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Young Transgender Women Survivors of Intimate Partner Violence: A Latent Class Analysis of Protective Processes

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Abstract

Research is critically needed to understand protective processes that may lessen the impact of intimate partner violence (IPV) on negative outcomes for transgender individuals. The current study utilized a latent class analysis to identify combinations of protective processes (i.e., collective self-esteem and social support) in relation to internalizing mental health symptoms among young transgender women (YTW) survivors of IPV. Data from Project LifeSkills (2012–2015), a multisite trial for HIV sexual risk reduction intervention, were used for the present study. A subsample of 78 YTW (ages 16 to 29) who were IPV survivors (i.e., indicated lifetime IPV) were included in the analyses. Participants completed measures of general social support, perceived social support from their mother and friends, and collective self-esteem, as well as mental health symptoms. Three latent classes emerged: 1) YTW who perceived high levels of social support and collective self-esteem (48%), 2) YTW who perceived low levels of collective self-esteem, but average to high levels of social support from mother and friends (23%), and 3) YTW who perceived low levels of collective self-esteem and low to average levels of social support from mother and friends (29%). YTW in the overall low class had significantly higher levels of depressive, anxiety, and somatization symptoms, compared to the other two classes. These findings highlight how low levels of social support and collective self-esteem can place

YTW survivors of IPV at significant risk for experiencing negative internalizing mental health symptoms.

Keywords

young transgender women; intimate partner violence; protective processes; social support; collective self-esteem

National statistics estimate that one in four women experience a form of intimate partner violence (IPV) in their lifetime, placing them at risk for experiencing problematic health and mental health conditions (Smith et al., 2018). To date, the majority of IPV research has been conducted among cisgender women in heterosexual relationships, despite studies estimating greater IPV prevalence among transgender individuals (i.e., individuals whose gender identity or gender role does not conform to their sex assigned at birth; American Psychological Association, 2018). For example, one study estimated that 31% of transgender individuals had experienced IPV victimization in their lifetime compared to 20% of cisgender individuals (Langenderfer-Magruder, Walls, Whitfield, Brown, & Barrett, 2016). Other studies have found that 35% to 50% of transgender individuals have experienced IPV (Brown & Herman, 2015; Garthe et al., 2018; National Center for Transgender Equality, 2015), and transgender women are six times more likely to experience IPV than cisgender women (Valentine et al., 2017). A few studies have found that experiencing IPV is associated with suicidal ideation and substance abuse (Testa et al., 2012), as well as negative mental health outcomes and sexual risk behaviors (Reuter, Newcomb, & Whitton, & Mustanski, 2017). Finally, transgender individuals may experience distinct forms of IPV, including violence related to their gender identification or role (e.g., forced to do something that did not agree with their gender identification, or verbal harassment over one's gender identity; Garthe et al., 2018)

An area critically needed within the IPV literature among transgender populations is to explore protective processes that may lessen the impact of IPV on negative mental health outcomes. Research among cisgender women suggests that social support (i.e., perceiving emotional, tangible, or other forms of support from another person) and a positive identity (i.e., high self-esteem or sense of belonging to a social group) may protect survivors of IPV from negative outcomes (Coker et al., 2002; Kim & Kahng, 2011). The current study utilized a latent class analysis to identify combinations of protective processes (i.e., collective self-esteem and social support) in relation to internalizing mental health symptoms among a sample of young transgender women (YTW) survivors of IPV.

The Role of Protective Processes among IPV Survivors

Social support and a positive identity have been found in studies with cisgender women to be a source of protection in the relationship between IPV and mental health outcomes (Coker et al., 2002b; Kim & Kahng, 2011). However, survivors of IPV may be at a higher risk for social isolation as their partners may isolate them to maintain control and power; additionally, survivors may distance themselves from their familial and friend relationships to conceal their abusive relationship, often attributing this distance to feelings of shame or

embarrassment (Levendosky et al., 2004). IPV also may impact one's self-esteem and sense of worth, feeling helpless and/or powerless within the abusive relationship. Furthermore, low self-esteem can weaken a survivor's connection to their community, impacting their connections and feelings of self-agency (Papadakaki, Tzamalouka, Chatzifotiou, & Chliaoutakis, 2009). To our knowledge, no research has examined these processes in relation to mental health symptoms specifically for transgender individuals who are survivors of IPV.

