Ethnicity and Risk for Symptoms of Posttraumatic Stress Following Intimate Partner Violence: Prevalence and Predictors in European American and African American Women
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Ethnicity and Risk for Symptoms of Posttraumatic Stress Following Intimate Partner Violence

Prevalence and Predictors in European American and African American Women

Michelle M. Lilly
Sandra A. Graham-Bermann

University of Michigan

The present study uses a feminist theoretical framework to explore risk factors for the development of posttraumatic stress symptoms following intimate partner violence, with a community sample of 120 low-income European American and African American women. Hierarchical regression analyses were used to examine demographic, violence, and mental health variables that predict posttraumatic stress symptoms. The data reveal that African American women report lower levels of posttraumatic stress symptoms than do their European American peers. This difference was observed despite the presence of more empirically identified risk factors for African American women. Regression analyses show that symptoms of depression increase risk for posttraumatic stress for both groups. However, a difference was observed such that past victimization increase risk for only European American women, whereas amount of psychological violence in the previous year increases risk for only African American women. Potential explanations for observed ethnic differences are offered.

Keywords: intimate partner violence; ethnicity; posttraumatic stress disorder

Research on risk factors for developing posttraumatic stress following intimate partner violence (IPV) has increased dramatically in recent years. Significant predictors of posttraumatic stress have been identified, including
demographic variables, characteristics of the violence, and the psychological health of survivors. However, several shortcomings in the literature exist. Among these is the fact that the original diagnostic criteria for posttraumatic stress disorder (PTSD) were primarily developed from work with male combat survivors whose experience of trauma is qualitatively different from that of women who endure IPV. In addition, empirical studies often control for ethnicity, which may lead to the loss of clinically relevant information useful in working with ethnically diverse populations. Using a feminist theoretical framework that locates individuals’ experience within a matrix of social constructs (e.g., gender, socioeconomic status, education), we used a sample of European American and African American battered women of predominantly low income to examine how ethnicity interacts with variables known to predict the development of posttraumatic stress symptoms.

**Effects of IPV on Women**

Recent estimates indicate that between 4 million (Misra, 2001) and 10 million women (Schafer, Caetano, & Clark, 2002) each year experience IPV. We define IPV in this study as any number of physically, emotionally, or sexually abusive acts intentionally inflicted on a woman by her intimate partner with the objective of injuring, controlling, and/or demeaning her. Women who experience IPV suffer from a variety of adverse outcomes, including high rates of PTSD (Fowler & Hill, 2004; Stein & Kennedy, 2001). For example, although an estimated 7.8% of Americans will suffer from symptoms of posttraumatic stress (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), rates of PTSD in victims of IPV have been reported to be as high as 45% to 60% (Houskamp & Foy, 1991; Saunders, 1994).

**Risk for PTSD**

Various demographic variables place women at risk for posttraumatic stress, such as low educational attainment, young age, and low socioeconomic status (Brewin, Andrews, & Valentine, 2000; Vogel & Marshall, 2001). Additionally, ethnicity has been identified as an influential predictor of posttraumatic stress reactions, showing inconsistent patterns in prevalence rates. For example, some authors have found no difference between African American and European American trauma survivors whether they are paramilitary or combat veterans (Monnier, Elhai, Frueh, Sauvageot, & Magruder, 2002; Pole et al., 2001), female assault survivors (Zoellner,
Feeny, Fitzgibbons, & Foa, 1999), or part of the general population (Breslau et al., 1998). In contrast, higher rates of posttraumatic stress in African Americans have been reported in the literature (McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000), although these differences disappear once higher rates of cumulative trauma exposure reported by African Americans are controlled. Still, other researchers have provided evidence of lower rates of posttraumatic stress in minority populations. Seng, Kohn-Wood, and Odera (2005), for example, examined diagnoses of PTSD in Medicaid recipients’ medical records, finding that African American women were underrepresented among PTSD diagnoses. Further discussion of mixed results in regard to ethnicity and PTSD is presented later.

