ATTACHMENT STYLES AND OUTCOMES OF A GROUP INTERVENTION FOR AFRICAN AMERICAN WOMEN WITH A HISTORY OF INTIMATE PARTNER VIOLENCE AND SUICIDAL BEHAVIOR

by

EMILY B. JACKSON

(Under the Direction of Alan Stewart)

ABSTRACT

The purpose of this paper was to determine the influence of attachment styles of women who have experienced IPV and suicidal behavior on outcome in a 10 week intervention. Intimate partner violence (IPV) and suicide-related behaviors are increasingly significant social problems. Attachment, IPV, self-esteem, social support, suicidal behavior, depression and hopelessness were examined along a social and contextual continuum. Results confirm that secure, fearful, and dismissing attachment styles correlate with perceived social support. It was also found that participation in the Grady Nia Project Group Intervention led to increased self-esteem, decreased levels of suicidality, decreased levels of depression, and decreased hopelessness. It was hypothesized that attachment style would predict individuals' outcome variables. However, no significant results were seen regarding attachment style and outcome variables

INDEX WORDS: Attachment, Intimate Partner Violence, Domestic Violence, Suicide

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CHAPTER 1

INTRODUCTION

Purpose of Study/Significance

Intimate partner violence (IPV) and suicide-related behaviors are increasingly significant social problems. IPV has been identified as a major public health issue for African American women (Joseph, 1997) and low-income, African American women are at particularly high risk for being battered (C. M. West, 2004). Suicide is an increasing problem. Rates of suicide threats and attempts have been reported to be higher among women versus men (Canetto & Sakinofsky, 1998). This paper seeks to determine the influence of attachment styles of women who have experienced IPV and suicidal behavior on outcome in a 10 week intervention. Attachment, IPV, self-esteem, social support, suicidality, depression and hopelessness will be examined along a social and contextual continuum.

An increasing number of researchers are making a connection between attachment theory and coping in adult relationships (Bartholomew, 1990, 1997; Bylsma, Cozzarelli, & Sumer, 1997). Theoreticians and researchers also have begun to focus on the link between early childhood experiences and self-development (Toth, Cicchetti, Macfie, & Emde, 1997). At the root of attachment theory and research is the basic tenet that parental responsiveness and connectedness is critical for children to develop a sense of “felt security” (Sroufe & Waters, 1977) and that through the attachments formed with family members in early childhood, individuals gain a sense of intimate

connection with others (Ainsworth, 1985; Bowlby, 1978). These attachments impact the development and stability of relationships throughout the lifespan. Researchers and clinicians increasingly have become interested in attachment theory as a useful paradigm in viewing interpersonal relationships, the development of psychopathology, and clinical interventions (Bartholomew, 1990, 1997; Cyranowski et al., 2002; Levy et al., 2006; McBride, Atkinson, Quilty, & Bagby, 2006).

IPV continues to be a major public health problem (Breiding, Black, & Ryan, 2008). In 2000, it was reported that between 850,000 – 1.5 million women experience raped and/or assaulted by an intimate partner annually (Tjaden & Thoennes, 2000a). Breiding et. al. utilized data collected from the 2005 Behavioral Risk Factor Surveillance System survey developed by the CDC to collect data on health risks among non-institutionalized adults and found that one in four women experience some form of physical or sexual IPV during their lifetime. Researchers' reports show that IPV rates are higher among younger women, women with lower income, women with less education, single mothers, and women with a history of abuse as a child (Ashcroft, Daniels, & Hart, 2004; Kaslow et al., 2002; R. S. Thompson et al., 2006). This makes IPV disproportionately widespread in marginalized populations. African Americans and American Indians/Alaska Natives report more IPV than individuals from other minority groups (Tjaden & Thoennes, 2000b). IPV has been identified as a major public health issue for African American women (Joseph, 1997) and low-income, African American women are at particularly high risk for being battered (C. M. West, 2004). It has been found also that individuals who experience IPV report increased difficulty in

psychological and psychosocial functioning (Kernic, Wolf, & Holt, 2000; Kessler, Berglund, Borges, Nock, & Wang, 2005; Lee, Sanders Thompson, & Mechanic, 2002).

Suicide is also a major public health issue (D'Orio & Garlow, 2004; Goldsmith, Pellmar, Kleinman, & Bunney, 2002) and suicide rates are increasing despite an increase in treatment options (Kessler et al., 2005). Suicidal behavior is a leading cause of death worldwide (Kessler et al., 2005); is one the top five leading causes of death in the United States, and Georgia (http://www.cdc.gov/ncipc/dvp/Suicide/default.htm); and the twelfth leading cause of death for African Americans ages 18-64 (Joe, Baser, Breeden, Neighbors, & Jackson, 2006). Researchers have delineated a number of risk factors for suicide-related behaviors and have noted the most significant predictor for suicide completion is suicide attempt (Compton, Thompson, & Kaslow, 2005; Harris & Barraclough, 1997; Kessler et al., 2005). It also has been found that for each suicide completion there are 12-15 incidences of suicidal behavior (i.e., ideation, gestures, plan) (Classen et al., 2006). Rates of suicidal behavior have been reported to be higher among individuals who are younger, with less education, less family and community social support, and those who have been previously or never married (Kaslow, Price et al., 2004; Kessler et al., 2005; Kessler, Borges, & Walters, 1999; Willis, Coombs, Drentea, & Cockerham, 2003). In addition to social risk factors, researchers also have pointed out significant clinical predictors related to suicidal behavior. It has been reported that individuals that attempt suicide report experiencing more psychological distress (Kaslow, Price et al., 2004; Kessler et al., 2005). Individuals with a history of anxiety disorders and mood disorders, substance use disorders, and borderline

personality disorder are significantly more likely to experience suicidal behavior (Kessler et al., 1999; Oquendo et al., 2007).

There is limited research specifically focused on suicide in the African American community (Gibbs, 1997) although recent trends show an increase in suicide rates among this group (Compton et al., 2005). Suicide rates traditionally have been lower in the African American community as compared to those of European Americans (Griffith & Bell, 1989; Heckler, 1985; Willis, Coombs, Cockerham, & Frison, 2002), but researchers have noted that African Americans living in the southeastern regions of the United States are at a higher risk for suicide (Willis et al., 2003). Suicide is the twelfth leading cause of death for African Americans ages 18-64 and there is a 4.1% lifetime prevalence of attempted suicide in this population (Joe et al., 2006).

There are a number of specific groups of individuals who are at increased risk for suicide attempts and/or completions. Women are more likely than men to attempt suicide (Weissman et al., 1999) and abused women represent one group of individuals who are at an even higher risk for suicide attempts (Kaslow, Borden et al., 2004; Kaslow et al., 1998; Kaslow et al., 2002; M. P. Thompson, Kaslow, & Kingree, 2002). Kernic and colleagues found that abused women were more likely to be hospitalized with a psychiatric diagnosis or following a suicide attempt (Kernic et al., 2000). Kaslow and coworkers, in their research with African American women, discuss IPV as a major risk factor for suicide attempts (Kaslow et al., 2002).

There is a paucity of research on African American women experiencing suicidality and IPV although rates of these problems are particularly high among this population (Joe et al., 2006; C. M. West, 2004). Much of the current research has been

conducted with Caucasian women and focuses on violence perpetrated by strangers and not intimate partners (Lee et al., 2002).

IPV occurs within a social and cultural context and these factors influence help seeking behaviors (Lee et al., 2002; Raj, Silverman, Wingood, & DiClemente, 1999). Following in line with the American Psychological Association's Multicultural Guidelines (American Psychological Association, 2003), this project focuses on developing an effective and culturally competent intervention for African American women by helping the project team members become more aware of their own cultural being, become more knowledgeable about the women's culture, and develop skills in order to provide effective care while recognizing and addressing the contextual factors that impact their lives in an empathic and sensitive manner. In a similar vein, Social justice themes are part of psychology's professional ethical code. One of the social justice focuses of the profession is to be agents of change (Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006). It is part of this current research study to examine how the Nia Project groups can more effectively help this particular underserved and underprivileged group of people. The Nia Project specifically works to advocate on a number of levels for the women that are part of the program. Team members and clinicians reach out to the community; including the hospitals, churches, schools, and other community resources, to educate and increase awareness of the impact intimate partner violence and suicide have on these women. In addition, the intervention emphasizes empowering the women to lead violence free lives and to connect with appropriate community resources in order to lead more productive lives.

It is necessary to examine the particular factors that will assist African American women in decreasing IPV and suicidality in their lives. The development of culturally informed services and interventions that build upon protective factors within this community will facilitate the increase of self-esteem and self-efficacy through building social supports and connections to community resources. We will be better able to serve women if we are aware of their connectedness and attachment styles which will inform us of their commitment and needs within the group.

Research Questions and Hypotheses

This study examined the following research questions and corresponding hypotheses:

1. Do attachment styles (secure, fearful, dismissing, preoccupied) correlate with self reported levels of IPV (physical and non-physical), self-esteem, and social support?

Hypothesis: First, scores on the secure attachment subscale of the Relationship Scales Questionnaire (RSQ) will be negatively correlated with levels of IPV (physical and non-physical); in that individuals who obtain high secure attachment scores will report lower levels of IPV in adulthood as evidenced by lower scores on the Index of Spouse Abuse (ISA). Second, scores on the secure and dismissing attachment subscales of the RSQ will be positively correlated with level of self-esteem, in that individuals who obtain higher secure and dismissing attachment scores will report a higher level of self-esteem as measured by the Taylor Self-Esteem Inventory (TSEI). Third, scores on the secure and preoccupied attachment subscales of the RSQ will be positively correlated with measures of social support, in that individuals who obtain higher secure and dismissing attachment scores will report higher levels of perceived

social support as evaluated by the Multidimensional Scale for Perceived Social Support (MSPSS).

2. Do attachment styles (secure, fearful, dismissing, preoccupied) correlate with levels of suicidality, depressive symptoms, and hopelessness?

Hypothesis: First, scores on the secure attachment subscale of the Relationship Scales Questionnaire (RSQ) will be negatively correlated with levels of suicidal ideation, in that individuals who obtain high secure attachment scores will report lower levels of suicidality in adulthood as evidenced by lower scores on the Beck Scale for Suicide Ideation (BSSI). Second, scores on the secure attachment subscale of the RSQ will be negatively correlated with levels of depressive symptoms, in that individuals who obtain higher secure attachment scores will report lower levels of depressive symptoms as evidenced by lower scores on the Beck Depression Inventory – II (BDI-II). Third, scores on the secure attachment subscales of the RSQ will be negatively correlated with measures of hopelessness, in that individuals who obtain higher secure attachment scores will report lower levels of lower levels of hopelessness as evidenced by lower scores on the Beck Hopelessness Scale (BHS).

3. Does participation in the 10 week Nia Project Group Intervention predict change in levels of IPV, self-esteem, perceived social support, suicidality, depression, and hopelessness?

Hypothesis: Random assignment to the Grady Nia Project Group Intervention groups will be negatively correlated with levels of IPV (physical and non-physical), suicidality, depressive symptoms, and hopelessness; and higher levels of self-esteem and social support following the 10 week Nia Project Group Intervention. However,

women randomly assigned to TAU will not evidence such significant changes regarding the outlined outcome measures.

4. Do attachment styles (secure, fearful, dismissing, preoccupied) predict change in levels of IPV experienced, levels of self-esteem, perceived social support, suicidality, depressive symptoms, and hopelessness following a 10 week intervention?

