Changes in Women's Mental and Physical Health After Ending Violent Relationships[1]

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[1] The larger study was funded by grant no. R49/CCR610508 from the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention and by grant no. 3691 from the Hogg Foundation for Mental Health, both awarded to the fourth author. This article was also made possible by grant no. 2001-WT-BX-0504 from the National Institute of Justice awarded to the third and fourth authors. These agencies are not responsible for the results.

Bio:

Jessica A. Sergio graduated cum laude from the University of North Texas with a Bachelor of Science degree in Psychology and a minor in Business Management. While at UNT, Sergio volunteered her time in one of the Psychology Department's research labs, Project HOW: Health Outcomes of Women, where she continues to explore her interests in domestic violence issues. She is a member of Psi Chi, the American Psychological Association, and the American Psychological Society. She presented her work "Changes in Women's Mental and Physical Health after Ending Violent Relationships" at the 2004 APS convention in Chicago. Sergio is currently a graduate student at the University of North Texas, pursuing a Ph.D. in Counseling Psychology, with a focus on Marriage and Family issues.

Abstract:

This study examines the negative relationship between partner violence and women's mental and physical health. Women who have sustained intimate partner violence have been found to disproportionately suffer from depression, thoughts of suicide, gastrointestinal complaints, and reproductive problems. Rates and consequences of physical violence are likely underreported. Despite the negative effects of being in a violent relationship, abused women often remain with their violent partner. The results of this study suggest that negative health consequences of sustaining violence persist, despite ending a violent relationship. Mental health appears to be worse for women exiting violent relationships, who sustained threats, acts of violence, and sexual aggression, significantly more often than women who remained in violent relationships or reported no violence at all.

Introduction

A great deal of research has examined the negative relationship between partner violence and women's mental (Bennice, Resick, Mechanic, & Astin, 2003; Carlson, McNutt, & Choi, 2003; Coker, Smith et al., 2002; Golding, 1999; Laffaye, Kennedy, & Stein, 2003) and physical health (Goodman, Koss, & Russo, 1993; Sutherland, Bybee, & Sullivan, 2002; Wingood, DiClemente, & Raj, 2000) health. In fact, partner violence is a leading cause of intentional injuries among women treated in emergency departments (Henning & Klesges, 2002). Moreover, it has been reported that a total of one third of women murdered each year in the United States are killed during domestic disputes (Laffaye et al., 2003; Murty et al., 2003).

Partner Violence and Mental Health Consequences

Research has consistently shown that women suffer severe and long-lasting emotional disorders because of sustained partner violence (Gelles & Harrop, 1989). Indeed, victims of intimate partner violence exhibit a variety of psychological symptoms that are similar to those of victims of other types of trauma, such as war and natural disasters (National Research Council, 1996). Women who have sustained intimate partner violence have been found to disproportionately suffer from specific mental health consequences including anxiety (Coker, Davis et al., 2002), depression (Andrews & Brewin, 1990), posttraumatic stress disorder (PTSD) (Laffaye et al., 2003), and suicidal ideation (Barnett, Miller-Perrin, & Perrin, 1997; Gelles & Harrop, 1989; Herman, 1992; Hilberman & Munson, 1978). For example, a national survey (Straus & Smith, 1990) found that depression and suicide attempts were four times more likely in female victims of severe assault than among women who were not victims of violence.

Although the concept was initially constructed to explain reaction patterns in survivors of natural disasters and combatants in war, it is not surprising to find a high prevalence of PTSD

among survivors of intimate partner violence (National Research Council, 1996). For example, some researchers suggest that PTSD is most likely to develop when traumatic events occur in an environment previously deemed safe (Foa, Steketee, & Rothbaum, 1989), a dimension clearly applicable to intimate partner violence. When a woman is in the midst of an abusive relationship, she must expend an enormous amount of energy in surviving the physical abuse (Humphreys, 1995). In spite of her best efforts, the more physical and psychological energy an abused woman expends in defending herself from her abuser and in coping with the negative events in her life, the less energy she has left for her own survival and functioning (Constantino, Sekula, Rabin, & Stone, 2000; Smith, 2003).

