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Negative Social Contextual Stressors and Somatic Symptoms Among Young Black Males: An Exploratory Study

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Abstract

This study examines whether negative social contextual stressors were associated with somatic symptoms among young Black males ($N = 74$) after accounting for background and psychological characteristics. Using Cunningham and Spencer's Black Male Experiences Measure, negative social contextual stressors connoted those experiences connected to the personal attributes, devaluation, and negative imagery of young Black males, such as being followed when entering a store or police or security guards asking them what they are doing when hanging out (e.g., in the park or playground or on the street corner). Results showed that such stressors made a unique and significant contribution to the experience of somatic symptoms. Future research directions and implications for addressing the larger societal perceptions of young Black males are discussed.

Keywords

Black males; negative social contextual stressors; somatic symptoms; invisibility syndrome

INTRODUCTION

Studies examining correlates of somatic symptoms among young Black males are limited. Yet Franklin (1992) has suggested that somatic symptoms are a usual consequence of the coping efforts of Black males in response to stressors connected to negative ascriptions. The "anonymous Black male," according to Anderson (1990, p. 13), must contend with an onslaught of negative ascriptions such as criminal, uncivilized, tough, and street smart. Contemporary negative ascriptions of young Black males in American society can be significantly attributed to data that indicate their overrepresentation in special education and the juvenile and criminal justice systems (e.g., Hayes & Ward, 2015; Knoll & Sickmund, 2011; Puzzanchera & Adams, 2011). The reality that the majority of young Black males are civil and law-abiding is unfortunately overshadowed by the ubiquitous, albeit accurate crime data (Anderson, 1990). The following statement by D'Souza (1995) in his controversial book *The End of Racism* illustrates this state of affairs for young Black males:

Most people on the street cannot be expected to be familiar with official data on crime rates. No one goes around with a pocket calculator computing the probabilities of criminal attack. Yet everyone knows that young blacks are convicted of a high percentage of violent crimes, and since most Americans are highly risk-averse to crime, they have good reason to take precautions and exercise prudence. Compounding these alarming statistics is the intimidating ethnic style of many underclass black males, which everyone observes but few writers acknowledge in public. (p. 261)

More than a decade ago, in a roundtable discussion held with young Black males, they stated that some of the worst things about being a young Black male were being viewed solely as a statistic and automatically being classified as a thug or gang member (*Essence*, 2003). The recent case of Trayvon Martin brought the insights of Black males and their day-to-day lives back into the national spotlight (e.g., Amber, 2012; Powell, 2012). In Powell's (2012) article, James, a 15-year-old Black male stated the following:

Last week, my cousin Julian and I were going to walk to the store a couple of blocks from the house. My mother and my aunt were worried because I had a hoodie on, and they were afraid something could happen. My mother told me not to put the hood on, not to put my hands in my pockets [while I'm] in the store. She told me to make sure if I picked up something more than once, I should buy it. She said to make sure I put my stuff in a bag and got a receipt. It made me feel like I had restrictions on me; like I was a target. (p. 124)

This statement by James reflects the Black male experience in American society and bespeaks the "essential tragedy," as asserted by Marable (1994, p. 70), which is their inability to define themselves beyond the stereotypes imposed upon them. Furthermore, Franklin (1999, p. 763) conceived *invisibility syndrome*, a model that encapsulates the "intrapyschic struggle" of Black males to resolve and manage this tragedy and conundrum.

Crime statistics, negative media portrayals, and the exaggeration and focus on incendiary images about urban culture serve only to create and foster stereotypes that result in negative social contextual experiences. Negative contextual experiences connected to the personal attributes, devaluation, and negative imagery of young Black males, *such as* being followed when entering a store *and* police or security guards asking them what they are doing when hanging out (e.g., in the park or playground or on the street corner) constitute social stressors (Cunningham & Spencer, 1996). Indeed, multiple studies show such social stressors occur among Black males regardless of socioeconomic position, professional status, or age range (e.g., Meeks, 2000; Weitzer & Tuch, 2002).

