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# Intimate Partner Violence and Suicidality in Low-Income African American Women

## A Multimethod Assessment of Coping Factors

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This study used quantitative and qualitative methods to examine psychological factors that influence links between intimate partner violence (IPV) and suicidality in a sample of low-income African American women. Quantitative results demonstrated greater general coping, more efficacious behavioral strategies in response to IPV, more effective use of resources, greater use of social support, and less substance use among women who did not attempt suicide compared with those who did. Qualitative findings showed that suicide attempters showed less adaptive coping strategies aimed at accommodating the abuser, whereas nonattempters were more focused on strategies that supported leaving the relationship and/or avoiding further harm.

**Keywords:** *coping; intimate partner violence; suicide*

The relationship between intimate partner violence (IPV) and suicidality among women is a pressing public health problem, as research shows that IPV is a significant risk factor for attempting suicide (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Bergman & Brismar, 1991; Kaplan, Asnis, Lipschitz, & Chorney, 1995; Roberts, Lawrence, O'Toole, & Raphael, 1997; Sharhabani-Arzy, Amir, Kotler, & Liran, 2003; Stark & Flitcraft, 1996). Women who experience IPV are more likely

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to attempt suicide than those without an IPV history, with an estimated 35% to 40% making a suicide attempt at some point during or after the termination of an abusive relationship. Additionally, 20% of women experiencing IPV make multiple suicide attempts compared to 8% of women who are not experiencing IPV (Stark & Flitcraft, 1996). This link between IPV and suicidality may be related in part to feelings of powerlessness and depression, loss of control to abusers, social isolation, and blocked access to material and financial resources (Campbell, Sullivan, & Davidson, 1995; Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Walker, 1991). Suicidal thoughts and behavior may reflect an attempt at asserting control and/or power, a fantasy of escape from an intolerable situation, a call for help or attention, or an expression of helplessness and hopelessness.

Although the extant research literature clearly demonstrates a link between IPV and suicidality among women, many women who experience IPV do not become suicidal. The purpose of the study reported herein is to investigate differences between women who do and do not manifest suicidality in the context of IPV experiences. Specifically, differences in modes of coping to manage the psychological and psychosocial impact of IPV experiences are examined in a sample of low-income African American women presenting for medical services in an urban public hospital setting. Self-efficacy and substance use patterns also are considered as they relate to psychological reactions to IPV experiences.

Epidemiological findings suggest that African American women may experience higher rates of IPV than women of other ethnicities (e.g., Bailey et al., 1997; Rennison & Planty, 2003). Also, IPV survivor profiles suggest that women who are African American, young, poor, and reside in urban areas are the most frequent IPV targets (Rennison & Welchans, 2000). Additional epidemiological data also point to higher IPV-associated mortality rates for African American women compared to Caucasian women (Crowell & Burgess, 1996), with homicide by an intimate partner constituting the leading cause of death among African American women between the ages of 15 and 24 (National Center for Health Statistics, 1997). Furthermore, African American women who are experiencing IPV are more likely than their Caucasian cohorts to be the sole providers for their families, to have scarce financial resources, to take care of more children, and to live without a car (Asbury, 1987; Coley & Beckett, 1988; Sullivan & Rumpitz, 1994). Scarcity of resources may result in poorer IPV outcomes, because the decision to stay with an abusive partner frequently involves economic dependence on that partner (Belle, 1990).

A growing body of research has documented a broad array of clinically significant sequelae of IPV in African American women, including depression, anxiety, posttraumatic stress disorder (PTSD), dissociative phenomena, low self-esteem, feelings of helplessness and hopelessness, maladaptive cognitive distortions, social isolation, and adverse health outcomes (Huang & Gunn, 2001; Kaslow et al., 1998; Kaslow et al., 2000; Kaslow et al., 2002; Lawson, Rodgers-Rose, & Rajaram, 1999; Manetta, 1999; Sutherland, Sullivan, & Bybee, 2001; Thompson et al., 1999; Thompson, Kaslow, &

Kingree, 2002). Studies of linkages between IPV and suicidality in African American women have yielded findings that are consistent with those of the research literature for women in general. For instance, one recent study revealed that African American women who attempted suicide were 2.5 times more likely to report physical partner abuse and 2.8 times more likely to report nonphysical (emotional) partner abuse within a 12-month period compared to demographically similar nonattempters (Kaslow et al., 2000). Additional research has suggested that African American women who attempt suicide were more likely than their Caucasian counterparts to have a history significant for IPV (Stark & Flitcraft, 1996).

