WOMEN, MOTHERHOOD,

AND INTIMATE PARTNER VIOLENCE

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To the Faculty of Washington State University:

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Abstract

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Several decades of feminist activism, public attention, research, policies, and program interventions have attempted to address the scope of intimate partner violence and its deleterious effects on society, but the majority of this attention and research has centered on the experiences of middle class White women. This dissertation considers variability in the risk of intimate partner violence among five groups of young, low-income, first time mothers who vary by race, ethnicity, and nationality. Respondents come from a national health program, the Nurse-Family Partnership, which promotes prenatal care for first time mothers and establishes healthy behaviors between parents as infants develop. Drawing from an intersectional framework, I consider heterogeneity in risk of violence among first generation Latinas, Black women, White women, second generation Latinas, and immigrant women from Eastern Europe, Africa, and Asia. I examine structural differences in their social locations and relate this to their risk of experiencing violence by a partner. I consider whether a widely used methodological tool, the Conflict Tactic Scales 2, is appropriate for estimating violence experienced by women of diverse backgrounds. Principal components factor analysis is used to reduce the 39 items of the CTS2 to five factors to measure partner violence among women. Descriptive data show diverse and dynamic constellations of family and gender relations that translate to different levels of risk of

partner violence among women. Regression analyses show that immigrant women are less likely to experience abuse by an intimate than U.S. born women. Black women are more likely than White women to experience partner violence; second generation Latinas are less likely to be abused. Factors associated with partner violence are being younger, having higher levels of education, moving frequently in the past year, having low levels of partner support, and experiencing high levels of stress and a past history of trauma. The reporting of sexual coercion without physical force is a common pattern among women in each group, which may indicate that it is an underlying mechanism of control that opens the door for escalating levels of partner violence and abuse.

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CHAPTER ONE

INTRODUCTION

Much attention has been given to addressing the social problem of intimate partner violence (IPV) between men and women. Research has established that IPV is a significant public health problem in the United States and throughout the world (Krug et al. 2002).[1] In the U.S., nearly one and a half million women and 800,000 men are physically assaulted by their partner every year. These numbers translate to one in four women and one in seven men. According to recent estimates of severe violence, 1300 women are murdered by their partners each year (Rennison 2003).

The Centers for Disease Control and Prevention estimates that IPV against women results in approximately two million injuries per year in the United States. Violence against women is estimated to cost about six billion dollars a year in lost productivity at work and health care costs (National Center for Injury Prevention and Control 2003). Female victims report more injury, greater fear of injury, more time lost from work, and more frequent use of medical and justice service systems than their male counterparts (Tjaden & Thoennes 2000). Victims of IPV may suffer a range of negative physical and mental health consequences including rape, stress related illnesses, broken bones, cuts, bruises, fear, anxiety, depression that can lead to suicide attempts, chronic pain, and gynecological problems (Bent-Goodley 2004; Campbell et al. 2000; Kaslow et al. 1998; Plichta 2004). Victims of intimate partner violence are also more likely to suffer from chronic health conditions and participate in risky health behaviors such as increased substance abuse (Bent-Goodley 2004).

[1] The social magnitude of intimate partner violence has led to an entire branch of the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, to maintain a division dedicated to preventing intimate partner violence. The CDC began receiving government funding to develop and evaluate programs to prevent violence against women, most of which is attributed to IPV, in 1994 (Klevens 2007).

Although problems of rape, battering, and other forms of violence against women have existed throughout history (Davis 1981; Miller and Knudsen 2007), it is only since the 1960s that these issues have received significant attention in the United States. Early calls to view IPV (or domestic violence) as a major social problem began during the second-wave feminist movement as White, middle class feminists worked to politicize men's violence against women, framing the issue of partner violence as one of men acting against women, primarily their wives (Brush 2005). The initial focus was on protecting women from violent partners by offering resources such as women's shelters to escape abuse, and by treating male batterers in intervention programs to stop future partner violence. From these politicized struggles the widely utilized Duluth Model was developed.[2] Recently, debate has raised questions as to whether or not batterer intervention programs using the Duluth Model are effective in reducing partner violence and if use of the model is good public policy (National Institute of Justice 2003, <www.duluth-model.org>). Much of the controversy over batterer interventions' effectiveness is built on an understanding of men and women as fundamentally different groups, with men being the more likely of the two groups to engage in partner violence, whether for biologically based or culturally driven reasons (Hearn and Whitehead 2006).

More recent research on partner violence has focused on gender symmetry, arguing that men and women commit violent acts against each other at or near equivalent rates. Specifically, research using data from the National Family Violence Survey has shown that men and women are equally likely to be physically assaulted by an intimate partner, but that "the dynamics of battering differ for males and females [suggesting a] need for batterer intervention programs

[2] The Duluth Model is a cognitive behavioral based batterer intervention program that is widely used across the United States. A central assumption of this model is that nature and culture are separate. Men are cultural beings who can be educated to stop battering because abusive behavior is culturally rooted, not innate within them because of their sex.

designed specifically to meet the needs of female batterers" (National Institute of Justice 2003:3). In contrast, data from the Bureau of Justice Statistics' National Crime Victimization Survey has shown that women are at significantly greater risk of intimate partner violence than are men.

An important conclusion from discrepancies in gender symmetry research is that contradictory results stem from differences in theoretical perspectives, measurement issues, and sampling techniques employed across studies. The context in which surveys are distributed (Tjadden and Thoennes 2000); the use of large national crime victimization surveys vs. smaller random samples or convenience samples from shelters, policy reports, and other public agencies (Kimmel 2002); and different conceptualizations of aggression within families (Johnson 1995; Johnson and Ferraro 2001) have all been used to explain differences in findings on gender symmetry and partner violence. Today much of the focus of IPV research and intervention continues to target women as victims and men as aggressors. Thus, several decades of feminist activism, public attention, national and international research, and public policies and program interventions have attempted to address the scope of intimate partner violence and its deleterious effects on society.

Research Goals

Intimate partner violence research is built on an understanding of women and men as distinctive groups separated by biologically and/or culturally based differences. For example, men and women are considered different because of anatomical or physiological differences which are then translated into cultural differences in society that result in unequal power, status, and the like. Very little research on partner violence has considered variability among members

of each gender category, specifically how women vary from other women, or men from other men.

Most researchers have tended to ask questions related to the extent, nature, and consequences of IPV using essentialist, binary categories including: women and men, Hispanic and non-Hispanics, same sex and heterosexual couples, etc. Few have considered how the intersection of race, class, gender, ethnicity, and nationality place some women at higher risk of being a victim of IPV than others. Evidence of this limitation in IPV research is echoed by Tjaden and Thoennes (2000) who found in the National Violence against Women Survey that rates of IPV vary significantly among women of diverse racial backgrounds. According to the authors:

> Studies are needed to determine why the prevalence of intimate partner violence varies significantly among women of different racial and ethnic backgrounds. It is unclear from the survey data whether differences in intimate partner victimization rates among women of different racial and ethnic groups are caused by differences in reporting practices. It is also unclear how social, environmental, and demographic factors intersect with race and ethnicity to produce differences in intimate partner victimization rates among women of different racial and ethnic backgrounds. Thus, more research is needed to establish the degree of variance in the prevalence of intimate partner violence among women (and men) of diverse racial and ethnic groups and to determine how much of the variance may be explained by differences in such factors as cultural attitudes, community services, and income….Finally, research is needed to determine whether differences exist

in intimate partner victimization rates among minority women born in the United States and those who have recently immigrated (56).

This research addresses the calls of Tjaden and Thoennes (2000) by examining variation in the risk of intimate partner violence among five diverse groups of low income women who vary in race, ethnicity, and U.S. citizenship status. They include 1) first generation immigrant Latinas currently residing in the U.S., 2) second generation Latinas who were born in the U.S. but whose parents were not, 3) White women, 4) Black women, and 5) first generation immigrant women who identify as non-Latina. Specifically, this last group of immigrant women originates from Latin America, Asia, Africa or Eastern Europe and currently resides in the United States.[3] I pay particular attention to the heterogeneity of the women in this study to assess their social locations in relation to partner violence. I consider individual, interactional, and structural factors to explain variability in women's abuse. In comparing women's reports of physical, emotional, psychological, and sexual abuse by their partners, I hope to contribute to the improvement of existing public health programs aimed at preventing partner violence by making legislators and researchers aware of the need for the modification of existing programs into accessible, successful, and culturally relevant programs.

A second common aspect of IPV research is the utilization of the Conflict Tactics Scales (CTS) as a standardized methodological tool for measuring levels of IPV. The CTS were designed and first utilized by sociologist Murray Straus in the 1970s to measure a variety of behaviors or tactics used in response to a conflict situation. They are based on the theoretical

[3] Women in this fifth group (N=7) are analyzed together because of small sub-sample sizes, in order to maintain participant confidentiality. It should be noted that socio-cultural differences among women in this smaller immigrant group, based on their racial, ethnic, and citizenship background, are significantly greater than among White women or Black women from the U.S. For example, non-Latina immigrant women in this group originate from places as diverse as Ukraine and Ethiopia. The socio-cultural variability among 1st and 2 generation Latinas falls between the ends of this intersectional spectrum, i.e., Latinas are not a homogeneous group either and should not be perceived as such.

framework of Conflict Theory (Coser 1956). The CTS include assessments for different ways of dealing with conflict: reasoning, verbal aggression, and physical aggression. The CTS and their recent revisions, the Conflict Tactics Scales 2, are the most widely used instruments for obtaining data and estimates of the prevalence of intimate partner violence (Dietz and Jasinski 2007). To date, there are few other instruments that have been developed to measure IPV (for example, Hegarty et al. 1999; Marshall 1992; Hudson and McIntosh 1981). Because most IPV researchers in the U.S. use the CTS as a primary measure of IPV (Shwartz 2000), this allows for comparisons of IPV across studies.

Despite being nearly the sole measure of domestic violence, however, the CTS instruments are not without their criticisms. The scales have been critiqued for their length, the inclusion of particular items of violent acts in the scales over others, the use of a time referent of one year, and the exclusion of any context to understanding violent acts (Straus and Gelles 1990). In 1996, Straus et al. revised the CTS to address some of researchers' concerns and criticisms. The CTS2 added improved versions of the three original scales that measured physical assault, psychological aggression, and negotiation and added two supplemental scales to measure victim injury resulting from an assault by a partner and sexual coercion. Straus argued that further expanding the number of items in the scale would increase reliability and validity (Straus et al. 1996). More recently, researchers' concerns regarding the methodological appropriateness of the CTS2 have led to examination of the factor structure of the five subscales among non-college populations (Newton et al. 2001) , on gender differences in reporting violence (Mouradian 2003), and the impact of item order on the reporting of IPV (Mouradian 2003; Ramirez and Straus 2006; Dietz and Jasinski 2007).

Currently, there are few studies that have questioned the cross-cultural applicability of the CTS2. The one exception, an analysis conducted by Straus (2004) using data from the International Dating Violence Study (IDVS), considers the scales outside of a North American context. But data from the IDVS comes from a convenience sample of university students from 17 countries. Thus, the applicability of the CTS2 has not yet been examined in measuring partner violence among lower income, less educated, racially, ethnically, and culturally diverse women. The limited consideration of the CTS2 outside of a higher education context suggests an area in need of researchers' attention. Filling this methodological gap in IPV research is a second goal of this study.

To summarize, this study addresses two major gaps in research on intimate partner violence. First, I provide a systematic comparison in the variance of risk of intimate partner violence among five diverse groups of women and consider factors that explain these differences in IPV victimization rates among these women. Second, I determine if the widely used Conflict Tactics Scales 2 are an appropriate survey tool to use in assessing IPV among the women of different backgrounds. Particularly, I assess whether the CTS2 should be used by researchers to evaluate the prevalence of IPV among women of color and immigrant women in the United States.

A Note on Language

This study's central focus is on how race, class, gender, ethnicity, and nationality structure women's risk of experiencing violence by an intimate partner and whether the CTS2 adequately capture this variation of risk among several groups of women. Race and ethnicity are important concepts in need of explanation. "Race" is often characterized as a group of people who are related in some way by particular physical characteristics (such as skin color, hair

texture, eye color, etc.) that are fixed and immutable (Bonilla-Silva 1996; Omi and Winant 1994). Ethnicity is used to characterize particular groups of people who share in common a language, history, place of origin, religion, or social customs (Rodríguez 2000). Both of these concepts are social constructions; neither represents a "real" category with genetic, natural, or biological bases (Bonilla-Silva 1996; Omi and Winant 1994; Rodríguez 2000).

Racial and ethnic identities and labels change from place to place and over time. Racial and ethnic groups do not have one history, rather a diverse range of experiences based on race, ethnicity, social class, gender, region, age, and nationality. Naming racial and ethnic groups can be problematic, especially when diverse members of a group contest labels applied by other members, the government, or the society at large. Although race in itself is not real, it is real in its effects because the idea of race is used in contemporary U.S. society to structure opportunity, advantages and disadvantages, power and privilege among social groups (Bonilla-Silva 1996).

Research on the racial identification and self-reporting of "Hispanics" in particular suggests that Latino identity is dynamic and diverse, among and within Latino groups (Rodrígez 2000). Although the historically constructed terms "Hispanic" and "Latino" are sometimes used interchangeably by researchers, both are problematic and carry with them ideological baggage (as do other socially constructed labels associated with concepts such as race, ethnicity, and gender). These labels reflect categories that are neither discrete nor mutually exclusive. Racial constructs, especially in Latin America, are much more fluid and based on many variables including race, class, ethnicity, and national identity. For example, among Mexicanos (people native to Mexico), there are cultural differences between mestizos and indigenous-origin immigrants, between distinct indigenous groups, and migrants from different sending villages (Stephen 2007).

Unfortunately, data in this study are not systematically disaggregated beyond the categories Hispanic, White, Black, and Asian American. Some respondents voluntarily reported their place of origin or birthplace during interviews and a discussion of where immigrant women come from as it relates to their risk of abuse is considered later in this paper. However, respondents who did not volunteer information about their country of origin were not probed further in interviews. The ways in which indigenous immigrants, mestizos, Mexicanos, and members of other Latino groups identify themselves vary considerably but one commonality is many people's rejection of the label Hispanic (see Rodríguez' 2000 discussion of Latino racial identification in the U.S. Census). I employ the term Latino instead of Hispanic because it is a construct more widely supported within Latino communities in the United States. Similarly, I capitalize Black and White to designate social groups that have claimed or constructed their own racial and ethnic identities.

Research Context

The respondents in this study are low income, first time mothers between the ages of 15-36 who are participants in a federally funded public health program called the Nurse-Family Partnership (NFP). In addition, they are all residents of a particular urban Oregon county that I call River County. Demographically speaking, River County has just over half a million residents among which approximately 5% are Black, 5% are Asian, 10% are Latino, and 80% are White (Census Bureau 2006). Roughly fourteen percent of all residents are foreign born.

In the last 20 years, Oregon's immigrant population has increased 217% (Singer 2004). The area around and including River County contains a foreign born population that has also grown considerably within the last decade, contributing to Oregon's place as the sixteenth fastest growing immigrant state in the United States (Lotspeich et al. 2003). Among all immigrants

living in the River County area, Latin Americans comprise 36% (of this, 29% are from Mexico), Asians 35% (primarily from Vietnam, China, Korea, India, and the Philippines), Europeans 20% (from the Ukraine, the United Kingdom, Russia, and Romania), and Africans two percent (Lotspeich et al. 2003). Of the 25,000 Oregon refugees from Africa, nearly half are from eastern Africa including Ethiopia, Kenya, Somalia, Tanzania, Uganda, Zambia, and Zimbabwe (Fairweather 2007). These statistics reveal considerable diversity among immigrant and refugee groups. At the same time, however, foreign-born immigrants have several things in common. They are more likely than naturalized immigrants or native citizens to live below the poverty level, to live in clustered settlements, to have lower levels of education, and to earn less than other groups (Lotspeich et al. 2003).

Latino population growth in particular is a recent phenomenon in Oregon and has been quite sizable over the past decade. The sudden demographic change in Latino presence has led to Oregon being characterized as a "new frontier" or "high immigration" (Padín 2005) as it continues to have a foreign born population that is above the national average. Latinos make up approximately ten percent of the state's population (Census Bureau 2006) and their historical presence and economic contributions to the state's economy are as significant as the numerical size of such a diverse group of people. Today within the Pacific Northwest, there is diversity between people of Latin American and Spanish descent because of their many points of origin before immigration to the United States. Additionally, there is diversity within the Mexican-American population based on factors including time of arrival to the U.S. and urban/rural residence (Cook 1986).

Latino presence in the Pacific Northwest can be traced to over 225 years ago when sailors from Mexico, Peru, and Spain approached the Oregon, Washington, and British Columbia

coastlines looking for settlement sites (Alamillo 2004; Nusz and Ricciardi 2007). Mexico's border was, up until 1846 when a treaty was signed between England and the United States, positioned between what are today Oregon and California (Stephen 2007). In the 1860s and 1870s, workers from Mexico, along with workers from China, Japan, and the Philippines built railroads linking east and west coasts. Since the time the U.S. re-constructed the border, U.S. immigration and economic trade policies have heavily influenced the migration of people from Latin America to the United States. One particularly influential migration policy was the bracero program.

The bracero program began in 1942 and eventually germinated large scale permanent settlement of Mexican immigrants in the United States. It was an immigration policy that encouraged millions of Mexican farm workers to migrate to the U.S. to work on temporary contract and meet labor demands due to wartime labor shortages in agriculture that had previously been filled by Chinese, Japanese and then Filipino predecessors (Hondagneu-Sotelo 1994). Many Mexicanos migrated from rural communities to cities in Mexico, such as Juarez or Chihuahua, and then to cities in the Southwest or California. Braceros comprised a major portion of the agricultural labor market until the program ended in 1964 amidst decries of significant human rights abuse and violations (<www.afsc.org>). At one point, Lee G. Williams, the U.S. Department of Labor officer in charge of the program, described it as a system of "legalized slavery" (<www.farmworkers.org>).

Today, many Latinos in the Pacific Northwest have made similar journeys – migrating from rural parts of Central America or Mexico, out of the Southwest U.S. to the Northwest (Perry and Schachter 2003). One factor drawing Latinos to the Northwest is the substantial expansion of labor intensive, irrigated crops, which require more farming labor and involve more

food processing (Cook 1986). Latino farm workers play a vital role in Oregon's agricultural economy (Kissam and Stephen 2006). Those working in agricultural production may be migrant farm workers whereby their principal employment is seasonally based and their residence is temporary, or they may be seasonal farm workers and remain in residence throughout the year.

The continued growth of the Mexican population in Oregon since the 1940s has largely been due to growth in agriculture, so much so that several cities in Oregon have established Latino settlements (Stephen 2007). For example, one town within a thirty minute drive of River County has a total population of around 20,000 people and Latinos make up fifty percent of this population. In addition, Latinos own businesses downtown, maintain a public radio station dedicated to Latino unionizing and labor rights, and attend local schools where educational curriculum is taught in their native language. All of this suggests Latinos are building and influencing political, economic, and social institutions in the region.

Several events that occurred during a year of data collection for this research project exemplify the context of reception for new immigrants in River County. Context of reception is a concept discussed by Portes and Rumbaut (2001) as the complexity of the situation that immigrants enter when moving to a new place, specifically, the existing policies and institutions that affect immigrants and the existence or nonexistence of co-ethnic immigrants. Context of reception speaks to the disadvantages that immigrants and their children confront. Success in the new place depends not only on what immigrants bring with them in terms of human and social capital, but also how immigrants are received by native residents. Immigrant Latinos' reception in Oregon is impacted by those in power, including the attitudes of native born White Americans, government policies, and institutional policies that exclude immigrant Latinos from

critical societal arenas. Padín (2005) suggests the mainstream media also plays a critical role in shaping a climate of reception for immigrants in Oregon and elsewhere.

On one hand, River County may be viewed as supportive and positively receptive to new immigrants due to the presence of several non-profit organizations which, through cross border organizing, fight for immigrant rights and offer new immigrants social and economic resources. For example, there are over a dozen active immigrant rights non-profit organizations currently operating in River County. Additionally, several universities maintain active student chapters of Movimiento Estudiantil Chicano de Aztlán (M.E.Ch.A.), an organization dedicated to Chicano political involvement and education for social change. In addition to educating the public about the social injustices faced by immigrants, these organizations offer cultural and social resources for immigrants to become established in their new residence. Recently, day laborers successfully organized to obtain local government support and funding for an agricultural day laborer site (Planchon 2008). The River County community regularly organizes and holds public demonstrations to promote awareness of the struggles faced by many immigrant groups, especially Latinos. Several Latino-centered and African-centered agencies operate to educate and mobilize community members around struggles for human rights and social justice throughout the Americas and Africa.