Hypothesis: For women randomly assigned to the Grady Nia Project Intervention groups, higher levels of secure attachment on the RSQ at time one (T1) will predict lower levels of IPV (physical and nonphysical), suicidality, depressive symptoms, and hopelessness; and higher levels of self-esteem and social support following the 10 week Nia Project Intervention. However, higher levels of fearful, preoccupied, and dismissive attachment will not evidence such significant changes regarding the outlined outcome measures.

CHAPTER 2

LITERATURE REVIEW

History of Attachment Theory and Styles

Bowlby has described attachment theory as dealing with affectional bonds between individuals, the origin of such bonds, and their development (Bowlby, 1977a, 1977b, 1978). According to Bowlby, children form attachments as soon as they are born and connect to the mother through sucking, clinging, following, crying, and smiling (Bowlby, 1958). Attachments in childhood are influenced by how the primary care giver responds to the child's needs (Bowlby, 1984). Attachment theory has been employed as a way to conceptualize the predisposition of individuals to develop strong intimate bonds with others (Bowlby, 1977a). Bowlby believed that many family situations and experiences affect the formation of personal bonds and can be distorted by parental behavior in childhood and throughout life (Bowlby, 1978). More current research with adults 65 and older has shown that adult attachment dimensions were differentially predicted by childhood socialization practices (Montague, Magai, Consedine, & Gillespie, 2003).

Ainsworth proposed factors relating to quality of maternal and infant relationships, stability and change of mother and infant relationships, and the intergenerational transmission of attachment patterns (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth's classification system characterizes infant attachment into three groups including securely attached, insecure-avoidant, and insecure-ambivalent

categories. Ainsworth and Bowlby have come together with their theories and merged their contributions into a new ethological approach to attachment. This has been developed as open ended; is eclectic; and takes into account all aspects of development including cognitive, social, personality, systems theory, and biological sciences to explain how individuals develop intimate relationships and attachments (Ainsworth & Bowlby, 1991).

Researchers have examined the relationship among attachment models and adult relationships (Bartholomew, 1990; Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994; Hazan & Shaver, 1987; Main, Kaplan, & Cassidy, 1985). Hazan and Shaver constructed their model of adult romantic attachment on the three styles that Ainsworth identified for infants (Hazan & Shaver, 1987; Hazan & Shaver, 1990). Similar to Ainsworth's styles, these styles have been termed secure, avoidant, and anxious ambivalent (Hazan & Shaver, 1987; Hazan & Shaver, 1990). They found that secure lovers experience their relationships as positive, are able to depend on others, and accept and support their partners despite any faults. Avoidant individuals tend to be uncomfortable being close to others (Mickelson, Kessler, & Shaver, 1997). These people characterize their love relationships by fear of intimacy, emotional highs and lows, and jealousy (Hazan & Shaver, 1987). Anxious/ambivalent lovers experience their relationships in a similar manner along with feeling of obsession, desire for connection, and extreme sexual attraction (Hazan & Shaver, 1987). These individuals feel as though others do not really care about them and are often viewed by others as clingy (Mickelson et al., 1997).

Bartholomew developed a four-category model of adult attachment patterns that utilizes the self and other underlying dimensions as conceptualized by Bowlby (Bartholomew, 1990; Griffin & Bartholomew, 1994). The Bowlby model suggests that individuals' abstract images of self and other are dichotomized (positive and negative) and that four combinations can be derived out of the two dimensions of self and other. The four patterns identified by Bartholomew are secure, preoccupied, dismissing, and fearful. Individuals who experience others as trustworthy, supportive, and available can be described as having a more positive other model and are labeled secure or preoccupied. Secure individuals show a sense of worthiness (lovability) and have a positive view of self, as well as an expectation that others are accepting and helpful. Those characterized as preoccupied show a sense of unworthiness combined with a positive view of others. These people tend to strive to gain acceptance of others. Individuals who experience others as unreliable and rejecting can be described as having a negative view of other model and are labeled fearful and dismissing. Fearful individuals experience others as rejecting and view self as unworthy of love and connectedness. These people tend to avoid close relationships with others as a means of protecting themselves from rejection. Dismissing individuals experience themselves as worthy of love, but have a negative view of other. These individuals protect themselves from close relationships and rejection by others by maintaining a sense of independence and invulnerability (Bartholomew, 1990; Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994).

Experiences of traumatic events in childhood impact the development of interpersonal attachment styles. Further, attachment styles impact the way individuals

cope with stress and handle daily life experiences as well as how they interpret experiences with others including how they respond to treatment (Kemp & Neimeyer, 1999; McBride et al., 2006; Toth et al., 1997). Kemp and colleagues found that women with more secure attachment styles (i.e., more positive self and other) showed higher levels of social support seeking. It has been shown also that individuals with more secure attachment styles have better outcomes in therapy and treatment (Meyers, Pilkonis, Proietti, Heape, & Egan, 2001).

Attachment and African Americans. There is a dearth of research specifically on African Americans and attachment patterns despite the fact that this group makes up one of the largest ethnic minority group in the United States (Magai et al., 2001). Montague and colleagues (2003) found several aspects of ethnicity that impact attachment later in life; early life socialization (e.g., family structure, parenting patterns) and religiosity. African American families are typically extended in nature (Magai et al., 2001). This fact makes it difficult to generalize attachment findings to this group. Most research conducted on the development of attachment patterns has been done using Caucasian American samples which are mostly made up of nuclear families. A parenting study conducted with low-income African American children found that 61% of the children were classified as securely attached (Barnett, Kidwell, & Leung, 1998). Another study was conducted with a geriatric population and found that African American reported smaller kinship networks than their European American counterparts (Magai et al., 2001). It has been found also that European Americans scored higher on attachment security and African Americans scored higher on dismissing attachment. Bartholomew and Horowitz (1991) found that younger adults reported more secure

attachment styles. This sample was made up of mostly White college students. It seems that there is a possibility that due to family make-up, there could be a difference in the development of attachment patterns between ethnic groups. It seems possible too that attachment patterns may shift through the life-span as seen in the data reported above.

Intimate Partner Violence (IPV)

IPV is a pattern of coercive behaviors, including psychical or sexual violence, threats of violence, and psychological and emotional abuse of one partner by a current or former partner (Salzman, Fanslow, McMahon, & Shelley, 2002). Women often experience multiple forms of IPV including physical, psychological and sexual (R. S. Thompson et al., 2006). It was reported in 2000 that between 850,000 and 1.5 million women experience being raped and/ or assaulted by an intimate partner (Tjaden & Thoennes, 2000a). It was also reported that each year, over 1200 women are murdered by an intimate partner (Tjaden & Thoennes, 2000b). Researchers' reports indicate that IPV rates are higher among younger women, women with lower income, women with less education, single mothers, and women with a history of abuse as a child (Ashcroft et al., 2004; Kaslow et al., 2002; R. S. Thompson et al., 2006). This makes IPV disproportionately widespread in marginalized populations.

IPV and African Americans. There has been a burgeoning literature focused on understanding IPV within a structural framework and cultural context for marginalized women (Sokoloff & Dupont, 2005). Sokoloff and Dupont have discussed at great length the intersectional (race, class, gender) and structural approaches to IPV. They have used these approaches to expand the understanding and definitions of women battering to include a broader cultural framework and emphasize the complex role that culture

has on understanding women and their responses to abuse. The APA multicultural guidelines suggest that in order for clinicians to work effectively with individuals from different cultural backgrounds it is important and essential to acknowledge their differences and learn about their unique backgrounds (American Psychological Association, 2003). There are unique differences and struggles within groups that influence experiences such as IPV. Several theories support the rationale that in order to understand the circumstances surrounding the experience of IPV, we need to understand the systems of power and privilege within various, diverse communities (Sokoloff & Dupont, 2005).

IPV has been identified as a major public health issue for African American women (Joseph, 1997). Although women from all socioeconomic backgrounds experience IPV, women who are African American, young, poor, divorced and separated, and who reside in urban areas are the most frequent victims (Cunradi, Caetano, Clark, & Schafer, 2000; Rennison & Planty, 2003; Wenzel, Tucker, Hambarsoomian, & Elliott, 2006; C. M. West, 2004) and IPV takes more violent forms in the African American community than in the Caucasian community (Hampton, Oliver, & Magarian, 2003; Kessler, Molner, Feurer, & Appelbaum, 2001).

Self-esteem and social support. IPV affects women in many areas of their lives and has been linked with lower self-esteem and decreased social support (Anderson, 2002; Coker et al., 2002; Riger, Raja, & Camacho, 2002; Russo, Denious, Keita, & Koss, 1997; M. P. Thompson et al., 2000). Riger and coworkers have illustrated the impact of IPV on women's lives using a wheel (Riger et al., 2002). They explained the effects in three levels; first-order, second-order, and third-order effects. At the center of

the wheel are the first-order effects including physical injury, fear, low self-esteem, and depression. Social support is addressed as a second-order effect within this conceptualization. Relationships with family and friends are often significantly impacted as a result of IPV. Social support can also serve as a necessary protective factor against further abuse. Researchers have found that African American adolescents who had a positive identification with their ethnic group reported a more positive sense of self-esteem (Phinney, Cantu, & Kurtz, 1997). Thompson and colleagues found that perceived social support was directly affected by partner violence and that lower levels of social support were associated with higher levels of distress (M. P. Thompson et al., 2000). Researchers have found that social support has a positive impact on abused women's social functioning and mental health (Coker et al., 2002; Riger et al., 2002; Warren, 1997). Studies have also found that African Americans rely heavily on their social and extended family networks in managing their health concerns or emergencies (Ford, Tilley, & McDonald, 1998; Kim & McKenry, 1998) and some researchers have found that African Americans' self-esteem is strongly influenced by their relationships with family, friends, and community (Hughes & Demo, 1989).

Attachment and IPV. Negative attachment patterns have been linked with intimate partner victimization (Henderson, Bartholomew, & Dutton, 1997; Henderson, Bartholomew, Trinke, & Kwong, 2005; Impett & Pepau, 2002; Lawson, 2003). Utilizing Bartholomew's four-categories of attachment model described above, Henderson and colleagues interviewed 63 physically and psychologically abused women and examined their attachment patterns (Bartholomew, 1990, 1997; Henderson et al., 1997). They found that 88% of the women had a negative attachment pattern (7% secure, 53%

preoccupied, 35% fearful, and 5% dismissing). Further, Henderson et al. found a positive link between preoccupied patterns of attachment and intimate abuse (Henderson et al., 2005).

Interventions for IPV. There are a number of services for abused women including shelters, legal help, advocacy services, and counseling (Saathoff & Stoffel, 1999). Despite the availability of these services, African American women are less likely than abused women from other ethnic groups to seek shelter services, use the legal system (i.e. calling the police, obtaining restraining orders), or seek mental health services (El-Khoury et al., 2004; Fraser, McNutt, Clark, Williams-Muhammed, & Lee, 2002; Joseph, 1997; Sorenson, Upchurch, & Shen, 1996). There is little controlled research being conducted on community based interventions and services for battered women (Lee et al., 2002; McFarlane & Wiist, 1997; C. Sullivan, Tan, Basta, Rumptz, & Davidson, 1992; Wathen & MacMillian, 2003), particularly culturally competent interventions for women of color (Bent-Goodley, 2005; C. M. West, 2004). There have been uncontrolled studies that have shown that community support groups were associated with reduced IPV, increased self-esteem and self-efficacy, more perceived support, and decreased stress (Tutty, Bidgood, & Rothery, 1993; Varvaro & Palmer, 1993).