Given the increased risk of suicidality in the context of IPV experiences among African American women, research examining psychological factors that may influence whether or not suicidal behavior will emerge has particular clinical relevance. One such factor is coping behavior, which is known generally to affect psychological adjustment to stressful events and circumstances (Folkman & Lazarus, 1986). Much of the work to date on coping with IPV has been guided by the concepts of problem-focused coping (i.e., active efforts to change a situation or stressor) and emotion-focused coping (i.e., efforts aimed at regulating emotional reactions to stressors) drawn from a well-known stress and coping model (Folkman & Lazarus, 1986). Some research has suggested that women experiencing IPV may tend to utilize fewer active, problem-focused coping behaviors, resulting in greater use of avoidant and dependent responses to IPV (Claerhout, Elder, & Janes, 1982; Clements, Sabourin, & Spiby, 2004; Clements & Sawhney, 2000; Finn, 1985). Although there is some controversy in the literature on which of these coping options constitutes a more adaptive coping strategy in relation to IPV, these findings can be understood to be consistent with clinical observations of a tendency to minimize or deny the presence or extent of IPV, a pattern that, in both partners, may perpetuate the cycle of violence. Furthermore, a pattern of avoidant and dependent responses may support passivity and disempowerment of the IPV target, as she attempts to manage the violence by becoming organized by the perpetrator's dynamics of control (Henning, Jones, & Holdford, 2005; Walker, 1984). In this context, coping strategies are focused on accommodation to the destructive situation via efforts to placate or pacify the perpetrator and/or use of potentially harmful strategies, such as alcohol or drug use, to numb the painful reality of IPV (Rogers, McGee, Vann, Thompson, & Williams, 2003). In this dynamic, it may be that active (problem-focused) coping behavior and a sense of self-efficacy (related to more favorable self-esteem) are associated with better psychological outcomes (Clements et al., 2004; Clements & Sawhney, 2000). This may involve using internal and external resources to gain insight into the reality of the IPV, developing a personal safety plan, and/or orchestrating strategies for leaving the violent relationship. Although research specific to coping behavior as it relates to suicidality in the context of IPV is lacking, coping effectiveness is linked to self-efficacy in managing IPV situations, with research suggesting that higher self-efficacy is associated with reduced suicide risk owing to the capacity to obtain resources, utilize adaptive coping skills, and secure

social support (Kaslow et al., 1998; Thompson et al., 2002). Substance use as a form of avoidance coping also may influence clinical outcomes, especially because women who experience IPV are more likely than those who do not to endorse substance abuse (Huang & Gunn, 2001), and such women are at increased risk for self-harm (Kaslow et al., 2002; Thompson et al., 2002; Thompson et al., 1999).

The purpose of the study reported here is to replicate and expand on the findings of previous investigations of psychological factors that influence the link between IPV and suicidality among low-income, African American women. Specifically, this study employs a multimethod approach that combines both quantitative (i.e., validated self-report measures) and qualitative (i.e., participant descriptions of IPV coping experiences) data sources to (a) examine relationships of coping activity (e.g., general coping, effectiveness of obtaining resources, use of social support, efficacious behaviors) and substance use patterns (as indicative of ineffective coping) to suicidality in response to IPV experiences and (b) elaborate on quantitative findings with respect to coping activities using qualitative (observational and descriptive) data to illuminate experiential themes derived from the narrative descriptions by participants of their IPV experiences.

## Method

### Design and Procedures

This report of a multimethod (i.e., quantitative and qualitative) assessment includes a sample ( $n = 200$ ) used for quantitative analyses and a subsample ( $n = 40$ ) queried for more in-depth qualitative exploration. Participants were recruited from a large public hospital in an urban setting serving primarily indigent and minority populations (see Kaslow et al., 2002). This study used a case-control design. Cases were African American women presenting to the hospital emergency room following a suicide attempt, and controls were African American women presenting to one of three ambulatory medical clinics (a general urgent care center, a women's urgent care center, and a family planning clinic) for nonemergent care at the same hospital during the same time period. Suicide attempt was operationalized as a self-injurious act requiring medical attention, excluding women who made suicidal gestures with doubtful intent.