Partner Violence and Physical Health Consequences

Many physical consequences are associated with sustaining partner violence and often mirror the negative effects found with mental health. Gastrointestinal complaints (Laffaye et al., 2003), reproductive problems (Campbell, Woods, Chouaf, & Parker, 2000; Champion, Shain, & Piper, 2004), and immune disorders (Gielen, McDonnell, & O'Campo, 2002) are among the health problems that are more frequently reported by women with a history of intimate partner violence than by women without such histories. Some of the more serious consequences of this problem are broken limbs (Sutherland et al., 2002), disablement, and even death (Henning & Klesges, 2002). Moreover, women who experience more frequent and severe forms of physical abuse are more likely to report higher rates of health problems than women who experience less violence in their relationships (Campbell et al., 2002; Sutherland et al., 2001).

Partner Violence and Socioeconomic Status

Multiple studies have confirmed the negative relationship between poverty and women's overall quality of life and well-being (Amato & Zuo, 1992; Belle, 2003; Cunradi, Caetano, &

Schafer, 2002; Myers & Gill, 2004; Sutherland et al., 2001). In addition, economic inequalities within societies are associated with reduced life expectancy and an assortment of lifelong negative health outcomes (Belle, 2003). Specifically, low socioeconomic status has been associated with a variety of mental (Belle, 2003; Myers & Gill, 2004) and physical (Jewkes, 2002; Lawson, 2003; Lee, Sanders Thompson, & Mechanic, 2002; Sutherland et al., 2001) health conditions (Hughes, Lerman, & Lustbader, 1996; Leserman, Li, Drossman, & Hu, 1998; Russo, Denious, Keita, & Koss, 1997). Women of lower socioeconomic status have also been found to be more at risk for domestic violence (Marshall, 1999), and less likely to leave the abusive relationship than middle-class women (Barnett, 2000).

Although violence is pervasive throughout all income levels (Sutherland et al., 2001), women living at or below poverty level who exhibit traits such as income instability and lower educational levels appear to be more susceptible to abuse (Cunradi et al., 2002). This is not surprising considering the interrelationship of education, income, and social class (Russell & Hulson, 1992). It is possible that women who have been unable to secure a higher degree of education and/or who are not familiar with the legal system and their rights will not have the knowledge or abilities to seek outside help. Moreover, women living in poverty are more susceptible to various illnesses and have limited access to quality health care and preventive services (Sutherland et al., 2001). Despite recent advances (Thomas, 1994), it remains unclear whether health symptoms attributed to abuse are at least partially the result of women living in poverty.

Partner Violence and Ethnicity

The association of ethnicity and violence is still unresolved and the available data are largely equivocal. Some research finds a higher proportion of general trauma and physical

assault among Euro-Americans (Cottler, Compton, Mager, Spitznagel, & Janca, 1992; Norris, 1992), while other studies indicate a higher degree of violence and mortality rate among minorities, especially Hispanics (Alder, Boyce, Chesney, Folkman, & Syme, 1993; Cunradi et al., 2002). Still, other studies find no differences (Bachman, 1994; Lee et al., 2002).

Despite which group sustains a higher level of violence, African American and Mexican American women tend to respond to the abuse differently than their Euro-American counterparts do. For example, in the National Crime Victimization Survey, African American and Mexican American women were more likely to report sustained violence to the police than were Euro-American women (Lee et al., 2002). Decisions about how and in what manner to respond to intimate partner violence are strongly influenced by beliefs and expectations about the impact of those choices on the woman, her family, and the extended community, all of which differ by ethnicity (Caetano, Schafer, & Field, 2002; Honeycutt, Marshall, & Weston, 2001). In addition, ethnicity may become a barrier, specifically in dealing with racial biases by medical health care professionals. For example, research has found discrepancies in diagnosis and treatment of African American and Mexican American patients compared to Euro-American patients (Cool, 1997; Shumaker & Smith, 1995).

Relationship Termination

Despite the negative effects of being in a violent relationship, abused women often remain with their violent partner (Barnett et al., 1997; Sackett & Saunders, 1999). For example, Hendy, Eggen, Gustitus, McLeod, and Ng (2003) explored the decisions of 196 participants who reported sustaining violence from their present partner during the course of the relationship. Interestingly, 84.7% of the women reported the decision to stay in the relationship compared to only 15.3% who reported making the decision to leave. It is possible that abused women feel

they are helpless when it comes to escaping a violent relationship (Barnett et al., 1997; Hendy et al., 2003; Herbert, Silver, & Ellard, 1991; Moss, Pitula, Campbell, & Holstead, 1997). Low self-esteem, inadequate social support, self-blame, and fearing that they will not be able to find another partner likely contribute to feelings of helplessness (Hendy et al., 2003). Battered women may subsequently have a difficult time seeing their options and marshaling the resources needed to leave the relationship (Sackett & Saunders, 1999).