Minority Stress Theory and Protective Processes

Transgender individuals, including IPV survivors and individuals who have not experienced IPV, experience social stigmatization, creating distinct stressors ("minority stressors") that can contribute to negative physical and mental health outcomes (Hendricks & Testa, 2012). These gender minority stressors include experiences with discrimination and victimization around one's gender identity, internalized transphobia, and expectations of rejection. Minority stress theory also details protective processes that may shield individuals from the adverse impact of minority stressors on one's mental health (Hendricks & Testa, 2012). Some of these protective processes are found within one's social environment, and may include connections to a sexual and gender minority (SGM) community, or perceived support from parents, family and/or friends (Hidalgo, Chen, Garofalo, & Forbes, 2017). Other protective processes may be internal, including one's self-esteem and a positive identity. Testa and colleagues examined community connectedness (i.e., connecting with transgender and gender nonconforming support groups and social networks) and positive identity (i.e., pride), both of which were associated with lower levels of depression and anxiety (Testa, Habarth, Peta, Balsam, & Bockting, 2015). As IPV survivors may experience increased rates of negative mental health outcomes, it is important to consider how protective processes, including social support, positive identity, and community connectedness, may protect survivors from negative mental health outcomes; though to our knowledge, this has yet to be empirically tested.

Social support.

Perceived social support from family members and friends may be instrumental in lessening the impact of minority stressors and IPV among transgender individuals. For example, researchers have found that social support can lessen anxiety and depression symptoms resulting from transphobia and discrimination (Budge, Adelson, & Howard, 2013; McConnell, Birkett, & Mustanski, 2016; Simons, Schrage, Clark, Belzer, & Olson, 2013). Perceiving support from both family and friend networks may allow transgender individuals to feel more accepted and in congruence with their gender identity (Budge et al., 2013; Simons et al., 2013). In particular, youth whose mothers respond positively to gender or sexual orientation disclosure, and youth who have close attachments and a high relationship quality with their mothers, are less likely to experience negative health outcomes (Katz-Wise et al., 2017; Padilla, Crisp, & Rew, 2010; Wypij et al., 2013). Therefore, family support – particularly from one's mother – was beneficial to young transgender individuals.

Finally, McConnell and colleagues (2016) examined clusters of social support among lesbian, gay, bisexual, and transgender youth, finding a cluster with low levels of social

support, a cluster with high social support, and cluster with non-family support. Youth who perceived low and nonfamilial support showed significantly higher levels of psychological distress in comparison to the youth who perceived high levels of social support. This study urged researchers to examine protective factors by using similar analytic approaches in order to see how forms of social support (and other protective processes) operate together.

Collective self-esteem.

A positive identity with one's social group, known as collective self-esteem, may also protect transgender individuals from negative mental health symptoms resulting from stressors or violence. Collective self-esteem consists of membership esteem (i.e., feeling worthy about being part of the transgender community), private esteem (i.e., how good one feels about being part of the transgender community), public esteem (i.e., how one believes others judge the transgender community), and identity esteem (i.e., how important the transgender community is to one's self-concept; Luhtanen & Crocker, 1992). In a recent review of protective factors among transgender youth, both aspects of collective self-esteem (i.e., perceptions of positive identity and connectedness to the transgender community), were shown to protect transgender individuals from experiencing negative health outcomes (Johns et al., 2019). However, this review also concluded that there was an underwhelming amount of research on transgender individuals and protective factors. In our review of the literature, only one study was found that examined both general social support and connectedness to the transgender community in relation to health outcomes. This study found that both of these protective processes were associated with fewer symptoms of depression and anxiety among participants on the trans female spectrum (Pflum, Testa, Balsam, Goldblum, & Bongar, 2015). More research is needed to expand our understanding of protective processes among transgender individuals, and particularly among IPV survivors.

The Current Study

Research indicates that perceptions of social support and collective self-esteem may be impacted by IPV experiences among cisgender women (Levendosky et al., 2004; Papadakaki et al., 2009), but that high levels of these factors may protect individuals from experiencing internalizing mental health outcomes (Coker et al., 2002b; Kim & Kahng, 2011). However, no research has examined how social support and collective self-esteem may protect transgender survivors of IPV from experiencing internalizing mental health outcomes (i.e., depression, anxiety, somatization symptoms). The current study makes a novel contribution to the literature by examining varying combinations of social support and collective self-esteem among transgender individuals who are survivors of IPV. Using a latent class analytic approach, we identified different combinations of YTW who perceived similar or distinct combinations of collective self-esteem and social support (i.e., general social support and perceived support and satisfaction within relationships with one's mother and friends). We then examined how class membership was associated with levels of their internalizing mental health symptoms.

