations to this study. Interpretations about the development of trauma, shame, or growth are limited because this study was not longitudinal. The accuracy of the direction of the paths specified in the mediation model is difficult to determine, as the data in this study are cross-sectional. For example, it is possible that posttraumatic stress symptoms mediate the relationship between IPV and disengagement coping. Also, statements about causation cannot be made. Additionally, this project was primarily retrospective in nature, which is influenced by selective memory. As a result, some participants may have been unable to accurately recall the violence they experienced or how they responded to their violent relationships. There is a possibility that their partners may not corroborate participants' responses about the presence and/or degree of violence due to low reliability of self-report measures. Finally, the sample consists primarily of college women who experienced violence in dating relationships, which may lead to sample-specific interpretations of the data. Future research should attempt to replicate the findings in this study using longitudinal data, which would offer more predictive power.

Conclusion

As is evidenced in the literature review, general and religious coping and social support can serve as either a growth-promoting factor or as a risk factor in the lives of trauma survivors. Most of the research examining IPV has focused on the negative physical and mental health impact of partner violence for women (Coker et al., 2003). Waldrop and Resick (2004) argue that there is little empirical evidence that examines the link between coping styles and negative mental health outcomes in women who have experienced IPV. Additionally, much of the research is limited to the negative impact of violence. Consequently, this proposal sought to understand the unique role of social support and coping in the development of shame, posttraumatic stress symptoms, and posttraumatic growth in survivors of partner violence.

The findings in this research project support the argument that disengagement coping indeed impacts negative mental health outcomes and engagement coping appears to promote growth in the aftermath of IPV. Those who assist survivors of IPV may need to target disengagement coping and affirm engagement coping to prevent shame symptoms and promote growth, respectively. Ultimately, the findings in this study also suggest that time away from the violent relationship is healing, lowering trauma symptoms and promoting growth. Future research should focus on studying interventions that target certain coping styles following violent relationships.

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Table 1

Means, Standard Deviations, and Ranges for Variables Used in Analysis

Variable	N	Mean	Standard Deviation	Range	Minimum	Maximum
CTS2-Partner						
Minor Violence Mean Score	79	10.56	2.66	13	1	14
Severe Violence Mean Score	79	14.81	7.68	32	0	32
Total Violence Mean Score	79	25.37	9.58	41	5	46
TSC-40						
Total Trauma Mean Score	78	44.31	18.09	92	7	99
ISS						
Total Shame Mean Score	78	48.92	21.90	84	10	94
PTGI						
Total Posttraumatic Growth Mean Score	79	59.20	24.12	94	5	95
CSI						
Disengagement Coping Mean Score	79	54.11	13.16	56	23	79
Engagement Coping Mean Score	79	46.71	10.24	46	22	68
Brief RCOPE						
Negative Religious Coping Mean Score	77	11.12	4.64	19	7	26
Positive Religious Coping Mean Score	78	14.05	6.76	21	7	28

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

Table 2

Correlations between Demographic Variables and Outcome Variables, Including Trauma Symptoms, Shame, and Posttraumatic Growth ([a] N = 71-79)

	Trauma, Shame, and Growth Measures		
Variable	TSC-40	ISS	PTGI
Time Since Relationship	-.249*	-.170	.225*
Age	-.124	-.131	.214
Victim's Education	-.008	-.016	-.066
Partner's Education	-.045	-.027	-.091
Victim's Income	.015	-.034	.070
Family's Income	-.045	.108	-.153
Childhood Sexual Abuse	.173	.023	.261*
Childhood Physical Abuse	.377**	.325**	.146
Religious	-.144	-.155	.057
Spiritual	.050	.053	.024

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

[a]Cases excluded pairwise

Table 3

Intercorrelations for Total Scores on Trauma, Shame, and Posttraumatic Growth Measures ([a]N =77-79)

Variables	*N*	TSC-40	ISS	PTGI
1. TSC-40	78	—		—
2. ISS	77	.619**	—	—
3. PTGI	78	.009	-.214	—

***p* < .01

[a]Cases excluded pairwise

Table 4

Correlations between Violence Experienced and Outcome Variables, Including Trauma Symptoms, Shame, and Posttraumatic Growth ([a]N = 77-79)

	Trauma, Shame, and Growth Measures		
Variables	TSC-40	ISS	Posttraumatic Growth
Mild Violence	.244*	.069	.338**
Severe Violence	.265*	.122	.328**
Total Violence	.281*	.117	.357**
Subcategories:			
Physical Violence	.183	.084	.214
Psychological Violence	.339**	.236*	.218
Sexual Violence	.106	.034	.334**
Injury from Violence	.197	-.043	.223*

*$p < .05$, ** $p < .01$
[a]Cases excluded pairwise

Table 5

Correlations between Coping Styles and Outcome Variables, Including Trauma Symptoms, Shame, and Posttraumatic Growth ([a] N = 78-79)

	Trauma, Shame, and Growth Measures		
Variables	TSC-40	ISS	PTGI
Disengagement Coping	.462**	.523**	.065
Engagement Coping	-.052	-.276*	.268*
Negative Religious Coping	.185	.234*	.178
Positive Religious Coping	-.002	-.042	.218
Religious Behavioral Indicators	-.133	.093	.004

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

[a]Cases excluded pairwise

Table 6

Correlations between Support Received and Outcome Variables, Including Trauma Symptoms, Shame, and Posttraumatic Growth ([a] N = 78-79)