Sullivan and colleagues compared a control group with women in an intensive community-based intervention that included an advocate to help them obtain community resources in order to maximize their ability to reduce IPV in their lives (C. Sullivan et al., 1992). They found women who received the advocacy services reported better effectiveness in obtaining resources, increased quality of life, and more social support

than women in the control group. In a related study, researchers found similar results when interviewing women leaving the shelter. At 10 weeks and 24 month follow-up, women who had been assigned an advocate reported less IPV over time, higher quality of life and social support (C. M. Sullivan & Bybee, 1999).

Suicide and Suicidal Behavior

Suicidal behavior is a leading cause of death worldwide (Kessler et al., 2005), is one the top five leading causes of death in the United States, and Georgia (http://www.cdc.gov/ncipc/dvp/Suicide/default.htm). Suicide is a major problem in the United States, although the rates of suicide have remained relatively stable over the past three decades (D'Orio & Garlow, 2004).

Suicidality, suicidal behaviors, and suicidal gestures usually include thoughts, attempts, and other maladaptive behaviors and actions (D'Orio & Garlow, 2004). Kessler et al., in their study based on the 1990-1992 National Comorbidity Survey (NCS) and the 2001-2003 National Comorbidity Survey Replication (NCS-R), determined if individuals had made a “gesture” or an “attempt” by asking participants to describe the attempt and based the decision on lethality and intent of the attempt (Kessler et al., 2005). Researchers have been working on a new classification system in order to better characterize suicidal behavior and establish the intent behind these behaviors (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007a, 2007b). The terminology in this new classification pertains to the essential components of suicidal behavior and includes suicide-related ideations, suicide-related communications, and suicide-related behaviors. Attention is paid to variations of intent within each of the categories.

Rates of suicide threats and attempts have been reported to be higher among women versus men (Canetto & Sakinofsky, 1998). Linehan suggested that suicide completions are viewed as more masculine and therefore women tend to choose less lethal forms of attempt (Linehan, 1973). It has been proposed, too, that traditional gender roles may inhibit women from developing or choosing appropriate coping responses (Stillion & McDowell, 1996). Wilson suggested that women may use suicide attempts as a coping response more frequently than men as a way of dealing with stress due to lack of resources and thinks perhaps this is a way for women to voice their need for support to those around them (Wilson, 1981). Research has shown too that individuals who attempt suicide tend to have less than a college education, be single, and be unemployed (Kessler et al., 2005; Willis et al., 2003).

Suicide and African Americans. There is limited research on suicide in the African American community (Gibbs, 1997) although recent trends show an increase in suicide rates among African Americans (Compton et al., 2005). Suicide rates traditionally have been lower in the African American community as compared to those of European Americans (Griffith & Bell, 1989; Heckler, 1985; Willis et al., 2002), but researchers have noted that African Americans living in the southeastern regions of the United States are at a higher risk for suicide (Willis et al., 2003). Suicide is the twelfth leading cause of death for African American ages 18-64 and there is a 4.1% lifetime prevalence of attempted suicide in this population (Joe et al., 2006). Suicide is the seventh leading cause of death for women and fifteenth for African American women (http://www.cdc.gov/ncipc/dvp/Suicide/default.htm).

Cultural influences within the African American community may create a buffer against stressors that would lead individuals to attempt or commit suicide (Gibbs, 1997; Willis et al., 2003). In a review of data from the Centers for Disease Control and Prevention in 1995, researchers found that since 1980 the suicide rate for African American females has been slightly higher for women ages 25-34 and 35-44 (Gibbs, 1997). Researchers have identified several risk factors for suicide among African Americans including age, depression, family dysfunction, interpersonal discord, and history of psychiatric disorders (Compton et al., 2005; Gibbs, 1997; Kaslow et al., 2005; Kaslow et al., 2000; Kaslow et al., 2002). Protective factors particular to African American also have been identified. These include religiosity and social support (Anglin, Gabriel, & Kaslow, 2005; Compton et al., 2005; Gibbs, 1997; Meadows, Kaslow, Thompson, & Jurkovic, 2005; Nisbet, 1996). Gibbs further discusses cultural patterns such as the roles of religion and the cohesive social environment as influences on the suicide rates among Africa American women (Gibbs, 1997). Through religion and spirituality, African Americans have subscribed to values of endurance, resilience, and persistence in the face of poverty and discrimination and suicide has been viewed as an unacceptable solution to life's challenges and stresses and viewed as a sinful act (Billingsley, 1992). Anglin, Gabriel, and Kaslow, in their study comparing African American female suicide attempters and non-attempters, found that suicide attempters expressed lower levels of religious well being and higher levels of suicide acceptability (Anglin et al., 2005). Other researchers have found that African Americans hold a stronger stigma for suicide if God was believed to be responsible for life and are less

likely to attribute suicide to interpersonal problems or outside triggers (i.e., work stress, conflicts, or domestic upheaval) (R. L. Walker, Lester, & Joe, 2006).

Willis and colleagues undertook a study reviewing the 1993 National Mortality Followback Survey (NMFS) conducted by the National Center for Health Statistics (NCHS) to determine cultural differences in hopes of developing more effective interventions (Willis et al., 2003). They found that many of the classical symptoms of suicide did not apply to African Americans. It was found that hallucinations, violent threats, and having the community complain about them were some of the symptoms associated more with African American suicide. They also noted that talking about or verbalizing suicidal thoughts tended to result in greater risk for suicide among African Americans.

Depression and hopelessness. There is a high prevalence of suicidal behavior and risk in individuals with a diagnosis of mental disorders based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Edwards & Holden, 2001; Kessler et al., 2005). Hopelessness has been widely used as a construct to predict suicidal risk (Edwards & Holden, 2001). Researchers have found that hopelessness plays a significant role in the relationship between depression and suicidal intent (Dyer & Kreitman, 1984) and has also been shown to be a significant predictor of suicide completions (Fawcett et al., 1987). It has been found that suicide attempters score higher on measures of hopelessness, subjective depression and suicidal ideation (Malone et al., 2000). In a study evaluating 6,891 psychiatric outpatients to determine specific risk factors for suicide, researchers found that suicide ideation, depression, and hopelessness, as measured by the Scale for Suicide Ideation, Beck Depression

Inventory and Beck Hopelessness Scale, respectively, were significant risk factors for suicide (Brown, Beck, Steer, & Grisham, 2000). In regard to psychiatric diagnoses, they found that individuals with mood disorders, major depression, and bipolar disorder were at significant risk as well (Brown et al., 2000). Kessler and coworkers found that individuals who had made a suicidal gesture within a 12-month period were most likely to have been diagnosed with major depressive disorder (Kessler et al., 2005).

There is a lack of research on depression in African Americans and more specifically in African American women (Carrington, 2006). Depression in African Americans has been examined and found to be more severe, disabling, and chronic than for other groups (D. R. Williams et al., 2007). These same researchers have found that African American women reports diagnostic depressive symptoms at almost a rate of twice that reported by their male counterparts. They found ultimately that African Americans have a lower lifetime prevalence of depression, but that they are at higher risk for persistent depressive symptoms. Researchers have noted that African American women are more likely to experience community and domestic violence which put them at greater risk for depression (Hill, Hawkins, & Raposito, 1995). In a similar vein, Kaslow and colleagues (1998) in their research with African American women have found that women who engage in suicidal behavior endorse more depressive symptoms and feelings of hopelessness. In another study they found that psychological distress and hopelessness were among several variables that put African American women at an increased risk for suicide attempts (Kaslow et al., 2000).

Attachment and Suicide. Throughout the attachment literature it suggests that individuals with mood disorders may fall into more avoidant attachment classifications

(Mickelson et al., 1997). Hazan and Shaver reported that adults classified as having insecure attachment styles reported more depressive symptoms than their secure counterparts (Hazan & Shaver, 1990). Furthermore, other studies have reported a link between negative attachment styles (i.e. anxious, insecure, avoidant, preoccupied) and depression (Pettem, West, Mahoney, & Keller, 1993; Zuroff & Fitzpatrick, 1995), dysthymia, and borderline personality disorder (Patrick, Hobson, Castle, & Howard, 1994; M. West & George, 2002). In a nationally representative sample, researchers found similar findings that all of the psychiatric disorders examined were positively related to being avoidant and anxious (Mickelson et al., 1997). There is a paucity of literature devoted to the link between attachment styles in adulthood and suicidal behavior. However, given the links between mood disorders and suicidal behavior and more negative attachment styles and mood disorders, it seems that individuals with more insecure attachments would be at greater risk for suicide.

Interventions for Suicide and Suicidal Behavior. There is a dearth of evidence-based intervention programs for suicidal adults (Knox, Litts, Talcott, Feig, & Caine, 2003). The efficacy of suicide prevention programs and interventions is difficult to prove (D'Orio & Garlow, 2004). There are a number of factors that make it difficult to conduct research on suicidal behavior. The Institute of Medicine stated that researchers would need 100,000 participants to have a 90% confidence rate for an event with an occurrence rate such as that of suicide attempts (Goldsmith et al., 2002). Many treatment studies exclude individuals with a high risk of suicide due to ethical and liability issues association with the management of suicidal participants (D'Orio &

Garlow, 2004). These issues lead to a lack of support and difficulty finding funds to examine prevention and treatment programs for suicidal individuals.

There are a small number of evidence-based intervention programs for suicidal adults (Knox et al., 2003) and even less specifically attending to African American women who have experienced suicidality (Willis et al., 2003). However, current treatments for suicidal behavior and prevention programs are on the rise (Goldsmith et al., 2002; Kessler et al., 2005) due to increased number of individuals seeking treatment for emotional problems (Olfson et al., 2002). When compared, mental health treatments have been shown to be more effective than general medical interventions, but any treatment was shown to be better than none (Kessler et al., 2005). Research has shown efficacy of specific interventions such as cognitive based therapy, cognitive behavioral therapy, problem solving, phone therapy offered by hotlines, dialectical behavior therapy, and brief psychodynamic interpersonal therapy (Brown et al., 2005; Hawton et al., 1998; Rhee, Merbaum, Strube, & Self, 2005; Rudd, Joiner, Jobes, & King, 1999; Townsend et al., 2001). Treatments have been shown to be quite effective in reducing symptoms of suicidality and maladaptive behaviors (Comtois & Linehan, 2006; Lester, 1997; E. A. Thompson, Eggert, Randell, & Pike, 2001).

CHAPTER 3

METHODS

Sample

Participants (*n* = 178) were recruited from a large, public urban university affiliated hospital in the southeastern United States that serves an indigent and minority population. The sample consisted of African American women, ages 18-55 (*M* = 34.57, *SD* = 9.22) seeking medical or psychiatric care.

Procedures

Institutional approval. Prior to the conduct of this investigation, the study protocol was approved by the Emory University Institutional Review Board. Once that approval was secured, the protocol also was approved by the Grady Health System (GHS) Research Oversight Committee. All research team members completed the appropriate CITI training. The sample was drawn from a larger study funded by ASPH/CDC/ATSDR. This project used a randomized control trial design to examine the efficacy and effectiveness of a culturally competent manualized psychoeducational intervention (Grady Nia Project) versus treatment as usual (TAU; control) for African American women who had a history of abuse and suicide attempt.