Methods

Study Design

Data for the current study were from Project LifeSkills, a multi-site trial in Chicago, Illinois and Boston, Massachusetts, which took place from 2012 to 2015. Project LifeSkills tested a group-delivered HIV prevention intervention among YTW ($N = 300$). A group of YTW were enrolled in the trial if they met the following eligibility criteria: 1) were between the ages of 16 and 29 years-old, 2) were assigned a male sex at birth, and who now self-identify as female, trans female or male-to-female, transgender woman, woman, or other on the trans-feminine spectrum, 3) spoke English, 4) reported a sexual risk behavior (e.g., condomless anal or vaginal intercourse; diagnosis with HIV or another sexually transmitted infection; anal or vaginal sex with more than one sexual partner or in exchange for money, food or shelter), and 5) reported that they would be staying in the local area during the 12-month study period. All recruitment and intervention information can be found in the study protocol (Kuhns, Mimiaga, Reisner, Biello, & Garofalo, 2017). Data for the current study were used from two waves of data following the intervention, spaced approximately four months apart. There were 204 participants at the first wave following the intervention.

Participants and Procedure

Questions about IPV experiences were asked at the first wave following the intervention ($N = 204$). Participants were included in this study if they indicated that they experienced at least one form of IPV in their lifetime ($n = 78$). These 78 participants were ages 16 to 29 ($M = 23.98$, $SD = 3.53$). All demographic information can be found in Table 1, including gender, sexual, and racial/ethnic identities. Assessments were completed through computer-assisted self-interviews, following written informed consent for participants older than 18. A waiver of parental consent and written assent was obtained from participants younger than 18. All procedures were approved by Institutional Review Boards at both study locations.

Measures

IPV.—Lifetime IPV (Wilson et al., 2009) was assessed using five items ($\alpha = 0.88$) that asked participants about their experiences with physical, psychological, sexual, and transgender-specific forms of IPV. All items are shown in Table 2. If participants indicated that they had ever experienced *any* of these five forms of IPV in their lifetime, they were included in the study

Collective Self-Esteem.—The Collective Self-esteem Scale (Luhtanen & Crocker, 1992) was used to assess for one's perceptions, thoughts, and feelings in regards to their social group. For this study, we adapted the items to read specifically for the transgender community. Participants rated 16 items ($\alpha = 0.78$) that assessed for membership esteem (e.g., "I am a worthy member of the transgender community that I belong to"), private esteem (e.g., "In general, I'm glad to be a member of the transgender community that I belong to"), public esteem (e.g., "In general, others respect the transgender community that I am a member of"), and identity esteem (e.g., "The transgender community that I belong to is an important reflection of who I am"). Participants rated these items on a 7-point scale, where 1 = *strongly disagree*, and 7 = *strongly agree*. For the current study, a dichotomous variable

was created so that 1 = “higher collective self-esteem” if the average score was above the median, and 0 = “lower collective self-esteem” if the average score was below the median.

Social Support from Mother and Friends.—In order to assess for perceived social support from mother and friends (Jaccard, Dittus, & Gordon, 1998), eight items were asked about participants’ satisfaction within their relationship with their mother (e.g., “I am satisfied with the emotional support my mother gives me,” or “I am satisfied with the love and affection my mother shows me,” $\alpha=.97$) and their friends (e.g., “I am satisfied with the way my friends and I solve conflicts,” or “I am satisfied with the fun my friends and I have together,” $\alpha=.96$). Participants rated items on a 5-point scale, where 1 = *strongly disagree*, and 5 = *strongly agree*. A dichotomous variable was created so that 1 = “higher social support” if the average score was above the median, and 0 = “lower social support” if the average score was below the median. Scores were kept separate for perceived social support from mother and from friends.

General Social Support.—General feelings of social support were assessed with six items (e.g., “How often have you had someone available to understand your problems?” or “How often have you had someone available to love you and make you feel wanted?” $\alpha=.94$) from the Medical Outcomes Study Modified Social Support survey (Sherbourne & Stewart, 1991). Participants rated items on a 5-point scale where 1 = *none of the time*, and 5 = *all of the time*. A dichotomous variable was created so that 1 = “higher general social support” if the average score was above the median, and 0 = “lower general social support” if the average score was below the median.