	Trauma, Shame, and Growth Measures		
Variables	TSC-40	ISS	Growth
Perceived Supportiveness of:			
Friends	-.164	-.221	.151
Family	-.279*	-.195	.101
Legal Resources	.089	-.027	.104
Law Enforcement	.077	.022	.042
Counselor	-.038	.032	.042
Shelter	.209	.062	.132
Support Groups	.157	.065	.063
Religious Resources	-.074	-.180	.338**
Financial Assistance	.055	-.196	.146
Medical Assistance	-.005	.026	.034
Vocational Assistance	.019	-.155	.075
Crisis Hotline	.077	-.043	.167
Neighbors	.079	-.014	.258*
Total Social Support (Sum)	-037	-.145	.245*

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

[a]Cases excluded pairwise

Table 7

Correlations between Violence Experienced and Coping Styles ([a] N =77-79)

	Coping Measures			
Variables	Disengagement	Engagement	Negative Religious	Positive Religious
Minor Violence	.218	.308**	.229*	.089
Severe Violence	.400**	.133	.442**	.174
Total Violence	.381**	.193	.418**	.164
Subcategories:				
Physical Violence	.267*	.170	.331**	.245*
Psychological Violence	.258*	.150	.217	.161
Sexual Violence	.291**	.043	.303**	-.039
Injury from Violence	.245*	.216	.326**	.099

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

[a]Cases excluded pairwise

Table 8

Correlations between Support Received and Violence Experienced (N = 79)

	Violence Experienced						
Variable	Total Violence	Mild Violence	Severe Violence	Physical Violence	Psych. Violence	Sexual Violence	Injury from Viol.
Perceived Supportiveness of:							
Friends	-.007	.135	-.056	-.035	.019	-.035	.076
Family	-.141	.021	-.183	-.072	-.092	-.153	-.065
Legal Resources	.045	.038	.043	.013	.221	-.054	-.029
Law Enforcement	.066	.058	.062	.045	.204	-.101	.106
Counselor	.100	.077	.098	-.043	.100	.227*	-.028
Shelter	.166	.159	.152	.058	-.032	.170	.335**
Support Groups	.258*	.178	.260*	.153	.014	.247*	.345**
Religious Resources	.196	.054	.225*	.203	.193	.052	.091
Financial Assistance	-.097	-.101	-.085	-.095	.045	-.071	-.160
Medical Assistance	.140	.075	.149	.125	.042	.081	.156
Vocational Assistance	.102	.019	.120	.083	-.082	.191	.038
Crisis Hotline	.146	-.100	.217	-.071	-.064	.449*	.044
Neighbors	.326**	.226*	.328**	.343**	.211	.168	.144
Total Social Support (Sum)	.153	.118	.150	-	-	-	-

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

Table 9

Summary of Hierarchical Regression Analysis for Variables Predicting Trauma Symptoms, Controlling for Time Since Relationship, Childhood Physical Abuse, and Total Violence Experienced (N = 77)

Variable	*B*	*SE B*	β	ΔR^2
Step 1				.262***
Time Since Relationship	-2.982	1.206	-.254*	
Childhood Physical Abuse	11.985	3.869	.316**	
Total Violence Experienced	.538	.194	.285**	
Step 2				.098**
Time Since Relationship	-2.482	1.148	-.211*	
Childhood Physical Abuse	9.455	3.745	-.249*	
Number of Other Violent Relationships	.291	.198	.154	
Total Violence Experienced	.419	.148	.305**	
Disengagement Coping	-.992	.919	-.108	
Supportive Family				

*$p < .05$, **$p < .01$, ***$p < .001$

Table 10

Summary of Hierarchical Regression Analysis for Variables Predicting Shame, Controlling for Childhood Physical Abuse and Psychological Violence (N = 77)

Variable	*B*	*SE B*	β	ΔR^2
Step 1				.144**
Childhood Physical Abuse	13.747	5.011	.300**	
Psychological Violence	1.460	.807	.198	
Step 2				.286***
Childhood Physical Abuse	10.185	4.253	.222*	
Psychological Violence	.861	.709	.117	
Disengagement Coping	.644	.162	.387***	
Engagement Coping	-.671	.202	-.314***	
Negative Religious Coping	.830	.455	.176	

*p < .05, **p < .01, ***p < .001

Table 11

Summary of Hierarchical Regression Analysis for Variables Predicting Posttraumatic Growth, Controlling for Time Since Relationship and Childhood Sexual Abuse (N = 77)

Variable	*B*	*SE B*	β	ΔR^2
Step 1				.189***
Time Since Relationship	2.336	1.687	.149	
Childhood Sexual Abuse	10.213	6.041	.183	
Total Violence Experienced	.762	.272	.303**	
Step 2				.155**
Time Since Relationship	2.654	1.554	.169	
Childhood Sexual Abuse	11.667	5.676	.209*	
Total Violence Experienced	.413	.270	.164	
Engagement Coping	.638	.235	.271**	
Supportive Neighbor	1.003	1.992	.054	
Supportive Church	4.617	1.499	.315**	

*$p < .05$, **$p < .01$, ***$p < .001$

Table 12

Summary of Hierarchical Regression Analysis for Variables Predicting Trauma Symptoms, Controlling for Time Since Relationship, Childhood Physical Abuse, and Total Violence (N = 77)