This study was guided by the following research question: Do negative social contextual stressors connected to the personal attributes, devaluation, and negative imagery of young Black males predict somatic symptoms after accounting for background and psychological characteristics? Across a number of studies, multiple background characteristics and behavioral and psychological challenges have been found to be related to somatic symptoms. Greater somatic symptoms have been found among foster care children with a history of sexual abuse (Kugler, Bloom, Kaercher, Truax, & Storch, 2012) as well as for young to older

male and female outpatients with a history of physical and emotional abuse (Sansone, Wiederman, Tahir, & Buckner, 2009). Among varied child and adolescent samples, a variety of psychological characteristics have also been found to be related to increased somatic symptoms or complaints, including greater suppression of anger (Johnson & Greene, 1991), symptoms of anxiety (Kingery, Ginsburg, & Alfano, 2007), symptoms of depression (Janssens, Klis, Kingma, Oldehinkel, & Rosmalen, 2014), and meeting diagnostic criteria (DSM-III-R) for oppositional defiant disorder and attention-deficit hyperactivity disorder (Egger, Costello, Erkanli, and Angold, 1999).

Adolescents and young adults with histories of placement in foster care may possess peculiar characteristics. For example, research indicates that foster care youth and alumni have higher rates of behavioral and emotional problems than their counterparts in the general population (e.g., Pecora, White, Jackson, & Wiggins, 2009). However, there is no current evidence that how foster care youth and alumni react or respond to stress is peculiar. Nonetheless, the distinctive challenges to their development due to child welfare involvement, such as a lack of social supports and disrupted and multiple living situations (Collins, 2001; Dore, 1999), may impact their responses to social stressors and thus should not be underestimated.

Study participants were part of a larger study examining the help-seeking readiness of young Black males upon their transition from the foster care system. Several background factors were assessed: foster care custody status, physical abuse, physical neglect, emotional abuse, and sexual abuse. The psychological factors assessed were anger expression, anger control, oppositional defiant disorder (ODD), conduct disorder (CD), major depression (MD), and attention deficit hyperactivity disorder (ADHD). Finally, the social stressors assessed were negative social contextual experiences. No specific hypotheses were posed given the exploratory nature of this study.

METHOD

Sample

Black males from a longitudinal study of older foster care youths in the care and custody of the Missouri Children's Division (MCD) were recruited to participate in a separate study that focused on their readiness to seek help for personal, behavioral, or emotional problems upon transitioning from the foster care system. At baseline, the longitudinal study consisted of 404 older foster care youth (mean age = 16.99, $SD = .09$), 97 (23.9%) of whom were Black males. Further details about the background and methods of the longitudinal study are described elsewhere (McMillen et al., 2004).

Of the 97 possible participants, 74 (76.3%) were successfully contacted and agreed to participate in this study. Participants were age 18 ($n = 68$, 91.9%) and 19 ($n = 6$, 8.1%). The majority were still in the care and custody of the MCD ($n = 44$, 59.5 %). As assessed at baseline in the longitudinal study by the Diagnostic Interview Schedule-Version IV (DIS-IV; Robins, Cottler, Bucholz, & Compton, 1995), almost half ($n = 34$, 45.9%) met criteria for lifetime or past-year psychiatric disorders based on DSM-IV diagnostic criteria. The most prevalent disorders were ODD ($n = 21$, 28.4%) and CD ($n = 15$, 20.3%), followed by MD (n

= 10, 13.5%) and ADHD ($n = 10$, 13.5%). Results of attrition analysis showed that the 74 Black male participants did not significantly differ on major study variables (e.g., age at entry into foster care, psychiatric history) from the 23 Black males in the larger longitudinal study who could not be located. This article is based on the 72 participants who ultimately completed the measure of somatic symptoms.

Measures

Anger—Anger expression and anger control were assessed with the Taylor Anger Inventory (Taylor & Tomasic, 1996). It uses six items to assess anger expression (e.g., “I express my anger anytime, anywhere”) and four items to assess anger control (e.g., “It takes a lot to get me angry”). The expression and control items are scored on a 10-point Likert scale ranging from 0 (*not at all true*) to 10 (*entirely true*). To simplify response options for the current sample, the response options were changed to 1 (*almost never*) to 4 (*almost always*), with higher total scores indicating greater levels of anger expression and anger control. In this study, item internal reliability estimates (α) were .72 for the anger expression items and .60 for the anger control items.