On a more practical level, research has shown that women may be more reluctant to leave violent relationships when they have investments of time, marriage, money, children, or emotional attachments to them (Anderson et al., 2003; Barnett, 2000; Hendy et al., 2003; Henning & Klesges, 2002). In addition, efforts to end abusive relationships are hampered by several factors including a lack of social support, medical services, and childcare (Coker, Smith et al., 2002; Henning & Klesges, 2002).

One of the major barriers encountered by women when choosing to leave an abusive relationship is that of family and social role expectations. Female socialization in a patriarchal society relegates her to the role of primary caretaker of her relationships and her family (Anderson et al., 2003). The women's role as a caretaker may unfairly put the blame on her for the failing relationship; it may also and serve to amplify the burden of blame her abuser places on her (Anderson et al., 2003). Often, individual, spiritual, and societal values encourage her to love the batterer and to try to make the relationship work (Michalski, 2004).

Due to the high correlation between partner violence and low income (Bender, Cook, & Kaslow, 2003; Rosen, 2004), many of the women in these situations are at a disadvantage when it comes to seeking the help and assistance they need. Women who sustain partner violence use medical and other resources more often than those in nonviolent relationships do. Typically, it

has been found that low-income women must rely heavily on public resources, which may or may not be responsive to their needs (Marshall, 1999). Finding safe emergency housing is also a problem for economically dependent women. Without community support, many women must return to their batterers because housing is not available (Barnett, 2000).

Although having children with the partner has been found to be associated with a reluctance to leave the violent relationship, the safety of her children is often the turning point in a woman's decision to leave (Hendy et al., 2003). Because they are especially fearful of losing their children, a major obstacle for women trying to escape intimate partner violence are the laws governing child custody and visitation (Barnett, 2000). The legal system can make it especially difficult for women to extricate themselves from batterers because oftentimes the effects of partner violence are minimized (Lewis, Dobash, & Dobash, 2000). Custody battles may be considered a form of psychological maltreatment, designed to humiliate a woman by attacking her ability to mother and to deprive her of contact with her children (Tolman, 1992). Even if the woman is granted custody of her children, finding the resources necessary to take care of her children while finding a job to support her family is another major hurdle (Hendy et al., 2003).

On average, battered women typically do not leave the relationships the first time their partners abuse them (Barnett, 2000). Moreover, research has found that about half of all women who leave an abusive relationship typically reunite with the batterer (Griffing et al., 2003). Ultimately, the choice to leave or distance oneself from a violent relationship is a complicated decision that involves many personal and situational variables, depending entirely on the individual woman.

Whatever the reason some women stay with a violent partner, it is much more complex than is implied in the often-asked question, "Why doesn't she just leave him?" Furthermore,

because of the practical and emotional stressors associated with leaving an abusive partner, it is uncertain whether the negative ramifications associated with sustaining abuse cease when women terminate violent relationships. If so, women ending violent relationships would be expected to have better health than women who remain in such relationships. Thus, there were two goals in this study. First, previous research showing that partner violence adversely affects women's health was expected to be replicated. Second, we tested the hypothesis that women who exit a violent relationship would have significantly better health than women who remain in abusive relationships.

Method

Participants

The data were collected from Waves 1 and 2 of Project HOW: Health Outcomes of Women. Eight hundred and thirty-five low-income women from the southwest area of Dallas County were involved in this longitudinal study. For participation, women were between the ages of 20 and 48, involved in a long-term heterosexual relationship, and lived within 200% of poverty and/or received public assistance. Women received a membership card, $15 in cash, bus passes, a tote bag, and a T-shirt with the project logo.

Most (n = 696, 83.3%) of the initial sample of 835 women completed both waves. Women were African American (n = 272, 39.1%), Euro-American (n = 208, 29.9%), and Mexican American (n = 216, 31.0%). On average, women were 33.3 years old and in relationships for 7.7 years at Wave 1. At Wave 2, women were asked about the status of their Wave 1 relationships. The majority of the sample (n = 394, 56.6%) were still in their violent relationships from Wave 1. Very few women who had reported violence in their Wave 1 relationship had left their partners (n = 70, 10.1%).