Mental Health Symptoms.—Symptoms of depression, anxiety, and somatization were assessed using the Brief Symptom Inventory-18 (Derogatis, 2001). Participants were asked how much they had been bothered by symptoms in the prior week. Six items assessed for depression symptoms (e.g., “feeling no interest in things,” or “feeling of worthlessness,” $\alpha=.89$ at both waves) six items assessed for anxiety symptoms (e.g., “feeling restless,” or “feeling tense,” $\alpha=.88$ at wave 1 and $\alpha=.91$ at wave 2), and six items assessed for somatization (e.g., “Nausea” or “Trouble getting breath,” $\alpha = .84$ at both waves). Participants rated items on a 5-point scale where 0 = *not at all* and 4 = *extremely*. Raw scores were converted to t-scores based on community sex norms (males and females combined) so that t-scores equal to or greater than 63 indicated “case-ness” or clinically significant levels of symptoms.

Covariates.—For the current study, we included study site (1 = Chicago, 0 = Boston) and intervention condition (1 = LifeSkills intervention, 0 = other condition) as covariates.

Analysis Plan

Descriptive statistics and the latent class analysis (LCA) were conducted in Mplus (version 8.4; Muthén & Muthén, 2012). An LCA was used to identify the number of classes of YTW IPV survivors with similar response patterns to collective self-esteem, social support from mother and friends, and general social support. Researchers have demonstrated that a LCA can be estimated with smaller sample sizes (Dziak, Lanza, & Tan, 2014; Muthén & Muthén,

2012). The current study estimated latent classes using dichotomous categorical indicators, which may improve the quality of indicators even with small samples (Wurpts & Geiser, 2014).

Models with increasing number of classes were compared using statistical fit indices, including the Bayesian Information Criteria (BIC) and the sample-size adjusted Bayesian Information Criteria (ABIC), where lower values indicated a better fit (Tofighi & Enders, 2007). We also compared the Lo-Mendell-Rubin Adjusted likelihood ratio test (LMR-LRT) for each additional class to see if adding another class significantly improved model fit. Finally, fit indices including entropy and average latent class probabilities were compared, where higher values indicated a better fit. Once the optimal number of classes were identified, three-step LCA procedures were followed, examining covariates as auxiliary variables, and comparing mean level differences in mental health symptoms by class using a Wald test (Petras & Masyn, 2010).

Results

Descriptive Statistics

IPV survivors experienced different forms of IPV in their lifetime, including controlling behaviors (67.9%), physical threats and anger (47.4%), and sexual abuse (38.5%). Additionally, as shown in Table 2, IPV survivors also experienced transgender-specific forms of IPV, including making them do something that did not agree with their gender identification, 42%, and psychologically abusing them because of their gender identity, 53%.

Latent Class Analysis

Fit indices are presented in Table 3. Both the three- and four-class models showed decent fit; both had significant LMR-LRT tests, indicating that adding additional classes significantly improved the model fit. However, the third class had a higher entropy value and a stronger average latent class probability. Therefore, the three-class solution was selected for the current study and is shown in Figure 1. The first class included participants who perceived high levels of collective self-esteem, high social support from mother and friends, and high general social support ($n = 37$, 48%). The second class included participants who perceived low levels of collective self-esteem, but high levels of social support from mother and friends, and average general social support ($n = 17$, 23%). Finally, the third class included participants who perceived low levels of collective self-esteem, low levels of social support from mother and friends, and average general social support ($n = 24$, 29%).

Associations of Class Membership, Covariates, and Mental Health Outcomes

Associations between class membership, covariates, and mental health outcomes were examined, though no covariates were significantly associated with class membership. As shown in Figure 2 and Table 4, participants in the class with low levels of collective self-esteem and social support showed significantly higher levels of depression, anxiety and somatization symptoms at Wave 1 and 2 compared to the other two classes. Participants in this class also showed levels of mental health symptoms that were at or above the clinical threshold (scores of ≥ 63). There were no statistically significant differences between the

other two classes in their levels of associated mental health symptoms, though both classes had levels of mental health symptoms below the clinical threshold.

Discussion

Our results demonstrated that among IPV survivors there were heterogeneous groups of YTW who perceived varying levels and combinations of social support and collective self-esteem, and these groups showed differences in their levels of mental health symptoms. Although rates of IPV may be higher among YTW in comparison to cisgender men and women, as well as individuals with other gender identities (Valentine et al., 2017), relatively little research has explored protective processes of mental health outcomes among transgender individuals. Furthermore, prior to this study, these protective processes had not been examined among YTW survivors of IPV. Previous research has indicated that, with samples of cisgender women, IPV survivors may be at a higher risk for experiencing greater mental health symptoms due to lower levels of social support and self-esteem (Coker et al., 2002; Kim & Kahng, 2011). The current study contributed to this underdeveloped area of literature, examining perceptions of social support and collective self-esteem in relation to mental health outcomes.