Maltreatment—Physical abuse, physical neglect, and emotional abuse were assessed with the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). The CTQ uses five items to assess each type of maltreatment, with score ranges of 5 to 25. Youth indicated the extent to which they had been victims of physical abuse (e.g., “When I was growing up, I was punished with a belt, a board, a cord, or some other hard object”), physical neglect (e.g., “When I was growing up, I didn’t have enough to eat), and emotional abuse (e.g., “When I was growing up, people in my family called me things like “stupid,” “ugly,” or “lazy”). Responses occurred on a five-point, Likert scale ranging from 1 (*never true*) to 5 (*very often true*), with higher total scores indicating greater levels of each type of maltreatment. In a sample of male and female street youth, the following reliability estimates were found: .81 (physical neglect), .86 (physical abuse), and .83 (emotional abuse) (Forde, Baron, Scher, & Stein, 2012). For participants in this study, the internal reliability estimates (α) were .60 for physical neglect, .80 for physical abuse, and .79 for emotional abuse.

Sexual Abuse—To assess sexual abuse history, three items adapted from Russell (1986) and used in a prior study of older foster care youth (Auslander et al., 2002) were used. Youth were asked to indicate (1) if they were ever made to touch someone’s private parts against their wishes, (2) if anyone had ever touched their private parts (breasts or genitals) against their wishes, and (3) if anyone ever had vaginal, oral, or anal sex with them against their wishes. Youth were dichotomized into two sexual abuse history groups: youth responding “yes” to any of the three questions were identified as having a history of sexual abuse (1), and youth responding “no” to all three questions were identified as having no history of sexual abuse (0).

Negative Social Contextual Stressors—Negative social contextual stressors were assessed using the Black Male Experiences Measure (BMEM; Cunningham & Spencer, 1996). The BMEM is a 33-item scale that assesses the experiences and perceptions of Black males in four domains: proximal negative experiences (PNE; 13 items), distal negative

experiences (DNE; 9 items), negative inference experiences (NIE; 5 items), and positive inference experiences (PIE; 6 items). Given the overall research aims, only three of the four BMEM domains were assessed: PNE (e.g., “How often do people you don’t know think you are doing something wrong like selling drugs, preparing to rob somebody, preparing to steal something, etc.”), DNE (e.g., “How often are you harassed by police?”), and NIE (e.g., “How often do White people tend to lock their car doors when you pass?”).

Proximal negative experiences (PNEs) were measured by 8 of the 13 subscale items. Three items were not used because they assessed the experiences of others (brothers, sisters, male friends). In addition, two items that assessed how often teachers and school administrators thought they were “doing something wrong” were not administered because many participants were not active students. Participants responded to items on a five-point, Likert-type scale ranging from 1 (*never*) to 5 (*always*), with higher mean scores indicating more frequent negative social contextual stressors. For this study, the internal reliability estimates (α) were .91 (total scale), .92 (PNE subscale), .68 (DNE subscale), and .73 (NIE subscale).

Somatic Symptoms—The Cardiovascular Arousal and Sleep Disturbances scale (CASD; Siegel, 1982) was used to assess somatic symptoms. The CASD consists of 14 items, 10 that assess symptoms of cardiovascular arousal (e.g., shortness of breath, light-headedness) and four that assess symptoms of sleep disturbance (e.g., could not sleep well, hard to fall asleep). Participants reported the extent to which they experienced each symptom in the past 4 weeks on a four-point, Likert-type scale ranging from 1 (*never*) to 4 (*almost always*), with higher mean scores indicating greater somatic symptoms. In a study by Johnson and Greene (1991) among a sample of 78 Black adolescent males between the ages of 14 and 16, reported alpha coefficients were .84 (cardiovascular arousal) and .76 (sleep disturbance). In the present study, the internal consistency coefficients were .74 (cardiovascular symptoms), .74 (sleep disturbance symptoms), and .81 (total scale).

