

# **Partner Violence, Social Support, and Distress Among Inner-City African American Women<sup>1</sup>**

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*This study examined the role of social support in the partner violence–psychological distress relation in a sample of African American women seeking medical care at a large, urban hospital (n = 138). Results from bivariate correlational analyses revealed that partner violence was related to lower perceived social support and greater psychological distress, and lower social support was related to more distress. Furthermore, findings based on path analysis indicated that low levels of social support helped account for battered women’s increased distress. Findings point to the*

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*need for service providers to screen for partner violence in nontraditional sites, such as hospital emergency rooms, and to address the role of social support resources in preventive interventions with African American battered women.*

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**KEY WORDS:** partner violence; social support; psychological distress; African American women.

Partner violence represents a serious public health problem in the United States. In a nationally representative survey, approximately 1.8 million women reported being severely assaulted by their male partners during the preceding year (Straus & Gelles, 1990). Approximately 30% of all females murdered in the U.S. are killed by their male partners (U.S. Department of Justice, 1996). In fact, women are 3.7 times more likely to be killed by their male partners than by strangers (Kellermann & Mercy, 1992). Nonfatal injury statistics are just as staggering. For example, one study found that over one-third of women seeking emergency medical care for violence-related injuries had been injured by their current or former spouses (Rand & Strom, 1997). Medical costs due to injuries resulting from partner violence have been estimated conservatively at \$44 million per (Randall, 1990).

The psychological consequences of partner violence parallel the reactions found among other types of crime victims (Council on Scientific Affairs, 1992). Documented reactions include depression, anxiety, suicidal ideation, low self-esteem, hopelessness, fear, social isolation, decreased trust, and posttraumatic stress disorder (PTSD; Astin, Lawrence, & Foy, 1993; Browne, 1993; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Dutton, 1992; Goodman, Koss, & Russo, 1993; Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Houskamp & Foy, 1991; Kemp, Rawlings, & Green, 1991). However, partner violence is distinct from other types of victimization because exposure typically is chronic rather than acute. The severity and chronicity of the violence, as well as the meaningful nature of the interpersonal context in which the battering occurs, exacerbate the negative psychological sequelae of the trauma (Browne, 1993).

Despite the burgeoning empirical literature on partner violence, few investigations have been conducted on the role of partner violence among women of color and women from disadvantaged backgrounds (Coley & Beckett, 1988; Goodman *et al.*, 1993b; Kanuha, 1994; Reid, 1993). This limited empirical data base is of particular concern given that homicide is a leading cause of death for young African American women ages 11–24 (Centers for Disease Control and Prevention, 1997). Furthermore, partner violence is more prevalent in lower socioeconomic strata (SES; Sorenson, Upchurch, & Shen, 1996), and women from lower SES backgrounds have been shown to be more vulnerable to the negative psychological sequelae

following partner violence than their higher SES counterparts (Belle, 1990; Sullivan & Rumpitz, 1994).

One factor that may illuminate how partner violence affects psychological distress levels is social support resources (Mitchell & Hodson, 1983). Researchers have found that battered women often experience a lack of tangible support resources, such as alternative housing, money, and employment, as well as a lack of available emotional support from family and friends (Gelles, 1979; Sullivan, Tan, Basta, Rumpitz, & Davidson, 1992). The stigmatization faced or anticipated by many battered women, as well as the chronicity of the abuse, are likely to result in low levels of perceived social support. Because battered women may perceive themselves as stigmatized if others know of their abuse status, many women in violent relationships may become isolated at a time when support is most needed. In a study with 60 women who had sought help from a battered women's shelter, friends' avoidance in discussing battering as well as battered women's lack of contact with family and friends were related to increased depression (Mitchell & Hodson, 1983). Battered women also may not seek support due to the notion that violence in the home is a private matter or due to fear instilled by their partners' coercive threats not to disclose the violence (Mitchell & Hodson, 1983; Sullivan *et al.*, 1992). Additionally, even if battered women seek support, they may not receive the support they need, as support providers may blame the victim in order to maintain their own feelings of invulnerability, or may feel uncomfortable discussing sensitive and emotionally laden topics (Ryan, 1971; Bolger, Foster, Vinokur, & Ng, 1996; Coates, Wortman, & Abbey, 1979). Furthermore, the chronicity of the violence may deplete emotional and tangible support resources due to provider burnout (Kaniasty & Norris, 1993; Lepore, Evans, & Schneider, 1991), or providers' inability to continue to offer material resources.