Procedure

In addition to personal contact and referrals made by other participants, women were recruited to participate in a longitudinal study of factors that impact their health through a variety of mass media forms, as well as announcements made at churches, schools, community gatherings, social service and health care agencies.

Screening consisted of asking women how long they had been in their relationship, their household income, the number of people dependent on that income, and their ethnicity. Income was matched to federal tables with women reporting greater than 200% of poverty eliminated. Twice the poverty threshold was chosen because some types of public assistance designed to alleviate the effects of poverty were available at this level. Receipt of public aid itself was considered evidence of poverty.

Data were collected using structured interviews conducted by trained undergraduate and graduate students. Moreover, standardization, confidentiality, and other relevant issues (e.g., response bias) were emphasized. Continual feedback was given to the interviewers as the study progressed to ensure accuracy of the study. A total of 62 students, each conducting between 1 and 57 interviews, participated as interviewers for Wave 1.

Strict procedures of confidentiality were devised for the study. A Certificate of Confidentiality was obtained from the Public Health Service to protect women's anonymity and the data they provided. With this certificate, neither women's names nor their answers can be released even to a court of law. Women also completed Permission to Contact forms to facilitate retention in later waves. This enables researchers to more efficiently locate and contact subjects for future interviews.

Measures

Participants completed a structured interview containing open-ended questions as well as items that utilized rating scales. Questions were read and responses recorded by the interviewers. Although several measures were included, only those used in the current study are described here, because it was anticipated that many of the women in the sample would have less than a high school education. Care was taken to ensure their understanding, by making minor wording changes to some items and using 7-point rating scales whenever possible to lesson confusion for women not accustomed to this kind of task.

Abuse. Marshall's (1992) Severity of Violence Against Women Scale (SVAWS) was used to assess partner violence. At Wave 1, women were asked about their current partners' history of violence in the relationship. At Wave 2, women reported threats of violence, acts of violence, and sexual aggression expressed since the first interview by Wave 1 partners, regardless of whether women were still in that relationship. The SVAWS is a 46-item measure that differentiates threats of violence (symbolic violence; threats of mild, moderate, and serious acts), acts of violence (minor, mild, moderate, and serious), and sexual aggression inflicted by a male partner. Items were organized in order of perceptions of severity among community women in the scale development study. In this study, women reported how often their current partner had inflicted each of the acts during the entire relationship on a 6-point scale (0 – never to 5 – a great many times).

Based on the responses to these measures of abuse, women were divided into three categories: women who were not in an interpersonal violent relationship in either Wave 1 or 2 (referred to hereafter as the no IPV group), women who were in an interpersonal violent relationship in both Waves 1 and 2 (current IPV group), and women who were in an

interpersonal violent relationship at Wave 1 but had exited that relationship by Wave 2 and were not in another interpersonal violent relationship (past IPV group).

Psychological symptoms. Mental health was comprised of a global distress subscale from the Hopkin's Symptoms Check List-90 (Derogatis, Lipman, & Covi, 1973), dissociative symptoms (Briere & Runtz, 1990), and Posttraumatic Stress symptomatology (Saunders, Arata, & Kilpatrick, 1990). Items were commingled, assessing symptoms during the previous month. The means for each of the indexes for the total sample and for each of the three ethnic groups are presented in Table 1 and the reliability coefficients are presented in Table 2. Women reported how much they were bothered by each symptom on a 5-point scale anchored by not at all and extremely. The means for Time 1 for global distress (α = .98 for sample and all three groups), dissociation (α = .92, ranging from .88 for Euro-Americans, .92 for Mexican Americans, and .93 for African Americans), and PTSD (α = .95, ranging from .94 for Euro-Americans and .95 for African Americans and Mexican Americans) were positive indicators for psychological symptoms. In addition, the means for Time 2, including global distress (α = .98 for sample and all three groups), dissociation (α = .93, ranging from .90 for Euro-Americans, .93 for African Americans, and .94 for Mexican Americans), and PTSD (α = .95, ranging from .93 for Euro-Americans and .96 for African Americans and Mexican Americans) were also positive indicators for psychological symptoms.