Despite all this, two major events occurred during the year of data collection for this project that contradict the notion of a positive context of reception for immigrants and reflect racial tension and a hostile environment. Approximately four months into the study, a federal raid at a Del Monte processing plant led to over 200 workers being arrested and detained (Slovic 2007, 2007b; Beaven and Hallman 2007). The effects of this raid were seen during the initial introduction and consent of some immigrant Latinas into the study, especially those who lived in

neighborhoods near the plant, had relatives working there, or were themselves employed at the plant. Respondents were much more difficult to contact (Beaven 2007) and were hesitant to return researchers' calls to be interviewed. Several months after the raid, another incident occurred in which White business and community members publicly protested the renaming of a city street after agricultural labor leader César Chávez. This exerted enough political pressure on the city government to kill the renaming project (Howd and Swart 2008).[4]

The experiences of Blacks in the River County area are similarly rooted in intergenerational mistrust and displacement (McKeever, Koroloff, & Faddis 2006). For example, Oregon's original constitution contained a law prohibiting Blacks from permanent residency in the state. In the 1860s, Blacks who migrated to Oregon faced widespread prejudice and intolerance and were forced to live in a small area along the Columbia River (CRBEHA < http://www.vancouver.wsu.edu/crbeha/projteam/ >). During World War II, Black's migration to work in the county's shipyards resulted in a severe housing shortage that was exacerbated by the county's refusal to grant building permits to Blacks (Maben 1987). A local shipbuilding company eventually erected a housing development situated on land reclaimed from the Columbia River and surrounded by dikes, but in 1948, disastrous flooding destroyed the development and left 18,000 Blacks homeless (McGregor 2003). The flood increased many Blacks' mistrust of local authorities and other officials and this mistrust exists today.

The racial climate of River County is important to consider because it shapes existing social arrangements and institutions where women and their partners currently reside. The context of their homeland – be it in the U.S. or not – also provides key insight into their potential

[4] Protest to the street renaming was a very public event. Many neighborhood associations and businesses attended a series of community meetings to vent their frustrations. These events often pitted White community members against Latino community members. While opposition expressed reservations about renaming a city street due to the economic costs, just a few years earlier a nearby street was renamed for Civil Rights activist Rosa Parks with less resistance.

risk for being a victim of intimate partner violence. Some aspects of the context are constant for all respondents. They are all in an important stage of their life course – giving birth and becoming mothers. Additionally, three fourths of the mothers in this sample are under the age of twenty-one and transitioning from being teenagers to becoming young adults. As young, first time mothers with limited financial resources and variable social support from family members and other important social ties, women may be at heightened risk of being victims of intimate partner violence due to their potential isolation and dependency on their partners – financially, socially, and emotionally. But it should not be assumed that they are all at equal risk. Intersections of gender, race, ethnicity, and nation structure this risk very differently among the women.

Intersectional Framework

The framework which guides this study is an intersectional framework, one that recognizes multiple and intersecting structural inequalities related to factors associated with the differences in the risk of partner violence for these young women. Debates about the relationship between gender and race are at the center of feminist theorizing in the United States. As gender scholar Joan Acker (2006) suggests:

> Thinking in a vocabulary of intersectionality is powerful because it demands that we connect many processes, such as race, gender, class, and sexuality, which previously have been isolated in bounded categories, to see the very complex, interlinked production of inequalities and identities. Thinking intersectionality is difficult because it is not clear how to break down the boundaries of reified categories to show how multiple inequalities are simultaneously reproduced. Each categorical name—e.g., gender or class—represents complex and highly variable

> social relations, usually simplified as sub-categories—e.g., masculine and feminine or middle class and working class….Intersectional analysis must also be historical, for practices always take place in real time, linked to past time (446).

In addition to shifting conceptualizations of gender within the field of gender studies, there is a methodological divide between public health agencies that identify factors associated with partner violence in dominant group populations using quantitative methods and feminists who examine violence against women at the margins through ethnographic or case study research. The difference in these approaches lies in treating gender as a variable (Stacey and Thorne 1985) versus treating gender as a construct that interacts with other social constructs and organizes social life.

Quantitative approaches to the intersection of gender, race, nation, and class are rare; this is my primary endeavor. My research agenda concerns comparing groups of women with each other to find out which groups are at greatest risk of being a victim of partner abuse. I also hope to identify what factors account for some women's reduced risk of violence – information important in informing existing violence prevention programs. My starting point for examining intimate partner violence is consideration of the interconnections of systems of oppression that shape women's daily lives and that structure their risk of victimization. Structuralist and institutional scholars have established that gender (Acker 1990; 1992) and race (Bonilla-Silva 1996; Omi and Winant 1994) play enduring roles in the social structure of contemporary U.S. society. In addition, race and gender organize social institutions in ways that privilege some groups over others.

Institutional forces may operate independently or concurrently in how they create opportunities or barriers for different groups of women. At another level, institutions also shape

the social context of private matters between intimate partners and family members. For example, although all women may be vulnerable to male violence, there are disparities in social, economic, and cultural circumstances that render women of color vulnerable to male violence at individual and institutional levels in ways that White women are not (Richie and Kanuha 2000). Immigrant women experience cultural, structural, and social changes after migration, a process which in itself is gendered (Hondagneu-Sotelo 1992, 1994). Migration influences intimate behaviors between partners, changes relationship goals, and may offer immigrant women increased access to education and greater economic opportunities (Hirsch 2003) relative to their homeland. In a new context, immigrant women may find that their partners have less power to constrain their activities and they may experience increased autonomy and independence. These possible sources of empowerment may lower some immigrant women's risk of IPV vis-à-vis women of color who are citizens of the United States.

This study begins with the assumption that – in addition to gender – race, ethnicity, and nationality are key factors in shaping heterosexual women's risk of experiencing intimate partner violence. This assumption draws from an intersectional framework and rejects "sameness" and "difference" models. "Sameness" models assume that women are essentially similar to men and, therefore, the sexes should be treated equally. A "difference" approach suggests that women have distinctive characteristics that require special treatment to overcome discrimination based on gender (Burgess-Proctor 2006). Underlying these models is the assumption of a universal "woman," which is a false notion. "Additive" models are another type that characterizes much of the existing research on partner violence. This is where variables such as race, class or sexuality are "added" into an otherwise unaltered framework or analysis of IPV. From an

intersectional perspective, race, class, gender, and nationality are key explanatory factors of intimate partner violence (Bograd 1999).

An intersectional framework is informed, in part, by Black woman scholar-activists who in the early 1980s called for a new approach to analyzing Black women's lives by recognizing that women's experiences are shaped not just by their gender, but also by their race, social class, and sexuality (Collins 2000b). Similar calls have been made by lesbian scholar-activists (Lorde 1984), Chicana feminists (Anzaldúa 1987), and Third World global feminists (Mohanty 1997). Intersectionality recognizes the ways in which, at a micro level, race, class, gender, and nationality shape identities and how, at a macro level, institutions are organized by race, class, gender, nationality, and other social constructs. Race, class, gender, ethnicity, nationality, etc. are components of both social structure and social interaction.

Most importantly, an intersectional framework considers disparities in power and privilege among women. It emphasizes that a power hierarchy—what Collins (2000) calls a "matrix of domination"—exists in which groups of people are socially situated according to their differences from one another. Regardless of individual women's social location, intersections of race, class, gender, and citizenship create disadvantages for some groups of women (women of color in the U.S.) and provide unacknowledged benefits for those at the top of the social hierarchy (i.e., native born White women of the middle and upper class) (Baca Zinn & Thornton Dill 1996). Two other key aspects of intersectionality are its emphasis on relationality and the interaction between social structure and women's agency. Relationality means that among women, socially constructed differences based on race, ethnicity, sexuality, and nationality are connected in systematic ways (Baca Zinn & Thornton Dill 1996).

In the following chapter, I summarize literature on the Conflict Tactics Scale 2 to determine its origins, use, strengths and limitations as a survey tool for measuring intimate partner violence. Then, I review how Black women, White women, Latinas and other immigrant women are differently situated to access critical social and material resources including health care, employment, and social support. These resources are important to consider because they moderate the risk that mothers face with regard to partner violence. I follow this with a discussion of each group of women's risk of IPV. Relying on an intersectional framework to guide me, I review literature from several disciplines and substantive areas including sociology, feminist studies, race studies, immigrant studies, public health, psychology, and criminology.

CHAPTER TWO

LITERATURE REVIEW

Measuring Intimate Partner Violence

No other instrument has been used more than the Conflict Tactics Scales (CTS) to measure different types of abuse and violence that occur in dating, cohabiting, and marital relationships. The original CTS consisted of two forms. One was designed to be self-administered and to measure family abuse among a sample of university students in the early 1970s (Straus and Gelles 1990). The second was designed for face-to-face interviews and later adapted for telephone survey in broader populations (Miller and Knudsen 2006). The original CTS consisted of 19 items which were intended to summarize the following aspects of conflict: 1) verbal reasoning, 2) verbal aggression, and 3) physical aggression. These aspects are often distinguished in research as emotional abuse and physical abuse, and as a range of violence from none to severe. The CTS revision, the CTS2, includes measures of 4) sexual coercion and 5) injury, and these modifications increased the scales to a lengthy 39 items. The five subscales of the CTS2 are often referred to as: physical assault, sexual assault, injury, psychological aggression, and negotiation. Figure 1 provides a summary list of the items that comprise each of the five subscales.

Figure 1. Revised Conflict Tactics Scales 2

Negotiations
Has your partner shown care for you even though you disagreed?
Has your partner explained his/her side of a disagreement to you?
Has your partner shown respect for your feelings about an issue?
Has your partner said s/he was sure you could work out a problem?
Has your partner suggested a compromise to a disagreement?
Has your partner agreed to a solution to a disagreement that you suggested?

Physical Assault
Has your partner used a gun or knife on you? *
Has your partner burned or scalded you on purpose? *
Has your partner grabbed you?
Has your partner kicked you?
Has your partner thrown something that could hurt you?
Has your partner twisted your arm or hair?
Has your partner pushed or shoved you?
Has your partner punched you or hit you with something that could hurt?
Has your partner choked you?
Has your partner slammed you against a wall?
Has your partner beat you up?
Has your partner slapped you?

Psychological Aggression
Has your partner insulted or sworn at you?
Has your partner called you fat or ugly?
Has your partner destroyed something belonging to you?
Has your partner shouted or yelled at you?
Has your partner stomped out of the room during a disagreement?
Has your partner accused you of being a lousy lover?
Has your partner done something to spite you?
Has your partner threatened to hit or throw something at you?

Injury
Have you passed out from being hit on the head by your partner in a fight? *
Have you gone to the doctor because of a fight with your partner? *
Have you needed to see a doctor because of a fight with your partner, but didn't? *
Have you had a broken bone from a fight with your partner? *
Have you felt a pain that hurt the next day because of a fight with your partner?
Have you had a sprain, bruise, or small cut because of a fight with your partner?

Sexual Coercion
Has your partner used force (like holding down) to make you have oral or anal sex? *
Has your partner used force (like holding down) to make you have sex? *
Has your partner used threats to make you have oral or anal sex? *
Has your partner used threats to make you have sex? *
Has your partner made you have sex without a condom?
Has your partner insisted you have oral/anal sex when you did not want to (but did not use force)?
Has your partner insisted on sex when you didn't want to (but did not use force)?

*Subscale item dropped from analyses due to non-reporting.

All of the CTS, CTS2, or portions of it have been used to measure the abuse experienced by adolescents, college students, state prison inmates, and men and women in the general population (Miller and Knudsen 2007). The structure of the scales has undergone a number of empirical investigations and nearly all of these investigations have been based on samples of university students. Several studies conclude that the CTS are a reliable and valid tool, including

concurrent validity, content validity and construct validity (Archer 2000; Boris et al. 2002; Cascardi 1999; Straus and Gelles 1990). Preliminary data analysis of the CTS2 by Straus and colleagues (1996) indicated that all scales had good reliability, good construct validity, and evidence of adequate discriminant validity.

Newton and others (2001) also examined the reliability of the factor structure of the CTS2, but they used a sample of high risk post-partum women and excluded the sexual assault and injury subscales from their analysis. They found high reliability scores for the negotiation and psychological aggression subscales, but found low scores for the physical assault scale. Confirmatory factor analyses indicated that structuring the items into a five factor solution, with psychological aggression and physical assault disaggregated into minor and severe forms, provided a better fit than a three factor solution (which does not disaggregate the psychological aggression and physical assault subscales into minor and severe). In a recent study, Dietz and Jasinski (2007) used experimental design methods to reorder the questions to determine if item order affected men and women's disclosure of IPV events. It was concluded that the items can be reordered without losing reliability.

Although the scales have been tested and used outside of the U.S. (Gelles and Edfeldt 1986; Hinshaw and Forbes 1993; Kumagai and Straus 1993; Tang 1994), samples have included either university students or couples in marital relationships, therefore excluding people who have lower levels of education, income, and those not married. Considering the significant differences in the participants in this study with the standard sample used in previous CTS2 evaluations, it seems important to ask if the CTS2 are an instrument useful in assessing partner abuse among diverse groups of women. Several limitations seem possible and are worthy of note.

First, the CTS2 only ask about violence in the past year, ignoring systematic abuse over many years (Kimmel 2002). For immigrant women in transnational families,[5] sporadic visits or lengthy separations may make measurement error based on estimating violence experienced in the last year more likely. The assumption that partners regularly see each other is one probably not met by some first generation Latina respondents because many women and their partners migrate at different times due to seasonal variations in employment (Hondagneu-Sotelo 1994). Secondly, context and how it relates to memory matter. The CTS2 rely on retrospection. For many of the respondents in this study, time is organized by that which occurred before they were pregnant or that which occurred after they were pregnant. The initiation of motherhood is a salient referent that organizes the perceptions and behaviors of respondents towards themselves and others.[6] Among immigrant women, life before and after arrival to the U.S. may serve as the referent. These important considerations may make the CTS2 inappropriate tools to estimate violence against low income, first time mothers of diverse backgrounds and structural locations.

Locating Woman: Unequal Access to Resources

In his analysis of 1890 census data in Philadelphia, Black sociologist W.E.B. DuBois was among the first to have noted the prevalence of racial and ethnic disparities in health (DuBois 1906). His conclusion that health disparities reflected a set of problems with a common center or origin can be applied to virtually every major institution that organizes daily life in the U.S. today including health, education, housing, and employment. Note that the categories of race and ethnicity are not the "cause" of variation in health status; rather, they are descriptive labels that

[5] Transnational families have relatives including children, partners, parents, siblings, etc. living in the U.S. and in their country of origin. Relatives live in both places and maintain important kinship and social connections between places (Ricciardi 2007).

[6] This point was noted among several respondents who indicated during the survey that they could not estimate how many times something had occurred, only if it happened before or after they were pregnant. This most often occurred during interview questions about drug and alcohol use or sexual history.

reflect variation in risk factors associated with ill health (Williams 1997). This means that health disparities between groups have a social origin. Frequently, disparities between institutions overlap and produce cumulative disadvantages. Access to resources in health care, employment, and social support appear in the literature as related to risk of violence and these resources are not distributed equally among all women. I highlight disparities in resources below and connect these with risk factors associated with intimate partner violence.

Largely due to gender and racial segregation in the paid labor market and lower economic returns for the same level of educational attainment, women of color from the United States are much less likely to have health insurance and, they are less likely to have employer-sponsored coverage than their White counterparts (Hogue and Hargraves 2000). Immigrant women are more likely than their American born counterparts to work full time in low skilled, low paying jobs in the United States. These are often jobs that U.S. women are unwilling to take and offer no health benefits whatsoever. Among all women, Latinas are the most vulnerable to health access problems, have higher rates of uninsurance, and these patterns are similar among Latino subpopulations[7] (Guendelman and Wagner 2000). Lack of health insurance is associated with significant delays in seeking medical care, so women who are uninsured and sick or injured will often not visit a clinic or emergency room until their condition is very bad (Campbell 1999).

Immigration policies and politics further impede access to health insurance for many immigrant women. In most states, immigrants who have been in the U.S. for less than five years, regardless of legal status, are denied Medicaid coverage for essential health care despite the fact that they pay taxes and contribute to the U.S. economy (Doriss 2007). It is important to note, at the time of arrival, the health status of immigrants is better than their U.S. counterparts but health often begins to deteriorate after arrival (Kramer, Tracy, and Ivey 1999). The new adoption of

[7] In this study, the authors did not distinguish between Latina immigrants and Latinas born in the United States.

poor health habits and the increased exposure to environmental risks often accompany acculturation to U.S. culture (Kramer, Tracy, and Ivey 1999). This suggests that as immigrant women adopt health and relationship patterns similar to American women, they face greater physical and mental health risks.

Greater proportions of women of color and immigrant women live in poverty than White women. Poverty leads to poor health care and increased illness. Poverty and lack of insurance means poor people pay higher out of pocket fees, experience longer waits in crowded, under-funded clinics, and face problems of admittance into hospitals and clinics (Giachello 1994). Poverty is also associated with an increased risk of abuse by a partner. Estimates suggest staggering figures – 92 percent of homeless women have experienced severe physical or sexual abuse at some point in their lives, and 63 percent of women living in poverty have been victims of IPV (Josephson 2005). Although partner violence cuts across all class boundaries, people living in poverty are, overall, more vulnerable to abuse than those who are better off (Cazenave and Straus 1990). Poverty increases women's vulnerability to partner violence because poverty is related to increased relationship conflict, women's reduced economic and educational power, and men's reduced ability to live in a manner that they regard as successful (Jewkes 2002).

In the U.S., Latinas, Black women, and White women at similar socioeconomic levels face different life chances. This is in part due to persistent patterns of residential segregation that relegate middle class Black women and Latinas to less affluent neighborhoods and working class Black women and Latinas to neighborhoods where poverty is more concentrated (Massey and Denton 1993). As a result, Blacks and Latinos at all income levels are more likely to live in medically underserved areas with access to fewer health services. Income differences in health care are especially notable in preventive services (Keith 2000). Preventive services include

screening procedures by providers to assess the risk of family violence, physical and mental health conditions, and chronic diseases such as cancers and heart disease. Preventive services may also entail the distribution of information and resources to women to promote prenatal health, and obstetric, gynecological, and pediatric care to improve the health and well-being of mothers and their children.

I situate women's risk of experiencing partner violence within the context of their access to health care, employment, and support because these structural barriers translate to differences in living and working conditions among major groups in the United States. Health care institutions are the primary, and usually first, access point for battered women of color (Richie and Kanuha 2000). There are now standardized screening protocols for IPV required by the Joint Commission on Accreditation of Healthcare Organizations and some evidence suggests that screenings increase the accurate identification of physical abuse of women by their husbands, boyfriends, or other intimates (Srinivasan and Ivey 1999). Additionally, programs aimed at preventing intimate partner violence often reach out to women in health clinics, assess their risk, and provide them with resources to escape abusive relationships.[8] As women of color and immigrant women are less likely to access health services and are less likely to receive adequate services, they are more likely to be invisible to public health officials' detection and understanding of the scope and severity of intimate partner violence.

Within the health care setting, experiences of discrimination are commonly reported by all minority groups and these reports increase as the number of visits to practitioners increases (LaVeist, Diala, and Jarrett 2000). As a result of discrimination, minority group members are

[8] Of the IPV screenings and domestic violence prevention programs that do reach women at the margins, much of the content is based on a model that is not culturally competent (Bent-Goodley 2004). The content of screenings and programs often assume White women as victims, use English to the exclusion of other languages, and are based on a Eurocentric cultural model.

more likely to postpone getting care when it is needed and this may further exacerbate the condition(s) needing treatment. Latinas are less likely than any other group to be linked to regular sources of care (Lieu et al. 1993). In contrast, white women are more likely to report being very satisfied with the quality of care they receive than their Black and Latina counterparts (Mays, Cochran, and Sullivan 2000).

Related to discrimination, research suggests that stress is not randomly distributed in society. Stressors related to the experiences of racial discrimination and blocked opportunity also adversely affect the mental health status of minority groups. Blacks have among the highest mean scores of overall stress, followed by Latinos. Both groups experience stress at significantly higher rates than Whites (Williams 2000). Within the U.S., Black and Latino immigrants have higher rates of stress than Blacks and Latinos who are U.S. citizens. Interestingly, public health research has concluded that the relationship between stress and race/ethnicity is no longer significant when controlling for size of household (Williams 2000). That is, Black and Latinos who are at higher risk of experiencing stress are less likely to report experiencing stress when they reside in larger households with greater amounts of familial support. In the face of stress, those living in a larger household may be able to mobilize enough social support to reduce the negative effects of stress on mental health. It follows that within households composed of supportive family based networks, women may be able to garner enough support to reduce the risk of being abused by their partner.

Re-Conceptualizing Violence Against Women

Intimate partner violence, first referred to as domestic violence, was publicly acknowledged as a widespread social problem worthy of attention and social change during the second-wave feminist movement of the late 1960s and early 1970s. As Miller (2008) suggests,

"the slogan *the personal is political* encapsulated radical feminist efforts for consciousness raising among women" (149, original emphasis). Feminists' articulation of the personal, particularly the violence experienced by women at the hands of men in their private lives, brought attention to systemic gender inequalities rooted in structural forces. The etymology of the term domestic violence reflects White, middle class feminists' focus on challenging patriarchy within the household, but also their disregard for social dimensions other than gender inequality as key explanatory factors of violence and abuse.