Variable	*B*	*SE B*	β	ΔR^2
Step 1				.262***
Time Since Relationship	-2.982	1.206	-.254	
Childhood Physical Abuse	11.985	3.869	.316	
Total Violence Experienced	.538	.194	.285	
Step 2				
Time Since Relationship	-1.983	1.028	-.169	.238***
Childhood Physical Abuse	5.717	3.439	.151	
Total Violence Experienced	.365	.177	.193*	
Disengagement Coping	.104	.150	.076	
Supportive Family	-.902	.818	-.098	
Total Shame	.380	.086	.460***	

*$p < .05$, ***$p < .001$

Table 13

Testing the Mediator Effects of Disengagement Coping Using Multiple Regression, Controlling for Time Since Relationship and Childhood Physical Abuse (N = 79)

Testing steps in mediation model	*B*	*SE B*	*β*
Testing Step 1 (Path c)			
Controlling for: Time Since Relationship and CPA			
Outcome: Trauma Symptoms			
Predictor: Total Violence Experienced	.538	.194	.285**
Testing Step 2 (Path a)			
Outcome: Disengagement Coping			
Predictor: Total Violence Experienced	.524	.145	.381***
Testing step 3 (Path b and c)			
Controlling for: Time Since Relationship and CPA			
Outcome: Trauma Symptoms			
Mediator: Disengagement Coping	.452	.145	.329**
Predictor: Total Violence Experienced	.301	.198	.159

** $p < .01$, *** $p < .001$

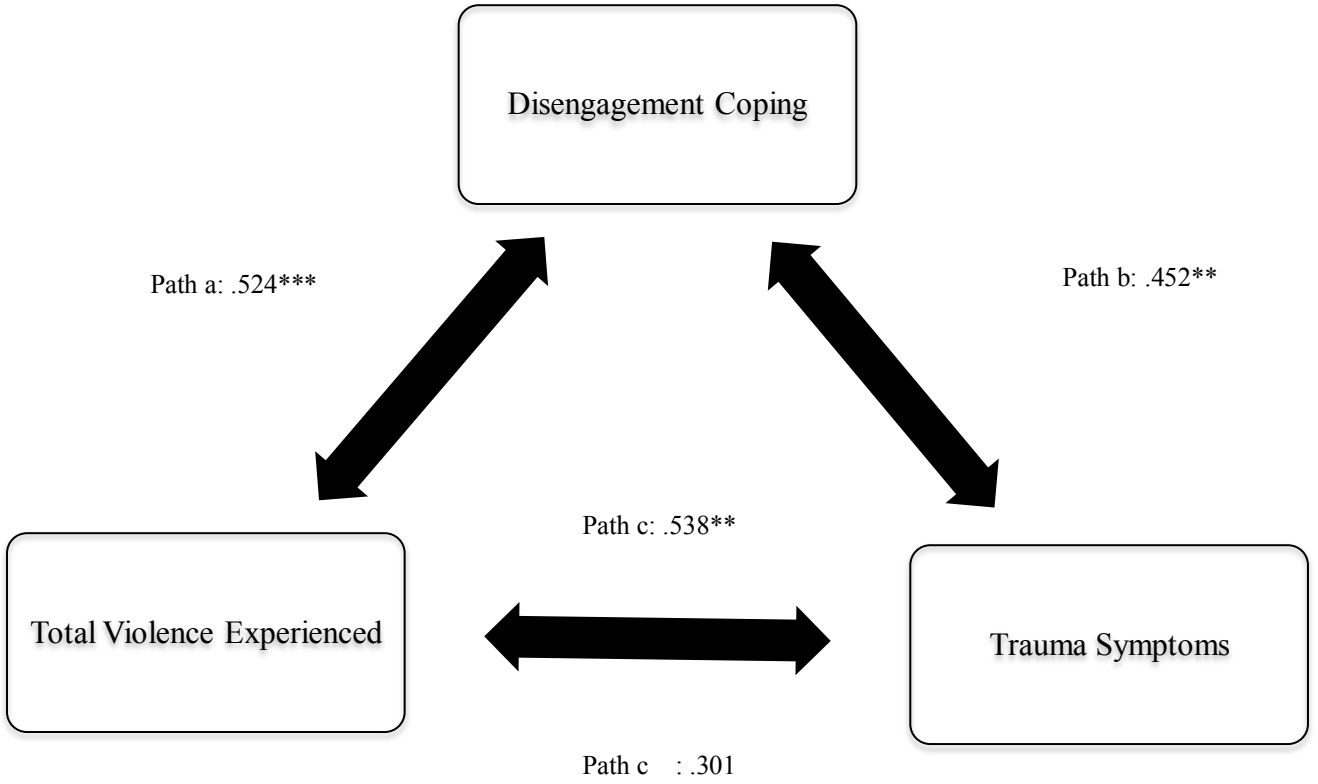
Table 14

Testing the Mediator Effects of Negative Religious Coping Using Multiple Regression, Controlling for Time Since Relationship and Childhood Physical Abuse (N = 77)

Testing steps in mediation model	*B*	*SE B*	β
Testing Step 1 (Path c)			
Controlling for: Time Since Relationship and CPA			
Outcome: Trauma Symptoms			
Predictor: Total Violence Experienced	.538	.194	.285**
Testing Step 2 (Path a)			
Outcome: Negative Religious Coping			
Predictor: Total Violence Experienced	.203	.051	.418***
Testing step 3 (Path b and c)			
Controlling for: Time Since Relationship and CPA			
Outcome: Trauma Symptoms			
Mediator: Negative Religious Coping	.417	.490	.107
Predictor: Total Violence Experienced	.482	.237	.255*