Finally, women rated their perceived mental health status using three 7-point items. They reported their current mental health and emotional well-being on a scale ranging from extremely bad to extremely good. They compared their current mental health and well-being to a year ago anchored by very much worse to very much better. In addition, mental health and well-being over the past 6 months was assessed on a scale ranging from extremely unhappy to extremely

happy. For these items, a 7-point scale was used. The means for mental health status for Time 1 (α = .78, ranging from .77 for African Americans and Mexican Americans and .79 for Euro-Americans) and Time 2 (α = .83, ranging from .83 for African Americans and Mexican Americans and .84 for Euro-Americans) were calculated as a negative indicator of psychological symptoms.

Physical symptoms. Physical health was assessed with three measures. First, women responded to three items measuring their subjective health status on 7-point scales. Second, women rated their overall physical health (from extremely bad to extremely good), their current health compared to a year ago (from very much worse to very much better), and happiness about health in the past 6 months (from extremely unhappy to extremely happy). The mean of these items for Time 1 (α = .74, ranging from .71 for Euro-Americans, .74 for African Americans, .76 for Mexican Americans) and Time 2 (α = .80, ranging from .78 for African Americans, .80 for Mexican Americans, and .81 for Euro-Americans) represent perceived health status, a negative indicator of physical symptoms. Finally, participants rated their overall quality of life in terms of health using an 11-point scale anchored by worst possible and best possible. Quality of health is a negative indicator of physical symptoms.

In addition, women completed 11 items assessing how they perceived their health (Hays, Sherbourne, & Mazel, 1993). In essence, this is a measure of women's attitudes about their health. Using the stem, "How often do you feel," women completed the 11 items using a scale anchored by never (1) and always (7). Three items were negative indicators of physical symptoms (i.e., as good as ever; very healthy; pleased with your health). The remaining eight items were positive indicators of physical symptoms (i.e., like you are in poor health, like your health would get worse; discouraged about your health; that you would catch whatever illness is

going around; somewhat ill; frustrated about your health; worried about your health; weighed down by your health problems). The mean of these items for Time 1 (α = .90, ranging from .89 Mexican American, .90 African American, and .92 Euro-American) and Time 2 (α = .91, ranging from .90 African American and .91 Mexican American and Euro-American) represented women's attitudes about health, a negative indicator of physical symptoms.

Stress. Women's perceived stress and suicidal ideation were also measured. Using the Perceived Stress Scale (Cohen, Kamarack, & Mermelstein, 1983), women rated their current life stress in various situations on a 7-point scale from never to always. This 14-item measure yields a global score, which assesses the degree to which situations in one's life are appraised as stressful. The scale was normed on two college samples of men and women as well as participants in a smoking-cessation program. The coefficient alpha was reported to be .84 and .85 for the two college samples and .86 for the smoking-cessation sample. The mean score was used for global stress in Time 1 (α = .98, for sample and all three groups) and Time 2 (α = .98, for sample and all three groups), a positive indicator of stress.

Suicidal ideation was measured with five of the seven items on the severe depression subscale of the General Health Questionnaire (Goldberg & Hillier, 1979). Women indicated how often they experienced symptoms related to suicidal thoughts on a 7-point scale from never to almost always. Because the scale was developed for use in the United Kingdom, some modifications were necessary. The mean of these items for Time 1 (α = .92, ranging from .90 for African Americans, .92 for Mexican Americans, and .93 for Euro-Americans) and Time 2 (α = .90, ranging from .88 for African Americans, .91 for Mexican Americans, and .92 for Euro-Americans) were used as an indicator.

Results

As shown in Table 3, one-way ANOVAs revealed main effects for 11 health variables. Surprisingly, mental health appears to be worse for women exiting violent relationships. Women in the no intimate partner violence (no IPV) group had the best mental health (M = 4.72), women in the past intimate partner violence (past IPV) group had the worst score on mental health status (M = 4.01), and women currently in intimate partner violence (current IPV) relationships were intermediate between the other two groups (M = 4.34). Women in the no IPV group were significantly more mentally healthy than women in the other two groups $F(2, 695) = 9.37$, $P < .001$. To understand this unexpected set of results, we considered whether differences existed in violence recently sustained by women. One-way ANOVAs (not shown in Table 3) revealed main effects for past partners' threats, $F(2,694) = 50.57$, $P < .001$, acts, $F(2,695) = 26.66$, $P < .001$, and sexual aggression, $F(2,694) = 19.34$, $P < .001$.