Recruitment. The female participants were recruited in two ways. First, African American women ages 18-64 who presented to the Emergency Care Center or Psychiatric Emergency Service following a suicide attempt (required medical attention and/or reported significant suicidal intent) or an IPV incident were considered eligible to

be screened and recruited for study participation. Nadine Kaslow, Ph.D. (the Principal Investigator) and other designated research personnel were able to be contacted by pager 24 hours/day, 7 days/week by hospital personnel regarding all potentially eligible participants. Once women were medically stabilized a research team member then approached the women, explained the purpose of the study, answered questions, obtained written informed consent, and determined if she met inclusion criteria. Research team members also recruited women in abusive relationships with a recent history of a suicide attempt from other clinics in the hospital (e.g., Family Practice Center, Women's Urgent Care, Urgent Care Center, Emergency Care Center). A research team member was available three hours per day to screen women who presented to one of these clinics. If a woman met initial criteria the team member would explain the purpose of the study, answer questions, and obtain written informed consent. Once written informed consent was obtained, a brief screening was conducted at the recruitment site to assess women's suitability for the study.

Inclusion/exclusion criteria. Potential participants were administered the Universal Screening Tool for Domestic Violence (UVPSP) (Dutton, Mitchell, & Haywood, 1996; Heron, Thompson, Jackson, & Kaslow, 2003). To qualify for the study they must have answered “Yes” to one of the five questions regarding the presence of physical or nonphysical IPV in a current partnership. For these screening questions, *partner* was defined as an individual with whom the women are dating, living with, or to whom they are committed. Those women who answered “No” to all of the screening questions, were excluded from the study. Women who qualified on this measure then were administered the Suicide Screening Tool. The 5-item Suicide Screening Tool, created

for the current study, was used to assess for any suicide attempt within the past year. If responses indicated no evidence of a suicide attempt within the prior year, women were excluded from the study. If there was evidence that they have attempted suicide in the past year, they then were screened using the Mini Mental State Exam (MMSE) (Folstein, Folstein, & McHugh, 1975) and the Rapid Estimate of Adult Literacy in Medicine (REALM) (M. V. Williams et al., 1995). Women were excluded if they have MMSE scores < 24/30 if literate (REALM > 18) or < 22/30 if functionally illiterate (REALM < 18), as such scores indicate diffuse cognitive dysfunction.

If during the screening, a woman was identified as imminently suicidal, homicidal, severely depressed, or as having other acute psychiatric difficulties (e.g., actively psychotic) during any of the assessments, she was immediately referred to the psychiatric emergency service (PES) for appropriate psychiatric intervention (e.g., hospitalization, medication, psychotherapy referral).

Assessment procedure. All participants were assessed at pre-intervention (T1) and post-intervention or 10 weeks following T1 (T2). The T1 assessment gathered baseline data. Following T1 assessment, women were randomly assigned to the Grady Nia Project or TAU. The T2 assessment occured immediately post-intervention for women in the Grady Nia Project and 10 weeks after T1 for women in the TAU, control condition. The T2 assessment evaluated the effects of the intervention on participants' psychological functioning and short-term efficacy and effectivness of the two conditions. T1 and T2 assessment batteries were the same (plus an Intervention Satisfaction Survey at T2). Each assessment took approximately two hours and occured on the units or clinics in privacy, or in the Women's Study Research Office. Due to the overall low

rates of functional literacy in patients who receive services at GHS, questionnaires were read aloud to all women. In addition, measures were modified to match the overall literacy level of these individuals. Participants received $20 for T1 and $30 for T2 and money for transportation. The women in the Grady Nia Project who attended the 10 week intervention received $10 per group attendance and money for transportation.

Approximately 22,500 women consented to be screened for the study. Of those 22,500 screened, 244 women met criteria for the study, and 178 were interviewed. The overall participation rate of women who were approached throughout the hospital was nominal, but the participation rate of those who met inclusion was 73%.

Measures

Demographic Data Form. Questions were asked regarding age, literacy, employment, family make up, education, marital status, number of children, employment, medical and psychiatric history, religious affiliation and individual income.

Relationship Scales Questionnaire (RSQ) (Griffin & Bartholomew, 1994). The RSQ is a 30-item self-report inventory based on a two dimensional, four-category model of adult attachment. It assesses how individuals feel about their romantic relationships. Participants are asked to rate items on a five-point Likert type scale ranging from one (*not at all like* me) to five (*very much like me*). It yields four subscales for the attachment patterns defined by the four-category model: secure, fearful, preoccupied, dismissing; and two dimensions: self and other. The measure has moderate to high internal consistency (α = .81 to .84 for view of self and .72 to .85 for view of other) (Scharfe & Bartholomew, 1994). The scale has been show to have moderate test retest reliability and reasonable construct validity (Scharfe & Bartholomew, 1994). Reliability for the

current sample was found to be moderately high (α = .70).

Index of Spouse Abuse (ISA) (Hudson & McIntosh, 1981). The ISA is a 30-item measure that assesses presence and severity of physical (11 items) and nonphysical (19 items) IPV on a five-point Likert type scale (*1=never to 5=very frequently*). Each of the items describe behaviors or interactions that are considered abusive. The scale has shown good internal consistency reliability (r = .92). Both subscales of the ISA (physical, ISA-P and non-physical, ISA-NP) have proven to have good reliability with alphas ranging of .90 and .97 respectively (Hudson & McIntosh, 1981). Hudson et. al. examined the discriminant validity and found that the coefficient for ISA-P was .73 and for ISA-NP was .80. This means that the ISA is good at discriminating between physical and non-physical abuse. Utilizing the composite sample which the scale is based on, Campbell et al. found average scores for the physical subscale to be 15.63 and 21.86 for the non-physical subscale. Investigators have also found the ISA to be suitable for use with African Americans (Campbell, Campbell, King, Parker, & Ryan, 1994). The ISA has been shown to have good reliability and validity within this specific population (Grady Nia Project) (Cook, Conrad, Bender, & Kaslow, 2003). Campbell et al. found that African American women that had been identified as abused reported a mean score of 12.2 on the ISA-P and 5.78 on the ISA-NP. In the current sample the ISA showed to have high reliability (α = .95)

Taylor Self-Esteem Inventory (TSEI) (J. M. Taylor & Tomasic, 1996). The TSE is a 16-item measure consisting of 8 reward items and 8 cost items. The reward items refer to the positive domain of self-esteem. These items are: (1) “I am satisfied with the kind of person I am,” (3) “I feel happy inside,” (5) “I tackle my problems head on,” (7) I

defend my opinions," (9) "I feel proud of the way I do things," (11) "I think about things I've done well," (13) "I have a sense of purpose," and (15) "I follow through on decisions I make." The cost items refer to the negative dimension of self-esteem. These items include statements such as: (2) "I later regret things I've said," (4) "My behavior is inconsistent with my values," (6) "I criticize myself over the least little things," (8) "I feel ashamed of things I do," (10) "I distrust my judgment," (12) "My problems get the best of me," (14) I worry," and (16) "I dwell on my faults." The measure has been shown to be a psychometrically sound measure that assesses total self-esteem on an 8-point Likert-type scale ranging from never to always. High scores indicate high self-esteem. Mean self-esteem scores were found to be 86.03. Split-half reliabilities have been reported to range from .81-.84 (J. M. Taylor & Tomasic, 1996). The TSEI was shown to have moderate reliability in the current sample (α = .62).

Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). The MSPSS is a 12-item self-report measure of subjective social support. Items are rated on a 5-point Likert-type scale ranging from 1=very strongly disagree to 5=very strongly agree and was developed on a fourth grade reading level (Canty-Mitchell & Zimet, 2000). The measure is composed of three subscales: (1) family, (2) friends, and (3) significant other. Each subscale has been found to have strong internal reliability; .87, .85. and .91 respectively. Mean scores ranged between 5.58 and 6.01 (Zimet et al., 1988; Zimet et al., 1990). Terms are used to describe sources of social support that are relevant to the respondents such as the use of "special person." This term is used as it could refer to a boyfriend, girlfriend, teacher, counselor, etc. The measure has previously demonstrated

high internal reliability (α = .84-.92), and construct and factorial validity (Dahlem, Zimet, & Walker, 1991; Zimet et al., 1990). The MSPSS has demonstrated high reliability in the current sample, α = .90.

Beck Scale for Suicide Ideation (BSSI) (Beck, Kovacs, & Weissman, 1979; Beck & Steer, 1991). The BSS is a self-administered 19-item scale. The measure uses a 3-point Likert scale with items from 0 (no suicidal ideation present) to 2 (maximum severity of suicidal ideation). Scores range from 0-38, with higher scores indicating increasing suicidal ideation and risk. Beck, Kovacs, and Weissman (1979) designed the scale to measure the various dimensions of suicidal thoughts and wishes. The items were developed based on clinical interviews of suicidal patients. The list includes preoccupations, concerns, and wishes often experienced by suicidal patients as well as thinking and behavior patterns (Beck et al., 1979). The scale has high internal consistency ($\alpha > 0.89$) and good interrater reliability was obtained and found to be (α = .83). The measure has been shown to have good construct validity. Mean scores for suicidal ideation were found to be 9.43 for psychiatric inpatients following a suicide attempt and 4.42 for individuals seeking outpatient services for depression (Beck et al., 1979). Utilizing the BHS and BDI, Beck et al. found that hopelessness and depression positively correlated with the scales measure of suicidal ideation ($r = .47$, $p < .001$ and $r = .39$, $p < .001$, respectively) (Beck et al., 1979). Reliability of the measure for the current sample has shown to equal .86.

Beck Depression Inventory – II (BDI-II) (Beck, Steer, & Brown, 1996). The 21-item BDI-II measures severity of depressive symptoms. Items are rated on a four point scale. Item scores range from 0-3; total scores range from 0-63 and higher scores

reflect increased severity. Classification of depression and cutoff scores are as follows: 0-12, nondepressed; 13-19, dysphoric; and 20-63, dysphoric or depressed. Items consist of four statements reflecting increasing levels of severity for each depressive symptom. Items include thinking and behavior patterns associated with six of the diagnostic criteria for depression (Dozois, Dobson, & Ahnberg, 1998). Dozois et al. assessed the factor structure of the BDI-II and found two underlying dimensions to consist primarily of cognitive-affective and somatic symptoms. The BDI-II has high internal consistency among outpatients ($\alpha = .92$) and good factor structure (Beck et al., 1996; Dozois et al., 1998). The BDI has been shown to have high reliability in the current sample ($\alpha = .90$).

Beck Hopelessness Scale (BHS) (Beck, Weissman, Lester, & Trexler, 1974). The 20-item true-false BHS assesses negative expectations about the future. Scores range from 0-20; higher scores indicate more hopelessness. Items were selected from a test of attitudes about the future and select pessimistic statements from psychiatric patients who had been deemed “hopeless” by their clinicians. The items reflect negative attitudes about the future that seem to occur frequently in hopeless individuals. The scale was shown to have good internal consistency ($\alpha = .93$). Concurrent validity was examined by comparing hopelessness scores with other measures of negative feelings toward the future. The scale was found to have good concurrent validity (.74) with clinical ratings of hopelessness. It was found also that the scales provided and valid measure of hopelessness and demonstrates good construct validity. Mean scores for suicide completers have been shown to be 13.27 (Beck, Steer, Kovacs, & Garrison,

1985) and 8.36 (Dyce, 1996) for a sample from an outpatient clinic. Reliability in the current was found to be high with an alpha of .94.