Before the interview, women were screened for eligibility and exclusion criteria. Potential participants were excluded if they met any of the following criteria: (a) no intimate partner (i.e., male or female whom she was dating, cohabitating with, or married to) within the previous year, (b) no experience of physical or nonphysical IPV within the previous year, (c) significant cognitive impairment as measured by the Mini-Mental State Exam (Folstein, Folstein, & McHugh, 1975), (d) inability to complete the protocol because of acute psychosis or delirium, or (e) presence of a life-threatening medical condition in which death was judged to be imminent based

on self-report and/or reports from the medical team. Women were excluded from the control condition if they had a history of one or more prior suicide attempts. Of 141 women approached for participation in the attempter group, 29% were excluded because they refused to participate or met one of the above criteria. Among 320 potential controls, 69% were excluded because they refused to participate, had at least one prior suicide attempt, had not had an intimate partner within the previous year, had not experienced any physical or nonphysical violence within an intimate relationship within the previous year, or were unable to complete the protocol. One control was recruited following the recruitment of each case.

### **Quantitative Data Collection**

After recruiting potential participants, written informed consent and screening measures were administered. Once eligibility was established, the interviewer administered questionnaires verbally to prevent confounding by known low levels of functional literacy in this population (Williams et al., 1995). Data collection consisted of a 2- to 3-hour face-to-face administration of self-report instruments. For their participation, women were paid \$25 and provided with referrals to community agencies (e.g., domestic violence shelters, community mental health centers). All study procedures were approved by the university and hospital Institutional Review Boards.

### **Qualitative Data Collection**

A subsample of women in each group (20 controls, 20 attempters) was selected randomly for in-depth, qualitative interviews. Every other case and control was interviewed until a total of 40 interviews was completed. These participants returned for a separate interview session of approximately 1-hour duration, and they were compensated an additional \$25. Consent for audiotaping was obtained, and the interviews were audiotaped and transcribed, and transcriptions were back-checked again against the recorded interviews. Interviews, conducted by licensed psychologists, psychology postdoctoral fellows, and advanced doctoral students, followed one of two structured protocols developed for the study. Attempters were asked about the nature of the IPV relationship, early abuse history, insights about IPV being connected in any way to early abuse, coping strategies used to deal with IPV, and possible links between IPV and suicide attempts. Controls were queried about the same, but instead of queries concerning suicidal behavior, they were asked about how they avoided suicidality. Following transcription of the interviews, the transcripts were reviewed extensively by two licensed psychologists to assess interviewer adherence to the interview guide and uniformity with other interviews. On the basis of this review, two of the transcripts (one from each group) were removed from the subsample, leaving 19 per group for analysis.

## Quantitative Measures: Screening Variables

*Screening Questionnaire (SQ).* The SQ, developed for this study, assessed for study inclusion/exclusion criteria. The SQ includes demographic questions (e.g., relationship status, medical illnesses) as well as a checklist assessing psychosis and sobriety. Additionally, control participants were asked if they had ever attempted suicide.

*Universal Violence Prevention Screening Protocol (UVPSP).* The UVPSP is a 5-item measure that provides a brief assessment of exposure to physical, sexual, and emotional abuse from an intimate partner within the past year (Dutton, Mitchell, & Haywood, 1996). This measure has demonstrated good reliability (Heron, Thompson, Jackson, & Kaslow, 2003). A positive response to at least one item was required for inclusion in the study.

*MMSE.* The MMSE is a 30-point measure assessing current mental status (Folstein, Folstein, McHugh, & Fanjiang, 2001). Women were excluded if scores indicated diffuse cognitive dysfunction (scores of 24/30 if literate; 22/30 if functionally illiterate).

*Demographic Data Form.* The Demographic Data Form was developed for this study to obtain key sociodemographic data.