Procedure

Black males in the longitudinal study were contacted to solicit their participation in the present study; none of those successfully contacted refused to participate. Upon providing informed consent, all participants were interviewed at their place of residence ($n = 66$, 89.2%) or by telephone ($n = 8$, 10.8%). Participants interviewed by phone resided in locales that were a significant distance from the project site (more than 100 miles). To control for reading difficulties, items from the measures were read aloud. Participants’ remuneration was \$20. An institutional review board approved the procedures for this study.

RESULTS

Preliminary Analyses

Table 1 shows the means, standard deviations, skewness, and ranges of the study variables. Exploration of the distributional characteristics of the study variables indicated that none deviated significantly from normality.

Results of bivariate analyses (see Tables 2 and 3) suggested that the following variables were related to the experience of somatic symptoms: conduct disorder, anger expression, and

negative social contextual experiences. Specifically, somatic symptoms tended to be greater among participants meeting DSM-IV diagnostic criteria for conduct disorder as well as those reporting greater anger expression and more frequent negative social contextual stressors.

Hierarchical Multiple Regression Analysis Predicting Somatic Symptoms

Hierarchical regression analysis was conducted to examine what factors significantly contributed to somatic symptoms. Results are shown in Table 4. Because of the high correlation between physical abuse and emotional abuse ($r = .71, p = .001$), a composite measure of physical and emotional abuse was created by averaging the total scores from both measures. In addition, Cunningham and Spencer (1996) recommended standardization of the BMEM because of the different number of questions representing each domain. Thus, the BMEM, which assessed negative social contextual stressors, was standardized for these analyses.

In Step 1, the background characteristics were entered. They accounted for 6% of the explained variance in somatic symptoms, adjusted $R^2 = .01, F(4, 66) = 1.14, p = .35$. None of the background characteristics evolved as significant predictors of somatic symptoms. In Step 2, the psychological characteristics were added. Psychological characteristics accounted for an additional 14% of the explained variance in somatic symptoms, adjusted $R^2 = .07, F(6, 60) = 1.80, p = .11$, with conduct disorder ($\beta = .34, p = .01$) emerging as the only significant predictor of somatic symptoms. Results indicated that meeting DSM-IV diagnostic criteria for conduct disorder predicted increased somatic symptoms. In Step 3, negative social contextual stressors were added and accounted for an additional 7% of the explained variance in somatic symptoms, adjusted $R^2 = .14, F(1, 59) = 5.60, p = .02$. More frequent negative social contextual experiences predicted greater somatic symptoms; however, conduct disorder was no longer a significant predictor.

Given the significant association of conduct disorder to somatic symptoms in Step 2, an interaction term was created with negative social contextual stressors: Conduct Disorder $\times$ NSCS. The hierarchical regression was rerun with the interaction term entered in Step 4. A significant interaction would be indicated if the change in R^2 for the interaction term is significant. Results (not shown) indicated that the interaction term accounted for 1% of incremental variance in somatic symptoms, adjusted $R^2 = .14, F(1, 58) = 1.17, p = .28$. The interaction of NSCS $\times$ Conduct Disorder ($\beta = -.19, p = .28$) did not contribute significantly to explaining somatic symptoms.

DISCUSSION

The purpose of this study was to explore whether negative social contextual stressors were associated with somatic symptoms among young Black males after accounting for background and psychological characteristics. Negative social contextual stressors were operationalized by experiences such as people thinking they are doing something wrong (e.g., selling drugs, preparing to rob somebody, preparing to steal something) that arise out of Black males' own personal attributes, their membership in a larger devalued group, and

the generally projected negative imagery of Black males. Results showed that such stressors made a unique and significant contribution to the experience of somatic symptoms.

The background characteristics assessed in this study, namely, the extent to which participants were the victims of physical and emotional abuse, physical neglect, and sexual abuse, were not only unrelated to somatic symptoms but explained very little of the variance. This finding is inconsistent with other studies across varied population samples. For Black males transitioning from foster care, how experiences of child maltreatment are appraised may be more related to somatic complaints than the actual reports of abuse and/or neglect itself.