This approach to violence has been criticized by women of color, particularly womanist and multicultural, postcolonial, feminist scholars from intersectional and transnational frameworks (Volpp 2005). Criticisms of early domestic violence work concerned the assumption of a universal "woman" – womanist and multicultural feminists argued for an understanding of intragroup differences in women's experiences (Collins 2000b; Crenshaw 1991; Davis 1981; Hooks 2000; Sokoloff and Pratt 2005). Another criticism of the near exclusive focus on violence by men towards women in private is that it ignores larger patterns of subordination rooted in institutionalized forms of violence against women of color in the U.S. For example, during the mid 1970s when middle and upper class feminists were demanding women's right to "voluntary motherhood" through reproductive and abortion rights, they were fighting for a fundamental prerequisite for the empowerment of all women. At the same time, feminists were ignoring a history of government funded, forced sterilization associated with eugenic ideas of the birth control movement that relinquished poor, Black, and immigrant women's right to reproduction itself (Davis 1981:202). This example demonstrates that as feminists have fought for women's political and sexual emancipation, it has not necessarily been for "all" women because feminists have historically failed to consider how institutions have structured women's oppression in

different ways. In sum, critics of middle and upper class feminists of the second wave feminist movement called for a shift away from conceptions of violence against women as defined by White, middle class women, rooted in the pathologies of men, taking place primarily in the home.

In some respects, critics' calls were answered. Changes in oppressive legislation that differentially impacted immigrant women in the United States illustrate this point. For example, in 1990 Congress amended the marriage fraud provisions of the Immigration and Nationality Act to include protection for immigrant women who were battered by their partners (U.S. citizens or permanent residents). Before the act was amended, a person who immigrated to the U.S. to marry a U.S. citizen or permanent resident had to remain married for two years before applying for permanent resident status, and both spouses were required to fill out applications for the immigrant's permanent status (Crenshaw 1991). In effect, women were dependent on abusive partners for their permanent status and reluctant to leave abuse for fear of deportation. Later, Congress made a provision to the Immigration Act of 1990 that amended the marriage fraud rules to allow for women to apply for a waiver for hardship caused by domestic violence (Crenshaw 1991). Yet, some immigrant women remained vulnerable to battering because of not meeting the conditions established for a waiver. Evidence required for a waiver was based on reports from "legitimate" authorities including the police, medical personnel, psychologists, and school officials. As many immigrant women have limited access to these resources, this made it very difficult for them to obtain the evidence needed for a waiver (Crenshaw 1991).

More recently, Congress recognized that immigration laws perpetuated a cycle of violence against immigrant women. Under traditional family based immigration laws, immigrant victims' status depended on their relationship to their abuser. The immigration provisions in the

Violence Against Women Act (VAWA) of 2000 expanded access to legal protections for battered immigrants by addressing remaining legal obstacles (Reuss 2004). An update to VAWA, VAWA 2005, removed additional obstacles to battered immigrants seeking immigration assistance (Scott 2007). In effect, if an immigrant woman can prove she is abused by her spouse, she can self petition to apply for citizenship. To qualify for VAWA self-petitioning, a woman must prove she is an abused spouse of an U.S. citizen or legal permanent resident, that she is married, that she entered into the marriage in good faith, that her spouse subjected her to battery or extreme cruelty during marriage, and that as petitioner, she is of good moral character (Scott 2006). Despite these legal changes, the cultural and communication barriers remain for immigrant women who must often acquire legal assistance to navigate this process of self-petitioning and medical "proof" of abuse.[9]

Although the example above suggests that some criticisms of early feminists' conceptualizations of domestic violence have been heard, others still have not. Notions of family and motherhood that relegate women to the domestic arena of private/public dichotomies and that rely on the conflation of family, woman, reproduction, and nurturance must continue to be challenged (Glenn 1994; Thorne and Yalom 1992; Hondagneu Sotelo 2003). In order to re-conceptualize violence against women to include the experiences of different groups of women, one must include private and public factors that influence partner risk of violence. As Pierrette Hondagneu-Sotelo (2005) suggests, "looking for gender and analyzing gender only in the household blinds us to other gender dynamics" (2). Her research on Mexican undocumented migration (1994) counters the image of a unitary household undivided by gender and depicts the complexity of gender conflicts and negotiations present in immigrant families. Hondagneu-

[9] Research has documented negative consequences of VAWA, including the arrest and prosecution of victims, and increases in the incarceration of men of color (see Parmley 2004).

Sotelo (2005) emphasizes the need to consider other gendered institutions such as employment and its subsequent impact on gender relations within households and families. For example, some labor markets may give some immigrant women an advantage in finding work over their partner; as a result, new ideals about companionate marriage and household divisions of labor may emerge together (Hirsch 2000). Some immigrant women may find jobs faster, work more often, and secure income that is, on average, greater than their husbands. This may or may not translate to more egalitarian relations within family (Menjívar 2003; Espiritu 2003).

As immigrant women's social status may increase after migration to the United States through jobs, social network resources, or new interactions with social institutions, their partners may experience the loss of public and domestic status. For the first time, immigrant men in the United States may occupy subordinate positions in class, racial and citizenship hierarchies relative to their partners (Hondagneu-Sotelo 2005). These structurally situated, gendered dynamics differentially impact women's risk of being abused. To date, most researchers of intimate partner violence have failed to consider this.

It is also important to re-conceptualize violence against women by reframing the notion of family and household as it exists for many women in this study. Transnational families vary from other family forms in the United States. They are by definition not just those that have crossed an international border, but those whose nuclear or extended family are dispersed across international borders and where different family members spend time in one or the other country depending on a variety of factors (Hondagneu-Sotelo 1997; 2003). Transnational families exist due to the rise of communication and transportation technologies, economic transformations, and cultural features in their countries of origin (Portes and Rumbaut 2006). Transnational families result from the process of migrants establishing social fields (social arenas where they live, work,

and interact with family and friends) that cross geographical and cultural borders (Mahler 2003). As a result, women may reside in households where extended family members and their partner are present, households where extended family members are present but their partner is not, or households where only their partner is present. For many women, extended family members may offer sources of support and intervention when faced with partner violence, or they may buffer women from potential abuse altogether (Hirsch 2000).

Additionally, immigrant households may be intergenerational and composed of first, second, and third generation immigrants, for example, containing children born in the U.S. with parents and grandparents who were not. Research shows that as second generation immigrants, the children of immigrants face social and economic marginalization, racism, discrimination, and strong pressure to abandon their family's cultural roots (Portes and Rumbaut 2001; Portes and Zhou 1993). These obstacles can lead them to a downward assimilation path, most especially among Mexican American adolescents (Portes and Rumbaut 2006). Children of immigrants often face a role reversal – when their level of acculturation has moved far ahead of their parents, key family decisions become dependent on children's knowledge and English language skills. As a result, second generation youths are able to define the situation for themselves and their interests, freeing them from parental control (Portes and Rumbaut 2006). This process not only shapes the relationship dynamic between parents and children, but also between young men and women who are about to become parents.

Household formations relate to the decision making, autonomy, and control of women by their partners, the possibility of violence within the household, and control over family resources (Hirsch 2000). Households tend to be affected by the economic vulnerability of men more so than the economic well-being of women (Hondagneu-Sotelo 2003). Household

formations also affect the relationship between women's employment and the division of household labor, thereby impacting the relationship dynamic between women and their partners, the amount of control that partners have over women, and the level of dependency that women have on their partners.

A final consideration in the re-conceptualization of intimate partner violence relates to the notion of "partner." A majority of the women in this study are in the life stage of late adolescence. As teenagers transitioning from childhood to young adulthood, they are not likely to have a partner per se. Some women may not characterize or label their relationship with the father of their unborn child as a dating relationship. This has important implications for abused young women as many states do not recognize boyfriend/girlfriend relationships as being covered by domestic violence protection orders (Wolfe 2003). In order to be protected by state laws that guard women from domestic violence, intimate partners must at least cohabit (Miller and Knudsen 2007). Although laws do not formally recognize these types of relationships (dating or brief intimate encounters) as situations that put women at risk of abuse, this study does.

Several empirical studies document an intimate partner violence problem within this adolescent demographic group. According to the Massachusetts Youth Risk Behavior Survey, 20 percent of girls in grades nine through twelve indicated they have been physically or sexually hurt by someone they were dating or going out with (Buel 2002). Data from the National Longitudinal Study of Adolescent Health suggest that among teens in middle or high school who are in dating relationships, one-third reported some form of dating abuse, and 12 percent reported physical violence by their date (Hagan and Foster 2001). These statistics reveal that the abuse of young women by those they are involved with is not limited to those in "partner" relationships.

The diversity in family and household composition and in the type of relationships that women have with the fathers of their unborn children suggest that understanding the factors associated with the risk of partner violence are more complex than the husband/wife role traditionally presented in past domestic violence research. How do these diverse and dynamic constellations of family and gender relations, shaped by cultural and structural forces, translate to different young women's risk of being abused by an intimate? In this following section, I summarize what research on violence against women has concluded thus far and formulate hypotheses regarding the women in this study.

Risk of Partner Violence Among Women

Research on intimate partner violence is really quite vast when considering the many academic disciplines and public agencies aimed at eradicating the abuse of women by their partners, but it has narrowly focused on the experiences of White women. IPV affects people at all levels of society, however, certain factors put some women at greater risk for experiencing intimate partner violence than others. Research indicates that 20 percent of all women who are battered experience their first incident during pregnancy (McFarlane 1989). Being under the age of thirty is a moderately strong risk factor for IPV (Catalano 2007; Schumacher et al. 2001; Tjaden and Thoennes 2000), as is being of a lower socio-economic status (Catalano 2007). Data from a wide array of sources including the National Family Violence Survey, the National Youth Survey, and the National Crime Victimization Survey indicate that violent victimization is strongly concentrated in the early life course (MacMillan 2001). In addition to pregnancy, the first few years after the birth of a child are situational risk factors for IPV (Bowen et al. 2005; Martin et al. 2001; McFarlane et al. 1999; Saltzman 2003). IPV increases health risks for mothers and their prenatal babies (Amaro et al. 1990; Campbell et al. 1992; Curry and Harvey

1998; McFarlane 1999). After delivery, intimate partner violence puts babies at risk for negative health outcomes such as low birth weight and child abuse (Campbell et al. 1999; Curry and Harvey 1998; Murphy et al. 2001; Staus and Gelles 1990). In sum, abuse by an intimate partner negatively affects women's health and is especially detrimental to the health of low-income women (Sutherland et. al. 2001) and their children.

Studies of U.S. born Latinas and Black women and partner abuse that have emerged from different corners of the social sciences tend to appear as rich ethnographic studies or single chapters in volumes on women and violence using national victimization surveys. Few comprehensive investigations provide a comparative perspective on Latinas, Black women, White women, and immigrant women and speak to the structural factors related to their risk of experiencing partner violence. Cross-cultural assessments by anthropologists consider the context where women live (and their power and status in their homeland) as related to extreme abuse – wife beating (Counts et al. 1999). But, the cultural context of the U.S. and the power and status of women of color and immigrant women within it has largely been ignored in empirical assessments of violence against women.

Another limitation of existing research is the consideration of IPV rates within single populations rather than across groups (Adames and Campbell 2005; Lee 2002). Studies of the prevalence of IPV within and across communities of color are also extremely limited (Jasinski and Williams 1998; Saltzman et al. 2000; Yoshioka et al. 2003). Some research has examined battered women of color, their response to abuse, and the context in which abuse occurs (Dutton 1996), but data come from battered women's reports at shelters and emergency rooms, and therefore represents the most extreme cases of physical abuse rather than a continuum. Of the research that considers IPV across marginalized communities, a majority of the data comes from

measurement on the dependent variable, i.e., based on reports from battered women to estimate the prevalence and risk of IPV within the community at large. This practice could be problematic as it may lead researchers to overestimate the prevalence of IPV in marginalized populations or overestimate the severity of the violence experienced by some women. In effect, this contributes to distortions and inaccurate perceptions of the relationships between women of color and men of color. In addition, few studies have examined access to resources and context as influencing the risk of partner abuse and violence towards women of color and immigrant women. As previously mentioned, factors that are associated with an increased risk for intimate partner violence for the women in this study are their youth, their poverty, and their status as soon to be mothers – these aspects are constant across groups. But, other factors impact each group's level of risk differently. I discuss these factors for each group of women separately below.

Research on the magnitude and severity of intimate partner violence against Latinas is mixed. Most studies compare Latinas with non-Latina White women and fail to take into account generational status, citizenship status, as well as variation among Latinas based on nationality and ethnicity. In the National Violence Against Women Survey, Tjaden and Thoennes (2000) find that Latinas' rate of IPV exposure over their lifetime is at 23.4% while Denham et al. (2007) reports a lifetime rate of 19.5% among Latinas living in rural areas. Ingram's (2007) study using a random digit dial survey of households finds that half of Latinos report being exposed to some type of IPV and that these rates are equal to or lower than non-Latinos from the same communities. According to Sorenson and Telles (1991), Latinos and non-Hispanic White American families may not significantly differ in their risk for IPV. Gondolf et al. (1988) and

O'Keefe (1994) also find risk levels that are nearly equivalent between Latinos and other racial and ethnic groups.

Other national and population based probability surveys have found higher (Kantor et al. 1994; Sorenson and Telles 1991; Straus and Smith 1995) lower (Sorenson, Upchurch, and Shen 1996), and similar (Kantor 1997; Rennison and Welchans 2000) rates of IPV among Latinos versus non-Latinos. However, once differences in income, urban or rural residence, age, alcohol abuse (Kantor et al. 1994; Sorenson and Telles 1991; Straus and Smith 1995), impulsivity, and family history (Caetano, Cunradi, Clark, & Schafer 2000) are controlled for, these differences disappear. Speaking to a more specific Latino population, research has found that domestic violence and sexual assault are serious issues in the migrant farm worker community. A recent study in California found that 20% of women reported physical abuse within the past year and 10% reported forced sexual activity within the same year (Rodriguez et al. 2003). In summary, the literature on intimate partner violence among Latinas paints an unclear picture as it tends to ignore variation among Latinas (e.g., by generational status) and make comparisons vis-à-vis White women.

An important factor in first generation Latina's risk of IPV is women's experiences in the process of migration (Parrado, Flippen, and McQuiston 2005). The context where Latinas are from, the gender norms, and the ideologies attached to gender roles structure relations between women and men. The context which women come from also provides clues about the conditions under which IPV is more or less likely to occur. Social norms vary across cultures and nations and situate gender roles in specific contexts. They therefore impact the dynamic among household and family members with regard to stresses, strains, and risks of domestic violence.

Ethnographic research on violence against women in Central America and Mexico suggests that patterns of marriage, postmarital residence, family structure, and conceptions of gender are important cultural aspects of women's lives that may limit incidences of partner violence both in severity and frequency (Kerns 1999). They may also provide women with the means to protect themselves from chronic abuse by making it easier for them to leave relationships (Gutmann 1996). For example, when a couple separates, each person is free to form a new union, regardless of whether they were legally married. Furthermore, the practice of marrying within one's community is a common practice. As a consequence, women usually live near relatives, especially female kin. Domestic space is rarely private space – houses are not very large and the social ties among those living close serve to monitor risky situations (Kerns 1999). These aspects of women's lives make interventions, when necessary, nearly inevitable because family and community members are usually aware of conflict between women and their partners. The connectedness of people within the community make intervention feasible before conflict escalates to high levels of abuse and control (Kerns 1999).

Many of the first generation Latinas living in River County come from rural parts of Central America (including Colombia, Guatemala, Nicaragua or Paraguay) or Mexico in towns such as Oaxaca, Chihuahua, and Cuernavaca. Before locating to River County, some women left their homes to migrate to larger cities in Mexico to find work in agricultural production or maquiladoras. Maquiladoras are manufacturing plants that came about with the demise of the Bracero Program and the implementation of the Border Industrialization Program in 1965. In this program, the Mexican government allowed materials to cross the Mexico/U.S. border duty free, be assembled, shipped back to the U.S., and only the "value added" component of the good was taxed by the U.S (Hondagneu-Sotelo 1994). This lowered the cost of production and reduced

tariff rates. Today, over 3,000 of these assembly plants are located on the border, spread throughout Mexico, and make up 45% of Mexico's economy (Villabos et al.).

This particular export industry is very gendered - young, single, childless women comprise most of the workforce, pay is low, and some operators have been accused of sexually exploiting women (Fernández-Kelley 1983). Factory supervisors have been accused of enforcing strict childbearing policies, including forcing women to take urine tests as a prerequisite to employment and terminating pregnant employees to keep maternity costs down (Human Rights Watch 1996). Fertility rates have declined significantly among women in Mexico since the 1970s and 1980s, in part due to these restrictive practices of employers (LeVine and Correa1993).

As a result, changes in Latin American women's roles in the household are occurring, as is their participation in the paid labor market. Women in Latin America are engaging in new forms of employment and work organization and experiencing new forms of living arrangements and intergeneration support. In contrast to mainstream U.S. culture which places emphasis on individualism, self-sufficiency, and independence, Latin American culture places a high value on family or kinship based networks as primary units of social support. These aspects of first generation Latinas' lives preceding their living in the U.S. may provide protective factors for preventing IPV among this group upon their settlement in the U.S. (Hazen and Soriano 2005).

The renegotiation of the authority of husbands over wives is a central theme in research on gender and migration (Hirsch 1999; Hondagneu-Sotelo 2003; Pessar 1999). As Hondagneu-Sotelo (1994) explains in her study of Mexican immigrants in California, after immigration and settlement, relationship patterns between partners may shift as separations, conflicts, and negotiations, along with new working and living conditions, change the rules that organize gendered daily life. Interestingly, in contrast to patterns exhibited prior to migration, some

immigrant families demonstrate more egalitarian gender relations within the household division of labor, family decision-making processes, and women's mobility (Hondagneu-Sotelo 1994). This shift in gender ideology and practice may signify new roles for Latinas as a change in context facilitates the reconstruction of patriarchal gender relations in families. Women have increased power and this decreases the likelihood they will be physically or sexually abused by a partner.

Immigration status greatly impacts relationships between partners, within families, and within communities. Research on the challenges and adaptation processes of children of immigrants suggests that second generation youth face a pluralistic, fragmented environment that offers both opportunity and dangers. The ways in which the second generation adopts the attitudes, values, beliefs, and customs of the U.S., while maintaining aspects of the cultural identity of their parent's homeland, depends on the social location and status of their parents. Immigrant parents with higher levels of human capital and access to supportive networks in immigrant communities are in a better position to support their children's adaptation and lead them to upward mobility (Portes and Rumbaut 2001; Portes and Zhou 1993). Additionally, second generation Latinos who maintain a strong connection with their parent's culture and language (i.e., are bilingual) and incorporate some limited aspects of American culture are more likely to live in households with high family cohesion and less conflict with their parents. These circumstances often lead to good outcomes such as lower high school dropout rates, higher levels of educational achievement, and lower levels of depression (Rivera 2007).

Parents that face persistent barriers in the U.S. due to racism, poverty, and a lack of material or social resources may find it extremely difficult to navigate the attitudes, behaviors, or customs of the U.S. As a result, the second generation may actually experience role reversal, in

which parents rely on children to maneuver life in the U.S., and youth face greater risks which lead to downward assimilation (Portes and Rumbaut 2001). It is this lack of support and opportunity that may increase second generation immigrant women's likelihood of being abused by their partner. Current research on acculturation and high risk behavior finds evidence of higher levels of substance abuse among acculturated Latinos compared to their non-acculturated counterparts (Akins, Mosher, Smith, and Gauthier 2008), increased social and health risks including sexual activity at earlier ages (Afable-Munsunz and Brindiz 2006), smoking, drinking, and lower birth-weight rates for babies, less positive attitudes about pregnancy (Guendelman et al. 1990), and less support from the father of the child (Zambrana et al. 1997). One study, specifically of Latino adolescents of Mexican descent in ninth grade, also finds that greater acculturation is associated with greater risk of dating violence (Sanderson et al. 2004). Thus, there seems to a clear pattern in second generation Latina's risk of being abused and this risk is notably different than the risk for first generation Latinas.

Some research estimates that Black women, no matter what socioeconomic level, experience a disproportionate amount of partner violence (Field and Caetano 2004; Hampton and Gelles 1994; Rennison and Welchans 2000). Additionally, data from the National Crime Victimization Surveys and the Uniform Crime Report suggest that Black women experience among the highest rates of IPV and report more serious injury and greater mental health consequences (Lee, Thompson, and Mechanic 2002). Evidence also indicates that Black women face higher risk of being killed by a spouse or boyfriend than other groups (Hampton, Carrillo, and Kim 2005). Overall, rates of partner violence among Blacks have been shown to vary by family structure (Messner and Tardiff 1986; Smith and Jarjoura 1988), social class (Lockhart 1985), community characteristics (Sampson and Lauritsen 1994), and the degree of social

network embeddedness (Cazenave and Straus 1990). Single parent households headed by women, lower socioeconomic status, and concentrated disadvantage within neighborhoods have been shown to be associated with higher levels of violence (Sampson, Morenoff, and Raudenbush 2005).