*Index of Spouse Abuse (ISA).* This 30-item scale measures the severity of physical (ISA-P) and non-physical (ISA-NP) abuse (Hudson & McIntosh, 1981). This measure queries frequency of specific abusive behaviors on a 5-point Likert scale. Items are differentially weighted to adjust for more or less serious forms of abuse (see Hudson & McIntosh, 1981). The ISA has excellent internal consistency reliability, good discriminant validity for the subscales (.73 physical abuse; .80 nonphysical abuse), and excellent construct and factorial validity with a low-income, African American sample and other demographic samples (Campbell, Campbell, King, Parker, & Ryan, 1994; Hudson & McIntosh, 1981). Both the subscales demonstrated good internal consistency reliabilities in the current total sample ( $\alpha = .88$  for both), as well as for controls ( $\alpha = .89$  for both subscales) and cases ( $\alpha = .86$  physical; .87 nonphysical). The ISA was used to compare controls and cases relative to abuse severity.

## Quantitative Measures: Dependent Variables

*Preliminary Strategic Approach to Coping Scale (P-SACS).* The P-SACS is a 34-item measure that assesses coping abilities using a 5-point Likert format allowing scores to be calculated for overall coping and 8 subscales (Hobfoll, Dunahoo, Ben-Porath, & Monnier, 1994). For the present study, mean scores (ranging 1 to 5) are calculated just for overall coping. The P-SACS has good internal consistency

reliability, validity, and reliability with the population sampled in this study. Alpha for this study was .76.

*Effectiveness of Obtaining Resources Scale (EORS).* The 11-item EORS ascertains perceived effectiveness in obtaining material resources in 11 domains (housing, material goods, education, employment, health care, child care, transportation, social support, legal assistance, finances, other issues regarding children; Sullivan, Tan, Basta, Rumpitz, & Davidson, 1992). Items are rated on a 4-point Likert scale (score ranging from 1 to 4), with higher scores reflecting greater perceived EORS. The scale showed good internal consistency reliability for the current sample ( $\alpha = .87$ ).

*Self-Efficacy Scale for Battered Women (SESBW).* The SESBW is a 12-item measure assessing ability to perform positive help-seeking actions and adaptive living skills in coping with an abusive relationship (Varvaro & Palmer, 1993). Each item is rated on an analog scale (0 to 100), with higher ratings indicating greater efficacy. The scale authors reported an internal consistency reliability (.88) and good construct validity (Varvaro & Palmer, 1993). The scale showed good internal consistency reliability with the current sample ( $\alpha = .88$ ).

*Social Support Behaviors Scale (SSBS).* The 45-item SSBS measures availability of social support from family and friends on a 5-point Likert format in five domains (emotional, social, practical, financial, and guidance), resulting in five subscales for family, five for friends, and two overall scores collapsing domains into a friend support score and family support score (Vaux, Riedel, & Stewart, 1987). Higher scores reflect higher levels of perceived social support resources (range for summary scales [family, friends]: 45 to 225). The scale authors also reported good reliability with an African American sample ( $\alpha = .89$  and  $.90$  for friend and family support scales, respectively). The scale has shown good construct and convergent validity (Vaux, Riedel, & Stewart, 1987). The measure demonstrated good internal consistency reliability with the current sample ( $\alpha = .99$  friend scale;  $\alpha = .99$  family scale).

*Brief Drug Abuse Screening Test (Brief DAST).* The 20-item DAST uses a yes/no format to screen for drug-related problems with a simple summed score ranging from 0 to 20 (Skinner, 1983). Good internal consistency and concurrent validity have been demonstrated (Skinner, 1983), and the scale had high internal consistency in the current sample ( $\alpha = .92$ ).

*Brief Michigan Alcoholism Screening Test (Brief MAST).* The 10-item MAST uses a yes/no format to screen for alcohol-related problems, with yes/no (0/1) ratings weighted for a possible total score range from 0 to 29 (Pokorny, Miller, & Kaplan, 1972). The scale demonstrated adequate internal consistency in the current sample ( $\alpha = .83$  total sample).