Battered women from disadvantaged backgrounds may be particularly vulnerable to experiencing low levels of social support resources. In his conservation of resources theory, Hobfoll (1988) postulates that although support resources are always important for mental health, they are particularly crucial in times of stress. According to Hobfoll's (1988) theory, people lacking in adequate resources prior to stressful events are more vulnerable to psychological distress following a stressor than those who have adequate resources available prior to experiencing the stressor. The concept of loss spiral is used to describe situations where initial loss begets future loss, and this is especially the case when preloss resources are weak (Hobfoll & Lilly, 1993). Because women from disadvantaged backgrounds likely have low support resources, especially low tangible resources, they are particularly vulnerable to experiencing loss spiral, and are likely unable to accrue the resources needed to deal effectively with partner violence. For example,

a woman who experiences ongoing violence at the hands of her partner not only must cope with the psychological effects resulting from the violence *per se*, but also must deal with other losses and concerns, such as how to protect her children from the abusive situation, how to ensure that basic survival needs (e.g., food, shelter) would be met if she were to leave, and feelings of shame, loss of personal control, and isolation. Consistent with this, in one study, women who experienced higher levels of partner violence and who were of lower SES reported lower levels of received and perceived social support than their respective counterparts (Mitchell & Hodson, 1983).

Although most studies have treated social support as a moderating variable (i.e., buffering model of support), we have chosen to conceptualize social support as a mediating (i.e., intervening) variable. This decision was based on our hypothesis that partner violence impacts support directly, which in turn mediates the effects of partner violence on distress. This direct effect of a stressor on support has been documented in prior studies (Bolger, Foster, Vinokur, & Ng, 1996; Kaniasty & Norris, 1993; Quittner, Glueckauf, & Jackson, 1990). In a study specific to partner violence, Mitchell and Hodson (1983) found that women who experienced partner violence were at greater risk for experiencing low levels of social support resources (i.e., direct effect of partner violence on support). However, the interaction of Support  $\times$  Partner Violence severity did not predict psychological outcomes.<sup>3</sup> Although the mediating role of social support is hypothesized by the social support deterioration model (Barrera, 1986; Kaniasty & Norris, 1993), we are unable to test this model directly in our study because our data are cross-sectional and do not allow for testing if support deteriorated over time. However, we are using a cross-sectional adaptation of this model. This model suggests that low levels of support help explain the partner violence–distress link.

The present study examined the role of social support in the partner violence–distress relation in a sample of low-income, African American women seeking usual medical care at a large, urban hospital. The purpose of the study was to determine if a lack of social support resources helped explain why battered women reported higher levels of distress than their counterparts who experienced minimal or no violence. Based on the model, we hypothesized three significant main effects: (1) partner violence on perceived social support, with higher levels of reported partner violence being related to lower levels of social support; (2) partner violence on distress, with higher levels of partner violence being related to greater

<sup>3</sup>Methodologically, the expected correlation between partner violence and social support precludes a test of a buffering model, as moderator variables should be independent of the stressor which they are expected to counteract (Quittner, Glueckauf, & Jackson, 1990; Thoits, 1982).

levels of psychological distress; and (3) social support on distress, with lower levels of perceived social support being related to more psychological distress. Finally, we hypothesized that social support would mediate the partner abuse–distress association (i.e., account for battered women’s increased distress). The conduct of this study with a low-income African American sample is important given that African Americans are less likely to seek traditional mental health and social services and are more likely to rely on naturally existing support systems than their nonminority counterparts (Kanuha, 1994). Thus, it is crucial that we gain a more in-depth understanding of the role of social support in the lives of disadvantaged African American women in abusive relationships.