Much of the research on IPV in Black communities has focused on the most violent forms of abuse rather than less severe forms or emotional and psychological abuse, oftentimes with the characterization that Black communities are in themselves violent places (Hampton, Carrillo, and Kim 2005; Oliver 1999). In addition, Black women, more than any other group of women, have been identified as engaging in violence that is reciprocal (Straus and Gelles 1990). As with research on Latinas and IPV, much of this research in built on comparisons with White women as the reference group. Very little research has explored IPV in dating relationships among young Black women. This is rather surprising given that dating violence is correlated with future marital or intimate partner violence (APA 2004).

Within comparative research, differences in rates of partner violence among Black and White women have been explained by differences in the perceptions of the occurrence of partner violence and its reporting (Campbell, Masaki, and Torres 1997; Bent-Goodley 2004). It has been suggested that Black women who are more likely to lack access to resources are also more likely to report abuse to the police (Bachman and Coker 1995). In contrast, White women with higher incomes and greater resources may be able to afford private care and shelter thereby escaping detection by law enforcement and social and health service agencies.

Explanations to account for Black women's experiences of higher rates of relationship violence and extreme forms of violence have focused on family disruption, the concentration of joblessness, social isolation, sparse social networks, and social instability (Sampson and

Lauritsen 1994). It is argued that these aspects of community context make Black men and women act more violently towards each other and at greater rates. Yet it is the historical legacies of institutionalized slavery, redlining, and Jim Crow segregation that have greatly impacted the structural location of and resources available to Black people today (Davis 1981). The oppression that Black women have faced by men of all races and the social processes that have limited their educational and occupational mobility are rarely acknowledged in studies on partner violence. These processes and other considerations of partner violence within a larger social context of privilege, power, and oppression have largely gone unexamined in creating and maintaining social and economic disadvantages that contribute to Black women's increased risk of violence.

The issue of domestic violence within particular immigrant groups, such as African refugees, has been raised in some health agency settings, but neglected overall in academic literature. It is difficult to draw clear conclusions from the existing research because it is so sparse and relatively new. A study on immigrant women and risk of intimate partner violence in Canada finds that the risk of IPV is significantly lower among more recent arrivals compared with non-recent immigrant women (Hyman, Forte, et al. 2006). Country of origin, age, and marital status are associated with women's risk of partner violence. That is, immigrant women born outside of North America or Europe, younger women, and women who were married or cohabiting are less likely to experience abuse (Hyman, Forte, et al. 2006).

There are large contrasts between public responses to domestic violence in the U.S. versus responses in other countries (Fairweather 2007). For example, consider the variability in response to domestic violence within the legal systems of the 58 countries that make up the continent of Africa. There are major differences in the way many African countries' judicial

systems treat the abuse of women. In Ethiopia, the abuse and rape of girls and young women are rampant and the country has no specific legal provisions against domestic violence or sexual abuse against children (Zewde and Pausewang 2002). As a result of experiences in their homeland, Ethiopian women in the U.S. may not know of existing resources for escaping abuse, or may skip contacting shelters altogether where cultural and barriers are significant.[10] In contrast, other African countries such as Ghana have passed laws that ban rape, wife beating, and other actions that violate women and children (The Center for Reproductive Law and Policy 1997). These public factors impact immigrant women's perceptions of abuse. They also influence the likelihood of women trying to escape from abuse through the support of extended family or the larger community. These perceptions and help seeking behaviors carry over to life in the United States.

Despite the extreme variability in immigrant women's experiences in their sending countries, researchers should be cautious not to reduce immigrant women's risk of abuse to cultural factors based on "an inherent cultural repertoire" (Menjívar and Salcido 2002) prone to violence. Furthermore, it is possible to identify certain factors that are present in cases of domestic violence in numerous contexts across groups. Menjívar and Salcido (2002) find that general rates of domestic violence in immigrant populations are not higher than native populations. Instead, they argue that the experiences of immigrant women in abusive situations are often exacerbated by their social location as immigrants. As immigrants, their citizenship status acts as a stressor when environmental circumstances such as limited language skills, isolation, and unemployment strain gender relations and place women in positions of dependency with limited resources and support. In sum, existing literature on immigrant women and partner violence suggests that women's risk of partner abuse is impacted by their social

[10] It is estimated that only about 5% of African women use shelters (Fairweather 2007).

location, their length of stay in the United States, the level at which they adopt the dominant values and beliefs of their community, and the financial and social resources available to them.

CHAPTER THREE

RESEARCH DESIGN & METHODOLOGY

Research Questions

The central focus of this dissertation is on answering the following research questions:

1) How is the risk of intimate partner violence distributed among the first and second generation Latinas, Black and White women, and other immigrant women in this study?

2) How appropriate are the Conflict Tactics Scales 2 for measuring violence against women of color and immigrant women?

3) What factors explain variation in partner violence among the five groups of women?

These questions lead to the following predictions, in light of the literature reviewed in the previous chapter:

1) Mothers' overall rates of IPV will be relatively higher among those who are younger and in an early stage of their life course relative to those who are older.

2) U.S. born women will experience higher rates of IPV than women born outside of the U.S.

3) Among all Latinas, second generation immigrant women will experience higher rates of IPV than first generation immigrant women.

4) Among all U.S. born women, Black women and second generation Latinas will experience higher rates of IPV than White women.

Next, I turn to a description of sampling, interview, and data collection methods.

Sampling & Interview Techniques

Data for this dissertation come from a larger research project led by principal investigator Lynette Feder at Portland State University and funded through a cooperative grant by the Centers

for Disease and Control. Over the course of a year, I served as research coordinator on this grant. My primarily role entailed managing all aspects of data collection including contacting respondents for interview, administering some interviews, organizing databases, and facilitating communication between community health nurses, other interviewers, and the principal investigator. As a result, I was able to obtain survey data and contextual information from nurses, interviewers, and the women themselves as they were interviewed.

Respondents involved in this study (N=146) come from a pool of women who have received public health services through a federally funded health program called the Nurse-Family Partnership Program (NFP). NFP is a two and a half year evidence-based nurse home visitation program that aims to improve the health, well-being and independence of low-income, first-time mothers and their newborn children. NFP pairs community health nurses with new mothers during a woman's pregnancy with her first child. To be eligible to receive nurse home visitation services, women must be age fifteen or older and in their first pregnancy but less than 28 weeks gestation at the time of entry into the program. During weekly visits, nurses and clients cover a broad range of material such as prenatal and post partum health for mother and child, also locating stable and affordable housing, employment, or educational opportunities. The visitations end when the child reaches the age of two. Participants are referred to NFP through other public health programs such as Medicaid. Upon signing up for NFP through one of several neighborhood health clinics, NFP participants are contacted for their first visit by their nurse.

For this study, during their initial contact with NFP participants, nurses asked each woman in her caseload if she would be willing to participate in a research study focusing on healthy relationships. Nurses provided details of the interview process to women – that a Spanish or English speaking female interviewer could meet them whenever and wherever most

convenient. For minors or women under the age of 18 and not emancipated, parent or guardian consent was also obtained. Eighty percent of the women in the NFP program eligible to participate in this study gave consented to participation. [11] Women were interviewed within one month of their entry into the NFP program.

Women who consented to being in the study had their choice of interview method. They could participate in a face to face interview with a female interviewer, or they could use a computer assisted automated survey instrument (ACASI) on a laptop computer to take the survey while the interviewer waited, but assisted when needed. Whenever possible, the racial/ethnic background of each participant was matched with that of the interviewer regardless of interview method. This was done to help respondents feel more comfortable during the interview and to increase the likelihood of accurate disclosure of events of intimate partner violence. When requested by Spanish speaking respondents, interviews were conducted in Spanish by a Spanish speaking interviewer from Puerto Rico or with a back translated ACASI version of the survey in Spanish. After completion of the survey, respondents were given a $25 gift card to a major department/grocery store for their participation. A copy of the survey is located in the appendix.[12] Unless otherwise noted, all data used in this study come from this data source.[13]

Respondents in this study are young first time mothers who, in seeking some kind of social or health service offered by River County, are referred into NFP. There are aspects of this referral process and of the demographic composition of nurses working for NFP that

[11] Unfortunately, restrictions from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevented me from obtaining individual level data on women in NFP who refused to participate in the survey. Therefore, it is difficult to determine if non-respondents systematically differ from survey respondents on a number of social characteristics.

[12] Readers may note that several subscales and measures are included in the survey but data from these items are not analyzed in this dissertation. These items were included in the survey by the principal investigator to address public health based research questions of primary interest to science officers at the CDC.

[13] Data analyzed for this dissertation received exemption from the Washington State University Institutional Review Board (Certification of Exemption, IRB Number 10317-001). Additionally, the larger research project funded by the CDC complies with and was approved by the State of Oregon's Public Health Institutional Review Board.

differentially structure women's opportunity to receive NFP services. These factors impacted the demographic composition of the sample of women interviewed for this study and decrease the likelihood that this sample is representative of all low income women living in River County who entered into NFP at the time of the survey. During a one year period of data collection, 600 women applied to the NFP program and of these women, over 20% could not be enrolled because nurses' caseloads were full. Of all the women turned away from NFP, 81% were Spanish speaking clients. Another smaller group of immigrant women who spoke neither English nor Spanish were also turned away due to language restrictions.[14] This process represents a structuring force that precludes some groups of women having access to NFP services relative to others. This suggests that researchers trying to examine the risk of IPV among smaller, diverse, immigrant communities must be conscious of how the existing organizational structure of health care limits particular group's access to needed care and exacerbates existing health disparities across groups. Additionally, it points to the need for researchers and health organizations to recruit health care workers and interviewers who are knowledgeable of and perhaps even identify with immigrant communities and other marginalized groups.

Another aspect of the referral process that facilitated particular women's entrance into the NFP program and this study relates to the composition of the pool of nurses working at River County. Of the 20 nurses who worked at the NFP program during data collection, two were women of color (a Latina and an Asian nurse). The racial/ethnic mismatch of clients with nurses may have contributed to some NFP clients being unwilling to participate in this study. It is reasonable to assume that some women were hesitant to participate in NFP and/or the survey

[14] This group includes indigenous women from parts of Mexico who did not speak Spanish and women from southeastern China.

because of concern for linguistic or cultural barriers with their nurse. For example, at entry into the NFP program, a woman from the Hmong tribe, a closed community[15] in Southern China, requested to meet with a specific nurse. Unfortunately, NFP protocol does not allow women to request specific nurses and as a result, the woman was randomly assigned a White nurse and subsequently left the program without receiving services. The impact of this mismatch on clients' participation in NFP and the interview applies to both non-White women with White nurses and White women with the two non-White nurses. Unfortunately, the data at hand do not permit deeper exploration of the possibility that racial/ethnic mismatch of nurse to client contributed to women dropping from the NFP program or the present study.

Given that a central question of this study is to assess the appropriateness of particular methodological tools (i.e., the Conflict Tactics Scales 2) for measuring partner violence within marginalized populations, it is also worthwhile to examine potential differences in interview methodology among the participants in this sample. The majority of all respondents conducted the survey using ACASI (67%) and in English (77%). The length of time it took respondents to complete the survey ranged from 25 minutes to three hours (mean = 65 minutes). To prevent respondent fatigue during longer interviews, women were encouraged to take a short break whenever necessary. Overall, face to face surveys tended to take longer than computer automated surveys. Most of the women interviewed in Spanish were 1st generation Latinas and over half of all Spanish interviews were face to face. In contrast, 21% of all English interviews were face to face. These significant differences in interview method and language of interview, displayed in table 1, indicate disparities in the reading and computer literacy skills among the young mothers and are reflective of differences in their level of education and familiarity with

[15] Hmong often keep with the same clan people, rarely marry outside of their community, and essentially do not socialize or interact with people who do not identify with a clan. As a closed community, it has few links to other communities (Sokoloff and Pratt 2005).

computer technologies. This is important to note because if women are not perceiving and interpreting survey questions in a similar way, it leaves open the possibility that differences in women's experiences of intimate partner violence are actually due to differences in reporting practices.[16]

Table 1. Interview Preferences of Sample

	1st Generation Latinas		2nd Generation Latinas		Black Women		White Women		Non-Latina Immigrants		Total	
Interview Preference	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
TOTAL	51	34.9	23	15.8	15	10.3	50	34.2	7	4.8	146	100
Language												
Spanish	32	62.7	1	4.3	-	-	-	-	-	-	33	22.6
English	19	37.3	22	95.7	15	100	50	100	7	100	113	77.4
Survey*												
Face to Face	23	45.1	5	21.7	3	20.0	12	24.0	1	14.3	44	30.1
ACASI	28	54.9	18	78.3	12	80.0	38	76.0	6	85.7	102	66.9
Language x Survey**												
Face to Face Sp	19	37.3	1	4.3	-	-	-	-	-	-	20	13.7
Face to Face Eng	4	7.8	4	17.4	3	20.0	12	24.0	1	14.3	24	16.4
ACASI Sp	13	25.5	-	-	-	-	-	-	-	-	13	8.9
ACASI Eng	15	29.4	18	78.3	12	80.0	38	76.0	6	85.7	89	61.0

*** p < .10 **p<.05**

Next, I provide a rich descriptive comparison of respondents on a number of demographic, family, residential, health, social support characteristics, and on the CTS2 subscale items. Using principal components factor analysis, I explore the underlying structure of subscale items to delineate linear patterns in reported violence among women. I consider the relationship between partner violence and each set of independent variables (demographic, residence, family, health, and social support characteristics) using bivariate analyses. Finally, regression analyses are performed to determine which variables best predict women's reporting of partner violence. Due to limitations of size that would produce inaccurate estimates, non-Latina immigrant women

[16] This possibility is revisited in chapter 5.

are included in descriptive statistics but dropped from factor and regression analyses. However, a discussion of this particular group's risk of partner violence is revisited in chapter 5.

Characteristics of Women

Demographic characteristics of all respondents and breakdowns by each group of women are presented in table 2. Note that variables with two asterisks indicate significant differences across groups at the .05 level. Due to the small size of several groups of women, the cutoff for statistical significance was relaxed, thus variables significant at the .10 level are designated with one asterisk. Respondents range in age from 15-36. The average age of all respondents is 19. Three quarters of the sample are age 21 or younger. Thirty five percent of respondents are first generation immigrant Latinas, 34% are White women, 16% are second generation Latinas, and 10% are Black women. The remaining five percent of respondents identified as African, Asian, or Eastern European immigrants born outside of the United States and currently residing in River County.

Table 2. Demographic Characteristics of Sample

	1st Generation Latinas		2nd Generation Latinas		Black Women		White Women		Non-Latina Immigrants		Total	
Respondent Characteristics	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
TOTAL	51	34.9	23	15.8	15	10.3	50	34.2	7	4.8	146	100
Age**												
15-18	19	37.3	14	60.9	8	53.3	19	38.0	2	28.6	62	42.5
19-21	16	31.3	7	30.5	7	46.7	15	30.0	1	14.3	46	31.5
22-25	8	15.7	1	4.3	-	-	14	28.0	-	-	23	15.8
26-36	8	15.7	1	4.3	-	-	2	4.0	4	57.1	15	10.3
Education**												
HS Diploma or higher	15	29.5	8	34.8	8	53.3	33	66.0	5	71.4	69	47.3
Income												
Under $10K	11	21.6	4	17.4	4	26.7	23	46.0	1	14.3	43	29.5
$11K-$15,999	12	23.5	4	17.4	3	20.0	6	12.0	1	14.3	26	17.8
$16K-$20,999	3	5.9	-	-	-	-	4	8.0	2	28.5	9	6.2
$21K-$25,999	7	13.7	1	4.3	2	13.3	4	8.0	-	-	14	9.6
$26K or above	1	2.0	3	13.0	1	6.7	6	12.0	-	-	11	7.5
Refuse to Answer	17	33.3	11	47.8	5	33.3	7	14.0	3	42.9	43	29.5
Employed**												
Currently Employed	37	72.5	9	40.9	6	42.9	25	50.0	4	80.0	81	57.0

*** p < .10 **p<.05**

All respondents are low income, a requirement to receive services through the Nurse-Family Partnership Program. Seventy six percent of women report an annual household income of less than $20,999 which is $300 shy of the federal poverty line for a family of four. All women report an annual family income less than $36,000. [17] Fifty seven percent all women report being employed; 38% have family that supports them. With regard to education, thirty five percent of respondents report receiving some high school education. Forty eight percent of

[17] This survey item had a number of missing responses. This could be due to women's fear of ineligibility in the NFP program for reporting a particular family income. Mean substitution is used in regression analyses for the income variable. In an analysis not shown, including the mean for missing data did not significantly alter regression models.

mothers have a GED, high school diploma, or some college education. The remaining 17% of mothers have an elementary or junior high level of education.

Despite being relatively young and living in poverty, the data suggest that there is variability in the education and employment situations among women, as sociological research on racial inequality and stratification in the U.S. indicates. Figures 2, 3, and 4 show the distributions of each group of women by age, income, and education.