*$p < .05$, ** $p < .01$, ***$p < .001$

Figure 1



**$p < .01$, ***$p < .001$

Appendix A

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. 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. When the violence occurred, how did you respond? (please check all that apply)
_____ with fear
_____ with laughter
_____ with humiliation
_____ with anger
_____ other

If you checked other, please explain how you responded_____

b. 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/she was employed, what was the occupation of your partner while you were together? _____
What is his/her 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?___/__ ___/__ __/__ ___/___ __/__ ___/__

13. What was your own annual income before taxes during 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?
_____

14. What was your annual family income before taxes during 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

15. Who was the primary breadwinner during the violent relationship? (Check one)
_____ You _____ Your violent partner _____ Other

16. Your race? (Check one)
_____ White _____ African-American
_____ Hispanic _____ Asian
_____ American Indian _____ Other (If more than one, please list)

_____

17. 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)

_____

18. Have you experienced childhood sexual abuse? _____ Yes _____ No

19. Have you experienced childhood physical abuse? _____ Yes _____ No

20. Do you attend a religious organization? _____ Yes _____ No (If no, please proceed to question 21)

a. If so, what religious organization do you attend?_____

b. How often do you attend religious services or events? (please check one)
____ 1 time per week
____ 2 times per week
____ 3 times per week
____ 4 times per week
____ 1 time per month
____ Only on special occasions or on a holiday
____ If other, please explain_____

c. How often do you pray? (please check one)
____ 1 time per day
____ 2 or more times per day
____ 1 time per week
____ 2 or more times per week
____ Only when I attend religious services

d. Do you pay tithes or offer gifts to the religious institution? ____Yes _____No

e. Do you fast? If so, how often?_____

21. If you do not consider yourself religious, do you consider yourself spiritual? ____Yes ____ No

22. 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/	1	2	3	4	5

job-related help?						
Crisis helpline?	1	2	3	4	5	
Neighbor?	1	2	3	4	5	

b. How supportive 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/	1	2	3	4	5	N/A
job-related help?						
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 B

Relationship Behaviors

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things, and how many times your partner did them.

How often did this happen?

1 = Once in the past year
2 = Twice in the past year
3 = 3-5 times in the past year
4 = 6-10 times in the past year
5 = 11-20 times in the past year
6 = More than 20 times in the past year
0 = This has never happened

1. I showed my partner I cared even though we disagreed.	1 2 3 4 5 6 0
2. My partner showed care for me even though we disagreed.	1 2 3 4 5 6 0
3. I explained my side of a disagreement to my partner.	1 2 3 4 5 6 0
4. My partner explained his or her side of a disagreement to me.	1 2 3 4 5 6 0
5. I insulted or swore at my partner.	1 2 3 4 5 6 0
6. My partner did this to me.	1 2 3 4 5 6 0
7. I threw something at my partner that could hurt.	1 2 3 4 5 6 0
8. My partner did this to me.	1 2 3 4 5 6 0
9. I twisted my partner's arm or hair.	1 2 3 4 5 6 0
10. My partner did this to me.	1 2 3 4 5 6 0
11. I had a sprain, bruise, or small cut because of a fight with my partner.	1 2 3 4 5 6 0
12. My partner had a sprain, bruise, or small cut because of a fight with me.	1 2 3 4 5 6 0
13. I showed respect for my partner's feelings about an issue.	1 2 3 4 5 6 0
14. My partner showed respect for my feelings about an issue.	1 2 3 4 5 6 0
15. I made my partner have sex without a condom.	1 2 3 4 5 6 0
16. My partner did this to me.	1 2 3 4 5 6 0
17. I pushed or shoved my partner.	1 2 3 4 5 6 0
18. My partner did this to me.	1 2 3 4 5 6 0
19. I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex.	1 2 3 4 5 6 0
20. My partner did this to me.	1 2 3 4 5 6 0
21. I used a knife or gun on my partner.	1 2 3 4 5 6 0
22. My partner did this to me.	1 2 3 4 5 6 0
23. I passed out from being hit on the head by my partner in a fight.	1 2 3 4 5 6 0
24. My partner passed out from being hit on the head in a fight with me.	1 2 3 4 5 6 0
25. I called my partner fat or ugly.	1 2 3 4 5 6 0
26. My partner called me fat or ugly.	1 2 3 4 5 6 0
27. I punched or hit my partner with something that could hurt.	1 2 3 4 5 6 0

1 = Once in the past year
2 = Twice in the past year
3 = 3-5 times in the past year
4 = 6-10 times in the past year
5 = 11-20 times in the past year
6 = More than 20 times in the past year
0 = This has never happened