## Qualitative/Observational Coding

All transcribed participant interviews were coded independently by two raters (either doctoral-level graduate students or licensed psychologists) blind to case/control status. First, in a free-response query, respondents were asked, "What have you done to try to cope with (name of abuser)'s abusive behavior?" For each response spontaneously offered by the participant, the interviewer queried, "How has this helped you cope" and following that, "Is there anything else?" until no further free responses were offered. To code the free responses, two raters worked independently to extract from the narrative all coping responses spontaneously offered and reduced these to the briefest possible phrase for ease in coding. Interrater reliability was calculated for correspondence in the items extracted for coding by tallying simple percentage agreement of the coping mechanisms identified, with an agreement of 70%. Where disagreement occurred, the extracted responses were examined in the context of the full transcribed narrative, and a consensus coding was obtained for agreement for analysis.

Then in a second coding pass, each extracted response was coded as either "adaptive" or "maladaptive" by two new raters not involved with the first pass of coding and also blind to group status. Adaptive coping was defined as coping aimed at increasing awareness of the cycle of abuse and denial often marking IPV relationships, acknowledging abuse as a significant problem, or taking steps toward safety planning. Maladaptive coping, in this scheme, was marked by a focus on the abuser (e.g., placating, pacifying, pleasing), denial and avoidance of recognition of the significance of the problem, or self-destructive behaviors (e.g., drug/alcohol abuse, self-injury) enabling avoidance of issues of safety and, possibly, reducing safety. Adaptive coping was defined as moving a woman out of the IPV situation, whereas maladaptive coping was defined as focusing on adapting to the IPV situation itself. In assessing interrater reliability on this coding pass, a kappa of 0.98 was obtained, followed by consensus coding to obtain agreement prior to analysis.

A sum tally of maladaptive responses and adaptive responses also was calculated for each participant. To accommodate for difference in total responses, a ratio of maladaptive to adaptive responses also was calculated to assess relative degree of maladaptive coping.

A second portion of the interview also was utilized for this study. In this portion, following the free-response query described above, the interviewer probed specific, broad coping categories: friends (i.e., "Have your friends helped you cope? How?"), family, religious or spiritual beliefs, work, children, community resources (e.g., crisis lines or shelters), and therapy or counseling. From these narrative responses, the coders used the probed response and the follow-up question to determine whether or not the probed coping strategy was utilized and coded these into a simple yes/no format. The coders obtained good interrater reliability (kappa = 0.91) prior to consensus coding.

**Table 1**  
**Sample Demographics**

	Full Sample; <i>N</i> = 200	Subsample; <i>n</i> = 38
Age mean/standard deviation	31.96/9.72	32.39/11.53
Age range	18–59	18–59
Partnered	47.5%	47.4%
Employed	41%	47.4%
High school	28%	28.9%
College/grad	28%	33.2%
Median income	\$500–\$999	\$500–\$999
Income < \$999/mo	72.8%	73.5%
Aid to Families with Dependent Children benefits	16%	13.2%
Food stamps	31%	26.3%

## Results

### Sample Descriptives

This case-control study was designed with the aim of equating attempters and nonattempters on demographics and IPV severity. Thus, differences between attempters and nonattempters on demographic variables and severity of physical and nonphysical IPV were examined before testing study hypotheses. Chi-square analyses were used to assess dichotomous variables, and *F* tests were used for continuous variables. There were no significant between-group differences on age, education, number of children, marital status, employment status, literacy level, or monthly household income. Overall, this is a sample of women in their early 30s, the majority of whom have not graduated from high school. These women tend to be unmarried and have on average two children. Less than half the sample is employed, and 80% have monthly incomes less than \$1,000. Table 1 provides more detailed demographic data separately for the quantitative sample (*n* = 200) and the qualitative sample (*n* = 38). Furthermore, there were no between-group differences in severity of partner violence (ISA-P, ISA-NP), although both groups reported high levels of both physical and nonphysical abuse. Given the lack of between-group differences on these variables, none was utilized as covariates in subsequent analyses.

Assessing suicide variables among the 100 attempters, 32% had attempted suicide previously, with 34% of these having made one prior attempt, 19% two prior attempts, 16% 3 prior attempts, and 31% 4 or more prior attempts. Overdose was the most common method of attempting suicide (76%).