Women exiting violent relationships sustained threats, acts, and sexual aggression significantly more often (Ms=38.68, 19.63, and 6.26, respectively) between Waves 1 and 2 than women who remained in violent relationships (Ms=16.66, 7.96, and 2.79, respectively) or reported no violence at Wave 1 (Ms=4.77, 2.37, and 0.69, respectively).

Women in the past IPV group were also significantly higher on all other measures of mental distress, including global distress (M = 1.21 for past IPV, M = .93 for current IPV, and M = .63 for no IPV), F (2, 695) = 23.02, P = .001: symptoms of dissociation (M = 1.05 for past IPV, M = .73 for current IPV, and M = .49 for no IPV), F (2, 695) = 17.33, $P < .001$; stress (M = 3.78 for past IPV, M = 3.65 for current IPV, and M = 3.40 for no IPV), F (2, 695) = 8.51, $P < .001$; PTSD (M = 1.14 for past IPV, M = .87 for current IPV, and M = .59 for no IPV), F (2, 695)

= 19.82, $P < .001$; and for suicidal ideation (M = 2.38 for past IPV, M = 1.78 for current IPV, and M = 1.59 for no IPV) F (2, 695) = 12.91, P <.001.

Women currently in an abusive relationship (M = 4.45) had significantly worse health than in nonviolent relationships (M = 4.34), F (2, 695) = 4.59, P <.001, as well as lower quality of life (Ms = 4.40 and 4.81, respectively), F (2, 695) = 4.79, $P < .01$, although the women who had exited IPV relationships in the past were not significantly different from the other two groups.

Discussion

Contrary to expectations, results suggest that negative health consequences of sustaining violence persist, despite ending a violent relationship. This illustrates the traumatic nature of partner violence and mirrors results found with victims of war and other trauma survivors (Bramsen & Ploeg, 1999). Just as a person distancing themselves from New York following the tragic events of September 11 may continue to experience health problems (Resnick, Galea, Kilpatrick, & Vlahov, 2004), so too does a woman ending a violent relationship. This has important implications for how counselors and/or community psychologists treat women who have exited or are contemplating leaving an abusive relationship. Treatment should be long term and persist well after the violent relationship has ended. In addition to helping abused women process and cope with their erstwhile abusive relationship, mental health workers should assist women with newly acquired situational stressors (e.g., finances, housing).

For some of the women, it seems that an increase in the abuse may be why they decided to leave. It is seen as a sort of “turning point” in the relationship, or an event that occurs after the initial occurrence of abuse, that provokes the women to leave (Patzel, 2001; Stroshine & Robinson, 2003). It is reported that women likely experience several “turning points” as they

repeatedly move closer to being able to terminate the relationship (Cook, Woolard, & McCollum, 2004; Patzel, 2001). The "turning point" varies with each individual woman, from a worsening of abuse or the escalation of violence, to the crossing of a previously set boundary that serves as the "straw that broke the camel's back." Whatever the pattern of abuse in the relationship, there may come a time when women begin to look at the relationship and the abuse differently.

In addition to the stressors associated with leaving a violent relationship, it is quite possible that the initial stress associated with leaving any intimate relationship will be quite strong (Davis, 2002). The termination of a romantic relationship is a highly stressful and traumatic process with varying emotional responses (Chung, Farmer, & Grant, 2003; Lepore & Greenberg, 2002). These problems range from posttraumatic stress (Chung et al., 2003), depression (Ayduk, Downey, & Kim, 2001), and a loss of self-identity (Drew, Heesacker, & Frost, 2004).

The negative effects abuse and other forms of stress have on women's mental and physical health were underscored by the findings. Consistent with previous research, sustained abuse was related to adverse mental and physical health symptoms (Lawson, 2003; Sackett & Saunders, 1999), with mental health appearing to be worse for women exiting violent relationships. Unfortunately, it is unclear whether violence increased because women left or the reverse. This is where the role of the counselor as a facilitator of change is especially important. By helping women manage not only their mental and physical health problems, but also their underlying need for social support and sense of control, health outcomes may be significantly improved (Henning & Klesges, 2002).

These results also have implications for other health care professionals. Being cognizant of the seriousness of invisible injuries related to abuse can increase the attention physicians give to their patients, possibly encouraging them to screen for abuse. Identifying and eliminating the violence would be one of the most effective ways to reduce women's stress and/or mental and physical health problems.