## METHOD

### Sampling Procedures

This sample was recruited as a comparison group for a larger case-control investigation. Only African American women from the control condition with current or former partners ( $n = 138$ ; 69%) were included in this study. African American women were chosen to comprise the sample because much of the research on battered women has not focused on this population.

Women were recruited from three medical walk-in clinics at various times of the day and days of the week for a period of 18 months. Research team members,<sup>4</sup> all of whom were graduate and undergraduate psychology students trained in interviewing techniques, approached all women seeking medical treatment in the clinics during the times they were stationed there. Potential participants were told that the study was being conducted in order to learn more about women’s emotional well-being (such as depression) and other types of behaviors (such as substance abuse and experiences with violence). Women were told that the information they provided would be confidential and would not affect the quality of their medical care. Of the African American women approached to participate, 21 declined (10%). Participants ( $M_{\text{age}} = 31.28$ ) were slightly younger than refusers ( $M_{\text{age}} = 36.20$ ). After written informed consent was obtained, women were interviewed orally in a private setting at one of the three clinics. Women were compensated financially for their participation and were provided with appropriate referral sheets following the interview.

<sup>4</sup>The majority of interviewers were Caucasian (90%) and female (80%).

## Measures

### *Sociodemographics*

The following demographic variables were assessed during the interviews: Age ( $M = 31.28$ ,  $SD = 9.60$ ); marital status [0 = unmarried (79%), 1 = married or cohabitating (21%)]; years of education ( $M = 12.05$ ,  $SD = 1.27$ ); homeless status [0 = not homeless (89%), 1 = homeless (11%), which was assessed by single item “do you consider yourself to be homeless?]; and employment status [0 = unemployed (67%), 1 = employed (43%)].

### *Partner Violence*

Partner violence was assessed with the Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981). The ISA is a 30-item self-report scale that assesses the presence and severity of physical abuse (ISA-PA;  $\alpha = .91$ ; 11 items;  $M = 6.94$ ,  $SD = 15.71$ , range = 0–100), and nonphysical abuse (ISA-NPA;  $\alpha = .89$ ; 19 items;  $M = 12.88$ ,  $SD = 19.63$ , range = 0–89.41) inflicted upon a woman by her partner. The scale has demonstrated good internal consistency reliability, and good discriminant content and construct validity among African American women (Campbell, Campbell, King, Parker, & Ryan, 1994). For completion of the ISA, partner was defined as a person the woman has been dating, living with, committed to, or separated from within the past year. Only women who reported having a partner within the last year were included in the analyses. Among these women, over three-quarters (77%) reported currently being in a relationship, and the remainder (23%) reported having been in a relationship within the past year. Women were told that the questionnaire was designed to measure the degree of violence they had experienced in their relationships with their partners.

Each ISA item assesses some aspect of a partner's behavior toward the respondent that is considered abusive. The scale includes items measuring physical (including sexual; e.g., “My partner beats me so badly that I must seek medical help”) and nonphysical abuse (emotional/psychological abuse; e.g., “My partner tells me I really couldn't manage or take care of myself without him”). Items are answered on a 5-point Likert scale, with higher scores indicative of greater levels of partner abuse. Based on the scale authors' recommendations, items are differentially weighted, as some items represent a more serious nature of partner violence.

### *Social Support*

Social support was assessed using the Perceived Social Support scale (PSS), a 15-item measure that assesses an individual's confidence that adequate support would be available if it were needed. The scale consists of items from the Interpersonal Support Evaluation List (Cohen & Hoberman, 1983) and the Social Provision Scale (Russell & Cutrona, 1984), and has demonstrated good internal consistency reliability ( $\alpha = .90$  in the current sample), as well as good validity (Norris & Kaniasty, 1996; Thompson, Norris, & Ruback, 1996). Higher scores indicate more perceived social support. The PSS has three subscales: emotional support (e.g., "There is no one that I feel comfortable talking to about intimate personal problems;" 5 items;  $M = 3.28$ ,  $SD = .72$ ), informational support (e.g., "There is someone I can turn to for advice about handling problems with my family;" 4 items;  $M = 3.12$ ,  $SD = .74$ ), and *tangible support* (e.g., "If I needed a place to stay for a week because of an emergency, I could easily find someone who would put me up;" 6 items;  $M = 3.16$ ,  $SD = .76$ )