Correlations were computed on all variables of interest and can be found in Table 2. Means and standard deviations for study self-report measures are summarized in Table 3.

**Table 2**  
**Correlation Matrix of Major Variables**

	P-SACS	EORS	SESBW	SSBS Friend Scale	SSBS Family Scale	MAST	DAST
P-SACS	—	.342*	.453**	.015	.375*	.051	-.075
EORS		—	.476**	.331*	.420**	-.378*	-.172
SESBW			—	.139	.206	-.085	-.241
SSBS friend				—	.166	-.216	-.314
SSBS family					—	.051	-.151
MAST						—	.54**
DAST							—

Note: P-SACS = Preliminary Strategic Approach to Coping Scale; EORS = Effectiveness of Obtaining Resources Scale; SESBW = Self-Efficacy Scale for Battered Women; SSBS = Social Support Behaviors Scale; MAST = Michigan Alcoholism Screening Test; DAST = Drug Abuse Screening Test.

\*Correlation is significant at the 0.05 level (2-tailed).

\*\*Correlation is significant at the 0.01 level (2-tailed).

## Quantitative Analyses

The larger sample ( $n = 200$ ) was used for quantitative analyses of coping measures. MANOVA or ANOVA procedures were selected as analytic strategies allowing a direct exploration of group differences relative to the various coping indicators, with case-control status (group) as the independent variable and the coping indicators as the dependent variables. For each analysis, subsample means and standard deviations were examined to determine correspondence with the larger sample, and for each variable except for the MAST, subsample means and standard deviations were consistent.

In assessing general coping (P-SACS), an ANOVA showed significant differences between groups [ $F(1,198) = 23.73, p < .001, R^2 = .11$ ], with suicide attempters reporting fewer coping responses than controls. (See Table 3 for means.)

In using resources effectively (EORS), an ANOVA showed significant group differences [ $F(1,198) = 27.86, p < .001, R^2 = .12$ ]. Controls (nonattempters) demonstrated higher mean scores than attempters, suggesting that controls utilize resources more efficaciously.

In considering ability to respond with efficacy to the abusive situation (SESBW), an ANOVA again revealed significant differences between cases and controls [ $F(1,196) = 22.30, p < .001, R^2 = .10$ ], with controls (nonattempters) demonstrating better means of coping with the abuse.

To evaluate group differences in utilization of social support, a MANOVA was computed using the two scales of the SSBS (family and friends) as the two dependent

**Table 3**  
**Means and Standard Deviations of Major Dependent**  
**Variables by Group Status**

Variable	Range	Mean/Standard Deviation of Attempters	Mean/Standard Deviation of Controls
P-SACS	1–5	3.24/0.41	3.50/0.36
EORS	11–44	25.85/7.67	31.23/6.70
SESBW	0–100	67.55/18.81	79.75/17.56
SSBS family scale	45–225	127.86/48.10	168.14/47.19
SSBS friend scale	45–225	130.53/46.64	155.47/46.35
MAST	0–29	5.85/8.50	2.93/5.86
DAST	0–20	5.81/5.27	3.14/4.36

Note: P-SACS = Preliminary Strategic Approach to Coping Scale; EORS = Effectiveness of Obtaining Resources Scale; SESBW = Self-Efficacy Scale for Battered Women; SSBS = Social Support Behaviors Scale; MAST = Michigan Alcoholism Screening Test; DAST = Drug Abuse Screening Test.

variables, with case-control status as the independent variable. There was a significant group difference [Wilks Lambda  $F(2, 197) = 18.89, p < .001$ , partial  $\eta^2 = .16$ ]. Post-hoc analysis demonstrated significant effects for both scales [family scale  $F(1, 197) = 35.74, p < .001, R^2 = .15$ ; friend scale  $F(1, 197) = 14.39, p < .001, R^2 = .07$ ]. Controls demonstrated greater use of social supports for both family and friends.

To examine the role of substance use, a MANOVA was computed using scores from the two substance abuse measures (MAST and DAST) as the dependent variables. The multivariate  $F$  was significant [Wilks Lambda  $F(2, 196) = 7.86, p = .001$ , partial  $\eta^2 = .07$ ], with cases (attempters) demonstrating significantly more substance use on both measures than controls.