Figure 2. Age

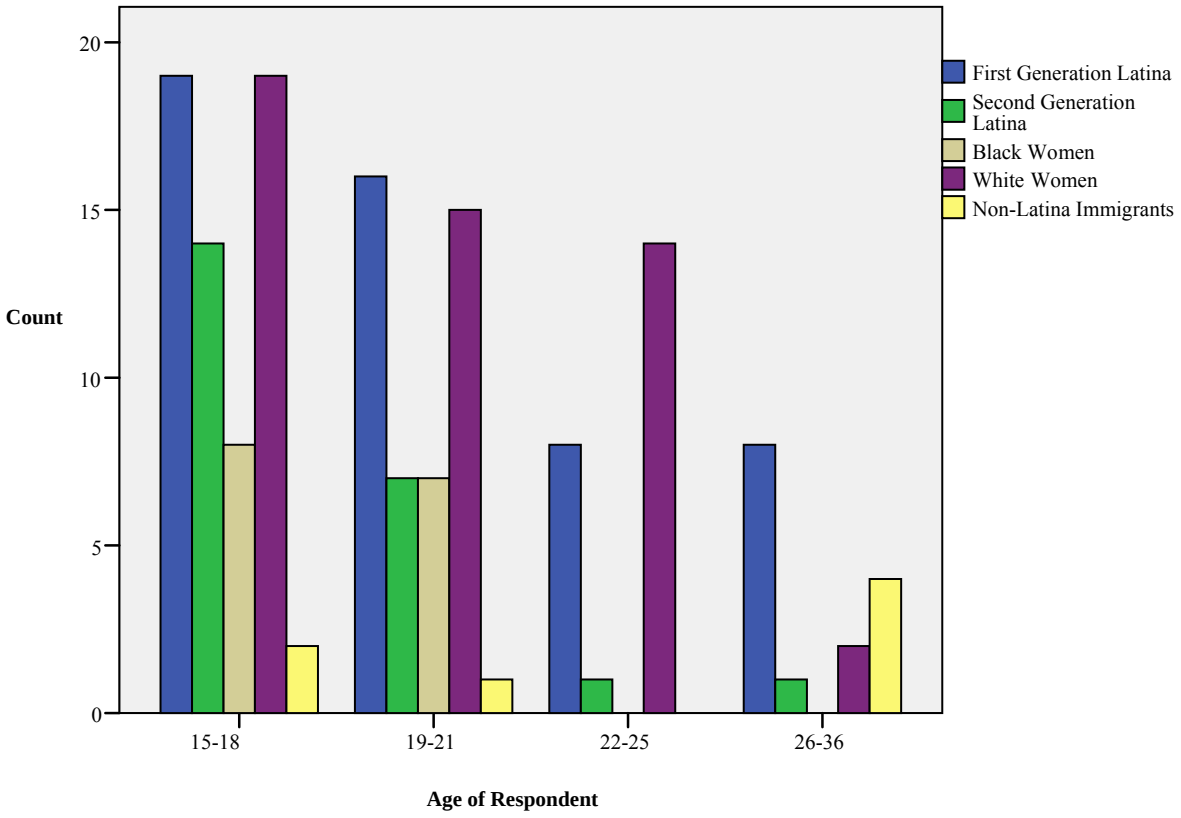
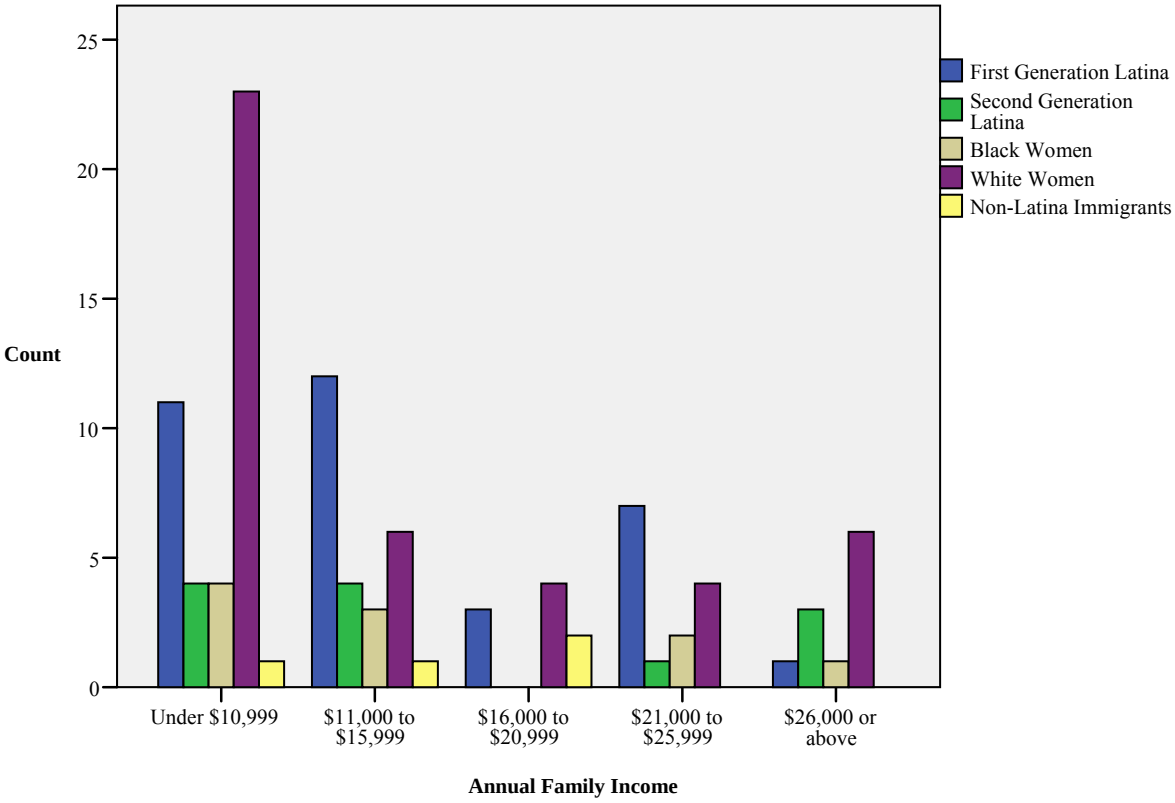
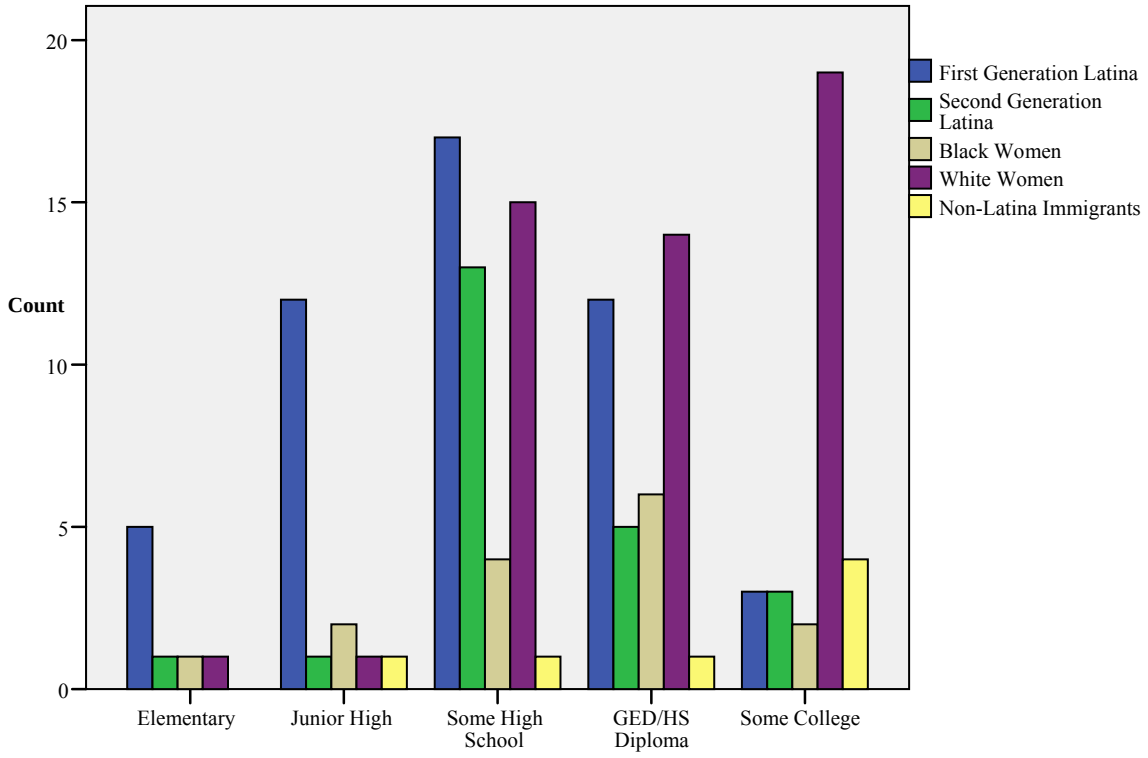


Figure 3. Income



There are several differences between the groups that should be noted. First, there is a wider age range among first generation Latinas and other immigrant women than among the U.S. born women, who tend to be younger. This means that many first generation Latinas and non-Latina immigrant women are having their first child later in life relative to the other groups of women. It could be that the process of migration delays childbearing for these women.

Figure 4. Education



Additionally, there are significant differences in employment patterns. First generation Latinas and non-Latina immigrant women are significantly more likely to be employed than U.S. born women. First generation Latinas report lower levels of education (elementary or junior high) than any other group. White women and non-Latina immigrant women are more likely to have some college experience than Latinas of any generational status or Black women.

Next, I consider family characteristics of the young mothers in this study presented in table 3. Among all women, 77% report that they are currently in a relationship with their child's

father.[18] Second generation Latinas are the most likely of all groups to report that they are currently in a relationship with their child's father – only 4% of these women are not partnered with their child's father. Foreign born women are significantly more likely to be married to their child's father than their U.S. counterparts. Black women are least likely to be engaged or married to their partners.

Table 3. Family Characteristics of Sample

	1st Generation Latinas		2nd Generation Latinas		Black Women		White Women		Non-Latina Immigrants		Total	
Respondent Characteristics	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
TOTAL	51	34.9	23	15.8	15	10.3	50	34.2	7	4.8	146	100
Status of Relationship*												
Dating	20	39.2	15	65.2	10	66.7	22	44.0	2	28.6	69	47.3
Engaged	5	9.8	3	13.0	-	-	7	14.0	1	14.2	16	10.9
Married	16	31.4	4	17.4	-	-	6	12.0	2	28.6	28	19.2
Not w/ Child's Father	10	19.6	1	4.4	5	33.3	15	30.0	2	28.6	33	22.6
Social Support**												
From Family	10	19.6	3	13.0	5	33.3	22	44.0	2	28.6	42	28.8
From Partner	10	19.6	5	21.7	5	33.3	8	16.0	1	14.3	29	19.9
Partner & Family	31	60.8	15	65.2	5	33.3	20	40.0	4	57.1	75	51.4

*** p < .10 **p<.05**

To what degree do women's partners and/or family members provide them with social support? To answer this question, women were asked to report their satisfaction or dissatisfaction with the support they receive from their partner and their family on a range of items (see appendix, survey, "Social Support"). Subscales' items were summed and then the difference between the sum of all partner support items was calculated from the sum of all family support items. Next, scores were collapsed into one of three categories of support with positive values indicating partner support, negative values indicating family support, or values of zero indicating support from near equivalent support from family and partner. Overall, 20% of

[18] Respondents who reported that they are not currently in a relationship with their child's father were instructed to survey questions about their current partner.

women report receiving support from their partner, 28% report receiving family support, and 51% receive support from both their partners and their families. Comparing sources of support across groups, first and second generation Latinas are significantly more likely to report receiving support from family and partner than the other groups of women. Black and non-Latina immigrant women are more likely to receive support from their partner, whereas White women are more likely to receive social support from family.

To consider patterns of residence among the women in this study, Census tract data from 2000 was collected from the Census Bureau for each woman's address at the time of the interview[19] to determine each tract's racial composition by percent Black, Latino, Asian, and White. Next, these data were collapsed into a dichotomous variable indicating the racial composition of each woman's census tract as having higher or lower minority populations (including Latinos, Blacks, and Asians). This cut off was at 80% White census tract. For example, women who live in a census tract with 80% or more of the tract composed of Whites were coded as having lower minority composition. Women who lived in a census tract with less than 80% White were coded as having higher minority composition. The rationale for this coding rule comes from population characteristics of River County. The coding was established because it approximates the size of the dominant population. If residents of River County were randomly distributed, we would expect census tract data to reflect this. The data show that approximately 1/3 of each group of women resides in a census tract with high minority concentration; however, second generation Latinas and Black women are overrepresented in minority tracts relative to their representation in this study. That is, although second generation Latinas and Black women

[19] Over the course of the NFP program, some women moved multiple times. This occurred on several occasions between the initial contacts that nurses made with clients to inquire about women's consent to be interviewed through the time of the actual interview. In some cases, multiple weeks passed. A discussion of the impact of residential change on women's IPV risk is discussed later.

make up 16% and 10% of the sample respectively, nearly 31% of second generation Latinas and 33% of Black women live in tracts with large minority populations.

Other important characteristics of women's residence are summarized in table 4.

Table 4. Residential Characteristics of Sample

	1st Generation Latinas		2nd Generation Latinas		Black Women		White Women		Non-Latina Immigrants		Total	
Respondent Characteristics	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
TOTAL	51	34.9	23	15.8	15	10.3	50	34.2	7	4.8	146	100
Census Tract Composition												
High Minority Concentration	16	31.4	7	30.8	5	33.3	18	34.0	-	-	46	32.0
Moved in Past Year**												
Zero	16	31.4	7	30.4	4	26.7	13	26.0	4	57.1	44	30.1
One	27	52.9	5	21.7	2	13.3	14	28.0	2	28.6	50	34.2
Two	8	15.7	3	13.0	4	26.7	8	16.0	-	-	23	15.8
Three or More	-	-	8	34.8	5	33.3	15	30.0	1	14.3	29	19.9
Live with**												
Parent	9	17.6	9	39.1	7	46.7	17	34.0	3	42.9	45	30.8
Partner	25	49.0	6	26.1	3	20.0	15	30.0	1	14.3	50	34.3
Other	17	33.3	8	34.8	5	33.3	18	36.0	3	42.9	51	34.9

*** p < .10 **p<.05**

There are significant differences in the frequency with which women have moved in the past year. This is important to note because research by Waltermaurer, McNutt, and Mattingly (2006) suggests that the risk of IPV is almost double for women who had recently moved compared to those who had not. On average, respondents have moved once in the last year. The data show that U.S. born women are more likely to have moved, and they have moved more frequently (i.e., more than once) than immigrant women. Again, we see evidence of how migration impacts women's lives – some who have migrated to the U.S. are more likely to have a social or familial network available to them, offering greater resources and more stability. First generation Latinas are less likely to live with their parents and more likely to live with their partner. In contrast non-Latina immigrant women are least likely to live with their partner.

Second generation Latinas, Black and White women fall between these groups and are more likely to live with parents or other relatives than to live with their partners.

Lastly, I consider health characteristics across the groups of mothers in this study. Summary statistics of women's health are shown in table 5. As an abundance of public health research indicates, women of color of any social class, especially those who are low income, are more likely to suffer greater stress, health problems, and illnesses than other groups of women. Although many immigrant women face barriers when accessing health care, their overall health is often better than their U.S. counterparts upon their arrival. As immigrant women remain in the U.S. and adopt new social and cultural practices, their health deteriorates. Health disparities represent another possible predictor of the risk of IPV.

Table 5. Health Characteristics of Sample

	1st Generation Latinas		2nd Generation Latinas		Black Women		White Women		Non-Latina Immigrants		Total	
Respondent Characteristics	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
TOTAL	51	34.9	23	15.8	15	10.3	50	34.2	7	4.8	146	100
General Health												
Fair	5	9.8	3	13.0	3	20.0	7	14.0	-	-	18	12.3
Good	39	76.5	17	73.9	10	66.7	36	72.0	6	85.7	108	74.0
Excellent	7	13.7	3	13.0	2	13.3	7	14.0	1	14.3	20	13.7
Level of Stress**												
High	15	30.0	5	21.7	9	60.3	30	60.0	1	14.3	60	41.4
Moderate	6	10.0	6	26.1	5	33.0	13	26.0	4	57.1	33	22.8
Low	30	60.0	12	52.2	1	6.7	7	14.0	2	28.6	52	35.9
Trauma History**												
No Trauma	33	64.7	6	26.1	1	6.7	6	12.0	4	57.1	50	34.2
1-4 Events	14	27.5	12	52.2	10	66.7	24	48.0	2	28.6	62	42.5
5+ Events	4	7.8	5	21.7	4	26.7	20	40.0	1	14.3	34	23.3

*** p < .10 **p<.05**

To measure women's current health status, respondents were asked, "In general, how is your health?" Seventy four percent of all women report being in good health, 14% in excellent health, and 12% in fair health. There are no significant differences among the groups. It could be

that the young average age of this sample (19 years old), and the fact that women are visited by registered nurses once a week in their homes, decreases the likelihood that women are suffering from major health problems during their pregnancy. At such a young age, many of the women may have not developed unhealthy habits that would impact their general health. Looking at certain aspects of women's health, particularly the amount of stress they experience, sheds further light on their risk of IPV.

To measure stress levels, respondents were asked to indicate the amount of stress they experience in their personal life on a variety of indicators. Eleven stress subscale items ranging from 1 (no stress) to 4 (severe stress) included questions about women's financial worries, problems related to family, having to move, the loss of a loved one, their current pregnancy, past abuse, and work problems (see the appendix for the precise wording of the items). The items that women most frequently report experiencing moderate or high levels of stress were: financial worries (79%), having to move (31%), family problems (30%), and their current pregnancy (25%). In addition, there are significant differences among the women. Black and White women report much higher levels of stress on a wider range of items – from financial concerns, to problems related to family, the loss of a loved one, or having to move.

To further explore this relationship, the sum of all 11 subscale items was calculated for each respondent. Then the summed values were collapsed into three categories indicating high, moderate, or low stress. Women in the low stress category either reported experiencing no stress on any of the subscale items or some stress on just a few items (sum of stress items ranging from 11-14). Those in the high stress category reported experiencing some stress on every item, or higher levels of stress on several items (sum of scores > 20). Women in the moderate stress category reported summed stress scores ranging from 15-20. Black and White women report the

highest levels of stress at nearly twice the rates of Latinas and other immigrant women. Black and White women report having higher levels of stress because they report lacking financial stability (recall that these women are less likely to be employed compared to first generation Latinas and other immigrant women) and have fewer sources of support in many dimensions of their lives. This may make these particular groups more vulnerable to partner abuse. There is one last possible predictor of abuse related to women's health that should be considered – women's lifetime experiences with past domestic violence and other childhood traumas.

To assess women's past experience with domestic violence and other traumatic events, respondents were asked to indicate if the following had ever happened: life-threatening illness, life-threatening accident, robbery, loss of a loved one, forced sex, attempted forced sex, unwanted sexual touching, childhood physical abuse, or other life-threatening or traumatic injuries (see appendix, survey, "Trauma History"). The items were summed and recoded into an ordinal level variable with a normal curve indicating the following levels: no trauma, one to four traumatic events, and five or more traumatic events in their lifetime. Overall, 24% of women report that they have experienced past domestic violence. U.S. born women report experiencing past domestic violence at greater rates than foreign born women. In addition, there are dramatic differences between the groups of young mothers in scores of overall trauma history. U.S. born women are significantly more likely to have experienced a traumatic event in their lifetime. Among U.S. born women, Black and White women report experiencing higher rates of trauma than second generation Latinas. Five percent of all respondents report a score of 10 or above and nearly all are Black women, indicating they have experienced nearly every traumatic item on the list.

To summarize, there are some important variations in health, resources, and social support among respondents in this sample. Taking into account the young age of U.S. born women and considering their increased experiences of traumatic events, fair health, higher unemployment, higher stress and fewer social support resources compared to the immigrant Latina women in this sample, does this put them at greater risk of being a victim of violence by a partner? And, to what extent is this risk distributed among Black, White, and second generation Latina women born in the U.S.? I explore answers to these questions in the next section by considering women's reporting of partner violence using the Conflict Tactics Scales 2.

Dependent Variables

Recall that the CTS2 are comprised of five subscales (see appendix, survey, "Conflict Tactics Scales 2") that measure physical assault, psychological aggression, sexual coercion, injury, and negotiation in the past 12 months. Response categories range from 0 (never) to 6 (20 or more times). Straus et al. (1996) suggests recoding some of the response categories in the CTS2 subscales to the midpoints, for example for a response category of 3 (three to five times) the midpoint is 4, and recoding response categories of 6 (more than 20 times) to 25. However, for CTS2 items on the most severe end of violence, particularly subscales that respondents infrequently report, recoding items can create problems of kurtosis for statistical models built on parametric procedures or assumptions of normality (Newton et al. 2001). Frequency distributions of the subscales (results not shown) suggest the ten items (i.e., nearly one fourth of all items on each of the five scales) had high kurtosis and that the recoding scheme suggested by Straus did not correct this problem. Items such as "has your partner used a gun or knife on you," "has your partner burned or scalded you," "has your partner used physical force to have sex," and "has your partner accused you of being a lousy lover" were rarely reported by most respondents, but

for the very few women who reported severe items, these types of violence occurred with greater frequency (more than two or more times). Thus, following the procedures of Newton et al. (2001), none of the response categories that comprise the CTS2 were recoded to the midpoint. Additionally, due to non-reporting and lack of variance, several subscale items that were not applicable to women in this study were omitted from factor analyses (see figure 1). They include two physical assault items, four injury items, and four sexual coercion items, leaving 29 items of the CTS2 for consideration. Do the remaining items adequately measure partner violence across the groups of young women in the Nurse-Family Partnership program? I explore this question next using factor analysis, a method for data reduction,[20] to uncover underlying causes or factors of different women's experiences of partner violence.

Principal components factor analysis may be used to identify a small number of underlying variables, or factors, that account for patterns of variation among observed variables (Hamilton 1992). In this dissertation, factor analysis is used to reduce the 39 items of the Conflict Tactic Scales to fewer items appropriate to measure violence against women of various cultural and linguistic backgrounds. For the total sample, the analysis produced one factor for four of the five CTS2 subscales (negotiations, psychological aggression, injury, and sexual coercion) with loadings of +/- .65 or greater. Factor analysis results, along with Cronbach's Alpha scores are presented in table 6. The eigenvalues for each subscale were 3.67, 4.46, 1.71, and 1.67 respectively. Alpha scores indicate good reliability on each factor. For the fifth subscale, physical assault, analysis produce two factors, however, two items with loadings less than .10 on the second factor were dropped from analyses. As a result, the remaining six subscale items for physical assault produced one factor with an eigenvalue of 3.43 and loadings of .56 or higher.

[20] Factor analysis has many methodological uses, not just as a tool for data reduction.