### *Psychological Distress*

Both general distress symptoms ( $M = .81$ ,  $SD = .69$ ) and traumatic stress symptoms ( $M = 3.90$ ,  $SD = 4.00$ ) were measured to examine overall psychological distress. General distress was assessed using the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982), a 53-item self-report scale. The scale has been used extensively in trauma studies, and has demonstrated very good internal consistency ( $\alpha = .95$  in current study) and test-retest reliabilities, as well as good convergent, construct, and criterion validity. Higher scores are indicative of greater distress.

Traumatic stress symptoms were measured using the National Women's Study (NWS) PTSD Module (Kilpatrick, Resnick, Saunders, & Best, 1989), a structured interview that can be used by trained, nonclinical interviewers. Higher scores indicate greater extent of traumatic stress symptoms. The NWS PTSD Module was modified from the Diagnostic Interview Schedule, and has demonstrated good validity and reliability (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In the current study, the scale had an  $\alpha$  of .91.

## **RESULTS**

### **Bivariate Relations Among Study Variables**

Pearson correlations of all study variables are presented in Table I. In addition to the intercorrelations for the main study variables, correlations

Table I. Intercorrelations of Observed Measures

	1	2	3	4	5	6	7	8	9	10	11	12
1. Age	1.00											
2. Employed	-.12	1.00										
3. Homelessness	.11	-.20 <sup>a</sup>	1.00									
4. Education	.13	.18 <sup>a</sup>	.01	1.00								
5. Marital Status	.14	.11	.10	.09	1.00							
6. Physical Abuse	.13	-.03	.26	-.02	.05	1.00						
7. Nonphysical Abuse	.15	-.08	.34 <sup>c</sup>	-.07	.26 <sup>b</sup>	.86 <sup>c</sup>	1.00					
8. Emotional Support	.00	.21 <sup>a</sup>	-.11	.24 <sup>b</sup>	-.05	-.27 <sup>b</sup>	-.34 <sup>c</sup>	1.00				
9. Informational Support	.03	.11	-.19 <sup>a</sup>	.23 <sup>b</sup>	-.09	-.32 <sup>c</sup>	-.38 <sup>c</sup>	.55 <sup>c</sup>	1.00			
10. Tangible Support	.05	.22 <sup>b</sup>	-.24 <sup>b</sup>	.20 <sup>b</sup>	-.03	-.34 <sup>c</sup>	-.40 <sup>c</sup>	.51 <sup>c</sup>	.51 <sup>c</sup>	1.00		
11. Distress (BSI)	.07	-.11	.24 <sup>b</sup>	-.05	-.07	.32 <sup>c</sup>	.34 <sup>c</sup>	-.18 <sup>a</sup>	-.16	-.40 <sup>c</sup>	1.00	
12. Traumatic stress	.00	-.04	.21 <sup>b</sup>	.00	.00	.25 <sup>b</sup>	.26 <sup>c</sup>	-.17 <sup>a</sup>	-.08	-.33 <sup>c</sup>	.57 <sup>c</sup>	1.00

<sup>a</sup>  $p < .05$ .<sup>b</sup>  $p < .01$ .<sup>c</sup>  $p < .001$ .

were computed between sociodemographics and the main study variables to determine if demographic variables needed to be controlled for statistically in the path analysis. As seen in Table I, higher levels of partner violence were related to homelessness and being married; lower levels of perceived support were related to unemployment, fewer years of education, and homelessness; and greater distress was related to homelessness.

The strongest correlations were between the measures assessing the same construct. The correlation for the distress measures (BSI, NWS-PTSD) was .57, the correlation between the partner abuse variables (ISA-PA, ISA-NPA) was .86, and the correlations for the social support subscales of the PSS ranged from .51 to .55. As expected, distress, partner abuse, and social support were related significantly, such that both measures of distress were related to physical ( $r_s = .32$  and  $.25$ , respectively) and nonphysical partner abuse ( $r_s = .34$  and  $.26$ , respectively) in a positive direction, and to tangible ( $r_s = -.40$  and  $-.33$ , respectively) and emotional support ( $r_s = -.18$  and  $-.17$ , respectively) in a negative direction; both measures of partner abuse (ISA-PA, ISA-NP) were related to tangible ( $r_s = -.34$  and  $-.40$ , respectively), emotional ( $r_s = -.27$  and  $-.34$ , respectively), and informational support ( $r_s = -.32$  and  $-.38$ , respectively) in a negative direction.