### Qualitative/Observational Analyses

To expand on the quantitative analyses of coping activities, the coded interviews were explored for group differences. The small subgroup  $n$  did not offer enough power to conduct general linear model analyses, so these data are explored descriptively to deepen understanding of coping strategies and to suggest avenues for further research and intervention.

First, the maladaptive coping ratio, derived from the free response query (spontaneously articulated coping behaviors), was examined relative to case/control status. Attempters articulated a higher ratio of maladaptive coping responses (relative to total responses) than did controls (attempter ratio Mean/Standard Deviation [ $M/SD$ ] = 80.42/29.82; controls = 67.92/40.33).

Examining probed coping resources, control participants reported higher utilization of positive coping strategies in general ( $M/SD$  for controls 4.19/1.60; attempters

3.21/1.58). Specifically, controls endorsed higher use of friends (66.7% of controls utilized support of friends vs. only 26.3% of attempters), family (77.8% controls; 31.6% of attempters), and work (controls 72.2%; attempters 57.9%). Both groups similarly reported coping via use of religion (controls 83.3%; attempters 84.2%) and use of community resources (controls 22.2%; attempters 21.1%). And attempters reported slightly higher use of therapy (controls 27.8%; attempters 36.8%) and focus on children (controls 55.6%; attempters 63.2%).

In examining further the free narrative responses to elucidate dynamics of coping with the IPV, attempters were more likely than controls to offer spontaneous responses focused on placating or changing the perpetrator (e.g., "I don't make him mad . . . try not to argue back." "Play it safe . . . made him think he was so important in order to shield myself." "I tried doing things his way or the way he said was right."). Attempters were also more likely than their nonattempter counterparts to use avoidance strategies (e.g., "[I] just don't think about it." "I depend on crack . . . it takes all my problems away." "I don't cope. I run away."). Not surprisingly, the attempters acknowledged more use of self-injurious or suicidal behaviors (e.g., "I cut myself for him." "Kill myself. That's the only thing I know how to do right now.") than did controls. Consistent with this, attempters responded to the IPV with helplessness to queries of how they coped (e.g., "Nothing! I just let [him] beat me." "Nothing. I just cried." "I haven't coped with it. . . . I didn't know how to deal with it."), whereas such a profound sense of disempowerment was less frequently noted in controls.

Although some of the control participants reported similar coping strategies, on the whole these more often were intermixed with strategies aimed at increasing insight into the reality of the IPV situation by talking to others (vs. the abuser) about the IPV (e.g., "I call and talk to friends" "I talk to my pastor, my aunt . . .") or by moving toward an end to the relationship by enhancing resources (financial, social, and internal) (e.g., "I went to counseling." "Getting money to get away from him." "I taught myself not to be dependent on men.").

Further elucidating the dynamics of coping as understood and articulated by the women themselves, those who attempted suicide were asked to speculate about why they attempted suicide and what may have prevented them from attempting. Their responses, in many cases, gave a sense of the extreme stress and hopelessness experienced. For example, to the query of why they attempted, suicide attempters often articulated themes of fear, helplessness, isolation, disempowered wish for escape, and internalization of the abusive dynamics in the form of self-blame (e.g., "I'm better off dead. . . . I can't never seem to make nobody happy." "All this pressure . . . I couldn't take it anymore. I was trying to get out of here the easy way." "I got tired of being hurt. So I figured if anybody was going to hurt me it was going to be me."). When queried about what may have prevented an attempt, in many cases there was often little sense of empowerment over their circumstances, with several of the women unable to articulate any means of preventing their attempts (e.g., "Nothing . . . nothing that I know of. . . . Do you know something?").

When the control participants were asked for their thoughts about what prevented them from coping via suicide attempt, they cited a range of factors that reflected, in many cases, a greater connection to external supports and responsibilities (and, hence, less isolation; e.g., "I like life, for one, and I love my little girl, and I don't think that'd be fair for me to be selfish."). But even more notable, the control participants articulated a stronger sense of self that was not reflected at all in any of the attempter responses (e.g., "Because I would at times think 'there's got to be something better than this. I can make a change some kind of way. I know the Lord didn't put me here on the earth to make me suffer like this.'" "My self-esteem was so much to know that was not the last scene, the situation was not going to last forever, that situations change, that things will get better." "I love me too much.").