28. My partner did this to me.	1 2 3 4 5 6 0
29. I destroyed something belonging to my partner.	1 2 3 4 5 6 0
30. My partner did this to me.	1 2 3 4 5 6 0
31. I went to a doctor because of a fight with my partner.	1 2 3 4 5 6 0
32. My partner went to a doctor because of a fight with me.	1 2 3 4 5 6 0
33. I choked my partner.	1 2 3 4 5 6 0
34. My partner did this to me.	1 2 3 4 5 6 0
35. I shouted or yelled at my partner.	1 2 3 4 5 6 0
36. My partner did this to me.	1 2 3 4 5 6 0
37. I slammed my partner against a wall.	1 2 3 4 5 6 0
38. My partner did this to me.	1 2 3 4 5 6 0
39. I said I was sure we could work out a problem.	1 2 3 4 5 6 0
40. My partner was sure we could work it out.	1 2 3 4 5 6 0
41. I needed to see a doctor because of a fight with my partner, but I didn't.	1 2 3 4 5 6 0
42. My partner needed to see a doctor because of a fight with me, but didn't.	1 2 3 4 5 6 0
43. I beat up my partner.	1 2 3 4 5 6 0
44. My partner did this to me.	1 2 3 4 5 6 0
45. I grabbed my partner.	1 2 3 4 5 6 0
46. My partner did this to me.	1 2 3 4 5 6 0
47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	1 2 3 4 5 6 0
48. My partner did this to me.	1 2 3 4 5 6 0
49. I stomped out of the room or house or yard during a disagreement.	1 2 3 4 5 6 0
50. My partner did this to me.	1 2 3 4 5 6 0
51. I insisted on sex when my partner did not want to (but did not use physical force).	1 2 3 4 5 6 0
52. My partner did this to me.	1 2 3 4 5 6 0
53. I slapped my partner.	1 2 3 4 5 6 0
54. My partner did this to me.	1 2 3 4 5 6 0
55. I had a broken bone from a fight with my partner.	1 2 3 4 5 6 0
56. My partner had a broken bone from a fight with me.	1 2 3 4 5 6 0
57. I used threats to make my partner have oral or anal sex.	1 2 3 4 5 6 0
58. My partner did this to me.	1 2 3 4 5 6 0
59. I suggested a compromise to a disagreement.	1 2 3 4 5 6 0
60. My partner did this to me.	1 2 3 4 5 6 0
61. I burned or scalded my partner on purpose.	1 2 3 4 5 6 0
62. My partner did this to me.	1 2 3 4 5 6 0
63. I insisted my partner have oral or anal sex (but did not use physical force).	1 2 3 4 5 6 0

1 = Once in the past year
2 = Twice in the past year
3 = 3-5 times in the past year
4 = 6-10 times in the past year
5 = 11-20 times in the past year
6 = More than 20 times in the past year
0 = This has never happened

64. My partner did this to me.	1 2 3 4 5 6 0
65. I accused my partner of being a lousy lover.	1 2 3 4 5 6 0
66. My partner accused me of this.	1 2 3 4 5 6 0
67. I did something to spite my partner.	1 2 3 4 5 6 0
68. My partner did this to me.	1 2 3 4 5 6 0
69. I threatened to hit or throw something at my partner.	1 2 3 4 5 6 0
70. My partner did this to me.	1 2 3 4 5 6 0
71. I felt physical pain that still hurt the next day because of a fight with my partner.	1 2 3 4 5 6 0
72. My partner still felt physical pain the next day because of a fight we had.	1 2 3 4 5 6 0
73. I kicked my partner.	1 2 3 4 5 6 0
74. My partner did this to me.	1 2 3 4 5 6 0
75. I used threats to make my partner have sex.	1 2 3 4 5 6 0
76. My partner did this to me.	1 2 3 4 5 6 0
77. I agreed to try a solution to a disagreement my partner suggested.	1 2 3 4 5 6 0
78. My partner agreed to try a solution I suggested.	1 2 3 4 5 6 0

Thank you.

Appendix C

Internalized Shame Scale

Name:_____ Date:_____

Directions: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

SCALE

0	1	2	3	4
NEVER	SELDOM	SOMETIMES	OFTEN	ALMOST ALWAYS

SCALE

0 1 2 3 4 1. I feel like I am never quite good enough.

0 1 2 3 4 2. I feel somehow left out.

0 1 2 3 4 3. I think that people look down on me.

0 1 2 3 4 4. All in all, I am inclined to feel that I am a success.

0 1 2 3 4 5. I scold myself and put myself down.

0 1 2 3 4 6. I feel insecure about others opinions of me.

0 1 2 3 4 7. Compared to other people, I feel like I somehow never measure up.

0 1 2 3 4 8. I see myself as being very small and insignificant.

0 1 2 3 4 9. I feel I have much to be proud of.

0 1 2 3 4 10. I feel intensely inadequate and full of self doubt.

SCALE

0	1	2	3	4
NEVER	SELDOM	SOMETIMES	OFTEN	ALMOST ALWAYS

SCALE

0 1 2 3 4 11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.

0 1 2 3 4 12. When I compare myself to others I am just not as important.

0 1 2 3 4 13. I have an overpowering dread that my faults will be revealed in front of others.

0 1 2 3 4 14. I feel I have a number of good qualities.

0 1 2 3 4 15. I see myself striving for perfection only to continually fall short.

0 1 2 3 4 16. I think others are able to see my defects.

0 1 2 3 4 17. I could beat myself over the head with a club when I make a mistake.

0 1 2 3 4 18. On the whole, I am satisfied with myself.

0 1 2 3 4 19. I would like to shrink away when I make a mistake.

0 1 2 3 4 20. I replay painful events over and over in my mind until I am overwhelmed.

0 1 2 3 4 21. I feel I am a person of worth at least on an equal plane with others.

0 1 2 3 4 22. At times I feel like I will break into a thousand pieces.

0 1 2 3 4 23. I feel as if I have lost control over my body functions and my feelings.

0 1 2 3 4 24. Sometimes I feel no bigger than a pea.