### Overview of Path Analysis

The Linear Structural Relations Program (LISREL 8; Joreskog & Sorbom, 1993) was used to examine the direct and indirect effects of partner violence on psychological distress. A LISREL model has two parts, a measurement model and a structural equation model. The measurement model, which specifies the relations of the observed indicators to their corresponding latent constructs (e.g., the relations between the observed measures of emotional, informational, and tangible support to their corresponding latent construct, social support), is presented in Table II. As can be seen from

**Table II.** Parameter Estimates from Measurement Model

Path	Latent → Observed	Solution	<i>t</i>	<i>R</i> <sup>2</sup>
$\lambda_{11}$	Partner Violence → Nonphysical	1.00	17.26 <sup>a</sup>	1.00
$\lambda_{12}$	Partner Violence → Physical	.84	12.84 <sup>a</sup>	.71
$\lambda_{22}$	Support → Tangible	.75	8.03 <sup>a</sup>	.57
$\lambda_{32}$	Support → Informational	.63	6.97 <sup>a</sup>	.40
$\lambda_{42}$	Support → Emotional	.67	7.41 <sup>a</sup>	.46
$\lambda_{13}$	Distress → General Distress	.74	8.38 <sup>a</sup>	.54
$\lambda_{23}$	Distress → Traumatic Stress	.67	8.27 <sup>a</sup>	.53

<sup>a</sup>  $p < .001$ .

the table, all indicators were related significantly to their corresponding latent constructs.

Maximum likelihood methods were used to examine the overall fit of the model to the data. Polychoric correlations were used for ordinal variables and Pearson correlations were used for continuous variables. Several criteria were used to test the model's overall fit:  $\chi^2/df$  ratio, with ratios of less than 3 indicative of good fit (Carmines & McIver, 1981); the Goodness of Fit Index (GFI) and the Adjusted Goodness of Fit Index (AGFI), with values above .90 indicative of good fit; and the Root Mean Square Residual (RMSR), with small values being indicative of better fit.

Baron and Kenney's (1986) criteria for mediation were used in testing the mediating role of social support. For social support to mediate the relation between partner violence and distress, partner violence must be related to lower perceived social support and greater distress, lower social support must be related to more distress, and the indirect effect of violence on distress must be significant, as this indicates if deteriorated social support accounted for battered women's increased distress.

### **Testing Main Effect of Partner Violence on Distress Using Path Analysis**

A model specifying the main effect of partner violence on distress provided adequate fit to the data,  $\chi^2/df = 115/38$ , GFI = .89; AGFI = .81; RMSR = .070. Education, employment, homelessness, and marital status were entered as control variables. The main effect for partner violence on distress specified in the structural equation model was significant,  $z = 3.89$ ,  $p < .001$  (beta = .41).

### **Testing the Mediation Model**

A model specifying the mediating role of social support in the partner violence–psychological distress relation was tested next. Education and employment were allowed to affect social support, homelessness was free to affect both abuse and support, and marital status was free to affect abuse. Results revealed that the model provided adequate fit to the data  $\chi^2/df = 98/37$ , GFI = .91, AFGI = .83, RMSR = .060. The decrease in  $\chi^2$  with 1  $df$  between the main effect model and the mediating model was 17.00, which was a statistically significant difference,  $p < .001$ . The direct effect of partner violence on social support was significant,  $z = -4.14$ ,  $p < .001$ , such that higher levels of partner violence were associated with