Table 6. Factor Analysis Results

	Loadings
Negotiation Factor	
Partner…	
Showed care for you	.77
Explained his side of disagreement	.77
Showed respect for your feelings	.79
Said you could work out a problem	.78
Suggested a compromise	.79
Agreed to a solution to a disagreement	.80
Eigenvalue	3.67
Cronbach's Alpha	.87
Physical Assault Factor	
Partner…	
Threw something that could hurt	.75
Twisted your arm	.56
Slammed you against a wall	.84
Beat you up	.84
Punched or hit you	.81
Choked you	.71
Eigenvalue	3.43
Cronbach's Alpha	.82
Psychological Aggression Factor	
Partner…	
Insulted or swore at you	.87
Called you fat or ugly	.71
Destroyed something belonging to you	.70
Shouted or yelled at you	.81
Stomped out of room b/c disagreement	.70
Done something in spite of you	.76
Accused you of being a lousy lover	.67
Threatened to hit or throw something	.74
Eigenvalue	4.46
Cronbach's Alpha	.87
Injury Factor	
You…	
Had a sprain, bruise or cut b/c of fight w/ partner	.92
Felt pain next day b/c fight w/ partner	.92
Eigenvalue	1.71
Cronbach's Alpha	.83
Sexual Coercion Factor	
Partner…	
Insisted on sex w/ you & used no force	.91
Insisted on oral or anal sex w/ you (no force)	.91
Eigenvalue	1.67
Cronbach's Alpha	.78

Next, values for the five subscale factors were added together to create the dependent variable, partner violence, for ordinary least squares regression analyses.[21] This sum of factors, referred to as partner violence, is the dependent variable of interest.[22] A comparison of CTS2 scores across the five subscales for all respondents, shown in table 7, reveal that women most often report high levels of psychological aggression from partners (mean = .69), followed by sexual coercion and physical assault (mean = .19 and .17 respectively). The average score on the negotiation items is 3.43, indicating higher levels negotiation with partners over other items that measure psychological and physical abuse. Fewer women report being severely injured by a partner (mean = .07).[23]

Table 7. Partner Violence Reported by Sample

	1st Generation Latinas		2nd Generation Latinas		Black Women		White Women		Non-Latina Immigrants		Total	
Conflict Tactics Scales 2	*mean*	*sd*	*mean*	*sd*	*mean*	*sd*	*mean*	*sd*	*mean*	*sd*	*mean*	*sd*
Negotiation	3.33	1.54	3.64	1.49	4.13	1.29	3.36	1.75	2.52	2.16	3.43	1.63
Physical Assault	.05	.13	.24	.51	.38	.77	.24	.52	.01	.03	.17	.45
Psych Aggression	.28	.55	.70	.92	.87	.68	1.11	1.24	.30	.47	.69	.97
Injury	.01	.05	.05	.18	.13	.31	.13	.39	0	0	.07	.26
Sexual Coercion	.14	.29	.25	.35	.29	.42	.21	.47	.02	.05	.19	.38
Sum of Factors: Partner Violence	-1.17	1.60	.11	2.59	1.59	3.77	.96	4.12	-1.91	1.41	.01	3.22

Summary statistics for the transformed dependent variable of the sum of factors, partner violence, are also displayed in table 7 for each subsample of women. Comparing mean scores of partner violence across groups, note that Black and White women have the highest scores,

[21] Additional analyses (results not shown) were conducted for each subsample of women and produced multiple factor solutions for each subscale. Of all five subscales, only sexual coercion had one factor for all groups. This appears to be an aspect of risk of partner violence that is similar across groups and discussed further in the next chapter.

[23] In results not shown, consideration was given to the positive skew of the dependent variable, partner violence; however, logging partner violence did not correct this problem.

followed by second generation Latinas. First generation immigrant women have the lowest scores.

Independent and Control Variables

The independent and control variables used in regression models represent key factors that are associated with risk of partner violence across groups. Four categorical variables indicate respondents' racial, ethnic, citizenship background (first generation Latinas, second generation Latinas, Black women, and White women – the reference category). Primary demographic characteristics include respondents' age, education (1=high school diploma or higher), income (with mean substitution for missing data), employment status (1=currently employed), and status with partner (1=married). The other variables included in models represent contextual or support level measures that indicate the degree to which respondent's current situation is characterized by instability, trauma, and stress, or stability, support, and good health. These variables include the number of times respondents have moved in the last 12 months, a dichotomous variable indicating whether respondents lived with their partner at the time of interview, two variables each of which are the sum of partner and family support scales, two variables measuring respondents' reported health and stress levels[24] during pregnancy, and one variable indicating the sum of all traumatic events experienced by respondents at any point in their lifetime. Summary statistics for these variables are presented in table 8.

[24] In other results now shown, the eleven items that make up the stress scale were analyzed using factor analysis for the entire sample and produced four factors with poor loadings for over half items. Additionally, reliability tests showed extremely low Alpha scores. For these reasons, the sum of stress items is the measure used in regression analyses to examine the relationship between stress and risk of partner violence.

Table 8. Summary Statistics

	mean	*sd*
Dependent Variables		
Negotiation Factor	.03	.98
Physical Assault Factor	.02	1.02
Psychological Aggression Factor	.02	1.02
Injury Factor	.01	1.02
Sexual Coercion Factor	.02	1.02
Partner Violence	.09	3.26
Independent & Control Variables		
Age (15-36)	19.82	3.89
% Life in US	76.43	36.96
High School Education (0-1)	.47	.50
Income (1-5)	2.26	1.19
Employed (0-1)	.56	.49
Married (0-1)	.19	.39
# Times Moved Past Year (0-2)	1.28	1.09
Live with Partner (0-1)	.36	.48
Social Support: Partner (1-66)	8.4	4.16
Social Support: Family (1-66)	54.1	12.74
Level of General Health (1-5)	3.14	.81
Level of Stress (1-44)	18.92	6.01
Past Trauma (0-13)	2.78	3.18

N=134

In regression models, the control and independent variables are entered into hierarchical blocks to isolate the effects of racial/ethnic/citizenship background, demographic, family, social support, and health characteristics on partner violence. Thus, the first model includes racial/ethnic/citizenship variables, the second adds demographic characteristics, the third regression model includes social support variables, and the last adds health related variables. These models are used to predict partner violence for three subsamples of women: 1) Latinas, Black and White women, 2) 1st and 2nd generation Latinas, and 3) U.S. born women. Modeling partner violence across groups will help identify which groups of women are most at risk and what factors account for these differences in risk of violence.

CHAPTER FOUR

RESULTS

Table 9 presents four ordinary least squares regression models of partner violence for first and second generation Latinas, Black women, and White women (the reference category). The first model includes racial/ethnic dummy variables and shows that women's risk of violence is not equally distributed across groups. White women are significantly more likely to experience partner violence than first generation Latinas, however, this relationship does not hold for second generation Latinas or Black women, who show no significant difference in risk of partner violence relative to White women. This gives some support for the hypothesis that immigrant women experience lower levels of violence than U.S. born women. In additional analyses (results not shown) conducted using each of the five subscale factors (negotiation factor, physical assault factor, psychological aggression factor, injury factor, and sexual coercion factor) as the dependent variable, first generation Latinas were also significantly less likely to report violence on every factor compared to White women.[25]

In the second model of table 9, differences in partner violence between White women and first generation Latinas disappear as age, education, income, employment, marriage, and the number of times moved in the past year are included. Factors that are associated with higher levels of violence include being younger, having a high school diploma or greater,[26] and moving frequently. With the addition of social support indicators, model three shows that being younger, being more educated, and moving frequently remain significant, as income and social support

[25] Results of regression modeling using the dependent variable partner violence are presented and discussed instead of models using each of the five factors as dependent variable because models using the sum of factors had a greater amount of explained variance and better overall fit.

[26] Recall that descriptive statistics indicate that there are important educational differences between first generation Latinas, the majority of whom reported elementary, junior high, or some high school, and U.S. born women who are more likely to have a high school diploma, GED, or some college education (see figure 4).

Table 9. OLS Regression Models Predicting IPV Among 1st, 2nd Generation Latinas, Black and White Women

	Model 1		Model 2		Model 3		Model 4	
Variable	*B*	*ß*	*B*	*ß*	*B*	*ß*	*B*	*ß*
1st Generation Latina	-2.14	-.32**	-.83	-.12	-.86	-.13	.44	.07
	(.63)		(.71)		(.71)		(.70)	
2nd Generation Latina	-.72	-.08	-.68	-.08	-.15	-.02	.77	.09
	(.81)		(.81)		(.83)		(.80)	
Black Woman	.68	.06	.42	.04	.79	.07	1.21	.11
	(.98)		(.96)		(.96)		(.89)	
Age			-.16	-.19**	-.15	-.18*	-.17	-.21**
			(.08)		(.08)		(.08)	
High School Education or More			1.46	.22**	1.17	.18*	.89	.14
			(.64)		(.67)		(.62)	
Income			.32	.12	.39	.15*	.55	.20**
			(.23)		(.23)		(.22)	
Employed			-.26	-.04	-.39	-.06	-.28	-.04
			(.56)		(.57)		(.53)	
Married			-.82	-.09	-.43	-.05	-.72	-.09
			(.75)		(.80)		(.74)	
# Moved Past Year			.72	.24**	.66	.22**	.58	.19**
			(.26)		(.26)		(.25)	
Social Support: Partner					-.17	-.21**	-.12	-.15*
					(.07)		(.07)	
Social Support: Family					.12	.12	.13	.12
					(.09)		(.08)	
Live with Partner					.34	.05	.76	.11
					(.67)		(.63)	
Level of General Health							-.10	-.03
							(.34)	
Level of Stress							.13	.23**
							(.05)	
Past Trauma							.28	.27**
							(.09)	
R^2	.10		.20		.25		.36	
Adjusted R^2	.08		.15		.18		.29	
Standard Error	3.2		3.0		2.9		2.8	
F	5.0		3.5		3.6		4.9	
Number of Cases	134							

*** p < .10 **p<.05**

from partner also have significant effects on risk of partner violence. That is, as income increases, so does risk of violence.[27] As would be expected, violence is lower with partners that

[27] Caution should be made when interpreting this result. Recall that the women in the NFP program are by definition low income, so an increase in income raises risk of violence but up to a certain point. For example, there is good

provide higher levels of social support. In the last model which adds health indicators, age, income, moving frequently, and partner support remain significant and increased stress and experiences of past trauma also predict higher risk of partner violence. With each of these models, the variables included increase the explained variance. In short, being younger, moving frequently, and experiencing high stress and past trauma are strong predictors of partner violence when other factors are controlled for. The impact of these demographic, family, and health and support characteristics suggests that the fewer resources and support available to women and the greater trauma and instability in their lives, the higher the levels of abuse they report. Additionally, this provides support for the first hypothesis that younger women in NFP are at greater risk of abuse by an intimate compared to older first time mothers.

Next, I turn to an analysis of the factors that predict partner violence among first and second generation Latinas. For this subsample, the models remain virtually unchanged, except that I exclude the racial/ethnic dummy variables included in model 1 with the previous subsample and include a variable that measures the percent of respondent's life lived in the U.S. Results are presented in table 10.

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reason to expect that an increase out of low income status to middle class would not significantly increase women's risk of partner violence – it would probably reduce it.

Table 10. OLS Regression Models Predicting IPV Among 1st and 2nd Generation Latinas

	Model 1		**Model 2**		**Model 3**		**Model 4**	
Variable	*B*	*ß*	*B*	*ß*	*B*	*ß*	*B*	*ß*
% Lived in US	.02	.40**	.004	.09	.01	.11	.01	.09
	(.01)		(.007)		(.01)		(.01)	
Age	-.05	-.10	-.12	-.26**	-.11	-.23*	-.13	-.28**
	(.05)		(.05)		(.06)		(.05)	
High School Education or More			.2.1	.47**	1.9	.44**	1.6	.38**
			(.53)		(.57)		(.49)	
Income			.04	.02	.03	.02	-.07	-.04
			(.23)		(.23)		(.20)	
Employed			-.11	-.03	-.09	-.02	.21	.05
			(.48)		(.50)		(.44)	
Married			-1.5	-.34**	-1.37	-.30*	-1.2	-.27**
			(.53)		(.61)		(.52)	
# Moved Past Year			.41	.18	.39	.18	.03	.01
			(.25)		(.25)		(.23)	
Social Support: Partner					-.03	-.06	.01	.02
					(.07)		(.06)	
Social Support: Family					.04	.06	.06	.08
					(.08)		(.07)	
Live with Partner					-.23	-.06	.12	.03
					(.53)		(.46)	
Level of General Health							.18	.07
							(.25)	
Level of Stress							.04	.09
							(.05)	
Past Trauma							.38	.45**
							(.09)	
R^2	.17		.37		.38		.57	
Adjusted R^2	.15		.30		.28		.47	
Standard Error	1.9		1.7		1.8		1.5	
F	13.4		5.3		3.7		5.7	
Number of Cases	70							

*** p < .10 **p<.05**

In the first model, percent of life lived in the U.S. is significant – the longer that Latinas live in the U.S., the higher their level of reported partner violence. This suggests support for acculturation theories that argue that the adoption of U.S. practices increases health and behavioral risks among immigrants and provides greater evidence that U.S. born women report higher levels of abuse than immigrant women. It also provides support for hypothesis three – second generation Latinas are at increased risk for IPV relative to first generation Latinas. In the

next model, this relationship disappears as age, marriage, and education exert significant effects. As with previous models, the direction of the relationship remains the same: younger women, those not married (i.e., casually dating or engaged) and those with higher levels of education are at higher risk of IPV. The addition of social support variables in model 3 shows no impact on partner violence suggesting little association between the levels of support that first and second generation Latinas receive from their partners and/or family and their reporting of partner violence. In the final model which includes health variables, past trauma is a significant predictor of partner violence. Thus, for first and second generation Latinas, risk of violence is associated with youth, living in the U.S. a greater portion of one's life, being single or dating as opposed to being married, having a high school education or higher, and having experienced a history of traumatic events. Compared with results using the subsample of Latinas and U.S. born Black and White women, the models predicting partner violence for 1st and 2nd generation Latinas have a higher explained variance.

Finally, I consider factors that account for differences in partner violence among a subsample of U.S. born including Black women, 2nd generation Latinas, and White women. Recall that an intersectional framework predicts differences in the risk of IPV among these women due to their social location – locations that are the result of overlapping inequalities in social institutions and interactions that privilege White women over other groups of women. This framework informs the prediction that Black women and second generation Latinas are more likely to experience IPV than White women. In the modeling procedures for analysis of this subsample, I exclude the percent of respondent's life lived in the U.S. due to lack of variability and include two racial/ethnic dummy variables - Black and second generation Latina. White women serve as the reference group.

Model 1 shows no significant differences between risk of partner violence among Black and White women, nor second generation Latinas and White women. However, the direction of the relationship is one that provides partial support for hypothesis #4. Black women report higher levels of IPV than White women, but the opposite is true for second generation Latinas who report lower rates of IPV compared with White women. Model 2 shows that U.S. born women who move more frequently report higher levels of partner violence. Model three indicates that as partner support increases, lower levels of partner violence are reported.

In model four, younger women report higher levels of IPV, women with higher income report higher levels of IPV, and women who move more frequently report greater levels of abuse. Additionally, partner support remains significant and family support exerts significant effects on partner violence. As family support increases, so does risk of violence by an intimate. This is a surprising finding among U.S. born women. It could be that women may face escalating conflict in situations where support from partner or from family is an either/or situation. Being more likely to have to choose between family or partner, U.S. born women's higher levels of reported violence may be attributed to the conflict occurring between their partner and their family such that strain in one relationship may be associated with more support from the other relationship.

With the addition of health variables, higher levels of stress and past experiences of trauma increase risk of partner violence. Overall, risk factors for first time mothers in the NFP program experiencing partner violence include being born in the U.S., being young, having a high school diploma or higher level of education, being in a situation of instability (moving frequently with little partner support) and having experienced past traumatic abuse. These results are displayed in table 11.

Table 11. OLS Regression Models Predicting IPV Among U.S. Born Women

	Model 1		**Model 2**		**Model 3**		**Model 4**	
Variable	*B*	*ß*	*B*	*ß*	*B*	*ß*	*B*	*ß*
2nd Generation Latina	-.61	-.07	-.75	-.09	-.20	-.02	.85	.09
	(.98)		(1.02)		(1.05)		(1.0)	
Black Woman	.79	.08	.39	.04	.88	.09	1.3	.12
	(1.2)		(1.2)		(1.2)		(1.1)	
Age			-.25	-.24	-.25	-.24	-.31	-.29**
			(.16)		(.16)		(.15)	
High School Education or More			1.4	.19	.95	.13	.78	.10
			(1.1)		(1.17)		(1.1)	
Income			.37	.13	.48	.17	.79	.28**
			(.33)		(.34)		(.31)	
Employed			-.39	-.05	-.25	-.03	-.27	-.04
			(.84)		(.84)		(.78)	
Married			-.33	-.03	.33	.03	-.19	-.02
			(1.5)		(1.5)		(1.4)	
# Moved Past Year			.84	.27**	.83	.27**	.84	.27**
			(.36)		(.35)		(.34)	
Social Support: Partner					-.26	-.27**	-.22	-.23*
					(.12)		(.11)	
Social Support: Family					.21	.18	.22	.19*
					(.14)		(.12)	
Live with Partner					.49	.06	1.1	.13
					(1.04)		(.97)	
Level of General Health							-.46	-.09
							(.54)	
Level of Stress							.15	.25**
							(.07)	
Past Trauma							.32	.27**
							(.14)	
R^2	.01		.11		.18		.36	
Adjusted R^2	.01		.02		.05		.22	
Standard Error	3.8		3.7		3.7		3.3	
F	.56		1.19		1.37		2.67	
Number of Cases	88							

*** p < .10 **p<.05**

Findings from the models predicting partner violence across the three subsamples of women suggest that the risk of partner violence is not equally distributed across groups. First generation Latinas are less likely to report partner violence relative to the other groups of women. However, there appear not to be significant differences in risk of IPV among U.S. born women. Although the relationship is not significant, compared with White women, second

generation Latinas are less likely to experience violence, but Black women are more likely to report IPV. For U.S. born women, the younger women are, the more instability in their lives, and the increased lack of support from their child's father (or current partner), the greater their risk of IPV. For all women, having a past history of trauma is a significant predictor of partner violence.

CHAPTER FIVE

DISCUSSION & CONCLUSIONS

The location of women at the intersection of race, class, gender, and nation makes their actual experiences of partner violence qualitatively different from each other (Crenshaw 1991). Women of color are overrepresented in social inequalities in the United States. Many are burdened by poverty, a lack of job skills, and access to affordable housing. This fact is evident in the sample of mothers in this study. A disproportionate number of clients referred to River County Health Department to participate in the Nurse-Family Partnership program are Latina or Black and are seeking public assistance in acquiring prenatal and post partum care, employment, and housing resources. These women are overrepresented as clients in the NFP program relative to their group size in the general population. Their burdens, largely a consequence of gender and class oppression, are multiplied when they face discrimination in the institutions and institutional policies. Although institutions may not overtly discriminate against women of color, many policies have unintended consequences, such as immigrant women being unable to receive assistance or care with someone familiar with their cultural background and fluent in their native language.

Of the violence reported by women in this study as measured by the CTS2, it is overall on the less severe end of physical assault, injury, and sexual coercion and falls more along the lines of frequent psychological aggression and low to moderate levels of negotiations. Considering how young most respondents are, it may be encouraging that only a portion of mothers are in severely violent relationships, though some young women may be in relationships that are escalating in conflict from psychological aggression to minor physical assault or worse and headed down a violent path.

What explanations can speak to the counterintuitive findings that income and education predict increased partner violence? Recall from descriptive statistics of the women in this study that there are fundamental differences in the life situation and social location of women across groups. All women are low income, first time mothers. However, immigrant women tend to be older and have less education and lower reported annual family income, but greater amounts of support from both family and partner. In contrast, U.S. born Latinas, Black and White women are on average much younger, tend to have at least some high school education, and report higher income. Results indicating that income and education increase partner violence should be interpreted as reflecting core differences between immigrant and non-immigrant women in their life situations and social locations in contemporary U.S. society. It should not be assumed that the impact of income and education on levels of partner violence operates in the same way among other groups of women from higher socioeconomic classes. This is an avenue of research worthy of further consideration. Does intimate partner violence across groups of middle or upper class women of diverse backgrounds vary in a similar way, and if so, do income and education have significant positive effect?

One aspect of IPV that seems to be relatively similar across groups is sexual coercion. Among the groups of women in this study, differences in the reporting of negotiations with partner, physical assault, psychological aggression, and injury from partner were greater than differences in the reporting of sexual coercion by partner. The CTS2 subscale items that composed the sexual coercion factor as part of the dependent variable, partner violence, were two items that measured whether respondents' partner had ever insisted on oral or anal sex without the use of physical force, or insisted on sexual intercourse without force. This aspect of abuse is one that is based solely on verbal instruction. Consistency in the reporting of these items

across groups suggests that this aspect of relationships may open the door for escalating conflict and violence. Once women lose control over what happens to their bodies sexually, their partners may develop control mechanisms in other aspects of the relationship. If this idea holds true, it may be useful in informing research on intimate partner violence in relationship where partners are of the same gender, such as within the LGBT community. Exploring how sexual control without force leads to the escalation of other types of partner abuse may shed further light on risk of intimate partner violence and may help inform prevention efforts.

Further consideration should also be given to the number of items on the CTS2 that were omitted for non-response. Three of the five subscales contained several items that were not reported by women. These points beg the question: are immigrant women truly less at risk of intimate partner violence, or do the data reflect differences in reporting practices? This is a question that still needs to be addressed (Tjaden and Thoennes 2000). Briefly revisiting the descriptive data from immigrant women from Asia, Africa, and Eastern Europe, these women reported the lowest levels of violence on every CTS2 subscale. While it is possible that immigrant women, who in this sample tend to be older, married, employed, and have less education, are at less risk of IPV than U.S. born women, overall, low reporting of violence among all immigrant women could also be related to issues of measurement. That is, the cultural specificity of survey questions and the language of items that comprise the CTS2 may not have been interpreted by all respondents in the same way. Despite efforts to ensure survey comprehension in English and Spanish through back translation methods, there are indications that women interpreted the questions differently and this may have led to measurement error. For example, the translation of "partner" was in itself problematic for some Spanish speaking respondents because it was interpreted as meaning women were engaging in a relationship with

someone of the same gender. Respondents were confused in situations where they were not asked explicitly about their relationship with their husband (*esposo*) or boyfriend (*novio*).