0 1 2 3 4 25. At times I feel so exposed that I wish the earth would open up and swallow me.

0 1 2 3 4 26. I have this painful gap within me that I have not been able to fill.

0 1 2 3 4 27. I feel empty and unfulfilled.

0 1 2 3 4 28. I take a positive attitude toward myself.

SCALE

0	1	2	3	4
NEVER	SELDOM	SOMETIMES	OFTEN	ALMOST ALWAYS

SCALE

0 1 2 3 4 29. My loneliness is more like emptiness.

0 1 2 3 4 30. I feel like there is something missing.

Appendix D

Trauma Symptom Checklist (TSC – 40)

TSC-40

How often have you experienced each of the following in the last two months?

0 = Never 3 = Often

1. Headaches	0 1 2 3
2. Insomnia (trouble getting to sleep)	0 1 2 3
3. Weight loss (without dieting)	0 1 2 3
4. Stomach problems	0 1 2 3
5. Sexual problems	0 1 2 3
6. Feeling isolated from others	0 1 2 3
7. "Flashbacks" (sudden, vivid, distracting memories)	0 1 2 3
8. Restless sleep	0 1 2 3
9. Low sex drive	0 1 2 3
10. Anxiety attacks	0 1 2 3
11. Sexual overactivity	0 1 2 3
12. Loneliness	0 1 2 3
13. Nightmares	0 1 2 3
14. "Spacing out" (going away in your mind)	0 1 2 3
15. Sadness	0 1 2 3
16. Dizziness	0 1 2 3
17. Not feeling satisfied with your sex life	0 1 2 3
18. Trouble controlling your temper	0 1 2 3
19. Waking up early in the morning and can't get back to sleep	0 1 2 3
20. Uncontrollable crying	0 1 2 3
21. Fear of men	0 1 2 3
22. Not feeling rested in the morning	0 1 2 3
23. Having sex that you didn't enjoy	0 1 2 3
24. Trouble getting along with others	0 1 2 3

25. Memory problems	0 1 2 3
26. Desire to physically hurt yourself	0 1 2 3
27. Fear of women	0 1 2 3
28. Waking up in the middle of the night	0 1 2 3
29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3

Thank you.

Appendix E

Posttraumatic Growth Inventory

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the partner violence you experienced, using the following scale.

0= I did not experience this change as a result of my crisis.
1= I experienced this change to a very small degree as a result of my crisis.
2= I experienced this change to a small degree as a result of my crisis.
3= I experienced this change to a moderate degree as a result of my crisis.
4= I experienced this change to a great degree as a result of my crisis.
5= I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life.	0	1	2	3	4	5
2. I have a greater appreciation for the value of my own life.	0	1	2	3	4	5
3. I developed new interests.	0	1	2	3	4	5
4. I have a greater feeling of self-reliance.	0	1	2	3	4	5
5. I have a better understanding of spiritual matters.	0	1	2	3	4	5
6. I more clearly see that I can count on people in times of trouble.	0	1	2	3	4	5
7. I established a new path for my life.	0	1	2	3	4	5
8. I have a greater sense of closeness with others.	0	1	2	3	4	5
9. I am more willing to express my emotions.	0	1	2	3	4	5
10. I know better that I can handle difficulties.	0	1	2	3	4	5
11. I am able to do better things with my life.	0	1	2	3	4	5
12. I am better able to accept the way things work out.	0	1	2	3	4	5
13. I can better appreciate each day.	0	1	2	3	4	5
14. New opportunities are available which wouldn't have been otherwise.	0	1	2	3	4	5
15. I have more compassion for others.	0	1	2	3	4	5
16. I put more effort into my relationships.	0	1	2	3	4	5
17. I am more likely to try to change things which need changing.	0	1	2	3	4	5
18. I have a stronger religious faith.	0	1	2	3	4	5
19. I discovered that I'm stronger than I thought I was.	0	1	2	3	4	5
20. I learned a great deal about how wonderful people are.	0	1	2	3	4	5
21. I better accept needing others.	0	1	2	3	4	5

Thank you.

Note: Scale is scored by adding all responses. Factors are scored by adding responses to items on each factor. Items to which factors belong are not listed on form administered to participants.

Appendix F

Brief RCOPE

The following items deal with ways you coped with the negative event in your life. There are many ways to try to deal with problems. These items ask what you did to cope with this negative event. Obviously different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something about a particular way of coping. We want to know to what extent you did what the item says. *How much or how frequently.* Don't answer on the basis of what worked or not – just whether or not you did it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can. Circle the answer that best applies to you.

1 – not at all
2 – somewhat
3 – quite a bit
4 – a great deal

(+) l. Looked for a stronger connection with God.	1	2	3	4
(+) 2. Sought God's love and care.	1	2	3	4
(+) 3. Sought help from God in letting go of my anger.	1	2	3	4
(+) 4. Tried to put my plans into action together with God.	1	2	3	4
(+) 5. Tried to see how God might be trying to strengthen me in this situation.	1	2	3	4
(+) 6. Asked forgiveness for my sins.	1	2	3	4
(+) 7. Focused on religion to stop worrying about my problems.	1	2	3	4
(-) 8. Wondered whether God had abandoned me.	1	2	3	4
(-) 9. Felt punished by God for my lack of devotion.	1	2	3	4
(-) 10. Wondered what I did for God to punish me.	1	2	3	4
(-) 11. Questioned God's love for me.	1	2	3	4
(-) 12. Wondered whether my church had abandoned me.	1	2	3	4
(-) 13. Decided the devil made this happen.	1	2	3	4
(-) 14. Questioned the power of God.	1	2	3	4

(+) Positive religious coping item
(-) Negative religious coping item

Thank you.