One group of YTW perceived low levels of social support from their mother and friends and had a low sense of collective self-esteem. This group also demonstrated clinically significant levels of anxiety, depression, and somatic symptoms. The other two groups of YTW displayed high levels of one or both protective processes. For example, one group of YTW perceived high levels of collective self-esteem and social support, while the other group perceived low levels of collective self-esteem, but high levels of social support from mother and friends. These two groups did not significantly differ from one another in terms of mental health symptoms. However, YTW in the class with low levels of these social supports and collective self-esteem showed significantly higher levels of depression, anxiety, and somatization symptoms, compared to these two classes. Prior research has found that both social support (McConnell et al., 2016; Pflum et al., 2015) and collective self-esteem (Pflum et al., 2015) are protective processes of mental health symptoms. This study extends these associations to a sample of YTW who are survivors of IPV, finding that low levels of social support and collective self-esteem placed this group at significant risk for negative internalizing mental health symptoms

These results stress the importance of low social support from mother and friends as key risk processes among YTW IPV survivors. Additionally, the other two classes, where there was either high collective self-esteem, high social support, or both, did not show significantly different levels of mental health symptoms from each other. In other words, YTW with high levels of social support and low collective self-esteem experienced similar levels of mental health symptoms as the group of YTW with only high levels of social support. Previous work has illustrated the continued importance of support from family members, particularly mothers, across adolescence and into adulthood for transgender youth (Katz-Wise et al., 2017; McConnell et al., 2016). The majority of YTW in this sample endorsed average to high levels of social support from their mother and friends (71%), and satisfaction with these key relationships was a source of protection for IPV survivors. Social support from these

relationships also may be critical due to the developmental processes occurring during adolescence and early adulthood. For example, youth and young adults may change aspects of their identity across these developmental periods, which may impact the level of family and friend social support that they perceive and receive.

Additionally, feelings and experiences of instability, self-focused behaviors, and identity exploration are all key developmental tasks during adolescence and into adulthood (Arnett, 2017). These periods are also when most individuals have identified a pattern for sexuality and identity realization, or are engaging in sexual and identity exploration (Morgan, 2013). Transgender individuals also may experience high levels of instability during adolescence and early adulthood, demonstrating high rates of homelessness, incarceration, and employment and housing upheavals due to negative reactions from others regarding their gender identity (Graham, 2014). Therefore, developing collective self-esteem, or establishing connections and integrating with the transgender community can be protective for transgender youth who are focused on identity exploration and finding a sense of stability (Graham, 2014). Together, findings from the current study suggest the importance of continuing to research the impact that social support from one's mother and friends, as well as collective self-esteem, can have on mental health symptoms for YTW who have experienced IPV.

Limitations & Directions for Future Research and Practice

The current study is not without limitations. First, we examined a sample of YTW who were at a high sexual risk for HIV acquisition and transmission; therefore, findings may not be generalizable to other groups of YTW. Second, the measure of social support from mothers may have not been applicable to all individuals (e.g., not coming from a family structure that includes a maternal figure). Thus, YTW may have disagreed with items because they were not relevant, rather than because they did not perceive a lack of support. Future researchers may consider using a more inclusive social support measure, or one that allows for a variety of family structures. Third, we had a small sample size, urging researchers to replicate these findings with larger samples of YTW survivors of IPV.

The current study also examined perceptions of protective processes at one point in time; future research should consider examining how patterns of social support and collective self-esteem change across adolescence and early adulthood, especially considering the many developmental processes also occurring across these years that may impact YTW's perceptions of these protective processes. Another important limitation is the lack of relevant norms for the mental health assessment utilized in the current study. We combined cisgender male and female norms to create a sense of clinical significance in the current study, though this may limit interpretations of mental health symptoms. However, current norm-referenced measures do not include community norms for transgender and gender expansive individuals. Future researchers are urged to expand instruments to include norms tailored to transgender populations so that clinical interpretations can be tailored to this population.

Our findings have clinical implications and underscore the importance of aiming to enhance parental support through psychotherapeutic interventions involving transgender youth and their parents. Parents (mostly mothers) of transgender and gender-nonconforming youth

consistently report to therapists their fears and concerns for the physical safety and emotional wellbeing of their children given their children's increased risk for exposure to violence, IPV, and minority stressors (Hidalgo et al., 2017; Katz-Wise et al., 2017; Kuvalanka, Weiner, & Mahan, 2014). Therapeutic approaches such as the Multi-dimensional Family Approach (MDFA), seek to both validate parental concerns while also underscoring to parents (through the use of psychoeducation) that their support of their transgender child is perhaps the most significant psychosocial protective factor (Malpas, 2011). The findings of the current study provide parents and clinicians alike with an even stronger evidence base for foundational psychoeducational approaches that ultimately benefit their children