Another key difference in interview methodology relates to differences in the amount of time it took respondents to complete interviews. Spanish speaking interviews took considerably longer than those in English regardless of whether they were face to face or using ACASI. The Spanish speaking interviewer who assisted with data collection frequently reported after interviews that she spent most of her time explaining the meaning of ambiguous CTS2 items such as "has your partner done something in spite of you." This suggests that immigrant women may have had difficulty comprehending the meaning of questions and response categories or just declined to disclose altogether for fear of financial and immigration status repercussions. This leads to the conclusion that is it worthwhile for researchers to explore better measures of partner violence than are currently offered through the CTS2, measures that include items that are cross-culturally applicable. This requires working with more diverse populations than is typical of nationally representative samples or randomly drawn community samples to create reliable and valid measures for diverse groups. Qualitative research, for example focus groups held in the language of respondents, can help identify aspects of IPV that can be measured across groups and used in quantitative survey assessments.

That immigrant women report less violence does not mean that they are not in abusive situations either. [28] The experiences of immigrant women in abusive situations are often exacerbated by their social location as immigrants. As immigrants, their citizenship status acts as a stressor when environmental circumstances such as limited language skills, isolation, and unemployment strain gender relations and place women in positions of dependency with limited

[28] Confidential communications with a River County nurse of the NFP program confirmed that at least one immigrant woman experienced severe incidents of partner violence, serious enough to warrant the police visiting her residence, but this respondent did not indicate such in her reporting of partner violence during her interview.

resources and support. Escaping abusive relationships can be especially difficult in such situations. It is only very recently that victims' advocates have begun reaching out to women and communicating support in alternative spaces where women of color, Latinas, and other immigrant women are more likely to be located. Health care delivery is complicated by linguistic problems and cultural differences between immigrants and American health care systems. Health care providers are ill-equipped to deal with the special needs of immigrant and refugee newcomers. In particular, clinics focused on maternal health and partner violence need to develop linguistic competency and cultural sensitivity in administering health care services. More attention should also be given to the demographic composition of health care providers who administer violence assessments, prevention and intervention materials to women. Providing screening for partner violence and care for its victims requires a multicultural awareness and preparation for dealing with the barriers that women at the margins confront daily.

A limitation of this study is that women who are at higher risk of IPV might have dropped out of the Nurse-Family Partnership program before they could be interviewed. This would include women who were referred to the program but never interacted with their community health nurse to begin home visitations, or those who never consented to being in the study for interview but remained in the NFP program. One other limitation is the reliance of individual level data to explore structural level patterns; however data limitations are inevitably part of all research. To address this limitation, I have tried to contextual the social environment in which women experience their private daily lives and the public, institutional forces that present obstacles to specific groups and therefore increase the risk of abuse. Context is often identified as a key piece that is missing from nearly all studies on partner violence (Kimmel

2002), especially those that declare gender symmetry in IPV. Feminists are just now beginning to explore the ways in which gender settings, for example research on college populations, particularly fraternities, increase risks of sexual violence and physical assault (Miller 2008). This is a direction that research on intimate partner violence should head in the future.

Future research could also address issues related to differences in reporting practices among women that are used to estimate risk of violence. As with any research on diverse groups of people who vary in their linguistic and cultural experiences, it is important to consider the methodological tools used to collect and organize information about participants. Future research on the differences in the reporting practices of different groups of women are possible as longitudinal data is being collected with this sample of women as they progress through the NFP program. During home visits, community health nurses are conducting routine assessments for IPV and this data can be compared with client's self reports of IPV at annual interviews. This will allow for a comparison of respondents' self-reporting of IPV to the interviewer with clients self-reporting of IPV to their community health nurse, or the nurse's own observation of violence (or evidence of violence) during visits. Given the strong attachment that respondents develop with their NFP nurse over a two year period from delivery to the time their child reaches toddlerhood, there is a great likelihood that nurses will be able to detect violence in levels of frequency and severity not reported in annual interviews. Refining the tools used to estimate intimate partner violence and examining the role that individual, contextual, and structural factors play in risk of violence are ways in which we can continue to address violence against women and include the voices and experiences of women at the margins.

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APPENDIX

Survey Instrument

1. Demographics
2. Quality of Life
3. Depression
4. Trauma History
5. Post Traumatic Stress Symptoms
6. Relationship History
7. Quality of Marriage Index
8. Conflict Tactics Scale
9. Proximal Antecedents of Violent Episodes Scale
10. Psychological Maltreatment of Women
11. Communication Patterns
12. Relationship Danger Items
13. Conflict Resolution Strategies
14. Sliding vs. Deciding Items
15. Relationship Locus of Control
16. Use of Community Resources
17. Prenatal Psychosocial Profile:
    Stress
    Social Support
    Self-esteem
18. Delinquent Behavior
19. Alcohol Use
20. Drug Use

Demographics

1. Sex
   - Male
   - Female

2. Age _____

3. What is your race/ethnicity?
   - Caucasian
   - Black/Black not Hispanic
   - Hispanic
   - Asian
   - Native American
   - Other
   - Don't Know

4.Were you born in the US? Y or N

   If no, how many years have you been in the U.S. _____

5. What is the highest level of education or degree that you have completed?
   - Elementary
   - Junior High
   - Some High School
   - GED
   - High School Diploma
   - Some College
   - College Degree
   - Post College

6.How much is your family yearly income?
   - Under $10,000
   - $11,000-$15,000
   - $15,000-$20,000
   - $21,000-$25,000
   - $26,000-$30,000
   - $31,000-$35,000
   - Above $35,000

7. What are the sources of your yearly income?
   - Employment
   - Social Services
   - Disability
   - Family support you

8. Who do you currently live with?
    - Biological Parent
    - Stepparent
    - Foster Parent
    - Sibling
    - Other Relative
    - Friend
    - Romantic Partner

9. How many times have you moved in the last year?
    - 0
    - 1
    - 2
    - 3
    - 4
    - 5 or greater

Health and Well-Being

This survey asks for your views about your current health. Please answer every question by marking an X in one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. The following items are about activities you might do in a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes limited little	No, not limited at all
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	☐	☐	☐
Climbing several flights of stairs?	☐	☐	☐

3. During the past 30 days, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Accomplished less than you would like?	☐	☐
Were limited in the kind of work or other activities	☐	☐

4. During the past 30 days, have you had any of the following problems with your work or other regular daily activity as a result of your emotional problems (such as feeling depressed or anxious)?

	Yes	No
Accomplished less than you would like?	☐	☐
Didn't do work or other activities as carefully as usual?	☐	☐

5. During the past 30 days, how much did pain interfere with your usual work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a lot	Extremely
☐	☐	☐	☐	☐

6. These questions are about how you feel and how things have been with you during the past 30 days. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 30 days:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

7. During the past 30 days, how much of the time has your physical health or emotional problems interfered with your usual activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Depression

Please indicate which response comes closest to describing how you have been feeling for the past 7 days.

1. I have been able to laugh and see the funny side of things:
   - As much as I always could 0
   - Not quite so much now 1
   - Definitely not so much now 2
   - Not at all 3

2. I have looked forward with enjoyment to things:
   - As much as I ever did 0
   - Rather less than I used to 1
   - Definitely less than I used to 2
   - Hardly at all 3

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time 3
   - Yes, some of the time 2
   - Not very often 1
   - No, never 0

4. I have been anxious or worried for no good reason:
   - No, not at all 0
   - Hardly ever 1
   - Yes, sometimes 2
   - Yes, very often 3

5. I have been scared or panicky for no very good reason:
   - Yes, quite a lot 3
   - Yes, sometimes 2
   - No, not much 1
   - No, not at all 0

6. Things have been getting on top of me:
   - Yes, most of the time I haven't been able to cope at all 3
   - Yes, sometimes I haven't been coping as well as usual 2
   - No, most of the time I have copied quite well 1
   - No, I have been coping as well as ever 0

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time 3
   - Yes, sometimes 2
   - Not very often 1
   - No, not at all 0

8. I have felt sad or miserable:

Yes, most of the time	3
Yes, quite often	2
Not very often	1
No, not at all	0

9. I have been so unhappy that I have been crying:

Yes, most of the time	3
Yes, quite often	2
Only occasionally	1
No, never	0

10. The thought of harming myself has occurred to me:

Yes, quite often	3
Sometimes	2
Hardly ever	1
Never	0

Trauma History

The items listed below refer to events that may have taken place at any point in your entire life, including early in your childhood. Please respond yes or no to indicate whether you have ever experienced any of the following events.

Has the following ever happened to you?

1. Life-threatening illness	NO	YES	_____
2. Life-threatening accident	NO	YES	_____
3. Robbery/mugging	NO	YES	_____
4. Loss of a loved one because of accident, homicide, suicide	NO	YES	_____
5. Forced intercourse, oral, or anal sex	NO	YES	_____
6. Attempted forced intercourse, oral or anal sex	NO	YES	_____
7. Unwanted sexual touching	NO	YES	_____
8. Childhood physical abuse	NO	YES	_____
9. Domestic violence	NO	YES	_____
10. Threats with weapons	NO	YES	_____
11. Being present when another person killed, injured or assaulted	NO	YES	_____
12. Other injury or life threat	NO	YES	_____
13. Other extremely frightening or horrifying event	NO	YES	_____

Posttraumatic Stress Symptoms

IN THE BLANK SPACE BEFORE EACH QUESTION, PUT A NUMBER TO TELL HOW MUCH THAT THING HAS HAPPENED TO YOU IN THE PAST TWO WEEKS.

Use the scale below to decide which number to put in the blank space. Put "0" if you never had the experience in the past two weeks, and put "10" if it was always happening to you or happened every day during the past two weeks. If it happens sometimes, but not every day, put in one of the numbers between "0" and "10" to show how much.

0 1 2 3 4 5 6 7 8 9 10
Never Always

_____ 1. I don't feel like doing things that I used to like doing.
_____ 2. I can't remember much about bad things that have happened to me.
_____ 3. I feel cut off and isolated from other people.
_____ 4. I try not to think about things that remind me of something bad that happened to me.
_____ 5. I feel numb; I don't feel emotions as strongly as I used to.
_____ 6. I have trouble concentrating on things or paying attention to something for a long time.
_____ 7. I have a hard time thinking about the future and believing that I'm going to live to old age.
_____ 8. I feel very irritable and lose my temper.
_____ 9. I avoid doing things or being in situations that might remind me of something terrible that happened to me in the past.
_____ 10. I am very aware of my surroundings and nervous about what's going on around me.
_____ 11. I find myself remembering bad things that happened to me over and over, even when I don't want to think about them.
_____ 12. I get startled or surprised very easily and "jump" when I hear a sudden sound.
_____ 13. I have bad dreams about terrible things that happened to me.
_____ 14. I get very upset when something reminds me of something bad that happened to me.
_____ 15. I have trouble getting to sleep or staying asleep.
_____ 16. When something reminds me of something bad that happened to me, I feel shaky, sweaty, nervous, and my heart beats really fast.
_____ 17. I suddenly feel like I am back in the past, in a bad situation that I was once in, and it's like it was happening all over again.

Relationship History

First, a few questions about your past relationships:

1. How old were you when you had your first dating relationship? _____

2. How old were you when you had sexual intercourse for the first time? _____

3. How many dating partners have you had, including anyone you are currently with? _____

4. How many of these dating relationships would you say were serious relationships? _____

5. How many different partners have you had sexual intercourse with ? _____

Next, we have a few questions about your current relationships:

6. Are you currently in a romantic relationship with your child's father? YES NO
   (If YES, ask for first name _____)
   IF YES, answer 7 and 8, then skip to 11
   IF NO, skip to 9

7. (IF participant is with child's father), what is the status of your relationship?
   A. Living separately, casually dating each other (may also be dating other people)
   B. Living separately, Dating each other exclusively
   C. Living together, dating each other but also other people
   D. Living together, dating each other exclusively
   E. Engaged
   F. Married

8. How long have you been together? _____ years _____ months

9. (IF participant is no longer with child's father), what was the most serious status of your relationship?
   A. Not dating, casual encounter with a stranger
   B. Not dating, casual encounter with an acquaintance/friend
   C. Living separately, casually dating each other (may also be dating other people)
   D. Living separately, Dating each other exclusively
   E. Living together, dating each other but also other people
   F. Living together, dating each other exclusively
   G. Engaged
   H. Married
      i. Separated
      ii. Divorced

10. How long were you together? _____ years _____ months

11. On a scale of 1-5, with 1 being very casual and 5 being very serious, how would you describe what your relationship is or was (if you are not together) with your child's father?

1	2	3	4	5
Very casual	Somewhat casual	In between casual and serious	Serious	Very serious

12. Was this pregnancy a planned pregnancy?
    A. Yes, we planned it together
    B. Yes, I planned it but he did not know I was trying to get pregnant
    C. No, it was not planned

13. If the pregnancy was not planned, were either of you using birth control or protection when you got pregnant?
    A. Yes
    B. No
    C. Can't remember/don't know

14. (If participant is no longer in a relationship with child's father or has another main partner) Are you in a relationship with someone now? YES NO
15. (If YES, ask for first name _____)
    (If multiple partners, ask participant to choose one main partner)
    IF YES, go to #15
    IF N/A or NO, skip to #18
16. IF YES, what is the status of your relationship?
    A. Living separately, casually dating each other (may also be dating other people)
    B. Living separately, dating each other exclusively
    C. Living together, dating each other but also other people
    D. Living together, dating each other exclusively
    E. Engaged
    F. Married

17. How long have you been together? _____ years _____ months

18. (IF YES) On a scale of 1-5, with 1 being very casual and 5 being very serious, how would you describe your relationship with this person?

1	2	3	4	5
Very casual	Somewhat casual	In between casual and serious	Serious	Very serious

Finally, we have some questions about things that may or may not have happened across all of your romantic relationships:

19. Thinking back on all of your dating relationships, how often have you insulted, sworn at, shouted at, yelled at, or said something to spite your partner?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

20. (If >1 time) How many partners have you done any of these things to? _____

21. Thinking back on all of your dating relationships, how often has your partner insulted, sworn at, shouted at, yelled at, or said something to spite you?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

22. (If >1 time) How many partners have done any of these things to you? _____

23. Thinking back on all of your dating relationships, how often have you called your partner fat or ugly, destroyed something that belonged to your partner or threatened to hit or throw something at your partner?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

24. (If >1 time) How many partners have you done any of these things to? _____

25. Thinking back on all of your dating relationships, how often has your partner called you fat or ugly, destroyed something that belonged to you or threatened to hit or throw something at you?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

26. (If >1 time) How many partners have done any of these things to you? _____

27. Thinking back on all of your dating relationships, how often have you thrown something at your partner that could hurt, twisted your partner's arm, pushed, shoved, grabbed, or slapped your partner?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

28. (If >1 time) How many partners have you done any of these things to? _____

29. Thinking back on all of your dating relationships how often has your partner thrown something at you that could hurt, twisted your arm, pushed, shoved, grabbed, or slapped you?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

30. (If >1 time) How many partners have done any of these things to you? _____

31. Thinking back on all of your dating relationships, how often have you punched, choked, kicked, beat up, or used a knife or gun on your partner?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

32. (If >1 time) How many partners have you done any of these things to?

33. Thinking back on all of your dating relationships, how often has your partner punched, choked, kicked you, beat you up, or used a knife or gun on you?

0	1	2	3	4	5	6
Never	Once	Twice	3-5 times	6-10 times	11-20 times	>20 times

34. (If >1 time) How many partners have done any of these things to you? _____

Relationship History II

IF SINGLE AT BASELINE or LAST ASSESSMENT:

1. In (MONTH) of this year/last year when we talked last, you were not currently with a relationship partner. Have you had any relationship partners since then? YES NO

IF YES

2. How many different relationship partners have you had since we last spoke in [MONTH]? _____

3. How many of these relationships would you say were serious? _____

4. Are you currently involved with anyone? YES NO
   (If YES, ask for first name _____)
   (If multiple partners, ask participant to choose one main partner)
5. What is the status of your relationship?
   a. Living separately, casually dating each other (may also be dating other people)
   b. Living separately, Dating each other exclusively
   c. Living together, dating each other but also other people
   d. Living together, dating each other exclusively
   e. Engaged
   f. Married

6. How long have you been together? _____

7. (IF YES) On a scale of 1-5, with 1 being very casual and 5 being very serious, how would you describe your relationship with this person?

1	2	3	4	5
Very casual	Somewhat casual	In between casual and serious	Serious	Very serious

IF IN A RELATIONSHIP AT BASELINE:

1. In (MONTH) of this year/last year when we talked last, you were in a relationship with (partner's name). Are you still with him (her)? YES NO (if YES, go to next page)

IF NO:

2. When did you break up? _____

3. Did you break up with him, or did he break up with you, or was it a mutual decision? _____

1= totally his decision
2= more his decision than mine
3 = mutual decision

4= more my decision than his
5= totally my decision

4. Can you tell me why you broke up?
    a. Drifted apart/one or both didn't care for the other person anymore
    b. Different values, life goals, etc.
    c. Cheating
    d. One or both people found someone else
    e. the Pregnancy
    f. Money
    g. He was abusive
    h. OTHER _____

5. How many relationship partners have you had since then? _____

6. Have any of these relationships would you say were serious?_____

7. Are you currently involved with anyone? YES NO
   (If YES, ask for first name _____)

8. How long have you been together? _____

9. What is the status of your relationship?
    a. Living separately, casually dating each other (may also be dating other people)
    b. Living separately, Dating each other exclusively
    c. Living together, dating each other but also other people
    d. Living together, dating each other exclusively
    e. Engaged
    f. Married
    g. Separated
    h. Divorced

10. How long have you been together? _____ years _____ months

11. (IF YES) On a scale of 1-5, with 1 being very casual and 5 being very serious, how would you describe your relationship with this person?

1	2	3	4	5
Very casual	Somewhat casual	In between casual and serious	Serious	Very serious

IF STILL IN A RELATSIONSHIP WITH SAME PERSON:

1. How long have you been together? _____

2. Have you dated anyone else or had any other relationship since we last talked outside of this relationship? YES NO (Note number of people/relationships _____)

3. IF YES, What is the status of your relationship now?
    a. Living separately, casually dating each other (may also be dating other people)
    b. Living separately, Dating each other exclusively
    c. Living together, dating each other but also other people
    d. Living together, dating each other exclusively
    e. Engaged
    f. Married
    g. Separated
    h. Divorced

4. On a scale of 1-5, with 1 being very casual and 5 being very serious, how would you describe your relationship with this person?

1	2	3	4	5
Very casual	Somewhat casual	In between casual and serious	Serious	Very serious

Quality of Marriage Index

Please mark the number for each item that best describes the degree of satisfaction you feel in various areas of your relationship with your romantic partner. A romantic partner is a person you have been in an intimate relationship with for at least 1 month. If you do not have a current partner, please complete this measure while thinking of your most recent romantic relationship that lasted for at least 1 month.

For items 1-5:
1=Very strongly disagree
2=Strongly disagree
3=Disagree
4=Neither disagree nor agree
5=Agree
6=Strongly Agree
7=Very Strongly Agree

1. We have a good relationship.	1 2 3 4 5 6 7
2. My relationship with my partner is very stable.	1 2 3 4 5 6 7
3. My relationship with my partner is strong.	1 2 3 4 5 6 7
4. My relationship with my partner makes me happy.	1 2 3 4 5 6 7
5. I really feel like part of a team with my partner.	1 2 3 4 5 6 7

All things considered, what degree of happiness best describes your relationship?

1	2	3	4	5	6	7	8	9	10
Unhappy				Happy					Perfectly Happy

Conflict Tactics Scales 2

No matter how well a couple gets along, there are times when they disagree and couples have many different ways of trying to settle their differences. Below is a list of some things that might happen when you have differences. Please circle how many times you did each of these things in the past year and how many times your romantic partner did them in the past year. A romantic partner is a person you have been in a relationship with for at least 1 month. If you do not have a current partner, please complete this measure while thinking of your most recent romantic relationship that lasted for at least 1 month. (If you have multiple romantic partners, please answer this set of questions and all questions in this interview that are about romantic partners about one, main romantic partner.)