Intervention Conditions

Treatment as Usual (TAU). The TAU control condition addresses the practical and ethical problems associated with a no intervention or a wait list control condition. Mental health resources will be available to participants assigned to the control condition. Participants who were assigned randomly to the control condition were referred for standard medical and psychiatric care offered by GHS when needed. Standard care included a medical and/or psychiatric evaluation, outpatient psychotherapy, psychiatric medication management, follow-up medical care, and referrals to community agencies (battered women's shelters, suicide/IPV crisis hotlines, and the Georgia Council on Child Abuse). GHS's PES, which provides crisis evaluation and stabilization, was available to all women in the control condition 24 hours/day, 7 days/week.

The Grady Nia Project. The experimental condition is the Grady Nia Project. Nia is a Kwanzaa term meaning hope. The Nia Project: Circle of Hope is a time-limited group that consists of 10 weekly, 1 ½ hour sessions based on a treatment manual. In the conduct of this culturally competent intervention, which includes both psychoeducationally and ego supportive approaches, the therapists work to create a balance between providing education and support to group members. The women in the intervention have had little prior exposure to psychoeducation about IPV and suicide. Likewise, their experiences with group process, if any, have not been safe, supportive, or empowering. As such, the Grady Nia Project Group Intervention was designed to

address those core needs and bolster their social support network including friends, family, and the community. Researchers have found that social support has a positive impact on abused women's social functioning and mental health (Coker et al., 2002; Riger et al., 2002; Warren, 1997). In addition, studies have also found that African Americans rely heavily on their social networks in managing their health concerns or emergencies (Ford et al., 1998; Kim & McKenry, 1998). The primary goal of each session was to cover one key topic associated with the stress-coping-adjustment model. Leaders remained sensitive to group process and allowed women the opportunity to share their questions and concerns within the group.

The manualized Nia Project Groups were co-led by two senior (advanced psychology graduate student or postdoctoral fellow) female project team members, at least one of whom was African American. A series of training session were led by the Principal Investigator or her appointee (Co-PI) to train therapists in the process of the manual. These training sessions provided information on suicidal behavior and IPV in the African American community; examined the research that served as a bases for the development of the project and intervention; reviewed session in detail and guidelines for their conduct; discussed effective working alliances, handing of suicidal emergencies and IPV incidents, and implementing the intervention protocols; and underscored strategies for increasing participant's adherence. Supervision occurred on a weekly basis again provided by the Principal Investigator or her appointee. Supervision reviewed video recordings of group meetings; discussed clinical material; and provided feedback about manual fidelity, therapeutic alliances, and management of individual group members. The Group Leader Manual Adherence and Competence Rating Form

(GLMACRF) was created to be completed by the group helper for every session in order to evaluate the group leaders' manual adherence (Open Discussion, Opening Greeting and Goals of the Meeting, Structured Discussion, Group Activity, Wrap Up) and competence (empathy, co-leader rapport, rapport with participants, active listening, and validation). The GLMACRFs were reviewed during supervision and examined for any problems in fidelity and competence. To ensure cultural competence; in accord with the American Psychological Association's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association, 2003); training and supervision focused on assisting therapists in recognizing their own cultural and racial biases; taught population specific culturally-based attitudes, beliefs, and behaviors; helped therapists gain an awareness of the clients' world view; educated them about culturally relevant intervention strategies; and aided them in dealing with racial and cultural issues raised throughout the intervention (Helms & Cook, 1999; Scott, Gilliam, & Braxton, 2005; Sue & Sue, 2003). Specific attention was paid to research and clinical writings on culturally competent interventions with low-income, African American women (Heron, Twomey, Jacobs, & Kaslow, 1997; Jackson & Breene, 2000; M. J. Taylor, 1999).

The group process was relatively structured. Each session began with a 30-minute check-in time to allow group leaders to talk to and visit with each group member on an individual basis. During this time, beverages and snacks were provided and the women were encouraged to socialize with one another. This time allowed the women to process events from the previous week in a relaxed atmosphere before the formal, more structured group began. Initially, group members were reluctant to engage, but as

sessions continued, they typically became more open with group leaders and other group members.

Following the check-in, there was a 30-minute structured discussion of the week's topic and this was the didactic portion of the session. During this time, group leaders introduced basic concepts and encouraged women to relate their experiences to the concepts presented. The leaders used a variety of methods (e.g., video clips and visual aids) to engage the women in topics that may have previously been unknown to them. The manual was written to provide a moderate amount of useful information, while allowing time for the women to process.

After a brief break, a 30-minute activity was presented. The activities were designed to help the women apply the concepts that they had just learned. Group activities were varied to keep the women interested and engaged in the group process. Activities included: creating safety plans, watching video tapes, participating in role-plays, playing games, and sharing during interactive discussions. The activity time, though structured, was designed to include one-on-one and/or group interactions that encouraged the women to focus on the new skills previously presented. It was believed that by allowing the women to practice new skills and concepts in a safe environment, they retain more information and are more willing to make necessary changes in their lives. The group is a place where the women had the opportunity to learn from their personal challenges and those of others, without fear of judgment.

The sessions ended with a brief review of the material covered. The group members also were given a chance to comment on the material presented during the

session. During this time, women had an opportunity to reflect on the material presented.

It was difficult to anticipate crisis experienced by women during the group meetings themselves. However, group leaders were well trained to manage crises should they arise. To the extent possible, group leaders remained focused on the topic of the week, while adequately addressing the crisis. In some cases, it was necessary for one group leader to take the group member in crisis out of the room to address the situation. In other cases, group leaders were able to use group time to address the situation. While this often required group leaders to think on their feet, allowing the women to see problem-solving and crisis intervention first hand exposed them to the possibility of the adoption of “good” skills. In cases where the group was exposed to the crisis, leaders were careful to follow-up with group members so they were able to see crisis resolution in action. In cases where crises had to be handled outside of the group, care was taken to meet the needs of the women immediately and in subsequent weeks. In some cases, outside agencies needed to be involved (e.g., Child Protective Services, shelters, job training centers, law enforcement).

A detailed session-by-session description of the intervention follows:

<u>Session I:</u> Though suicide and IPV are the common thread, the women come from various places in life. For example, some were recovering from drug addictions, homeless, dealing with mental illness, living with little to no money, and having to manage with children. During this first session, the focus was introducing group leaders and group members, setting group goals and expectations, and explaining the format and structure of the groups. Women were matched with “buddies”, similar to the

Alcoholics Anonymous model, to provide extra support to each other between group meetings, and encourage each other to attend each session. Women were also informed of the crisis policy created to allow women access to support on a 24-hour basis. The women were informed that they could call the Grady Nia Project office during regular business hours, and after hours, they had access to a 24-hour pager. In addition, the women were given a list of emergency phone numbers for both IPV and suicide. The women also were given a tour of the project's Resource Room. The Resource Room consisted of a library of books and videos on a variety of subjects (i.e. IPV, suicide, depression, parenting, self-esteem, and children's books) as well as binders with information on community resources that the women could utilize when they needed assistance with housing, childcare, job skills and placement, financial help and legal information. The rationale for developing a Resource Room for the project was that in addition to education and support, abused, suicidal women need access to the requisite resources to lead violence-free and productive lives. The women appreciated the availability of the Resource Room between sessions. Session one begins the process of building the women's social support network with each other.

Session II: This session was dedicated to IPV education. Women were educated about the different types of abuse, (emotional, physical, sexual etc). They were provided with an opportunity to share their thoughts about why women are abused. The women were presented with some of the most common reasons partner's abuse and the cycle of violence was presented (L. E. Walker, 1979). The group leaders provided examples of reasons specific to African American women such as religion, economics, partner roles and expectations (Lee et al., 2002; Raj et al., 1999). At the end of the session, the

women participated in an activity that focused on how IPV affects the other people in their lives (family and children). The goal of this session was to educate and inform the women about IPV in hopes of decreasing violence in their lives.

Session III: The focus of Session III was suicide education. Women were encouraged to identify some of the risk factors associated with suicide. Group leaders provided examples of specific risk factors for suicide in African American women (Kaslow et al., 2002; M. P. Thompson et al., 2002). The women also were provided with methods for decreasing one's chances of becoming suicidal. The women were presented with information on learning to manage feelings of depression and hopelessness. Consistent with Linehan's work individuals with borderline personality disorders, as a session activity, women were encouraged to identify reasons for living (Linehan, Goodstein, Nielsen, & Chiles, 1983) and practice relaxation exercises.

Session IV: The concept of safety planning was introduced in Session IV. The safety plan was presented as a structured way of increasing women's chances of staying emotionally and physically safe during a crisis. The safety plans focused both on IPV and suicidal behavior. The steps to safety planning that were addressed included: identifying safety needs, recognizing warning signs, and identifying personal coping strategies. During this session, the women began to create a personalized safety plan for themselves. As a session activity, barriers to using their safety plan were identified and discussed. Commonly cited examples included money, children, and transportation. The women were encouraged and reminded throughout the remainder of the intervention to update their safety plans as needed.

Session V: The focus of Session V was on accessing community resources. It has been reported that African American women less likely to report abuse or seek treatment from shelters; legal and advocacy services; or counseling (El-Khoury et al., 2004; Fraser et al., 2002; Joseph, 1997). Thus, this session has been designed to bring the resources to the women in a safe environment. During the session, representatives from local Domestic Violence Prevention and Suicide Prevention agencies were invited to come and talk about the services provided by their agencies. Women were encouraged to identify the areas in their lives where they could use some community assistance. Then, the women were helped to use the Resource Room and its resources to generate a list of agencies that they would then contact for assistance. Counseling options also were presented during this session, as many women have the need for mental health services above and beyond those provided by the Grady Nia Project. The women role-played contacting the various community resources as a session activity. This activity helped them to identify potential challenges and stumbling blocks and to generate potential strategies for overcoming these barriers.

Session VI: During Session VI, the focus was on social support. Researchers have found that African Americans rely heavily on their social networks in managing their daily concerns including health and mental health concerns (Ford et al., 1998; Kim & McKenry, 1998). During the psychoeducational component, social support was defined and the different types of social support were presented. The types of social support highlighted included family, friends, church or religious community, etc. Some researchers have found that these particular supports strongly influence African Americans' sense of self-esteem (Hughes & Demo, 1989). Women were encouraged to

identify the signs that indicate when they need support. Additionally, the women were taught how to ask for help, and how to ascertain who not to ask for help. During the session activity, women identified the types of social support that they have available to them, and the areas in which they would like to increase their levels of social support.

Session VII: Session VII targeted interpersonal communication. Effective communication rules and strategies were presented. The difficulties associated with adapting those strategies to communicating during conflict situations were highlighted. Special rules for communicating with children also were presented. As a session activity, the women used role-play to practice their communication skills with both adults and children in hopes of strengthening attachment bonds with significant individuals in their lives.

Session VIII: The goal of Session VIII was to help the women to identify how their thoughts influence their behaviors. The concept of positive and negative attributions is taught through the ABC's, where "A" represents activating events, "B" our beliefs and thoughts about those events, and "C" the consequences of the events. The women also were taught about adaptive and maladaptive attributional styles associated with optimism and hopelessness/depression. During this session activity, the women used the board game "Operation" to illustrate the attributions they make about their performance. Negative statements were reframed to practice the expression of positive attributions. As an exercise in making positive statements, the women took time before the end of this session to write at least two positive statements about each member of the group, including themselves. This exercise was used in hopes of empowering others and increasing self-esteem. At the end of this session, group leaders took some time to

address any concerns that the women may have about the pending termination of the Nia Project.

Session IX: The focus of Session IX was on coping and problem solving. Women were encouraged to identify the positive and negative coping skills that they currently use. They were presented with eight coping strategies and five steps of problem solving. As a group activity, the women were paired, identified a problem that they would like to solve, and followed the steps to problem solving. Group leaders took time at the end of this session to address any concerns that the women may have about the group ending.