Table 1. *Frequency Analyses*

	Sample		African American		Euro-American		Mexican American	
	Mean	Std Deviation	Mean	Std Deviation	Mean	Std Deviation	Mean	Std Deviation
Time 1								
Overall quality of life	6.58	2.12	6.70	2.24	6.37	1.92	6.67	2.17
Mental health status	4.42	1.39	4.53	1.43	4.29	1.39	4.43	1.33
Physical health status	4.10	1.32	4.21	1.40	3.97	1.26	4.12	1.29
Positive health attitudes	4.60	1.30	4.67	1.35	4.53	1.34	4.61	1.21
Global distress	1.08	0.75	1.08	0.79	1.11	0.71	1.05	0.73
PTSD	1.04	0.78	1.03	0.83	1.08	0.74	1.01	0.76
Dissociation	0.83	0.77	0.86	0.87	0.81	0.66	0.81	0.76
Stress	3.75	0.86	3.65	0.84	3.85	0.92	3.78	0.80
Suicidal ideation	2.15	1.38	2.06	1.33	2.12	1.35	2.29	1.47
Time 2								
Overall quality of life	7.14	2.35	7.30	2.38	6.67	2.22	7.40	2.37
Mental health status	5.09	1.40	5.33	1.41	4.90	1.38	4.95	1.36
Physical health status	4.59	1.40	4.83	1.40	4.36	1.34	4.51	1.40
Positive health attitudes	4.53	1.30	4.62	1.30	4.43	1.27	4.51	1.32
Global distress	0.86	0.73	0.85	0.78	0.85	0.62	0.88	0.76
PTSD	0.80	0.74	0.78	0.78	0.82	0.63	0.82	0.78
Dissociation	0.69	0.76	0.69	0.82	0.64	0.61	0.73	0.82
Stress	3.58	0.86	3.51	0.90	3.64	0.84	3.60	0.82
Suicidal ideation	1.77	1.19	1.69	1.12	1.72	1.11	1.93	1.33

Table 2. *Reliability Analyses*

	Sample	AA	EA	MA
Time 1				
Overall quality of life	NA	NA	NA	NA
Mental health status	0.78	0.77	0.79	0.77
Physical health status	0.74	0.74	0.71	0.76
Positive health attitudes	0.90	0.90	0.92	0.89
Global distress	0.98	0.98	0.98	0.98
PTSD	0.95	0.95	0.94	0.95
Dissociation	0.92	0.93	0.88	0.92
Stress	0.79	0.76	0.85	0.75
Suicidal ideation	0.92	0.90	0.93	0.92
Time 2				
Overall quality of life	NA	NA	NA	NA
Mental health status	0.83	0.83	0.84	0.83
Physical health status	0.80	0.78	0.81	0.80
Positive health attitudes	0.91	0.90	0.91	0.91
Global distress	0.98	0.98	0.98	0.98
PTSD	0.95	0.96	0.93	0.96
Dissociation	0.93	0.93	0.90	0.94
Stress	0.79	0.78	0.82	0.77
Suicidal ideation	0.90	0.88	0.92	0.91

Table 3. *Significant Main Effects for Intimate Partner Violence (IPV) Group*

	No IPV (n = 232)	Past IPV (n = 70)	Current IPV (n = 394)	F	df	$p <$
Overall quality of life	7.52[a]	7.09	6.93[b]	4.79	2, 692	.01
Mental health status	4.72[a]	4.01[b]	4.34[b]	9.37	2, 695	.001
Physical health status	4.75[a]	4.82	4.45[b]	4.59	2, 695	.02
Positive health attitudes	4.81[a]	4.34[b]	4.40[b]	8.39	2, 695	.001
Global distress	.63[a]	1.21[b]	.93[c]	23.02	2, 695	.001
PTSD	.59[a]	1.14[b]	.87[c]	19.82	2, 695	.001
Dissociation	.49[a]	1.06[b]	.73[c]	17.33	2, 695	.001
Stress	3.40[a]	3.78[b]	3.65[b]	8.51	2, 694	.001
Suicidal ideation	1.59[b]	2.38[a]	1.78[b]	12.91	2, 695	.001

Note. Means with different superscripts differ significantly.

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