0 = never in the past year
1 = once in the past year
2 = twice in the past year
3 = 3-5 times in the past year
4 = 6-10 times in the past year
5 = 11-20 times in the past year
6 = more than 20 times in the past year

1a.	Has your partner showed care for you even though you disagreed?	0 1 2 3 4 5 6
1b.	Have you showed your partner you cared even though you disagreed?	0 1 2 3 4 5 6
2a.	Has your partner explained his/her side of a disagreement to you?	0 1 2 3 4 5 6
2b.	Have you explained your side of a disagreement to your partner?	0 1 2 3 4 5 6
3a.	Has your partner thrown something at you that could hurt?	0 1 2 3 4 5 6
3b.	Have you thrown something at your partner that could hurt?	0 1 2 3 4 5 6
4a.	Has your partner insulted or sworn at you?	0 1 2 3 4 5 6
4b.	Have you insulted or swore at your partner?	0 1 2 3 4 5 6
5a.	Has your partner twisted your arm or hair?	0 1 2 3 4 5 6
5b.	Have you twisted your partner's arm or hair?	0 1 2 3 4 5 6
6a.	Have you had a sprain, bruise, or small cut because of a fight with your partner?	0 1 2 3 4 5 6
6b.	Has your partner had a sprain, bruise, or small cut because of a fight with you?	0 1 2 3 4 5 6
7a.	Has your partner shown respect for your feelings about an issue?	0 1 2 3 4 5 6
7b.	Have you shown respect for your partner's feelings about an issue?	0 1 2 3 4 5 6
8a.	Has your partner made you have sex without a condom?	0 1 2 3 4 5 6
8b.	Have you made your partner have sex without a condom?	0 1 2 3 4 5 6
9a.	Has your partner pushed or shoved you?	0 1 2 3 4 5 6
9b.	Have you pushed or shoved your partner?	0 1 2 3 4 5 6
10a.	Has your partner used force (like hitting, holding down, or using a weapon) to make you have oral or anal sex? (SS)	0 1 2 3 4 5 6
10b.	Have you used force (like hitting, holding down, or using a weapon) to make your partner have oral or anal sex? (SS)	0 1 2 3 4 5 6
11a.	Has your partner used a gun or knife on you? (SP)	0 1 2 3 4 5 6
11b.	Have you used a gun or knife on your partner? (SP)	0 1 2 3 4 5 6

12a.	Have you passed out from being hit on the head by your partner in a fight?	0 1 2 3 4 5 6
12b.	Has your partner passed out from being hit on the head by in a fight?	0 1 2 3 4 5 6
13a.	Has your partner called you fat or ugly?	0 1 2 3 4 5 6
13b.	Have you called your partner fat or ugly?	0 1 2 3 4 5 6
14a.	Has your partner punched you or hit you with something that could hurt? (SP)	0 1 2 3 4 5 6
14b.	Have you punched or hit your partner with something that could hurt? (SP)	0 1 2 3 4 5 6
15a.	Has your partner destroyed something belonging to you?	0 1 2 3 4 5 6
15b.	Have you destroyed something belonging to your partner?	0 1 2 3 4 5 6
16a.	Have you gone to the doctor because of a fight with your partner?	0 1 2 3 4 5 6
16b.	Has your partner gone to a doctor because of a fight with you?	0 1 2 3 4 5 6
17a.	Has your partner choked you? (SP)	0 1 2 3 4 5 6
17b.	Have you choked your partner? (SP)	0 1 2 3 4 5 6
18a.	Has your partner shouted or yelled at you?	0 1 2 3 4 5 6
18b.	Have you shouted or yelled at your partner?	0 1 2 3 4 5 6
19a.	Has your partner slammed you against a wall? (SP)	0 1 2 3 4 5 6
19b.	Have you slammed your partner against a wall? (SP)	0 1 2 3 4 5 6
20a.	Has your partner said he/she was sure you and your partner could work out a problem?	0 1 2 3 4 5 6
20b.	Have you said you were sure that you and your partner could work out a problem?	0 1 2 3 4 5 6
21a.	Have you needed to see a doctor because of a fight with your partner, but didn't?	0 1 2 3 4 5 6
21b.	Has your partner needed to see a doctor because of a fight with you, didn't?	0 1 2 3 4 5 6
22a.	Has your partner beat you up? (SP)	0 1 2 3 4 5 6
22b.	Have you beat your partner up? (SP)	0 1 2 3 4 5 6
23a.	Has your partner grabbed you?	0 1 2 3 4 5 6
23b.	Have you grabbed your partner?	0 1 2 3 4 5 6
24a.	Has your partner used force (like hitting, holding down, or using a weapon) to make you have sex? (SS)	0 1 2 3 4 5 6
24b.	Have you used force (like hitting, holding down, or using weapon) to make your partner have sex? (SS)	0 1 2 3 4 5 6
25a.	Has your partner stomped out of the room or house or yard during a disagreement?	0 1 2 3 4 5 6
25b.	Have you stomped out of the room or house or yard during a disagreement?	0 1 2 3 4 5 6
26a.	Has your partner insisted on sex when you did not want to (but did not use physical force)?	0 1 2 3 4 5 6
26b.	Have you insisted on sex when your partner did not want to (but did not use physical force)?	0 1 2 3 4 5 6
27a.	Has your partner slapped you?	0 1 2 3 4 5 6
27b.	Have you slapped your partner?	0 1 2 3 4 5 6

28a. Have you had a broken bone from a fight with your partner? 0 1 2 3 4 5 6
28b. Has your partner had a broken bone from a fight with you? 0 1 2 3 4 5 6
29a. Has your partner used threats to make you have oral or anal sex? (SS) 0 1 2 3 4 5 6
29b. Have you used threats to make your partner have oral or anal sex? (SS) 0 1 2 3 4 5 6
30a. Has your partner suggested a compromise to a disagreement? 0 1 2 3 4 5 6
30b. Have you suggested a compromise to a disagreement? 0 1 2 3 4 5 6
31a. Has your partner burned or scalded you on purpose? (SP) 0 1 2 3 4 5 6
31b. Have you burned or scalded your partner on purpose? (SP) 0 1 2 3 4 5 6
32a. Has your partner insisted you have oral or anal sex when you did not want to (but did not use physical force)? 0 1 2 3 4 5 6
32b. Have you insisted on oral or anal sex when your partner did not want to (but did not use physical force)? 0 1 2 3 4 5 6
33a. Has your partner accused you of being a lousy lover? 0 1 2 3 4 5 6
33b. Have you accused your partner of being a lousy lover? 0 1 2 3 4 5 6
34a. Has your partner done something to spite you? 0 1 2 3 4 5 6
34b. Have you done something to spite your partner? 0 1 2 3 4 5 6
35a. Has your partner threatened to hit or throw something at you? 0 1 2 3 4 5 6
35b. Have you threatened to hit or throw something at your partner? 0 1 2 3 4 5 6
36a. Have you felt a physical pain that still hurt the next day because of a fight with your partner? 0 1 2 3 4 5 6
36b. Has your partner a felt physical pain that still hurt the next day because of a fight with you? 0 1 2 3 4 5 6
37a. Has your partner kicked you? (SP) 0 1 2 3 4 5 6
37b. Have you kicked your partner? (SP) 0 1 2 3 4 5 6
38a. Has your partner used threats to make you have sex? (SS) 0 1 2 3 4 5 6
38b. Have you used threats to make your partner have sex? (SS) 0 1 2 3 4 5 6
39a. Has your partner agreed to try a solution to a disagreement that you suggested? 0 1 2 3 4 5 6
39b. Have you agreed to try a solution to a disagreement that your partner suggested? 0 1 2 3 4 5 6

Proximal Antecedents of Violent Episodes

[ACASI instructions: This scale is to be completed by participants who score one or higher on any of the following items from the CTS: 3b, 5b, 9b, 11b, 14b, 17b, 19b, 22b, 23b, 27b, 31b, 37b. Further, the actions they endorsed (e.g., kicking a partner if they endorsed 37b) should be filled in the blank space in the instructions below.]

You said that, in the past year, you _____ your partner. In thinking of all the times you did any of those things, say how often you did those things because of each of these reasons. For instance, if you said that you slapped and punched your partner within the past year, and the item said "My partner and I were arguing about money," and some of the time you slapped your partner had been while you were arguing about money, then you would put 3 for sometimes.

1 = Never
2 = A few times
3 = Sometimes
4 = A lot of the time
5 = Most or all of the time

1. My partner did something to offend or "disrespect" me.
2. My partner threatened to leave me.
3. My partner just wouldn't stop talking or nagging.
4. I walked in and caught my partner having sex with someone.
5. My partner said "I wish I never married you/got together with you."
6. My partner was spending a lot of time with close friends of the opposite sex.
7. I found out that my partner had been flirting with someone.
8. My partner came home late.
9. My partner spent money without consulting me.
10. When my partner and I would argue about sex.
11. My partner threatened to divorce or break up with me.
12. My partner ridiculed or made fun of me.
13. My partner told me not to do something that I wanted to do.
14. My partner was trying to control me.
15. My partner interrupted me when I was talking.
16. My partner did not include me in important decisions.
17. My partner was ignoring me.
18. My partner was being physically aggressive toward me first.
19. My partner tried to leave me during an argument.
20. My partner blamed me for something I didn't do.

Psychological Maltreatment of Women Index

Please rate how often the following behaviors occurred in your romantic relationship in the past 12 months with your current partner. If you are not currently in a romantic relationship, think about your most recent relationship and complete the items based on that partner's behavior. (If you have multiple romantic partners, please answer this set of questions and all questions in this interview that are about romantic partners about one, main romantic partner.) Please indicate how frequently, on average, these behaviors occurred.

1 = never
2 = rarely
3 = sometimes
4 = frequently
5 = very frequently

1. My partner monitored my time and made me account for where I was.
2. My partner used our money or made important financial decisions without talking to me about it.
3. My partner was jealous or suspicious of my friends.
4. My partner accused me of having an affair with another man.
5. My partner interfered in my relationships with other family members.
6. My partner tried to keep me from doing things to help myself.
7. My partner restricted my use of the telephone.

Communication Patterns Questionnaire

Directions: We are interested in how you and your romantic partner typically deal with problems in your relationship. If you do not have a current partner, please think about your most recent relationship and complete the items based on your communication with that partner. (If you have multiple romantic partners, please answer this set of questions and all questions in this interview that are about romantic partners about one, main romantic partner.)

Please rate each item on a scale of 1 (= very unlikely) to 9 (= very likely).

	Very Unlikely								Likely
1. I try to discuss the problem.	1	2	3	4	5	6	7	8	9
2. My partner tries to discuss the problem.	1	2	3	4	5	6	7	8	9
3. I express their feelings to my partner.	1	2	3	4	5	6	7	8	9
4. My partner expresses his feelings to me.	1	2	3	4	5	6	7	8	9
5. I suggest possible solutions and compromises.	1	2	3	4	5	6	7	8	9
6. My partner suggests possible solutions and compromises.	1	2	3	4	5	6	7	8	9
7. I blame, accuse, and criticize my partner.	1	2	3	4	5	6	7	8	9
8. My partner blames, accuses, and criticizes me.	1	2	3	4	5	6	7	8	9
9. I threaten my partner with negative consequences.	1	2	3	4	5	6	7	8	9
10. My partner threatens me with negative consequences.	1	2	3	4	5	6	7	8	9
11. I call my partner names, swear at him, or attack his character.	1	2	3	4	5	6	7	8	9
12. My partner calls me names, swears at me, or attacks my character.	1	2	3	4	5	6	7	8	9

Relationship Danger Assessment

Please answer the following questions using a 3 point scale to rate how often you or your romantic partner experience the following things. A romantic partner is a person you have been in a relationship with for at least 1 month. If you do not have a current partner, please complete this measure while thinking of your most recent romantic relationship that lasted for at least 1 month. If you have multiple romantic partners, please answer this set of questions and all questions in this interview that are about romantic partners about one, main romantic partner.

1 = Never or almost never	2 = Once in awhile	3 = Frequently

1.	Little arguments escalate into ugly fights with accusations, criticisms, name calling, or bringing up past hurts.	1	2	3
2.	My partner criticizes or belittles my opinions, feelings, or desires.	1	2	3
3.	My partner seems to view my words or actions more negatively than I mean them to be.	1	2	3
4.	When we have a problem to solve, it is like we are on opposite teams.	1	2	3
5.	I hold back from telling my partner what I really think and feel.	1	2	3
6.	I feel lonely in this relationship.	1	2	3
7.	When we argue, one of us withdraws...that is, doesn't want to talk about it anymore; or leaves the scene.	1	2	3

Conflict Resolution

Below are descriptions of the kinds of arguments people in relationships are likely to experience. Circle the number that indicates how much you agree that each statement fits your relationship. If you are not currently in a romantic relationship, please think about your most recent relationship and rate the items according to yours and your partner's behavior. (If you have multiple romantic partners, please answer this set of questions and all questions in this interview that are about romantic partners about one, main romantic partner.) The scale ranges from 1 (Strongly Disagree) to 5 (Strongly Agree) scale:

1= Strongly Disagree
2
3
4
5 = Strongly Agree

1. By the end of an argument, each of us has been given a fair hearing.
2. When we being to fight or argue, I think "here we go again".
3. Overall, I'd say we're pretty good at solving our problems.
4. Our arguments are left hanging and unresolved.
5. We go for days without settling our differences.
6. Our arguments seem to end in frustrating stalemates.
7. We need to improve the way we settle our differences.
8. Overall, our arguments are brief and quickly forgotten.

Sliding vs. Deciding

Please rate how much you agree or disagree with each statement below, based on your thoughts and behaviors in romantic relationships.

1= Strongly Disagree
2 =
3 =
4 =
5 = Strongly Agree

1. My relationships seem to just happen instead of me making decisions about them. (R)
2. I think a lot about what kind of person to be with in a relationship.
3. Sometimes I wonder what I'm doing with the kinds of guys I go out with. (R)
4. A guy has to have certain qualities for me to even consider going with him.
5. I want to know a lot about a guy before jumping into bed with him.
6. In relationships, it's important to me to get to know a guy becoming physical.
7. Going out with someone is an important decision that should given a lot of thought.
8. Having sex with someone is a decision that should be given a lot of thought.
9. Having a casual sexual relationship with someone is no big deal (R)
10. If I go steady with a guy, I want to know he can make me happy in the long run.
11. In relationships, it's important to just do what feel good (R)

Use of Community Resources

Next we would like to know whether your nurse has referred you to any specific programs in Multnomah County, and whether you contacted any of those programs.

In the past 12 months, has your nurse referred you to any of the following programs?

- ☐ Portland women's crisis line
- ☐ Sexual assault resource center
- ☐ Bradley Angle House
- ☐ Volunteers of America Home Free
- ☐ El Programa Hispano
- ☐ Legal Aid Domestic Violence Project
- ☐ Lewis and Clark Legal Clinic
- ☐ Multnomah county Courts for restraining order

In the last 12 months have you contacted any of the following programs:

- ☐ Portland women's crisis line
- ☐ Sexual assault resource center
- ☐ Bradley Angle House
- ☐ Volunteers of America Home Free
- ☐ El Programa Hispano
- ☐ Legal Aid Domestic Violence Project
- ☐ Lewis and Clark Legal Clinic
- ☐ Multnomah county Courts

Multidimensional Relationship Questionnaire

Instructions: Listed below are several statements about your romantic relationships. Please read each of the following statements carefully and decide how much it sounds like you.. For each statement indicate the response that applies most to you by using the following scale:

A = Not at all like of me.
B = Slightly like me.
C = Somewhat like of me.
D = Moderately like of me.
E = Very much like of me.

1. My intimate relationships are something I am responsible for.
2. What happens in my relationships is determined by my own behavior.
3. I have a great deal of control over my relationships.
4. The main thing which affects my relationships is what I do.
5. My relationships are something that I am in charge of.

Stress (Prenatal Psychosocial Profile)

Please indicate to what extent the following items are causing you stress in your personal life. Circle the number corresponding to the appropriate response: (1) No stress, (2) Some stress, (3) Moderate stress, or (4) Severe stress. Higher scores indicate increased stress.

A. Financial worries (e.g., food, shelter, health care, transportation)	1	2	3	4
B. Other money worries (e.g., bills, etc).	1	2	3	4
C. Problems related to family (partner, children, etc)	1	2	3	4
D. Having to move, either recently or in the future	1	2	3	4
E. Recent loss of a loved one	1	2	3	4
F. Current pregnancy	1	2	3	4
G. Current abuse: sexual, emotional, or physical	1	2	3	4
H. Problems w/ alcohol and/or drugs	1	2	3	4
I. Work problems (e.g., being laid off, etc.)	1	2	3	4
J. Problems relate to friends	1	2	3	4
K. Feeling generally “overloaded”	1	2	3	4

Social Support (Prenatal Psychosocial Profile)

The next set of questions asks how satisfied you are with the amount of support you receive from your romantic partner and/or other people. First of all, do you have a partner?"

1. No (*ask only about support from others)*
2. Yes

If you do have a current partner, rate the following items on a scale form 1 to 6 (1 being very dissatisfied and 6 being very satisfied), in order to indicate how satisfied you are with the support you receive from your partner. If you don't have a current partner, skip A-K and answer questions L-V.

A. Shares similar experiences with me	1	2	3	4	5	6
B. Helps keep up my morale	1	2	3	4	5	6
C. Helps me out when I'm in a pinch	1	2	3	4	5	6
D. Shows interest in my daily activities and problems	1	2	3	4	5	6
E. Goes out of his/her way to do special or thoughtful things for me	1	2	3	4	5	6
F. Allows me to talk about things that are very personal and private	1	2	3	4	5	6
G. Lets me know I am appreciated for the things I do for him/her	1	2	3	4	5	6
H. Tolerates my ups and downs and unusual behaviors	1	2	3	4	5	6
I. Takes me seriously when I have concerns	1	2	3	4	5	6
J. Says things that make my situation clearer and easier to understand	1	2	3	4	5	6
K. Lets me know that he/she will be around if I need assistance	1	2	3	4	5	6

For the following items, on a scale form 1 to 6,(1 being very dissatisfied and 6 being very satisfied), please indicate how satisfied you are with the support you receive from others in your life.

L. Shares similar experiences with me	1	2	3	4	5	6
M. Helps keep up my morale	1	2	3	4	5	6
N. Helps me out when I'm in a pinch	1	2	3	4	5	6
O. Shows interest in my daily activities and problems	1	2	3	4	5	6
P. Goes out of his/her way to do special or thoughtful things for me	1	2	3	4	5	6
Q. Allows me to talk about things that are very personal and private	1	2	3	4	5	6
R. Lets me know I am appreciated for the things I do for him/her	1	2	3	4	5	6

S. Tolerates my ups and downs and unusual behaviors	1	2	3	4	5	6
T. Takes me seriously when I have concerns	1	2	3	4	5	6
U. Says things that make my situation clearer and easier to understand	1	2	3	4	5	6
V. Lets me know that he/she will be around if I need assistance	1	2	3	4	5	6

Self-esteem (Prenatal Psychosocial Profile**)**

Below is a list of statements that people have used to describe themselves. Please rate the following statements according to how much you agree or disagree that the statement describes you. Respond to the questions as follows: (1) Strongly agree, (2) Agree, (3) Disagree, or (4) Strongly disagree.

A. Feel that you're a person of worth, at least on an equal basis with others.	1	2	3	4
B. Feel that you have a number of good qualities.	1	2	3	4
C. All in all, feel that you are a failure.*	1	2	3	4
D. Feel you are able to do things as well as most other people.	1	2	3	4
E. Feel you do not have much to be proud of. *	1	2	3	4
F. Take a positive attitude toward yourself.	1	2	3	4
G. On the whole, feel satisfied with yourself.	1	2	3	4
H. Wish you could have more respect for yourself. *	1	2	3	4
I. Feel useless at times.*	1	2	3	4
J. At times think you are no good at all.*	1	2	3	4
K. Feel like you have control over your life.	1	2	3	4

Delinquent Behavior Scale

Listed below are some behaviors that people engage in. Please indicate how often over the last 12 months you have behaved in that particular way, according to the scale listed below:

0 = never
1 = 1-2 times
2 = 3-5 times
4 = 6-9 times
5 = 10-19 times
6 = 20 or more times
9 = n/a

In the last 12 months, how often have you…

1. Stolen something
2. Stolen something worth more than $50
3. Damaged or destroyed property that didn't belong to you
4. Been detained or arrested by the police
5. Been required to appear in court for something you had done
6. Been sent to the principal or counselor for disciplinary reasons
7. Skipped class
8. Been suspended or expelled from school
9. Been fired from a job
10. Hit or threatened to hit someone other than a dating partner
11. Gotten into a physical fight that was not with a dating partner
12. Gotten hurt in a physical fight that was not with a dating partner
13. Sold drugs
14. Carried a knife or gun

Alcohol Use

These questions ask about your alcohol use over the past 12 months. Please indicate the response that is most similar to your drinking behavior.

1. How often do you have a drink containing alcohol?
(0) Never (1) Monthly (2) 2-4 times/month (3) 2-3 times/week (4) 4 or more times/week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more
3. How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) monthly (3) weekly (4) daily or almost daily
4. How often during the last year have you found that you were unable to stop drinking once you started?
(0) Never (1) Less than monthly (2) monthly (3) weekly (4) daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) Never (1) Less than monthly (2) monthly (3) weekly (4) daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never (1) Less than monthly (2) monthly (3) weekly (4) daily or almost daily
7. How often during the last year have you felt guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) monthly (3) weekly (4) daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of drinking?
(0) Never (1) Less than monthly (2) monthly (3) weekly (4) daily or almost daily
9. Have you or someone else been injured because of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year
10. Has a friend, relative or doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

Drug Use

These questions refer to the past 12 months. Please indicate the response that is most similar to your drinking behavior. Please answer Yes or No to each:

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you had "blackouts" or "flashbacks" as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Do your intimate partner or your parents ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc)?