Of the psychological characteristics assessed in this study, anger expression and conduct disorder were significant bivariate correlates of somatic symptoms. Conduct disorder, however, evolved as the only psychological characteristic that significantly predicted the experience of somatic symptoms in hierarchical regression analyses. The behaviors indicative of conduct disorder are deemed more pronounced and serious than those manifested in other disruptive behavioral disorders (del Valle, Kelley, & Seoanes, 2001). Furthermore, Burke, Loeber, & Birmaher (2002) noted that greater stress and more maladaptive coping tends to be evident among older youth with conduct disorder. Hence, a number of coexisting factors may explain greater somatic complaints among those meeting diagnostic criteria for conduct disorder.

Results from hierarchical regression analyses showed that negative social contextual stressors were a unique and significant predictor of somatic symptoms and that diagnoses of CD based on DSM-IV criteria did not moderate this relationship. Our findings with regard to negative social contextual stressors are consistent with the emerging evidence from studies that have examined the relationship of race- and gender-based discrimination to various indicators of emotional well-being (e.g., Banks, Kohn-Wood, & Spencer, 2006; Fischer & Holz, 2007; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003).

Jones, Gray, and Jospitre (1982) found in their seminal study that the most frequent area of unconscious conflict presented by Black males in mental health treatment was the conundrum of how to express justifiable anger and hostility in a manner that does not exacerbate negative ascriptions. They further asserted that the conflict between passiveness versus aggressiveness is monumental when considering the danger that Black males can subject themselves to when responding in ways that trigger stereotypes. Hence, greater somatic symptoms in response to frequent negative social contextual stressors might be influenced by the mixed feelings and emotions that they engender. The challenge of arriving at a response that not only alleviates mixed feelings and emotions but addresses the stressors in a manner that bolsters a sense of agency and esteem is likely to exacerbate somatic symptoms.

Greater somatic symptoms attributable to frequent negative social contextual stressors might also occur because of their contribution to an overall stress load. Outlaw (1993) asserted that Blacks are likely to automatically appraise racism-related experiences as stressful. The same can be proposed concerning negative social contextual stressors. It is the accumulation of

negative race-and gender-related experiences that override the stress load capacity of targets of unfair and unwarranted treatment (Harrell, 2000). The central point is that negative social contextual experiences are part of a constellation of general and specific stressors that are likely to contribute to greater somatic symptoms.

Strengths and Limitations

This study possessed a number of limitations. The findings are based on a unique subpopulation of young Black males. No generalizations can be made to Black males, in general, or older Black male foster youth and alumni, in particular. In addition, no causal inferences can be made due to the study's cross-sectional and correlational research design. Notably, a few of the scales used in this study were purposely modified for research purposes and to simplify their use. Hence, their psychometric properties were altered, which may have compromised their validity. Furthermore, a few measures had reliability estimates that were marginal. Thus, the findings should be viewed with this in mind.

A central limitation of this study is its failure to account for general stress and other stressful life events (e.g., Klonoff, Landrine, & Ullman, 1999; Pieterse & Carter, 2007). The extent to which negative social contextual stressors make an independent contribution to somatic symptoms after accounting for general life stressors could not be answered by this study. We also could not determine whether negative social contextual stressors have an indirect effect on somatic symptoms by influencing the stress state (e.g., perceived stress) of participants. Studies that account for a range of stressors will be valuable for unraveling the contribution of negative social contextual stressors to the physiological and psychological well-being of young Black males.

This study also has a number of strengths. Although it relies on a subset of the population, Black males in foster care, this is a population that is disproportionately represented in the child welfare system and often cross-system involved in special education and the juvenile justice system. Thus, their experiences may represent a larger portion of the population. This study also used hierarchical regression analyses. By employing this analytical method, we were able to examine the possible predictors successively from a theoretical perspective while also using statistical controls. It was also possible to identify the amount of variance that was attributable for each group of variables thus shedding light on the level of influence that each variable had on the outcome. Finally, this study explores an understudied but important topic. The societal challenges experienced by Black males are significant and increasingly acknowledged throughout popular media outlets such as in magazines including *Essence* (Amber 2012) and *Ebony* (Powell, 2012), in newspapers such as the *Chicago Sun Times* (Fountain, 2006), in television shows such as *The Wire* (Simon & Kostroff-Noble, 2002–2008), and in films such as *Do the Right Thing* (Lee, 1989) but are less explored in research. This study contributes to that small but necessary area of research and does so by shedding light on how such negative ascriptions and experiences are connected to the somatization experienced by some Black males.