Studies have shown that when traumatic events include interpersonal violence, several aspects increase risk for developing PTSD, such as severe physical violence (Brewin et al., 2000; Mertin & Mohr, 2000; Ozer, Best, Lipsey, & Weiss, 2003), prior exposure to violence or IPV (Breslau, Chilcoat, Kessler, & Davis, 1999), and more frequent and repeated abuse (Herman, 1992). When ethnicity is considered, however, research on trauma variables that predict posttraumatic stress has been limited. In addition to citing qualities of the violence, research has suggested that a history of depression or other pretrauma psychological disorder (Brewin et al., 2000), current symptoms of anxiety and depression (Mertin & Mohr, 2000; Stein & Kennedy, 2001), and low self-esteem (Ozer et al., 2003) increase risk for an adverse trauma reaction. Once again, research related to interethnic variability in mental health predictors of posttraumatic stress has been limited.

**Ethnicity and Posttraumatic Stress in Victims of IPV**

As mentioned, research on the impact of ethnicity in posttraumatic stress development has shown inconsistent patterns. Although the work of various researchers has emphasized the importance of considering ethnicity in studies of trauma, variations in study population and trauma type, while controlling for ethnicity, have limited our understanding of the effects of trauma in battered women’s lives. For instance, studies have included samples that are not ethnically diverse (Mertin & Mohr, 2000), are composed of one ethnic group (Fowler & Hill, 2004), and are divided into majority and minority (Breslau et al., 1998; Brewin et al., 2000), or they simply do not report on the ethnicity of the sample (Breslau et al., 1999). In other studies, an ethnically diverse sample is obtained, but ethnicity is not considered in the analyses, results, and/or discussion (Stein & Kennedy, 2001). When ethnicity is ignored or treated as a control variable, generalizability
is limited, likely contributing to the mixed findings on ethnicity and trauma. In particular, it may be that ethnicity interacts with other variables, such as income, age, total amount and/or frequency of violence, and psychological health, in ways that are obscured when ethnicity is not a focus.

The disparate interethnic findings may also be influenced by the varied forms of trauma being studied. IPV is a qualitatively different traumatic experience from that of combat (Monnier et al., 2002), police work (Pole et al., 2001), natural disasters (Perrilla, Norris, & Lavizzo, 2002), and single episodes of trauma (Breslau et al., 1999; Ozer et al., 2003); furthermore, qualitatively different traumatic experiences have been shown to produce qualitatively different trauma reactions (Cortina & Pimlott-Kubiak, 2006).

The present study operates within a feminist framework that seeks to explore how ethnicity interacts with multiple demographic, violence, and mental health variables to predict posttraumatic stress following a largely gendered experience. We used a sample of predominantly low-income battered women of African American and European American descent and hypothesized that demographic factors such as younger age, less education, and lower income level are related to higher levels of posttraumatic stress symptoms; marital status (i.e., being currently married) is also hypothesized to be related to increased levels of posttraumatic stress. Given the low-income nature of the majority of our sample, we predicted that European American women would report more symptoms of posttraumatic stress than would their African American peers (Seng et al., 2005). Furthermore, we hypothesized that trauma shows additive effects such that posttraumatic stress level increases with more trauma exposure in the previous year and a history of past violent relationships. Women who are currently living with their assailant are predicted to show increased levels of posttraumatic stress. We hypothesized that these relationships exist for both physical and psychological abuse. We posited that the presence of depressive symptoms and low self-esteem are similarly associated with higher levels of posttraumatic stress in both ethnic groups. Finally, we hypothesized that ethnicity is an important factor in predicting posttraumatic stress symptoms. Given the current inconclusive findings in literature, we did not make predictions for each ethnic group.

**Method**

**Procedure and Participants**

This study comprised a subsample of mothers who were enrolled in a larger study of mothers and children and who were recruited to participate in
a group treatment program aimed at mitigating the negative psychological effects of witnessing IPV. The women were recruited via newspapers, advertisements, and flyers posted at grocery stores and local social service agencies in five cities in southeastern Michigan. A prescreening process excluded women who had not experienced an incident of violence with an intimate partner at least once in the previous year. After obtaining consent from each woman, one of several female research assistants conducted an interview. Women were paid $20 for their time. The majority of the interviews were conducted between a participant and an interviewer of the same ethnicity.

