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Invisible Effects of Partner Psychological Aggression

Abstract

Partner psychological aggression has been shown to be positively correlated with psychological distress and low self-esteem for women. This study adds to the existing literature by including research on men since very little research had been done on the effects of partner psychological aggression and the self-esteem of men. However, there were a limited number of men who participated in this study and who endorsed experiencing partner psychological aggression. Hierarchical regression analyses were conducted with data from 153 males and females ($N = 153$) from national colleges and community samples to explore the relationship amongst partner psychological aggression, psychological distress as measured by depression and PTSD, self-esteem, and self-compassion. In this study, it was hypothesized that partner psychological aggression could predict psychological distress, as specifically measured by depression and posttraumatic stress disorder (PTSD). Results concluded that partner psychological aggression could predict depression but not PTSD for women and it was not predictive of psychological distress for men. Self-esteem and self-compassion were hypothesized and found to be significantly negatively correlated with psychological distress and believed to buffer against the impact of psychological distress. Looking more closely, it was found that self-esteem was not predictive of depression for men and self-compassion was not predictive of PTSD for men. Furthermore, it was hypothesized and found that individuals who experienced partner psychological aggression and also endorsed lower levels of self-esteem and self-compassion were more likely to also exhibit symptoms of depression and PTSD. Additional clinical implications, limitations, and suggestions for future research are also included.

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the Faculty of the Morgridge College of Education

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Galana T. Chookolingo

August 2016

Advisor: Ruth Chu-Lien Chao, Ph.D.

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ABSTRACT

Partner psychological aggression has been shown to be positively correlated with psychological distress and low self-esteem for women. This study adds to the existing literature by including research on men since very little research had been done on the effects of partner psychological aggression and the self-esteem of men. However, there were a limited number of men who participated in this study and who endorsed experiencing partner psychological aggression. Hierarchical regression analyses were conducted with data from 153 males and females ($N = 153$) from national colleges and community samples to explore the relationship amongst partner psychological aggression, psychological distress as measured by depression and PTSD, self-esteem, and self-compassion. In this study, it was hypothesized that partner psychological aggression could predict psychological distress, as specifically measured by depression and posttraumatic stress disorder (PTSD). Results concluded that partner psychological aggression could predict depression but not PTSD for women and it was not predictive of psychological distress for men. Self-esteem and self-compassion were hypothesized and found to be significantly negatively correlated with psychological distress and believed to buffer against the impact of psychological distress. Looking more closely, it was found that self-esteem was not predictive of depression for men and self-compassion was not predictive of PTSD for men. Furthermore, it was hypothesized and found that individuals

who experienced partner psychological aggression and also endorsed lower levels of self-esteem and self-compassion were more likely to also exhibit symptoms of depression and PTSD. Additional clinical implications, limitations, and suggestions for future research are also included.

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TABLE OF CONTENTS

Chapter One: Introduction	1
Overview and Background	1
Statement of the Problem.....	6
Chapter Two: Literature Review	13
Overview.....	13
Types of Partner Aggression.....	19
Partner Psychological Aggression and Physical Aggression.....	19
Partner Psychological Aggression and Sexual Aggression	20
Partner Psychological Aggression and Its Potential Consequences	20
Depression and Suicidality	23
Anxiety and Posttraumatic Stress Disorder	26
Substance Misuse.....	28
<i>Hypothesis One</i>	28
Self-Esteem Within Partner Psychological Aggression and Psychological Distress	29
<i>Hypothesis Two</i>	33
Self-Compassion Within Partner Psychological Distress and Psychological Distress.....	34
<i>Hypothesis Three</i>	37
Research on Men.....	38
<i>Hypothesis Four</i>	41
List of Hypotheses	41
Chapter Three: Method.....	44
Participants.....	44
Measures.....	47
Demographic Questionnaire	47
Composite Abuse Scale.....	48
Center for Epidemiological Studies Depression Scale.....	50
Trauma Screening Questionnaire.....	53
Rosenberg Self-Esteem Scale	55
Self-Compassion Scale Short Form.....	57
Procedure.....	60
General Procedures for the Statistical Analyses	61
Testing Hypothesis One	65
Testing Hypothesis Two.....	66
Testing Hypothesis Three	66
Testing Hypothesis Four	67

Chapter Four: Results	68
Overview	68
Data Preparation	69
Analysis of Missing Data	69
Initial Data Exploration	70
Analysis of the Assumptions of Multiple Regression.....	73
Analysis of the Primary Research Hypotheses.....	74
Hypothesis One	74
Hypothesis Two.....	80
Hypothesis Three.....	85
Hypothesis Four	91
Chapter Five: Discussion	99
Overview and Discussion of Hypotheses.....	99
Clinical Implications.....	111
Limitations	119
Future Research	121
Concluding Remarks.....	123
References	124
Appendices	149
Appendix A: Glossary	149
Appendix B: Demographic Information	161
Appendix C: Composite Abuse Scale	162
Appendix D: Center for Epidemiologic Studies Depression Scale	165
Appendix E: Trauma Screening Questionnaire.....	166
Appendix F: Rosenberg Self-Esteem Scale	167
Appendix G: Self-Compassion Scale Short Form	168
Appendix H: Project Information Sheet.....	169