Session X: Session X was a review and feedback session. Women were encouraged to offer suggestions and comments for future groups, discussed the things that they liked and disliked about the group including any sessions that were particularly salient to them, and shared their feelings about the group ending. Session X ended with a party (dinner provided). The women received certificates of completion, books containing the proverbs that accompany each session, and cards with the positive statements that the group members wrote about them during Session VIII.

CHAPTER 4

RESULTS

Preliminary Analyses

Prior to running the primary analyses, predictor and outcome variables were examined and graphed to assess for deviation from normal distribution. Skewness was examined and suicidality and hopelessness were determined to be positively skewed (i.e., a preponderance of lower scores at T2; see Table 1). These results are expected, as a major goal of the Nia Project intervention is to reduce suicidality and hopelessness. All other variables were deemed within the normal range (i.e., skew statistics < 1.0). Preliminary analyses were run to examine the demographic profile of the population studied; including age, relationship status, employment, homelessness, education, and individual income (see Table 1).

In addition, descriptive statistics were computed for all attachment styles and outcome variables. Overall means and standard deviations for Attachment Styles and outcome variables at Time 1 and Time 2 are presented in Table 2. Although no statistical analyses were conducted to compare the means the women in this sample obtained on the study measures and normative data, comparative inspection of mean scores revealed some interesting trends. Women in the current sample reported higher rates of both physical and non-physical abuse on the ISA at T1 compared to data reported from the composite sample on which the scale was developed (Campbell et al., 1994). These scores decreased at T2, but were still above the mean reported by the

scale developers. Mean self-esteem scores for the current sample of abused women were lower than means found by Taylor and Tomasic (1996). Typical scores on the MSPSS were found to range between 5.58 and 6.01 (Zimet et al., 1988; Zimet et al., 1990). Scores from the current sample ranged from 2.99 at T1 to 3.20 at T2. Mean scores for suicidal ideation at T1 were higher than scores found in a psychiatric inpatient population and slightly higher at T2 than was found for an outpatient population (Beck et al., 1979). At T1, women scored in the “depressed” range on the BDI. At T2, women’s scores decreased and fell at the lower end of the “dysphoric” range (Dozois et al., 1998). Hopelessness scores from the current sample were comparable to those found from a sample of individuals from an outpatient clinic (Beck et al., 1985). Thus, it appears that this sample has high levels of IPV, suicidal ideation, and depression and low self-esteem.

Bivariate Correlations

To answer the first two study questions, bivariate correlations were conducted to assess the associations that exist between attachment styles and the outcome variables being examined.

Question #1: Do attachment styles (secure, fearful, dismissing, preoccupied) correlate with self reported levels of IPV (physical and non-physical) and its correlates (self-esteem and social support)?

There were three hypotheses associated with this question: (1) individuals who score higher on the secure attachment subscale will report experiencing lower levels of IPV (physical and non-physical) (hypothesis #1), (2) individuals who score higher on the secure and dismissing subscales will score higher on measures of self-esteem

(hypothesis #2), and (3) individuals that score higher on the secure and preoccupied subscales will score higher on measures of social support (hypothesis #3).

To test these hypotheses, a series of bivariate correlations were conducted using the T1 and T2 data together (see Table 3). Consistent with predictions, higher levels of secure attachment were associated with higher social support at T1, $r(61) = .30$, $p < .05$ (hypothesis #3). Contrary to what was hypothesized, no significant relations existed between secure attachment and level of IPV (physical or non-physical) or self-esteem, dismissing attachment and self-esteem, or preoccupied attachment and social support (hypothesis #1, #2, and #3). Thus, African American women with a history of IPV and suicide attempts who are more securely attached endorse higher levels of social support, but do not appear to have lower self-esteem. Further, dismissing and preoccupied attachment styles do not appear linked to reports of social support or self-esteem in this sample.

Question #2: Do attachment styles (secure, fearful, dismissing, preoccupied) correlate with levels of suicidality and its associated correlates (e.g. depressive symptoms, hopelessness)?

Scores on the secure attachment subscale will be negatively correlated with (1) levels of suicidal ideation (hypothesis #4), (2) depressive symptoms (hypothesis #5), and (3) hopelessness (hypothesis #6).

To test these hypotheses, a bivariate correlations were conducted using T1 and T2 data together (see Table 3). Contrary to what was predicted, no significant relations existed between secure attachment and suicidality, secure attachment and depressive symptoms, or secure attachment and hopelessness (hypotheses #4, #5, and #6).

Multiple Regression Analyses

Hierarchical multiple regression analyses using step-wise methods were conducted to address questions #3 and #4. Listwise deletion was used in the regression analysis to eliminate the cases with missing data. Missing data is common in most experiments especially when dealing with longitudinal, follow-up data (Basilevsky, Sabourin, Hum, & Anderson, 1985). Researchers have found that this procedure performs just as well as procedures that are more computationally involved and is simpler than other estimating procedures. The advantage to this procedure is that listwise deletion is the oldest and most straightforward form of dealing with missing data. The main disadvantage is using listwise deletion is that there is a substantial decrease in the sample size and thus power is lost. As can be seen in Table 2, there was a large decrease in the sample size from T1 to T2 primarily due to lost contact with participants.

Question #3: Does participation in the 10 week Nia Project Group Intervention predict change in levels of IPV, self-esteem, perceived social support, suicidality, depression, and hopelessness?

It is anticipated that women randomly assigned to the Grady Nia Project Intervention groups will report lower levels of IPV (physical and nonphysical), suicidality, depressive symptoms, and hopelessness and higher levels of self-esteem and social support at T2 when compared to women in the TAU (hypotheses #7). Step 1 of the multiple regression tested whether each of the outcome variables differed based on group assignment (10 week Nia Project Intervention versus TAU). In order to predict

change at T2, T1 variables were included as control variable in step 2 to determine whether group status still predicts after controlling for T1.

Physical abuse scores were not significantly lower for the intervention group than for the TAU group at Step 1. Step 2 shows that T2 physical abuse was not significantly predicted by T1 physical abuse (see Table 4).

Similarly, it can be seen in Table 5 that non-physical abuse scores were not significantly lower for the intervention group than for the TAU group at Step 1. Step 2 shows that T2 non-physical abuse was not significantly predicted by T1 non-physical abuse.

As shown in Table 6, self-esteem scores were significantly higher for the intervention group than for the TAU group at Step 1 ($\beta = .31$, $p < .05$). Step 2 shows that T2 self-esteem was significantly predicted by T1 self-esteem ($\beta = .36$, $p < .05$), and intervention group differences were still significant with regard to self-esteem ($\beta = .25$, $p < .05$) after controlling for T1 measures, indicating that the women in the intervention group showed more significant improvement in self-esteem over time than did the women in the TAU condition.

As shown in Table 7, social support scores were not significantly higher for the intervention group than for the TAU group at Step 1. However, after controlling for T1 scores, Step 2 shows that T2 social support was significantly predicted by T1 social support ($\beta = .47$, $p < .01$), demonstrating that the women in the intervention group experienced greater gains in perceived social support over time than did their counterparts in the control group.

Results presented in Table 8 show that suicidality scores were significantly lower for the intervention group than for the TAU group at Step 1 ($\beta = -.32$, $p < .05$). Step 2 shows that T2 suicidality was not significantly predicted by T1 suicidality, but intervention group differences were still significant ($\beta = -.27$, $p < .05$) after controlling for T1 measures, indicating that the participants in the intervention group showed more significant improvement in suicidality over time than did those in the TAU group.

When testing for group difference in level of depression, regression analyses revealed that depression scores were significantly lower for the intervention group than for the TAU group at Step 1 ($\beta = -.33$, $p < .05$) (see Table 9). Step 2 shows that T2 depression was significantly predicted by T1 depression ($\beta = -.26$, $p < .05$), and intervention group differences remained significant ($\beta = -.29$, $p < .05$) after controlling for T1 measures, indicating that the intervention group showed more significant improvement in depressive symptoms over time than did those in the TAU group.

Regression analyses indicated hopelessness scores were significantly lower for the intervention group than for the TAU group at Step 1 ($\beta = -.41$, $p < .01$). Step 2 shows that T2 hopelessness was significantly predicted by T1 hopelessness ($\beta = .38$, $p < .01$), and intervention group differences were still significant ($\beta = -.26$, $p < .05$) after controlling for T1 measures, indicating that the intervention group showed significantly greater improvement in feelings of hopelessness over time than did their counterparts in the control condition.

Thus, individuals who participated in the Nia Project Group Intervention reported significantly lower levels of suicidality, depression, and hopelessness as compared to

those in the TAU group at the post-intervention assessment point, even when controlling for their pre-intervention scores.

Question #4: Do attachment styles (secure, fearful, dismissing, preoccupied) predict change in levels of IPV experienced, levels of self-esteem, perceived social support, suicidality, depressive symptoms, and hopelessness following a 10 week intervention?

It is believed that higher levels of secure attachment at T1 will predict lower levels of IPV (physical and nonphysical), suicidality, depressive symptoms, and hopelessness; and higher levels of self-esteem and social support at T2, controlling for group status and T1 outcomes. However, higher levels of fearful, preoccupied, and dismissive attachment will not evidence such significant changes regarding the outlined outcome measures, controlling for group status and T1 outcomes (hypothesis #8).

Step 3 of the multiple regression added four attachment variables to test whether attachment style predicts T2 outcomes after controlling for group assignment and T1. In addition, if differences were found between the treatment and TAU this step will test if these differences maintained after accounting for attachment styles.

After controlling for group status and T1 measures and adding the attachment style variables in Step 3, physical abuse did not add significantly to the variance of T2 physical abuse (see Table 4).

Similarly, after controlling for group status and T1 measures and adding the attachment style variables in Step 3, non-physical abuse did not add significantly to the variance of T2 non-physical abuse (see Table 5).

Table 6 shows that adding the attachment style variables in Step 3 and controlling for group status and T1 measures did not add significantly to the variance of T2 self-esteem.

Several significant findings regarding social support are presented in Table 7. Intervention group differences remained non-significant in Step 3, but after controlling for T1 measures, there was significant improvement in social support over time ($\beta = .55$, $p < .01$). Adding the attachment style variables in Step 3 significantly added to the variance of T2 social support for individuals with higher levels of fearful attachment ($\beta = .35$, $p < .05$). Results of the analysis revealed that 22% of the variance of social support at T2 is accounted for by T1. An additional 9% of the variance in social support at T2 is accounted for by attachment style. Therefore, attachment styles account for 9% of the variance in social support at T2 above and beyond T1 levels of social support. Specifically examining the four attachment styles, only fearful attachment style scores were predictive of T2 social support. Those who endorsed higher levels of fearful attachment style had significantly higher levels of social support at T2 above and beyond T1 level of social support. There was a statistical trend for those who endorsed higher levels of preoccupied attachment to have higher levels of social support at T2 above and beyond T1 social support ($\beta = .23$, $p = .06$).

Table 8 results reveal that adding the attachment style variables in Step 3 did not add significantly to the variance of T2 suicidality.

With regard to depression, group status differences continued to be significant in Step 3 ($\beta = -.28$, $p < .05$), but adding the attachment style variables in Step 3 did not add significantly to the variance of T2 depression scores (see Table 9).

Finally, Table 10 shows that T1 hopelessness scores continued to predict T2 scores in Step 3 ($\beta = .35$, $p < .05$), but adding the attachment style variables in Step 3 did not add significantly to the variance of T2 hopelessness scores.