## Discussion

This study of African American women with histories of IPV explored coping strategies utilized by those who attempted suicide compared with those who did not. The initial large-sample quantitative analyses demonstrated higher levels of positive coping strategies and indicators of positive coping (general coping, effective use of resources, efficacy in dealing with the IPV situation, and use of social support) and lower levels of less adaptive strategies (alcohol and drug use or abuse) in controls versus attempters. The qualitative analyses supported these findings by revealing, in the women's own free responses, the tendency for suicide attempters to use coping strategies aimed at accommodating or placating the abuser, whereas the controls reported a greater tendency toward safety, self-preservation, or finding means to leave the abusive relationship. Control participants also reported higher utilization of other positive probed coping strategies, including friends, family, and work, perhaps suggesting higher functional abilities. Both groups similarly reported coping via use of religion and community resources, and attempters reported slightly higher use of coping via therapy and focus on children.

Clinically, these findings suggest that intervening with women with histories of or current IPV should include a careful analysis of coping strategies aimed at assessing risk of suicidal behavior as a potential outcome, particularly in those with more limited external and internal resources. Previous research has identified risk and protective factors for suicidal behavior among abused women (Meadows, Kaslow, Thompson, & Jurkovic, 2005), and the present study supports and expands that literature by exploring coping strategies as identified and articulated by the women themselves. This also supports earlier theoretical and clinical literature utilizing a more systemic lens to understand chronic cycles of IPV by considering the stance of the IPV target relative to the perpetrator of the violence. Specifically, a stance of helplessness and accommodation to the abuser may portend greater risk of adverse outcomes, whereas a stance of greater empowerment, support, and problem-solving

may confer protection in either leaving the violent relationship or at least sustaining better psychological adjustment.

This study suggests that early clinical interventions with a woman in an IPV relationship might focus on understanding the overall coping stance as well as specific coping strategies to assess risk of suicidality and longer-term outcomes. Supportive interventions aimed at enhancing more adaptive coping responses may enable the woman over the longer term to leave a harmful relationship as she is ready to do so and may help reduce the likelihood of her engagement in future problematic relationships. Specifically, therapeutic interventions with women in IPV relationships might take into account the pervasive disempowerment often felt by women experiencing IPV by supporting the woman's own best coping and problem-solving. This can be accomplished by allowing her the freedom to examine her own ambivalence and/or functional constraints in leaving the relationship without assuming an advice-giving stance or otherwise engaging in unwitting coercive or disempowering strategies aimed at having her leave the IPV relationship before she has found her own resources and will to do so. Achieving this stance, without inadvertently colluding with the avoidance or denial that may make it more difficult to leave, requires careful attention to balance between helping her to recognize the clear reality of her situation while avoiding directives that involve telling her what she should or must do relative to the IPV relationship. This may involve supporting deepened insight, greater connection with internal and external resources, and safety planning toward the end of increasing her sense of independence, self-efficacy, and ability to utilize positive coping resources.

There are, of course, several limitations of this study. First, the cross sectional nature of the study precludes examination of causality. The qualitative sample is small, allowing only descriptive analyses, thereby limiting the interpretation and generalizability of results. The income range of this sample also is narrow, possibly limiting generalizability, and possible self-selection of participants, given the high exclusion rate among controls, may have some bearing on generalizability as well.

These results emphasize the importance of continued research on the coping strategies utilized in the complex interpersonal field of a couple or family system marked by IPV. More extensive qualitative analyses, using a larger sample and specific qualitative methodology, is indicated to explore more fully the nuances of these dynamics in informing targeted prevention and treatment strategies for women experiencing IPV. Specifically, examining more systematically and in greater depth the coping strategies and stance of the recipient of the violence relative to the perpetrator of IPV could elucidate these dynamics in a manner useful for clinical application. Rather than applying standard coping models that may or may not be suitable to this particular complex social and interpersonal dynamic, using multimethod approaches with more specificity and greater depth can inform both the clinical and research literature.

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