Future Research Directions

Future research might pursue several important directions in this area. For example, additional research is needed before conclusions can be made about the coexisting factors that might explain the greater somatic complaints among those meeting diagnostic criteria for conduct disorder. Studies that account for a range of stressors will be valuable for unraveling the contribution of negative social contextual stressors to the physiological and psychological well-being of young Black males. Furthermore, the investigation of the potential moderating and mediating effects of internal and external factors on the relationship between negative social contextual stressors and somatic symptoms as well as other biopsychosocial outcomes is vital. Physiological or psychological stress responses such as somatic symptoms are likely to vary among adolescent and young Black males based on internal factors such as their levels of self-esteem, self-efficacy, spirituality, hostility, and perceived control. External factors such as the size and closeness of their social networks and the extent to which they are embedded in or have access to community and organization supports can also be implicated (Clark, Anderson, Clark, & Williams, 1999; Harrell, 2000; Outlaw, 1993). For example, somatic symptoms in our study may have been greater among young Black males who were low in self-efficacy or high in hostility. Studies among varied clinical and community samples of adolescent and young adult Black males are needed to determine whether the findings can be replicated.

Finally, in this study, we were unable to assess how recent experiences of abuse and/or neglect occurred. There is evidence that clinical outcomes may be impacted by how recent one experiences child maltreatment (e.g., Kaplow & Widom, 2007). Thus, future research should explore the occurrence of multiple instances of child maltreatment and evaluate the impact over time.

CONCLUSION

Stressors emanating from the proximal and distal environments that young Black males navigate daily may significantly influence their emotional and physiological well-being. Helping them navigate the conundrum of feelings and emotions engendered by negative social contextual stressors is imperative for their well-being. As asserted by Stevenson (2004), the internalization of negative ascriptions can lead to behaviors detrimental to themselves and to others. Ironically, the engagement in risky behaviors and the adoption of aggressive postures that emerge as means of coping and self-protection can serve to foster and exacerbate negative ascriptions. Assuming a self-protective posture, furthermore, may trigger confrontations that sadly lead to life and death consequences.

In his study among adolescent Black males with a history of anger and aggression, Stevenson (2004) found that those reporting greater racial socialization messages from parents tended to show a lower inclination to react angrily to rejection experiences. Socialization about the racial landscape of American society and preparation to navigate it is generally considered essential for adolescent and young adult Black males. Stevenson (2004) asserted that much of this preparation needs to emanate from the home in that educational and mental health systems are ill equipped to do so. Nevertheless, as illustrated in the earlier quote of James, a 15-year-old Black male (Powell, 2012), some of the

messages received from parents and other concerned adults may be bewildering and actually contribute to the conundrum of how to react and respond to negative social contextual stressors.

In the *Essence* article “The Danger Outside,” which addressed the issue of how young Black males can keep themselves safe in the wake of the Trayvon Martin shooting, Amber (2012) noted that the fear of what will happen to adolescent and young adult Black males in the public places of their proximal and distal contexts is an ever-present concern among parents. Among the recommendations highlighted is the provision of spaces and opportunities for young Black males to emote their fears and frustrations. This can be cathartic and beneficial to their psyches by alleviating anger and hostility and can serve to abate responses that induce high levels of stress reactivity. Furthermore, utilizing popular mediums (e.g., rap music, movies, television, and news broadcasts) to enhance critical consciousness is important to consider in helping them channel their emotions, anger, and energy (Watts, Abdul-Adil, & Pratt, 2002). Addressing the larger societal perceptions of young Black males and the specific and general fears that their presence elicits cannot be left out of the equation, albeit eradicating longstanding and entrenched societal perceptions and reactions is no short order. Nonetheless, it is imperative that civic, community-based, as well as public education efforts be undertaken to do so.