Finally, some national organizations have published recommendations on working with IPV survivors within LGBTQ communities. For example, these organizations have suggested modified safety plans, such as critically thinking about how to include law enforcement and community organizations in the safety planning process (National Coalition of Anti-Violence Programs, 2017). The American Psychiatric Association suggests that providers and clinicians revise materials to be more reflective and inclusive of experiences of survivors within LGBTQ communities. For example, organizations can incorporate the "Power and Control Wheel in Lesbian, Gay, Transgender, and Bisexual Relationships" into sessions (American Psychiatric Association, 2019). Despite these advances, there remains a critical need for IPV intervention development and adaptations (Miller et al., 2016). The current study offers insight, suggesting that enhancing aspects of collective self-esteem and social support may be especially important to embed in clinical practices for YTW IPV survivors.

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Public Significance Statement

The current study found distinct latent classes of social support and collective self-esteem that put young transgender women who had experienced IPV at risk for negative mental health symptoms. Findings inform research and practice, stressing the importance of strengthening these processes among this population.

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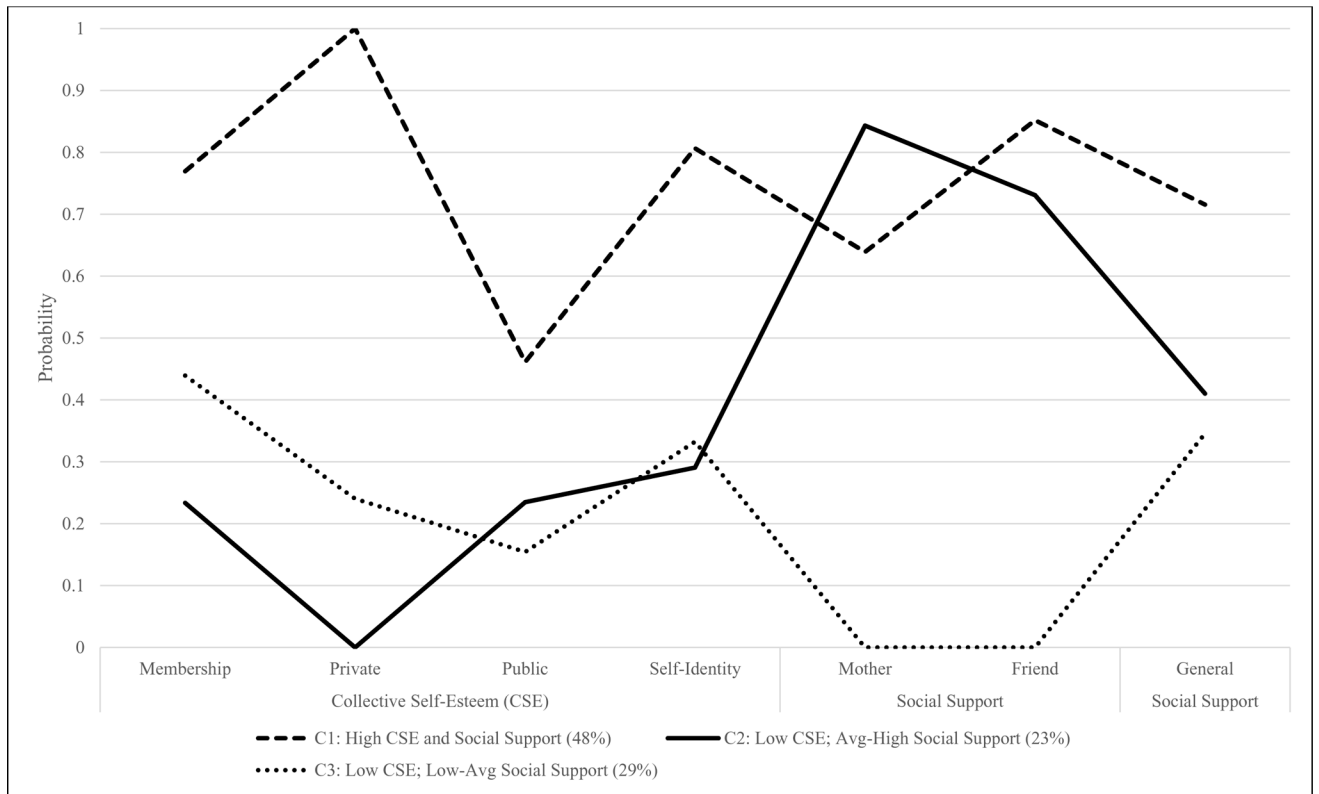


Figure 1. Latent class analysis indicating three classes with varying levels of collective self-esteem and social support (N = 78).