In sum, the study enrolled 132 women who were between the ages of 21 and 55 (M = 33.5, SD = 5.8). The self-reported ethnicity of the participants was as follows: 59.1% European American, 31.1% African American, 3.0% Latina, 1.5% Asian, 0.8% Biracial, 3.8% Other—although only the European American (n = 78) and African American (n = 42) women were used in this study (n = 120). The mean monthly income was $1,250 (SD = $1,052), which is only slightly above the current poverty level for an American family with three members (U.S. Census Bureau, n.d.-b). However, approximately 25% of the sample reported a monthly income above $1,500, with the top 10% reporting monthly income higher than $3,000. The participants worked a mean of 19 hr per week (SD = 19.1), and 18.3% of the women were married. Overall, 37% obtained some high school or a high school degree; 48.3% had some college or professional training; and 14.2% received at least a college degree. Of the participants, 64.2% were still in contact with their assailant; 16.7% were living with their assailant; and 42.5% endorsed having had more than one past violent relationship.

Measures

Posttraumatic Stress Scale for Family Violence. This 17-item scale by Saunders (1994) was used to assess current level of posttraumatic stress symptom endorsement. Each item includes a 9-point scale to indicate the annual occurrence of a symptom (0 = never, 8 = over 100 times). Women’s posttraumatic stress score is calculated by adding the frequency of all symptoms, with higher scores revealing not only the presence of a symptom but its frequency. The mean score was 70 (SD = 32.6), with a range of 17 to 135. Sample items include “unpleasant memories of the abuse you can’t keep out of your mind” and “feeling detached from others since the abuse.” This measure is internally reliable (α = .94) and correlates positively with subscales of the Impact of Events Scale (Saunders, 1994). Research has not examined whether this measure is valid and reliable for African American populations. Internal consistency for this study was α = .95.
**Beck Depression Inventory.** The 21-item Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) was used as a self-report measure to assess for current depressive symptoms. Each item has four response options, with a range reflecting lack of depressive symptom (*I do not feel sad*) to the presence of relatively severe depressive symptom (*I am so sad or unhappy that I can’t stand it*). Possible scores range from 0 to 63, with higher scores indicating more depressive symptoms. The average score on the inventory for the current sample was 17.0 (*SD* = 10.5), with a range of 1 to 51. A score of 17 is considered to be in the mild-to-moderate range of depression. The inventory has been shown to be a reliable and valid instrument in a variety of studies (Beck, Steer, & Garbin, 1988), including studies with low-income African Americans (Grothe et al., 2005). The internal consistency of the measure was .90.

**Rosenberg Self-Esteem Scale.** This 25-item scale developed by Rosenberg (1979) measures the extent to which an individual endorses positive and negative characteristics in relation to oneself. Respondents receive 1 point for endorsing a positive statement (“I’m a lot of fun to be with”) or rejecting negative statements (“Things are all mixed up in my life”). Higher scores reflect higher overall self-esteem. For this study’s participants, the mean score on the scale was 22.0 (*SD* = 1.6), with a range of 19 to 25. Studies have supported construct and concurrent validity, as well as an internal reliability coefficient higher than .80 (Fleming & Courtney, 1984). Several researchers have found the Rosenberg Self-Esteem Scale to correlate with other measures of self-esteem validated for African Americans, such as the Six-Factor Self-Concept Scale (Yanico & Lu, 2000). Internal consistency for this measure was .89.

**Conflict Tactics Scale.** Developed by Straus (1979), the 15-item Conflict Tactics Scale was used to assess the presence and frequency of physical violence in the year before study enrollment. Participants were asked whether the act of violence occurred and approximately how many times it occurred in the previous year. A composite score was generated by calculating the frequency of the violent acts. The mean score for this scale was 25.5 (*SD* = 41.0), with a range of 1 to 184. Items ranged from statements comprising mild forms of violence, such as “He pushed you,” to those of more severe forms of violence, such as “He used a weapon such as a gun or knife.” The Conflict Tactics Scale was shown by McGuire and Earls (1993) to have high test–retest reliability and internal consistency with African American mothers. Internal consistency for this measure was .83.
Severity of Violence Against Women Scale. Marshall’s Severity of Violence Against Women Scale (1992) includes 39 items that query whether and how often a violent tactic occurred in the previous year. A total score was calculated by summing the frequency of the acts. For this study’s participants, the mean was 176.1 (SD = 158.1), with a range of 0 to 768. Sample items include “He acted like a bully toward you.” The Severity of Violence Against Women Scale has been used in studies of minority populations (McFarlane, Willson, Malecha, & Lemmey, 2000); however, when used with minorities populations, psychometric properties have not been explicitly examined. Internal consistency for the scale was .73.

Past victimization and living with assailant. Forced-choice questions (yes or no) asked whether the participant was currently living with her assailant and whether she had a history of multiple violent relationships.