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TABLE 1

Means, Standard Deviations, Skewness, and Ranges for Primary Study Variables

Variable	M	SD	Skewness	Obtained Range	Possible Range
Anger					
Anger expression	12.60	4.11	.67	6.00–24.00	6.00–24.00
Anger control	10.72	2.84	.06	5.00–16.00	4.00–16.00
Anger: total score	17.89	6.01	.19	6.00–33.00	0–40.00
Maltreatment					
Physical abuse: total score	9.62	5.03	.88	0–21.00	0–25.00
Physical neglect: total score	9.05	4.34	.71	0–22.00	0–25.00
Emotional abuse: total score	10.51	5.38	.69	0–25.00	0–25.00
Negative social contextual experiences					
Proximal negative experiences	2.89	1.03	–.01	1.00–5.00	1.00–5.00
Distal negative experiences	2.05	.67	.47	1.00–3.75	1.00–5.00
Negative inference experiences	2.88	.93	–.08	1.00–4.80	1.00–5.00
Overall NSCE: mean score	2.57	.77	.03	1.00–4.24	1.00–5.00
Somatic symptoms					
Cardiovascular/general symptoms	1.35	.35	1.52	1.00–2.70	1.00–4.00
Sleep disturbances	1.86	.78	.97	1.00–4.00	1.00–4.00
Overall CASD: mean score	1.50	.42	1.16	1.00–2.86	1.00–4.00

TABLE 2

t-Tests of Difference in Somatic Symptoms by Categorical Variables

Variable	Somatic Symptoms
	<i>M (SD)</i>
Custody status at baseline	
Not in MCD custody (<i>n</i> = 29)	1.56 (.54)
In MCD custody (<i>n</i> = 43)	1.45 (.32)
Custody differences (<i>t</i>)	1.02
Sexual abuse history	
No (<i>n</i> = 62)	1.50 (.42)
Yes (<i>n</i> = 10)	1.44 (.44)
Sexual abuse differences (<i>t</i>)	.43
Oppositional defiant disorder	
No (<i>n</i> = 52)	1.46 (.41)
Yes (<i>n</i> = 20)	1.58 (.45)
Oppositional defiant disorder differences (<i>t</i>)	−1.03
Conduct disorder	
No (<i>n</i> = 59)	1.43 (.36)
Yes (<i>n</i> = 13)	1.81 (.53)
Conduct disorder differences (<i>t</i>)	−2.44 *
Major depressive disorder	
No (<i>n</i> = 62)	1.48 (.43)
Yes (<i>n</i> = 10)	1.57 (.33)
Major depressive disorder differences (<i>t</i>)	−.66
Attention deficit/hyperactivity disorder (AD/HD)	
No (<i>n</i> = 62)	1.47 (.42)
Yes (<i>n</i> = 10)	1.64 (.40)
AD/HD differences (<i>t</i>)	−1.19

*
 $p < .05$.

TABLE 3

Intercorrelations Among Primary Continuous Study Variables

	A	B	C	D	E	F	G
A. Anger expression	—						
B. Anger control	-.48***	—					
C. Physical abuse: total score	.12	-.06	—				
D. Physical neglect: total score	-.14	.19	.29*	—			
E. Emotional abuse: total score	.18	-.10	.71***	.32***	—		
F. Negative social contextual experiences	-.30**	-.09	-.06	-.02	-.17	—	
G. Somatic symptoms	.24*	-.05	-.12	-.08	.09	.40***	—

* $p < .05$;

** $p < .01$;

*** $p < .001$.

TABLE 4
Summary of Hierarchical Regression Analysis Predicting Somatic Symptoms (CASD Total)

Variable	Step 1		Step 2		Step 3	
	R^2	β^c	R^2	β^c	R^2	β^c
Background characteristics	.01		.14		.07	
Custody status at baseline ^a		-.16		-.14		-.08
Physical and emotional abuse		.18		-.02		-.02
Physical neglect		-.15		-.11		-.10
Sexual abuse ^b		-.10		-.08		-.04
Psychological characteristics						
Anger expression				.23		.15
Anger control				.13		.10
Oppositional disorder				-.14		-.15
Conduct disorder				.34 [*]		.26
Major depression				.05		.11
Attention deficit/hyperactivity disorder				.14		.07
Negative social contextual experiences						.31 [*]

^aComparison category is Not in Custody.

^bComparison category is No History of Sexual Abuse.

^cStandardized coefficients presented in regression steps.

^{*} p .05.