Taken together, the regression analyses conducted to address question 4 revealed that after controlling for T1 measures, there was a significant improvement in perceived social support over time. It was also found that attachment style accounted for 22% of the variance in social support scores for those with higher levels of fearful attachment and an additional 9% of the variance in social support was accounted for by this attachment style at T2. Only fearful attachment was predictive of perceived social support at T2. Adding attachment style variables in Step 3 did not result in significant findings regarding physical and non-physical abuse, self-esteem, suicidality, depression, and hopelessness.

CHAPTER 5

DISCUSSION

Summary of Findings

Results of this study confirm that attachment style was associated in the predicted direction with perceived social support, one of the correlates of IPV, but not with IPV itself nor with its other correlate, self-esteem. In addition, no significant associations were found regarding attachment style and suicidality or its correlates (depression and hopelessness). It also was found that consistent with predictions, participation in the Nia Project intervention led to greater increases in self-esteem and decreases in levels of suicidality, depression, and hopelessness than did being assigned randomly to treatment as usual. However, group assignment did not predict physical or non-physical abuse scores and social support as was expected. It was hypothesized that attachment style would predict individuals' outcome variables at post-intervention beyond that attributable to group assignment. It was found that by adding the attachment style variables they significantly added to the variance of T2 scores of social support for those individuals with higher scores on fearful attachment. No other significant results were found regarding attachment style as an additive predictor for the rest of the outcome variables.

This study adds to a limited body of literature on African Americans and attachment. In addition, the results provide interesting findings concerning African American women's participation in a culturally competent group intervention specifically

designed for women who have experienced IPV and suicidality. This study is also significant in that it follows in line with the professional themes in psychology of social justice and multicultural competence. However, the results do suggest that attachment patterns may have only a minimal unique predictive power for intervention response beyond that attributable to treatment condition.

Attachment Styles and IPV and Suicidality and Their Correlates

Individuals with higher scores on the secure attachment subscale of the RSQ reported higher levels of perceived social support. This is expected, as Griffin and Bartholomew (1994) describe secure individuals as having a more positive sense of self and other and hence will perceive help and support in a more positive light. Similarly, individuals with higher levels of dismissing attachment reported lower levels of perceived social support. Griffin and Bartholomew describe these individuals as having a more negative sense of others and hence do not expect others to be helpful in times of need and do not seek out help from others. Although no a priori hypotheses were made for fearful attachment styles, it was found that individuals with higher scores on the fearful attachment subscale of the RSQ reported higher levels of both physical and non-physical abuse and lower levels of perceived social support. This finding is in line with Bartholomew's description of her prototypic fearful individual. She describes these individuals as fearing rejection and desiring to be connected to others. Their low sense of self-esteem and self-worth puts them at risk for intimate partner violence. Similar to individuals with dismissing attachment, individuals with fearful attachment have also been described as avoiding intimacy because of a negative sense of others and a feeling that they cannot be helped by those around them (Griffin & Bartholomew, 1994;

Henderson et al., 2005). Further, those wither higher scores on the fearful subscale reported higher levels of depression. Again, given that individuals with more fearful attachment styles are characterized as having lower self worth these findings are not surprising.

It was hypothesized that individuals with higher scores on the secure attachment subscale of the RSQ would report lower levels of IPV. It was thought that individuals with more secure attachment would report higher levels of self-esteem. As noted above, those with more secure attachment styles have a more positive sense of self resulting in higher self-esteem and self-worth. Further, it was hypothesized that those with higher scores on the secure attachment subscale would report lower levels of suicidality, depression, and hopelessness as these would be buffered as a result of their higher levels of perceived social support and self-esteem. These hypotheses were not supported. In regard to levels of IPV and self-esteem, women with more secure attachment reported high levels of IPV and low levels of self-esteem. This is perhaps due to the fact that many of the women participating in the Nia Project are currently being abused. Thus, it is understandable that most of the women in the Nia Project, regardless of attachment style, would continue to report high levels of IPV; low levels of self-esteem; and high levels of suicidality, depression, and hopelessness.

Nia Project Group Participation, Levels of IPV, Self-Esteem, Social Support, Suicidality, Depression, and Hopelessness

There was considerable evidence that participation in the Nia Project was associated with more positive outcomes at post-intervention. In terms of IPV and its correlates, the Grady Nia Project intervention did not appear to be associated with more

positive IPV outcomes 10 weeks following pre-intervention assessment. However, differential gains were found with regard to the two IPV correlates examined following the intervention phase, with women in the Grady Nia Project showing more significant progress with regard to both their self-esteem and their levels of social support than the women in the treatment as usual condition. These findings were true even when controlling for pre-intervention scores. The main goal of the Grady Nia Project Group Intervention is to empower women in order to help them better access resources in the community and increase their social support network. There are specific group sessions that are focused on accessing community resources (session V) and social support networking (session VI). Self-esteem and empowerment are intertwined throughout the group sessions. The Nia Project team provides a foundation for building a network of community resources. The group leaders and team member work with each woman to help her identify her unique needs and the community resources that might be helpful as well as friends and family members she may be able to call upon in times of need.

These results are in line with researchers that have noted that self-esteem impacts perceived social support (Anderson, 2002; M. P. Thompson et al., 2000). Additionally researchers have found that women with better social support resources report lower levels of mental health distress (Coker et al., 2002; Riger et al., 2002). In the current study, it was found that both physical and non-physical abuse scores were not significantly lower for the intervention group than for the TAU and T2 scores were not significantly predicted by T1 score. This is not surprising. Again, many of the women were screened and interviewed immediately following an abuse incident. It is likely that many of the women in the Nia Project still remain in these abusive relationships. There

are a number of reasons women stay in abusive relationships including safety, economic, psychological, and a commitment to the relationship (Herbert, Silver, & Ellard, 1991; Strube & Barbour, 1983). The women who participated in the project (Nia Project Group Intervention and TAU) may remain in their currently abusive relationships for these very reasons. The Nia Project Group Intervention is not focused on helping women “leave”, but rather helping women develop coping skills and locate resources they will need when they are ready to leave the abusive relationship.

More robust intervention findings were found for suicidal behavior and its correlates. More specifically, low-income, abused and suicidal African American women who participated in the Nia Project Group Intervention reported significantly lower levels of suicidality, depression, and hopelessness as compared to those in the TAU group. These findings are consistent with previous research that shows interventions that utilize techniques such as cognitive based therapy, cognitive behavioral therapy, problem solving, dialectical behavior therapy, and brief psychodynamic interpersonal therapy have been effective in reducing symptoms of suicidality and maladaptive coping behaviors (Brown et al., 2005; Comtois & Linehan, 2006; Lester, 1997; Rudd et al., 1999; Townsend et al., 2001).

Taken together, the aforementioned results indicate that the Grady Nia Project Group Intervention is effective in achieving several of the main goals of the group. The Nia Project Group was developed as a culturally competent intervention to help women who have experience violence in their intimate relationships and suicidal thoughts and behaviors. The results presented as part of the current study show that The Nia Project Group helps women to develop a more positive sense of self-esteem which may enable

them to more effectively seek out the social support they need to cope and deal with stressful issues in their lives. One of the main focuses of the Nia Project Intervention is to provide the women with a stable social support network and various resources. Many of the women who participate in the Project (Nia Project Group Intervention or TAU) do not have a positive and consistent social network. As the women take full advantage of all of the resources that the Nia project provides they build connections and relationship with the Nia Project Team as well as other women in the program. The resources provided by the Nia Project Team include use of a resource room that holds information on various agencies throughout the community, support groups, and individual therapy.

Attachment Style, Levels of IPV, Self-Esteem, Social Support, Suicidality, Depression, and Hopelessness at T2

It was found that attachment style accounted for 22% of the variance in social support scores for those with higher levels of fearful attachment and an additional 9% of the variance in social support was accounted for by this attachment style at T2. After examining all attachment styles, only fearful attachment was predictive of perceived social support at T2. It has been explained that fearful individuals experience others as rejecting and view self as unworthy of love and connectedness (Griffin & Bartholomew, 1994; Henderson et al., 2005). These people tend to avoid close relationships with other as a means of protecting themselves from rejection. It is believed that through the experience of the Nia Project group these women were able to recognize that they can rely on others as a means of support and as a resource to cope with difficulties they experience in their lives. Thus, women with higher fearful attachment at T1 had lower levels of perceived social support because they did not feel they could rely on others.

However, after participation in the Nia Project their perceived social support increased as they had developed positive relationships with the other women participating in the group, group leaders, and Nia Project team members.

However, contrary to predictions, attachment style did not significantly add to the change in level of either physical or non-physical abuse, self-esteem, suicidality, depression, and hopelessness at T2. It was believed that individuals with more secure attachment would have lower levels of IPV; higher levels of self-esteem and social support; and lower levels of suicidality, depressive symptoms, and hopelessness at T2. These negative results could be due to the fact that secure individuals scores did not change significantly over the short amount of time they were involved in the Nia Project (approximately ten weeks). As described above, secure individuals are characterized has experiencing others as trustworthy, supportive, and available (Griffin & Bartholomew, 1994). Thus, they maintain these ideas about their perceived social supports and resources. Secure individuals show a sense of worthiness a positive sense of self. Research shows that individuals with more insecure attachments report more dysfunctional attitudes and lower self-esteem (Roberts, Gotlib, & Kassel, 1996). They found that such low levels of self-esteem led to more depressive symptoms over time. Thus, it seems higher levels of self-esteem protect individuals from depressive symptoms. It would follow then that working to increase individuals' self-esteem, could reduce the risk of suicidality, depression, and feelings of hopelessness.

Limitations

There are many possibilities for the inconsistencies found, including study limitations. The sample is drawn from a low-income population, all of whom have limited

resources. Not surprisingly therefore, there was high attrition, and the follow-up data often were limited. As can be seen from the demographic data (Table 1), half the women that participated in the Nia Project considered themselves homeless. This means that there often was not a way to follow-up with the women after their T1 interview, hence the significantly lower number of participants and T2 follow-up data.

Another limitation involves the use of self-report measures. The information that was collected was sensitive in nature and difficult for many women to discuss and report openly with individuals they have just met.

A further weakness pertains to the measure of attachment that was used. The measure did not include a full adult attachment interview, which would have provided a more detailed and thorough examination of the individuals' attachments in peer, romantic and family relationships (Bartholomew, 2008). However, the attachment interviews are quite extensive and require time to learn to administer, code, and interpret. The RSQ is briefer and takes less time to administer. An additional problem with the attachment measure is that the RSQ has not been used a lot with this particular sample. However, reliability for the current sample was found to be moderately high (α = .70). Further, measuring adult attachment relationships in abused and suicidal women may mean the ratings are influenced by current life state in terms of relationships and mental health stability. Also, there was no measure of attachment bonds with early care providers. This would provide a better understanding of what early relationships influenced the women's attachment styles.

It has been suggested in the literature that attachment style remains relatively stable throughout our lives (Scharfe & Bartholomew, 1994). However, it may be

possible that some of the characteristics associated with attachment styles, such as self-esteem and social support, were changed over the course of the intervention and impacted the results. The current study did not gather data on attachment styles at T2. This measure would provide information regarding whether or not women's attachment styles changed following the intervention.