Demographics. Women were asked their age, household income in the previous month, and highest educational attainment.

Results

The women in the study endured a high rate of potentially traumatic incidents with their partners. For example, women averaged 17 acts of mild physical violence (SD = 30.6), 10 acts of severe physical violence (SD = 18.8), 46 physical threats (SD = 49.8), 95 controlling behaviors (SD = 79.9), and 36 acts of sexual abuse (SD = 57.1) in the previous year.

Given our focus on ethnicity, Table 1 reflects ethnic differences on variables entered in subsequent analyses. Significant interethnic differences appeared after a Bonferroni correction in income and posttraumatic stress symptom endorsement, with European American women reporting higher income (t = −2.36, p < .05) and more symptoms of posttraumatic stress (t = −2.23, p < .05). This analysis supports the first hypothesis; namely, European American women report more symptoms of posttraumatic stress in comparison to their African American peers. Chi-square analyses also reveal that European American women are more likely to be married (χ² = 10.45, p < .01) and employed (χ² = 11.76, p < .001).

Four hierarchical regression analyses were then conducted, each in three steps. The first two regressions were performed to examine the first three hypotheses—namely, whether demographic, trauma, and psychological health variables were related to heightened levels of posttraumatic stress in
this sample of battered women. Demographic variables were entered first to evaluate whether they could independently predict posttraumatic stress. The first of these regressions used the Conflict Tactics Scale as a measure of physical violence, and the second used the Severity of Violence Against Women Scale as a measure of psychological violence. The subsequent regressions were run post hoc with the file split by ethnicity to examine whether predictors of posttraumatic stress would vary as a function of ethnic group. Before entering factors into a regression, however, each variable was checked for statistical assumptions of equal variance and normal distribution. Skew and kurtosis statistics determined that assumptions were satisfactorily met.
**Regression 1 and 2: Combined Sample**

The first and second regressions included demographic variables in Step 1, violence variables in Step 2, and depression and self-esteem in Step 3 (Table 2). Tolerance ranged from .75 to .90 in Regression 1 and from .77 to .89 in Regression 2, suggesting a low probability of multicollinearity in both regressions. None of the demographic variables entered in the first step of either regression significantly predict symptom level. Once trauma exposure is added, however, ethnicity becomes a significant predictor in both regressions. Higher amounts of violence in the previous year (whether physical or psychological) and past victimization are associated with higher levels of posttraumatic stress. In the third step, depression is shown to be a significant predictor, and ethnicity is no longer predictive. It is likely that the strength of the relationship between depression and posttraumatic stress absorbs and trumps the effect of ethnicity on posttraumatic stress. Each step of the analysis significantly strengthens the model in both regressions, with both analyses accounting for 36% of the variance of the complete model. The regressions ultimately reveal that a higher frequency of physical and psychological violence, past victimization, and the presence of depressive symptoms predicts that women will experience more frequent posttraumatic stress symptoms. Contrary to our hypotheses, income, age, education, living with the assailant, and self-esteem do not predict level of posttraumatic stress, regardless of step. The power of each regression was calculated to be .99 using the computer program G*Power, described by Erdfelder, Faul, and Buchner (1996).

**Regressions 3 and 4: Post Hoc Analyses Split by Ethnicity**

Because ethnicity was found to be a marginal predictor of symptom level, the file was split such that African Americans were grouped for further comparison with European Americans. Because of the small sample size, the number of factors that could be analyzed in the second set of regressions was limited. Therefore, only factors that were significant or approached the level of a trend in the first regressions were included. Although this solution is an imperfect one to the problem of small subsamples, the results of the initial regressions support the integration of these variables as the strongest predictors.