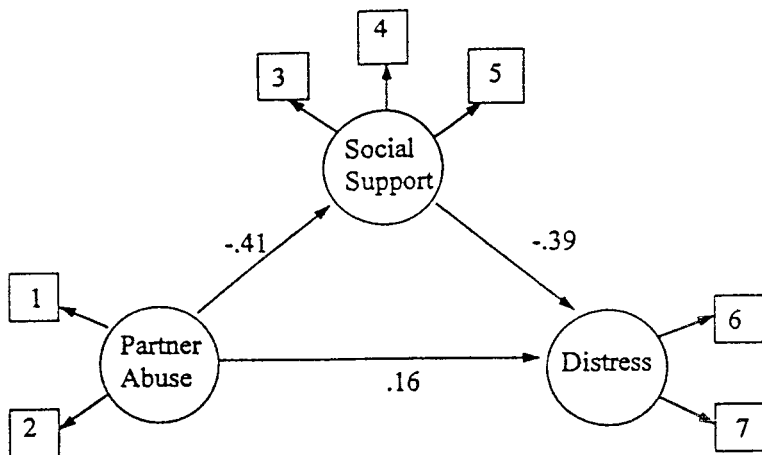
lower levels of perceived social support; social support was related significantly to distress,  $z = -2.77, p < .001$ , such that higher levels of social support were associated with lower levels of self-reported distress; and the indirect effect of abuse on distress was significant,  $z = 2.33, p < .001$ , indicating that social support mediated the relation between abuse and distress. Additionally, the previously significant direct effect of partner abuse on distress ( $z = 3.89, p < .001$ ) was no longer significant when social support was in the model ( $z = 1.19, p > .05$ ).

Because study data are cross-sectional, it is not possible to know if the direction of the paths specified in the model are accurate. Rather than abuse precipitating resource loss, it could be that women with low support resources are more likely to experience partner violence, and hence be more distressed. We tested a model specifying these relations, and the model did not provide a good fit to the data, GFI = .84, AGFI = .72, RMSR = .10. Another possibility is that distress levels mediate the partner violence–support relation, such that women who experience high levels of partner violence are more distressed, and this leads to low levels of perceived support. We tested a model specifying these hypothesized links, and this model also did not provide a good fit to the data, GFI = .83, AGFI = .72, RMSR = .11.

## DISCUSSION

Study results indicate that African American women seeking medical care at a large, urban hospital who experience partner violence report more psychological distress than their counterparts who experience comparatively less or no partner violence. Additionally, higher levels of partner violence were related to lower levels of perceived emotional, informational, and tangible social support, indicating that battered women do not perceive themselves as having social support resources available. Findings further revealed, consistent with our predictions, that low levels of perceived social support helped explain why battered women reported higher levels of psychological distress relative to their less abused or nonabused counterparts.

Before discussing implications of the findings, the limitations of the study should be addressed. A primary weakness of the study is that the data are cross-sectional, and consequently, we do not know if partner violence led to *decreases* in support over time. That the alternative models postulating reverse causal links among the variables did not provide good fits to the data suggests that the specification of path directions in the hypothesized model may be plausible. However, caution should be exer-



**Fig. 1.** Structural equation model showing relations among partner violence (variables 1 and 2), social support (variables 3–5), and distress (variables 6 and 7). Values are standardized regression coefficients.

cised in interpreting the findings, as the data are not longitudinal. Another limitation to the data are that they are based on self-report measures obtained from the women only. It is unknown whether or not women's partners would corroborate the presence and degree of abuse, or if the women may be underreporting the extent of the violence. Another problem with the design of the study was that only perceived social support, but not received social support, was assessed. Thus, circumspection is warranted in making recommendations to service providers, as we do not know if the actual receipt of support would explain the link between partner violence and distress in the same way that perceived support did. Although perceived support and received support have been found to be significantly correlated in prior studies, the magnitude of association is not as high as one might expect (Norris & Kaniasty, 1996). Future research efforts should be aimed toward replicating the current results using longitudinal data, and by incorporating measures of received social support.

Despite these methodological limitations, there are several implications based on the findings obtained. First, results from the current study underscore the need for service providers to focus on enhancing social support resources in their work with women who experience partner violence. Interventions for battered women should aim to help women amass or replace valued resources, including, but not limited to, social support. Early intervention is critical, as illustrated by Hobfoll and Lilly's (1993) concept of loss spiral, which is used to describe situations where initial loss begets future loss because resources are already low. Because the data only reveal that

*perceived* social support explains battered women's relatively increased distress levels, more research is needed to specify more accurately how service providers should proceed in helping women improve their social support resources.