Racism adversely affects mental health and experiences of discrimination have been shown to induce negative psychological reactions (D. R. Williams & Williams-Morris, 2000). One study using a sample from the current population, found that African American suicide attempters reported feeling less connected to their own ethnic group (Kaslow, Price et al., 2004). More specifically, internalized racism has been linked to a number of health related and social issues such as obesity and high blood pressure (Tull et al., 1999); cardio vascular disease (Wyatt et al., 2003); marital satisfaction ; maladaptive coping with stress, low self esteem, and decreased psychological well being (Brice-Baker, 1994; D. R. Williams & Williams-Morris, 2000). Internalized racism and the impact of stereotypes have been examined as factors in lowering self-esteem and have been looked at as contributing to African American women's acceptance of mistreatment (Brice-Baker, 1994). Given the significant affect racism and internalized racism has been shown to have on mental health, it would be prudent to examine the impact that these factors have on the development of attachment.

Future Directions

Future research should be directed at several levels. It is clear that the study confirms that participation in the Nia Project Group Intervention was helpful and produced significant change on a number of factors. It may be interesting to employ

qualitative interviewing methods to further examine individuals' reactions and feelings upon completion of the intervention. To enhance the efficacy and cultural competence of the Nia Project Group Intervention, it will be important to obtain information and feedback from the group members on adjustments that could be made. Given the significant change in social support for women, it will be important to increase support provided by the Nia Project as well as enhance outreach to community agencies. By connecting more with outside resources, the Nia Project Team will be able to better inform the women of their resources in the community. It is believed that by providing this knowledge and support, women will feel empowered to seek out the support from their community in order to meet their needs. Women in the Nia Project Group Intervention also showed improvement in self-esteem, suicidality, depressive symptoms, and feelings of hopelessness. It is unknown from the current study how long these improvements last. Further research might incorporate booster sessions and additional follow-up data collection. The booster sessions could follow the same focus as the final session of the 10 week Nia Project Group Intervention, which is a review of safety planning, coping, and resource utilization.

One of the main focuses of the Nia Project is to help women live violence free lives. There were no significant changes in levels of IPV reported by the women who participated in the Nia Project Group Intervention. As previously noted, change within an abusive relation is a long process and often dangerous (Kernic et al., 2000; Lee et al., 2002). It is assumed that many of the women who participated in the group remained in their currently abusive relationships. Again, the Nia Project Group does not teach the participants to leave their abusive as this can be the most dangerous time for abusive to

occur and it is important that the women feel financially and emotionally ready. The Nia Project Group Intervention focuses on safety planning for IPV in session IV. But this session focuses on safety planning for both IPV and suicidality. It would be beneficial to separate these into two sessions which would allow for time to discuss safety planning for IPV on a more individualized level. Communication plays a large role in abusive relationships. Interpersonal communication is addressed in session VII. This session focuses on effective communication rules and strategies as well as improving communication with children. However, there seems to be a need to focus more on the difficulties associated with adapting communication strategies during situations in which abuse is probable or already occurring.

It would be important to explore attachment on a broader conceptual model that includes the self-other categorization presented by Griffin and Bartholomew (1994). It could be hypothesized, for example, that attachment dimensions (self and other) predict change in levels of IPV experienced, levels of self-esteem, perceived social support, suicidality, depressive symptoms, and hopelessness following a 10 week intervention. The four-category model utilized in the current study has two underlying dimensions, the self and other, as conceptualized by Bowlby (Bartholomew, 1990; Griffin & Bartholomew, 1994). The Bowlby model suggests that individuals' abstract images of self and other are dichotomized (positive and negative). Individuals who experience others as trustworthy, supportive, and available can be described as having a more positive other model. These people tend to strive to gain acceptance of others. Individuals who experience others as unreliable and rejecting can be described as having a negative view of other model. These people tend to avoid close relationships

with others as a means of protecting themselves from rejection (Bartholomew, 1990; Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994). It would be assumed that women who participate in the Nia Project Group Intervention and who report higher levels of other attachment dimension of the RSQ at T1will report lower levels of IPV (physical and nonphysical), suicidality, depressive symptoms, and hopelessness. Women who report higher levels of self attachment dimension at T1 will report higher levels of self-esteem and social support following the 10 week Nia Project Intervention. It would follow that women with a more positive other model would be more likely to participate fully in a group and would be better able to make connections and utilize resources. In a similar vein, women with a more positive self model will be motivated and intrinsically empowered to continue to take steps to make changes in their lives.

Conclusion

Bearing the limitations in mind, this study poses some interesting findings. It has long been theorized that individuals develop attachment at an early age (Bowlby, 1988) and that these styles remain stable throughout ones' life and through adulthood (Scharfe & Bartholomew, 1994). It has also been supported that attachment styles impact all our relationships and functioning within relationships. For this very reason, research focused on attachment and how it impacts individuals' participation and outcome in therapy settings practical significance in the area of treatment. In order to provide informed treatment, we need to examine attachment as it relates to individuals' ability to connect in therapy (group or individual). The field of psychology continues to explore the impact of attachment on relationships.

It is necessary to continue to examine the particular factors that will assist African American women in decreasing IPV and suicidality in their lives. The development of culturally informed services and interventions that build upon protective factors within this community will facilitate the increase of self-esteem and self-efficacy through building social supports and connections to community resources. We will be better able to serve women if we are aware of their connectedness and attachment styles which will inform us of their commitment and needs within the group.

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Table 1

Demographic Characteristics of the Total Sample (N=178)

	M(SD)	Range
Age	34.57(9.22)	18-55
	N	%
Group Status		
Intervention	105	59.0
Control	72	40.4
Relationship Status		
Single/Never Married	52	29.2
Partner, Not Living Together	25	14.0
Partner, Living Together, Not Married	37	20.8
Married	12	6.7
Divorced/Separated	47	26.4
Widowed	5	2.8
Employment		
Employed	29	16.3
Not Employed	148	83.1
Homeless		
Yes	95	53.4
No	83	46.6
Education		
Less than 12th Grade	75	42.1
High School Diploma/GED	56	31.4
Some College/Tech Diploma	38	21.3
College Graduate	9	5.1
Monthly Individual Income		
Less than $500 per month	124	69.7
$500 to $999 per month	40	22.5
$1000 per month and up	12	6.7

Table 2

Descriptive Statistics for Attachment Styles, Level of IPV, Self-Esteem, Social Support, Suicidality, Depression, Hopelessness

	Range	Time 1				Time 2			
	Min-Max	*n*	*M*	*SD*	Skew	*n*	*M*	*SD*	Skew
Attachment Style									
Secure	1 – 4	143	2.64	.65	-.05	-	-	-	-
Fearful	1 – 5	143	3.67	.91	-.52	-	-	-	-
Preoccupied	1 – 5	137	3.15	.84	-.08	-	-	-	-
Dismissing	2 – 5	143	3.69	.68	-.40	-	-	-	-
Physical IPV	0 – 100	175	44.10	28.76	.27	44	29.46	24.49	.93
Nonphysical IPV	0 – 100	175	55.69	26.20	-.23	42	47.24	24.91	-.06
Self-Esteem	5 – 108	177	54.13	20.07	-.09	74	65.76	19.82	-.20
Social Support	1 – 5	166	2.99	.99	-.22	75	3.20	.86	-.17
Suicidality	0 – 39	173	13.64	10.43	.43	75	6.76	6.88	1.36
Depression	0 – 62	178	35.37	12.55	-.46	75	24.40	13.38	.11
Hopelessness	0 – 20	172	8.20	6.27	.41	75	5.23	5.77	1.35

Table 3

Intercorrelations among Attachment Styles, Level of IPV, Self-Esteem, Social Support, Suicidality, Depression, Hopelessness

	Secure	Fearful	Preoccupied	Dismissing
Physical Abuse	-.19	.13	-.03	.04
Nonphysical Abuse	-.19	.07	-.13	.08
Self-Esteem	.07	-.21	-.02	.09
Social Support	.30*	-.27*	.14	-.27*
Suicidality	-.04	.18	.11	-.04
Depression	.05	.24	.06	-.07
Hopelessness	.25	-.02	.03	-.10

**p*<.05, ***p*<.01

Table 4

Hierarchical Linear Regression Analyses Predicting Physical Abuse Following a 10 Week Intervention

Predictors	β	ΔR^2
Step 1:		.00
Group Status	-.06	
Step 2:		.10
Group Status	-.02	
Physical Abuse at Time 1	.31	
Step 3:		.06
Group Status	-.07	
Physical Abuse at Time 1	.30	
Secure	-.24	
Fearful	-.08	
Preoccupied	-.13	
Dismissive	-.02	
Total R^2		.16

Table 5

Hierarchical Linear Regression Analyses Predicting Non-Physical Abuse Following a 10 Week Intervention

Predictors	β	ΔR^2
Step 1:		.01
Group Status	-.10	
Step 2:		.04
Group Status	-.08	
Non-Physical Abuse at Time 1	.20	
Step 3:		.15
Group Status	-.14	
Non-Physical Abuse at Time 1	.18	
Secure	-.30	
Fearful	-.22	
Preoccupied	-.25	
Dismissive	.06	
Total R^2		.20

Table 6
Hierarchical Linear Regression Analyses Predicting Self-Esteem Following a 10 Week Intervention

Predictors	β	ΔR^2
Step 1:		.10*
Group Status	.31*	
Step 2:		.13**
Group Status	.25*	
Self-Esteem at Time 1	.36**	
Step 3:		.00
Group Status	.25	
Self-Esteem at Time 1	.34*	
Secure	.00	
Fearful	-.07	
Preoccupied	.02	
Dismissive	.06	
Total R^2		.23

* $p<.05$, ** $p<.01$

Table 7

Hierarchical Linear Regression Analyses Predicting Social Support Following a 10 Week Intervention

Predictors	β	ΔR^2
Step 1:		.00
Group Status	.02	
Step 2:		.22**
Group Status	.02	
Social Support at Time 1	.47**	
Step 3:		.13
Group Status	.02	
Social Support at Time 1	.55**	
Secure	.05	
Fearful	.35*	
Preoccupied	.23	
Dismissive	-.15	
Total R^2		.35

* $p<.05$, ** $p<.01$

Table 8

Hierarchical Linear Regression Analyses Predicting Suicidality Following a 10 Week Intervention

Predictors	β	ΔR²
Step 1:		.10*
Group Status	-.32*	
Step 2:		.02
Group Status	-.27*	
Suicidality at Time 1	.16	
Step 3:		.04
Group Status	-.27	
Suicidality at Time 1	.12	
Secure	.12	
Fearful	.14	
Preoccupied	.17	
Dismissive	-.17	
Total R^2		.16

* $p<.05$, **$p<.01$

Table 9

Hierarchical Linear Regression Analyses Predicting Depression Following a 10 Week Intervention

Predictors	β	ΔR^2
Step 1:		.11*
Group Status	-.33*	
Step 2:		.07*
Group Status	-.29*	
Depression at Time 1	.26*	
Step 3:		.03
Group Status	-.28*	
Depression at Time 1	.22	
Secure	.05	
Fearful	.19	
Preoccupied	-.04	
Dismissive	-.20	
Total R^2		.21

* $p<.05$, ** $p<.01$

Table 10

Hierarchical Linear Regression Analyses Predicting Hopelessness Following a 10 Week Intervention

Predictors	β	ΔR^2
Step 1:		.17**
Group Status	-.41**	
Step 2:		.12**
Group Status	-.26*	
Hopelessness at Time 1	.38**	
Step 3:		.03
Group Status	-.21	
Hopelessness at Time 1	.35*	
Secure	.19	
Fearful	.08	
Preoccupied	.01	
Dismissive	-.01	
Total R^2		.31

* p<.05, ** p<.01