Regressions 3 and 4 (Table 3) reveal that regardless of type of violence, marital status does not predict symptom level at any step for either ethnic group. When violence and depression are considered, depression remains a
Table 2
Regressions 1 and 2

<table>
<thead>
<tr>
<th>Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
</tr>
</thead>
<tbody>
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<td>Phys B (SE)</td>
<td>Psych B (SE)</td>
<td>Phys B (SE)</td>
</tr>
<tr>
<td>Income</td>
<td>0.00 (0.00)</td>
<td>0.00 (0.00)</td>
<td>0.00 (0.00)</td>
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<td>Ethnicity</td>
<td>-10.82 (6.73)</td>
<td>-100.91 (60.67)</td>
<td>-120.14 (60.50)*</td>
</tr>
<tr>
<td>Age</td>
<td>0.03 (0.55)</td>
<td>0.04 (0.55)</td>
<td>-0.16 (0.53)</td>
</tr>
<tr>
<td>Education</td>
<td>-2.00 (2.75)</td>
<td>-1.98 (2.74)</td>
<td>-1.18 (2.64)</td>
</tr>
<tr>
<td>Married</td>
<td>-0.68 (6.34)</td>
<td>-0.79 (6.26)</td>
<td>5.73 (6.30)</td>
</tr>
<tr>
<td>Phys/psych violence</td>
<td>0.17 (0.07)</td>
<td>0.06 (0.02)**</td>
<td>0.14 (0.07)*</td>
</tr>
<tr>
<td>Past victimization</td>
<td>-16.98 (6.07)**</td>
<td>-15.16 (5.96)**</td>
<td>-13.20 (5.37)</td>
</tr>
<tr>
<td>Live with assailant</td>
<td>10.76 (8.03)</td>
<td>10.41 (7.85)</td>
<td>10.36 (7.31)</td>
</tr>
</tbody>
</table>

Step 1a
\[ R^2 = .03/.03, R^2\Delta = .03/.03 \]
Step 2b
\[ R^2 = .15/.18, R^2\Delta = .12**/.15*** \]
Step 3c
\[ R^2 = .36/.36, R^2\Delta = .21***/.19*** \]

Note: Summary of hierarchical regression analyses of variables predicting posttraumatic stress symptom endorsement using physical (phys) and psychological (psych) violence (n = 119).

\*p < .05, **p < .01, ***p < .001.
strong significant predictor for both groups. A difference does exist in both regressions in that past victimization is predictive for only European Americans and that total psychological violence in the previous year is predictive for only African Americans. The regressions support results from Step 2 of the previous regressions—namely, that ethnicity matters in predicting posttraumatic stress when past victimization and total violence are considered, because each of these variables operates differently as a function of ethnicity. Power was computed four times: one time for each ethnic group in each regression. For Regressions 3 and 4, the power for European Americans was found to be .99 and .99, respectively, and for African Americans, .95 and .95. Tolerance ranged from .84 to .99 in the third regression and from .83 to .99 in the fourth regression.

**Discussion**

In this study, we used a feminist framework, which attempts to locate individuals’ experience amid a complex matrix of social variables. We hypothesized that demographic, trauma, and psychological health variables could account for the relationship between IPV and the presence of posttraumatic stress symptoms and that ethnicity would predict expression of posttraumatic stress symptoms. We hypothesized that young age, less education, and lower income, as well as being married, would predict greater adverse trauma reactions. This hypothesis was not supported in the analyses. This finding contradicts that of previous research (Brewin et al., 2000; Vogel & Marshall, 2001). The preliminary t tests reveal that ethnicity is a significant predictor of posttraumatic stress symptoms, with subsequent regressions suggesting marginally significant predictive ability for ethnicity.

The second hypothesis is partially supported—namely, that the occurrence of more violence in the previous year, having a past violent relationship, and living with the assailant would all predict higher levels of posttraumatic stress. A higher total amount of violence in the previous year and past victimization predict higher levels of posttraumatic stress. Our results follow research by Herman (1992) and Cortina and Pimlott-Kubiak (2006), who found that the experience of more frequent violence or repeated abuse increases the risk for developing PTSD.

The strength of the relationship among women’s level of depression, self-esteem, and posttraumatic stress is also partially supported. Although depression shows a strong relationship with posttraumatic stress symptoms, self-esteem does not. These results may lend further support to the empirical
Table 3
Regressions 3 and 4