Appendix G

Coping Strategies Index (CSI)
(Revised 1984)

Once again, take a few minutes to think about your chosen event. As you read through the following items please answer them based on how you handled your event.

Please read each item below and determine the extent to which you used it in handling your chosen event. Please do not mark on this inventory. Please use the provided answer sheet in the following manner.

a. Not at all
b. A Little
c. Somewhat
d. Much
e. Very much

1. I just concentrated on what I had to do next; the next step.
2. I tried to get a new angle on the situation.
3. I found ways to blow off steam.
4. I accepted sympathy and understanding from someone.
5. I slept more than usual.
6. I hoped the problem would take care of itself.
7. I told myself that if I wasn't so careless, things like this wouldn't happen.
8. I tried to keep my feelings to myself.
9. I changed something so that things would turn out all right.
10. I looked for the silver lining, so to speak; tried to look on the bright side of things.
11. I did some things to get it out of my system.
12. I found somebody who was a good listener.
13. I went along as if nothing were happening.
14. I hoped a miracle would happen.
15. I realized that I brought the problem on myself.
16. I spent more time alone.

17. I stood my ground and fought for what I wanted.

18. I told myself things that helped me feel better.

19. I let my emotions go. '

20. I talked to someone about how I was feeling.

21. I tried to forget the whole thing.

22. I wished that I never let myself get involved with that situation.

23. I blamed myself.

24. I avoided my family and friends.

25. I made a plan of action and followed it.

26. I looked at things in a different light and tried to make the best of what was available.

27. I let out my feelings to reduce the stress.

28. I just spent more time with people I liked.

29. I didn't let it get to me; 1 refused to think about it too much.

30. I wished that the situation would go away or somehow be over with.

31. I criticized myself for what happened.

32. I avoided being with people.

33. I tackled the problem head-on.

34. I asked myself what was really important, and discovered that things weren't so bad after all.

35. I let my feelings out somehow.

36. I talked to someone that I was very close to.

37. I decided that it was really someone else's problem and not mine.

38. I wished that the situation had never started.

39. Since what happened was my fault, I really chewed myself out. .

40. I didn't talk to other people about the problem.

41. I knew what had to be done, so I doubled my efforts and tried harder to make things work.

42. I convinced myself that things aren't quite as bad as they seem.

43. I let my emotions out.

44. I let my friends help out.

45. I avoided the person who was causing the trouble.

46. I had fantasies or wishes about how things might turn out.

47. I realized that I was personally responsible for my difficulties and really lectured myself.

48. I spent some time by myself.

49. It was a tricky problem, so 1 had to work around the edges to make things come out OK.

50. I stepped back from the situation and put things into perspective.

51. My feelings were overwhelming and they just exploded.

52. I asked a friend or relative I respect for advice.

53. I made light of the situation and refused to get too serious about it.

54. I hoped that if I waited long enough, things would turn out OK.

55. I kicked myself for letting this happen.

56. I kept my thoughts and feelings to myself.

57. I worked on solving the problems in the situation.

58. I reorganized the way I looked at the situation, so things didn't look so bad.

59. I got in touch with my feelings and just let them go.

60. I spent some time with my friends.

61. Every time I thought about it I got upset; so I just stopped thinking about it.

62. I wished I could have changed what happened.

63. 1t was my mistake and I needed to suffer the consequences.

64. I didn't let my family and friends know what was going on.

65. I struggled to resolve the problem.

66. I went over the problem again and again in my mind and finally saw things in a different light.

67. I was angry and really blew up.

68. I talked to someone who was in a similar situation.

69. I avoided thinking or doing anything about the situation.

70. I thought about fantastic or unreal things that made me feel better.

71. I told myself how stupid I was.

72. I did not let others know how I was feeling.

Thank you.

Appendix H

Bosch Support Measure

This measure assesses how often a resource provided you with the following supportive behaviors. Circle the number that best indicates your experience:

People often receive support from multiple resources. A separate measure has been included for a friend, clergy, law enforcement personnel, a therapist, a family member, and medical personnel. Please fill out a separate measure for each of the resources that assisted you when you disclosed your experience with partner violence.

1 = Never
2 = Sometimes
3 = About 1/2 of the time
4 = Often
5 = Always

During your abusive relationship, this person:

1. Gave you encouragement and would help you no matter what you you decided to do	1	2	3	4	5
2. Volunteered to help you with or without your request	1	2	3	4	5
3. Helped you know that there were safe places to go	1	2	3	4	5
4. Shared information with you about partner abuse	1	2	3	4	5
5. Referred you to someone who could help you (with partner abuse)	1	2	3	4	5
6. Gave you advice when you needed it or asked for it	1	2	3	4	5
7. Met with you more often when they found out about the abuse	1	2	3	4	5
8. Encouraged you to make decisions best for you (and your children)	1	2	3	4	5
9. Supported you in your choices of where to live (stay at home, leave home)	1	2	3	4	5
10. Supported you if you chose to continue your partner relationship with expectations partner would stop abusive behavior (returned to partner or if partner came back home)	1	2	3	4	5
11. Encouraged you to share your story and feelings with others	1	2	3	4	5