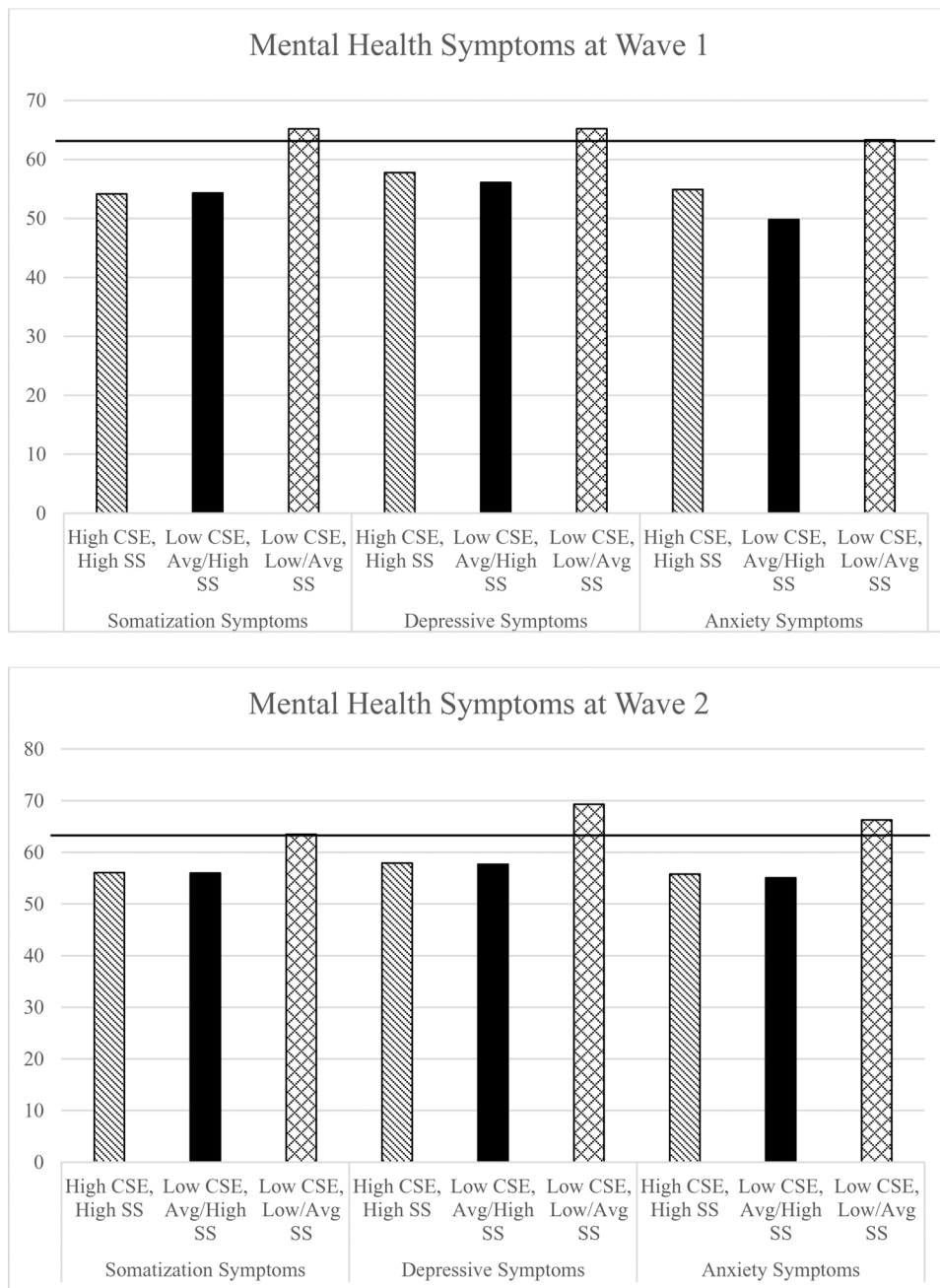


Figure 2. Differences in levels of anxiety, depression, and somatization symptoms at Wave 1 ($N=78$) and Wave 2 ($N=71$) by class membership. The bolded line at $M=63$ indicates the threshold for clinically significant levels of mental health symptoms.