<table>
<thead>
<tr>
<th>Variables Entered</th>
<th>Phys</th>
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<th>Psych</th>
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<td>B (SE)</td>
<td>B (SE)</td>
<td>B (SE)</td>
<td>B (SE)</td>
<td>B (SE)</td>
<td>B (SE)</td>
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<tr>
<td>European American (n = 78)</td>
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<tr>
<td>Step 1a</td>
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<tr>
<td>Married</td>
<td>0.25 (7.14)</td>
<td>0.06 (7.05)</td>
<td>3.06 (7.19)</td>
<td>0.77 (6.73)</td>
<td>4.75 (6.22)</td>
<td>3.60 (5.96)</td>
</tr>
<tr>
<td>Step 2b</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Phys/psych violence</td>
<td>0.15 (0.10)</td>
<td>0.05 (0.02)*</td>
<td>0.09 (0.08)</td>
<td>0.03 (0.02)</td>
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<tr>
<td>Past victimization</td>
<td>-14.53 (7.65)</td>
<td>-13.96 (7.38)</td>
<td>-15.35 (6.60)*</td>
<td>-14.49 (6.50)*</td>
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<td>Step 3c</td>
<td></td>
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<tr>
<td>Depression</td>
<td>1.70 (.33)***</td>
<td>1.60 (.34)***</td>
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</tr>
<tr>
<td>African American (n = 41)</td>
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<td>Step 1d</td>
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<tr>
<td>Married</td>
<td>-2.06 (11.36)</td>
<td>-2.06 (11.36)</td>
<td>5.25 (10.83)</td>
<td>3.74 (10.64)</td>
<td>1.58 (9.64)</td>
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<tr>
<td>Phys/psych violence</td>
<td>0.23 (0.11)*</td>
<td>0.07 (0.03)*</td>
<td>0.22 (0.10)</td>
<td>0.06 (0.02)*</td>
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<tr>
<td>Past victimization</td>
<td>-18.53 (9.65)</td>
<td>-14.84 (9.73)</td>
<td>-5.63 (9.36)</td>
<td>-2.75 (9.42)</td>
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<td>Step 3f</td>
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<tr>
<td>Depression</td>
<td>1.56 (0.46)**</td>
<td>1.50 (0.46)**</td>
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</table>

Note: Summary of hierarchical regression analyses of variables predicting posttraumatic stress symptoms as a function of ethnicity using physical (phys) and psychological (psych) violence.

a. $R^2 = .00/.00, R^2\Delta = .00/.00$
b. $R^2 = .08/.11, R^2\Delta = .08*/.11*$
c. $R^2 = .33/.32, R^2\Delta = .24***/.21***$
d. $R^2 = .00/.00, R^2\Delta = .00/.00$
e. $R^2 = .20/.22, R^2\Delta = .20*/.22*$
f. $R^2 = .39/.40, R^2\Delta = .19**/.18**$

*p < .05. **p < .01. ***p < .001.
literature that maintains current depressive symptoms as being predictive of posttraumatic stress (Brewin et al., 2000), but they contradict previous research that suggests a relationship between posttraumatic stress and low self-esteem (Ozer et al., 2003). Given the strong inverse relationship between depression and self-esteem, it is possible that the strength of the relationship between posttraumatic stress and depression trumps the effects of self-esteem on posttraumatic stress symptoms.

Our findings strengthen the empirical evidence that ethnicity influences the expression of posttraumatic stress symptoms. African American women report fewer symptoms of posttraumatic stress despite the presence of more risk factors, such as lower income. In addition, European American and African American women differ in what predicts levels of posttraumatic stress. For European Americans, past victimization and depression significantly predict level of posttraumatic stress. For African Americans, total psychological violence in the previous year and depression predict posttraumatic stress. These relationships are suggested in Regressions 1 and 2, but without splitting the file, the nuanced impact of the trauma variables may have been lost. Overall, it appears that European American women may be more affected by a long history of abusive relationships, as opposed to African American women, who are more traumatized by level of recent violence.

The puzzling results regarding interethnic differences can be neither easily nor definitively interpreted. Possible explanations include issues related to diagnostic criteria, phenomenology of abuse, resilience, and shattered assumptions. First, given that symptoms of posttraumatic stress were originally based on work with male combat veterans, the criteria may not globally reflect ways of coping with or responding to trauma, namely, as it applies to minority women who experience IPV. This debate is likely to continue as researchers find evidence for and against posttraumatic stress in a variety of populations.

Second, the phenomenology of violence is subject to ethnic variation in ways that may affect posttraumatic stress development and expression. Hampton, Oliver, and Magarian (2003), for example, argue strongly that when compared to violence in European American communities, violence in African American communities assumes different personal meanings, occurs for different reasons, and has political and social meanings that are very different. It may be that ethnic groups define, react to, and cope with violence in ways that influence the development and expression of posttraumatic stress symptoms but that are not asked about or examined in current research projects.