12. Listened to and responded to your comments, questions, and stories about the abuse	1	2	3	4	5
13. Let you know that the abuse was not acceptable to them	1	2	3	4	5
14. Told your partner to stop treating you like that	1	2	3	4	5
15. Recognized the abuse as abuse, including verbal and emotional abuse	1	2	3	4	5
16. Told you that you needed to be safe (and the children)	1	2	3	4	5
17. Encouraged you to be self-sufficient, to keep your job, to get an education or continue school	1	2	3	4	5
18. Encouraged you to access resources	1	2	3	4	5
19. Showed you they had time, were available or would help you if you needed help	1	2	3	4	5
20. Loved you and accepted you no matter what you did	1	2	3	4	5
21. Encouraged you to get professional help or counseling	1	2	3	4	5
22. Encouraged you to get medical assistance (doctor/clinic)	1	2	3	4	5
23. Encouraged a change in the relationship to end the abuse (leave him, make him leave, get separated/divorced, go to shelter, etc.)	1	2	3	4	5
24. Recognized that you felt burdened, frightened, embarrassed, and/or were grieving over a “lost love relationship.”	1	2	3	4	5
25. They knew you didn’t want to be abused.	1	2	3	4	5
26. Asked you if were safe, helped you feel safe at home, and would take you to a safe place if you needed to go	1	2	3	4	5
27. Helped you be self-sufficient (get a car, get a job, keep a job, get your education, etc.)	1	2	3	4	5
28. Helped with things like buying grocers, preparing meals, child care, home repairs	1	2	3	4	5
29. Helped you get resources available in the community	1	2	3	4	5
30. Would loan you money if you needed some	1	2	3	4	5

31. Helped you get professional help or counseling	1	2	3	4	5
32. Helped your partner get professional help or counseling	1	2	3	4	5
33. Helped you call police and/or a lawyer	1	2	3	4	5
34. Helped you get medical assistance (doctor/clinic)	1	2	3	4	5
35. Visited with you without your husband/partner present	1	2	3	4	5

This measure assesses how often a resource provided you with the following unsupportive behaviors. Circle the number that best indicates your experience:

People often receive support from multiple resources. A separate measure has been included for a friend, clergy, law enforcement personnel, a therapist, a family member, and medical personnel. Please fill out a separate measure for each of the resources that assisted you when you disclosed your experience with partner violence.

1 = Never
2 = Sometimes
3 = About 1/2 of the time
4 = Often
5 = Always

During your abusive relationship, this person:

1. Gave you discouraging advice or help and questioned your decisions	1	2	3	4	5
2. May not have helped you if you asked or needed help (not consistent or dependable)	1	2	3	4	5
3. Gave you help you didn't really want or need	1	2	3	4	5
4. Got frustrated or upset with you when you didn't take their advice or accept their help	1	2	3	4	5
5. Encouraged you to listen to your partner and cater (submit or give in) to your partner's wishes	1	2	3	4	5
6. Gave you their opinion or told you what to do but didn't ask you what you thought best for you (and your children)	1	2	3	4	5
7. Backed away from you or avoided you when they found out about the abuse	1	2	3	4	5
8. Thought you should be the one to change (not your abusive partner) that you could change enough to prevent or stop abuse (go to counseling, not get angry, pray)	1	2	3	4	5
9. Encouraged you to forgive your abusive partner for anything he did and not complain about his behavior	1	2	3	4	5
10. Tried to placate (appease) you and tell you it was going to get better	1	2	3	4	5
11. Ignored partner's abusive behavior	1	2	3	4	5

12. Really didn't want to know about the abuse (felt uncomfortable, frightened, etc.)	1	2	3	4	5
13. Didn't believe your story	1	2	3	4	5
14. Thought you probably couldn't find a better partner, even though your partner was abusive	1	2	3	4	5
15. Wanted you to handle your situation (the abuse) on your own	1	2	3	4	5
16. Thought your probably deserved to be abused (being a nag, expecting too much from your partner, etc.)	1	2	3	4	5
17. Thought you were overreacting or being too sensitive about your partner's abusive behavior	1	2	3	4	5
18. Felt that you should tolerate abuse from your partner in an effort to save your marriage/partner relationship and to prevent a breakup (especially with children involved)	1	2	3	4	5
19. Felt that you should get JOINT marriage counseling	1	2	3	4	5
20. Tried to excuse your partner's behavior because he/she was unemployed, had health problems, drank, had stress at work, etc.	1	2	3	4	5
21. Thought you should try to understand your partner better and be more patient with her/him	1	2	3	4	5
22. Treated you like a child who couldn't think for herself/himself or make it on her/his own	1	2	3	4	5
23. Thought you asked for the abuse (or caused it to happen). They blamed you for being abused	1	2	3	4	5
24. Encouraged you to stay in your abusive partner relationship (as is)	1	2	3	4	5
25. Talked to your partner when they wanted or needed something from your family (went over your head)	1	2	3	4	5
26. Helped you with food, clothing, or other material things but with strings attached, obligations, etc. (You felt you had to do certain things or act a certain way).	1	2	3	4	5
27. Stopped by to see you	1	2	3	4	5
28. Called to visit with you on the telephone (or email)	1	2	3	4	5

29. Asked if they could help you	1	2	3	4	5
30. Helped you with things like child care, yard work or a meal when you needed it, were sick or tired	1	2	3	4	5

Thank you.