Table 1

Demographic Characteristics among a Sample of Young Transgender Women Survivors of Intimate Partner Violence (N = 78)

	<i>n</i>	%
Gender identity		
Female	46	59.0
Trans-female/male-to-female	16	20.5
Transgender woman	13	16.7
Male	2	2.6
Other ^a	1	1.3
Sexual identity (not mutually exclusive)		
Heterosexual	27	34.6
Bisexual	19	24.4
Gay/Homosexual	15	19.2
Lesbian	4	5.1
Other ^b	13	16.7
Racial/ethnic identity		
Black/African American	32	41.0
White	26	33.3
Spanish/Hispanic/Latino/a	8	10.3
Asian	2	2.6
American Indian/Alaskan Native	1	1.3
Other ^c	9	11.5

Notes.

^a“Other” examples of gender identity included androgynous, gender queer, and questioning.

^b“Other” examples of sexual identity (not mutually exclusive) that were written in included pansexual, queer, open, self, 3rd gendered, transgender, and confusing/not sure/questioning.

^c“Other” examples of racial/ethnic identity (not mutually exclusive) included multiracial or multiethnic, Brazilian, Belizean, and Haitian.

Table 2.

Intimate Partner Violence Prevalence and Frequency by Type (N = 78)

	<i>n</i>	%
Has a partner ever tried to control most or all of your daily activities?		
Never	25	32.1
Once or twice	32	41.0
A few times	14	17.9
Many times	7	9.0
Have you ever been scared for your physical safety because of the anger or threats of a partner?		
Never	41	52.6
Once or twice	22	28.2
A few times	9	11.5
Many times	6	7.7
Has a partner ever hurt you sexually or made you do something sexual that you did not want to do?		
Never	48	61.5
Once or twice	19	24.4
A few times	4	5.1
Many times	7	9.0
Has a partner made you do something that did not agree with your gender identification? (e.g., make you hide your make up)		
Never	45	57.7
Once or twice	20	25.6
A few times	5	6.4
Many times	8	10.3
Has a partner ever repeatedly put you down, embarrassed you in front of other people, or made you feel bad about yourself because of your gender identity?		
Never	37	47.4
Once or twice	19	24.4
A few times	16	20.5
Many times	6	7.7

Table 3.

Fit Indices Specifying One to Four Classes (N = 78)

	1 Class	2 Classes	3 Classes	4 Classes
N Parameters Free	7	15	23	31
Loglikelihood	-370.93	-340.79	-329.08	-319.81
AIC	755.86	711.59	704.16	701.63
BIC	772.35	746.94	758.36	774.69
ABIC	750.28	699.65	685.85	676.95
Entropy	-	.88	.92	.91
Average Latent Class Probabilities	-	.95-.99	.92-1.00	.92-.97
LMR-LRT	-	58.59, p = .001	22.78, p = .02	18.01, p = .03

Note. Selected number of classes is bolded. LMR-LRT: Lo-Mendell-Rubin Adjusted likelihood ratio test

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Table 4.

Parameter estimates of mental health symptoms at Wave 1 and Wave 2 by class membership.

	High CSE and High SS	Low CSE and Avg-High SS	Low CSE and Low-Avg SS
Mental Health Symptoms Wave 1	M (SE)	M (SE)	M (SE)
Somatization Symptoms	56.08 (1.79)	55.98 (2.46)	63.50 (2.26)
Depression Symptoms	57.92 (1.86)	57.69 (2.40)	69.31 (1.63)
Anxiety Symptoms	55.78 (2.08)	55.07 (3.15)	66.27 (2.81)
Mental Health Symptoms Wave 2			
Somatization Symptoms	54.14 (2.04)	54.30 (2.95)	65.18 (2.80)
Depression Symptoms	57.76 (2.16)	56.08 (2.91)	65.21 (3.44)
Anxiety Symptoms	54.88 (2.49)	49.79 (2.96)	63.31 (3.03)
Comparisons	High CSE, High SS vs. Low CSE, Avg-High SS	High CSE, High SS vs. Low CSE, Low-Avg SS	Low CSE, Avg-High SS vs. Low CSE, Low-Avg SS
Mental Health Symptoms Wave 1	χ^2	χ^2	χ^2
Somatization Symptoms	.01	6.17*	4.80*
Depression Symptoms	.01	20.54**	15.77**
Anxiety Symptoms	.04	7.88**	6.34*
Mental Health Symptoms Wave 2			
Somatization Symptoms	.01	8.96**	6.57*
Depression Symptoms	.22	2.97	3.69
Anxiety Symptoms	1.74	4.23*	9.65**

Note. CSE = Collective Self-esteem; SS = Social Support

* $p < .05$;

** $p < .01$.