Still other researchers have supported the belief that lower levels of posttraumatic stress following trauma may reflect a form of resilience in
African American female trauma survivors. For example, Seng et al. (2005) cite evidence that “Blacks are significantly better at bearing burden, including emotional stress,” and that “African American women value resiliency in the face of distress” (p. 526). Taylor’s study (2000) of African American women’s experiences of IPV concludes that African American women have a preference for racially homogeneous support groups, namely, because the African American “women who attended groups saw themselves as strong in positive ways. . . . They were in the group not because they were weak, but because they wanted to remain strong” (p. 523).

Finally, the observed differences can be understood by considering Janoff-Bulman’s theory of shattered assumptions (1992). In this theory, shattered assumptions result when an individual conceptualizes life as being benevolent and meaningful but then encounters a trauma that “shatters” this worldview. When assumptions of what one’s life should or could be are shattered, these assumptions have the power to create pathology. Violence in the community, whether through heightened rates of homicide or assault, continue to be part of the life experience of many African Americans (Hampton et al., 2003). In contrast, European Americans are more likely to have higher income and higher employment than that of their African American peers (U.S. Census Bureau, n.d.-a). What may happen to European American women in the face of IPV is a shattering of assumptions of what their life should be like, thereby resulting in a pathological response to trauma.

**Limitations and Future Research**

The major limitations of the present study include the use of self-report measures, the cross-sectional design, and the relatively small sample size. From the analyses conducted here, it is not possible to tell whether the explored factors predict level of posttraumatic stress following IPV or are some of the outcomes of IPV, posttraumatic stress, or both. In addition, the sample size limits the number of factors in the regression model, perhaps leaving out key variables in understanding posttraumatic stress and increasing the possibility of Type I errors with higher numbers of comparisons.

Additionally, several protective factors that have been shown to be significant in the research, such as social support and spirituality, were not assessed at this point. These risk and protective factors often show variability between ethnic groups and could likely account for intraethnic variability. This point leads to another limitation—namely, that comparing two
ethnic groups without considering intragroup differences can be misleading. We cannot assume that the results found here apply to all the women within each ethnic group.

The current study warrants further exploration of interrelationships among IPV, posttraumatic stress, and ethnicity. The research on IPV may be expanded to incorporate and examine trauma reactions in all ethnic groups across both genders, and it may lead to a textured understanding of the ways in which ethnicity and gender affect trauma reactions.

This article explores racial differences between African American and European American women in relation to prevalence and predictors of posttraumatic stress symptoms following IPV. Many of the risk factors for posttraumatic stress found in past research are not supported in this research, such as low income, low educational attainment, and younger age. We found that African American women endorse fewer symptoms of posttraumatic stress than do European American women and that although depression predicts posttraumatic stress symptoms for both ethnicities, differences emerge in trauma variables. Researchers need to continue to explore how ethnicity may affect PTSD criteria and measurement, while focusing on issues such as access to care and resilience—issues that illuminate how social systems contribute to the expression of traumatic reactions.

References


Michelle M. Lilly, MS, is a doctoral candidate in the joint program in clinical psychology and women’s studies at the University of Michigan. She is interested in understanding how gender, race, and class affect one’s experience and understanding of violence, as well as one’s recovery from it. To date, her work has primarily been conducted with victims of intimate partner violence and police officers. Her doctoral research focuses on how the outcome of posttraumatic stress disorder in victims of intimate partner violence is mediated by race, world assumptions, religiosity, and methods of coping. She will continue at the University of Michigan as a postdoctoral fellow at the Psychological Clinic in fall of 2008.

Sandra A. Graham-Bermann, PhD, is professor in the Department of Psychology and Women’s Studies Program at the University of Michigan. She studies the impact of different forms of violence on children’s social and emotional adjustment. This work comprises children aged 3 to 13 and includes children in a variety of contexts, such as preschools, community settings, and shelters for battered women. Using a nested ecological framework, she is able to demonstrate which children are most affected by family violence, in what ways, and how best to intervene for children with particular adjustment profiles. She is consultant to local domestic violence programs and Head Start schools. Nationally, she is consultant to the U.S. Department of Justice, U.S. Department of Health and Human Services, and the National Academy of Sciences. In addition to authoring numerous research journal articles and chapters, she is the coeditor of *Domestic Violence in the Lives of Children: The Future of Research, Intervention, and Policy* (2001), with Jeff Edleson.