Second, service providers need to be pro-active in reaching minority women who are victims of partner violence in order to address their needs more effectively. Given that African American women are more likely than Caucasian women to seek routine care from medical facilities (Asbury, 1987), emergency departments and other medical settings may be key points of interventions for African American women who are victims of partner violence. Furthermore, medical settings may also be ideal places to intervene with battered women, as it has been found that over one-third of women seeking emergency medical care for violence-related injuries had been injured by their current or former spouses (Rand & Strom, 1997). This figure does not even capture the number of women who seek nonemergency health services for symptoms that are often secondary to partner violence, such as headaches, sexual dysfunction, sleep and eating disorders, and general aches and pains (Randall, 1990).

Research indicates that physicians detect only 5% of all cases of partner violence (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995), underscoring the need for the training of health care professionals to detect and address cases of partner violence. In one study in which emergency department nurses were trained in administering a partner violence screening protocol, the proportion of women patients identified as battering victims increased from 5.6% to 30.0% (McLeer & Anwar, 1989). Thus, improved screening for women experiencing partner violence would facilitate the identification of women in need of services. Training programs for health care professionals to improve identification and intervention efforts with women injured by male partners are becoming more and more common (Hamberger, Ambuel, Marbella, & Donze, 1998; Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981). In one study, researchers surveyed a group of ethnically diverse battered women and found that the women reported several undesirable interpersonal behaviors among physicians, including not assessing relationship history, too easily accepting false explanations for injuries, and treating injuries without inquiring as to their cause (Hamberger *et al.*, 1998). Thus, not only are efforts needed to screen more effectively for partner violence, but training is needed to improve how health care personnel interact with women at-risk for partner violence, as well as how they intervene to help them.

Before closing, it is important to highlight the contribution of our study sample. Social support is a resource of paramount importance for women in the African American community (Mays, Caldwell, & Jackson, 1996; Nisbett,

1996). While it is statistically difficult to document complete mediation (Baron & Kenny, 1986) as was done in this study, the finding of social support as a mediator in the partner abuse–distress link is not surprising and highlights the salience of this resource for low-income, battered women in the African American community. Because social support may be a less significant variable for women of other ethnic and cultural groups and economic backgrounds, the generalizability of the findings awaits further examination. This study also contributes to the literature on partner violence by documenting its effects among African American women, a group that historically has been underrepresented in research on partner violence (Coley & Beckett, 1988; Goodman *et al.*, 1993b; Kanuha, 1994; Reid, 1993), despite the fact that they are at increasingly high risk for a broad array of psychosocial difficulties (Comas-Diaz & Greene, 1994), including partner violence (Sorenson *et al.*, 1996). Although the mean scores on physical and nonphysical partner violence are somewhat lower in this sample compared to other samples, this is likely due to sample composition differences. In many of the studies in which the ISA was administered, the sample was comprised of women who were known to have experienced partner abuse, thereby inflating the mean scores. For example, in a study conducted with women presenting to public prenatal clinics, the means for African American women on the ISA-P and ISA-NP respectively, were 12.20 and 20.48. However, the means reported in the same study for nonabused African American women were 1.97 and 5.78 (McFarlane, Parker, Soeken, & Bullock, 1992). Additionally, in another sample of 485 African American women recruited from various sources, means for the ISA-P and ISA-NP were 15.63 and 21.86, respectively. One-fourth of the sample, however, was recruited into the study on the basis of having been abused during the preceding year, thereby inflating the mean scores on the ISA subscales (Campbell *et al.*, 1994). When examining differences in partner violence across studies, it is important to pay attention to how partner violence was assessed, how the sample was recruited, and the time frame used to assess partner violence.

To our knowledge, this is the first study to document that low levels of social support helps explain battered women's increased distress. Results are suggestive that interventions to help improve battered women's social support would serve to reduce the psychological distress associated with partner violence.

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