LIST OF TABLES

Table 1: Overview of Demographic Variables	46
Table 2: Type of Aggression Experienced within Relationship (in past 12 months-CAS	49
Table 3: Type of Aggression Experienced within Relationship by Gender using CAS....	50
Table 4: SCS	60
Table 5: Depression Experienced by Gender; PTSD Experienced by Gender	63
Table 6: Correlations, Means, Standard Deviations, and Significance Levels	71
Table 7: Overview of Variables by Experiences of Partner Psychological Aggression: Means, Standard Deviations, Skewness, and Kurtosis	71
Table 8: Correlational Analysis of all Variables by Experience by Gender.....	72
Table 9: Hierarchical Multiple Regression of Depression on Partner Psychological Aggression	75
Table 10: Hierarchical Multiple Regression of PTSD on Partner Psychological Aggression	76
Table 11: Hierarchical Multiple Regression of Depression on Partner Psychological Aggression by Gender.....	78
Table 12: Hierarchical Multiple Regression of PTSD on Partner Psychological Aggression by Gender.....	79
Table 13: Hierarchical Multiple Regression of Depression on Self-Esteem.....	81
Table 14: Hierarchical Multiple Regression of PTSD on Self-Esteem.....	82
Table 15: Hierarchical Multiple Regression of Depression on Self-Esteem by Gender ...	83
Table 16: Hierarchical Multiple Regression of PTSD on Self-Esteem by Gender	85
Table 17: Hierarchical Multiple Regression of Depression on Self-Compassion.....	86
Table 18: Hierarchical Multiple Regression of PTSD on Self-Compassion.....	87
Table 19: Hierarchical Multiple Regression of Depression on Self-Compassion by Gender	89
Table 20: Hierarchical Multiple Regression of PTSD on Self-Compassion by Gender....	91
Table 21: Hierarchical Multiple Regression of Depression	92
Table 22: Hierarchical Multiple Regression of PTSD	93
Table 23: Hierarchical Multiple Regression of Depression by Gender	96
Table 24: Hierarchical Multiple Regression of PTSD by Gender	98

CHAPTER ONE

Introduction

The Centers for Disease Control (CDC, 1999) has defined psychological aggression or emotional abuse as "trauma to the victim caused by acts, threats of acts, or coercive tactics," which includes a multitude of behaviors (p. 61). In 2015, this definition was updated to include the "use of verbal and non-verbal communication with the intent to: a) harm another person mentally or emotionally, and/or b) exert control over another person" (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 15). Some of these behaviors include humiliation, control, withholding information, expressed annoyance, disregard of the survivor's wants, isolation, threats, and destruction of property. It also includes deliberate attempts at making the survivor feel diminished or embarrassed, using the survivor's money or taking advantage of the survivor, prohibiting the survivor to access transportation or the telephone or money, encouraging the survivor to engage in illegal activities, using the survivor's children to control the survivor's behavior, threatening the loss of child custody, or disclosing tarnishing information on the survivor's reputation (CDC, 1999). Currently, the CDC acknowledges survivors of psychological aggression to be predominantly women, and does not include this definition for men, typically because women are usually on the receiving end of

aggression and men are usually the perpetrators. However, this is not always the case, and this author believes that it is also important to study men because they too are survivors of partner psychological aggression.

Partner psychological aggression has primarily been studied as a type of behavior that occurs concurrently with physical aggression, including sexual coercion (Loring, 1994). Only recently, within the past two decades, have researchers begun to identify partner psychological aggression as a phenomenon that occurs in isolation of other forms of abuse as well (Sorsoli, 2004). The *Journal of Emotional Abuse* was founded in 1998, bringing attention to the prevalence of partner psychological aggression in the United States. Jewkes (2010) comments that partner psychological aggression may be more widespread because of the variety of forms it can take. Carney and Barner (2012) found in their systematic review of the literature that prevalence rates of partner psychological aggression hovered around 80% for both men and women. In large population samples to small community samples, from universities to clinical samples, partner psychological aggression has been found to be the most prevalent form of aggression, higher than physical and sexual aggression (Carney & Barner, 2012). Schumacher, Slep, and Heyman (2001) declared that partner psychological aggression is a much more difficult problem to predict than partner physical aggression because of how pervasive, recurring, and relatively invisible it usually is. It occurs so frequently that often times, the survivors themselves are not even aware they were experiencing psychological aggression.

Marshall (1999) identified three manifestations of partner psychological aggression, including obvious (e.g., calling a partner derogatory names), overt (e.g., dominating or stonewalling a partner), or subtle (e.g., undermining or isolating a partner).

For example, one study found that men might say things like, "You have an amazing potential to look great if you put more effort into your appearance," leaving their partners feeling like they were not living up to the standards set for them and feeling inadequate (Lammers, Ritchie, & Robertson, 2005, p. 48). In this study, when the men disapproved of the women in a subtle way, it was more difficult for their partners to recognize this as psychological aggression because they were so used to hearing it and it was not as obvious as directly calling them "fat" or "ugly." Even if women were not able to recognize this statement as psychological aggression, they did notice that they began to devalue themselves when they did not get the approval of their partners, which is one of the consequences of this type of subtlety in aggressive behavior.

Geffner and Rossman (1998) asserted that the costs of partner psychological aggression are not well-known and are likely different for each individual. Some consequences of partner psychological aggression include mental health problems or psychological distress (Ali, Oatley, & Toner, 1999; Dutton, 2009; Frieden, 2005; Loring, 1994; Sims, 2008; Weston, 2008), and health problems (Arias, 1999; Hathaway, Mucci, Silverman, Brooks, Mathews, & Pavlos, 2000; Loring, 1994; Sims, 2008; Sutherland, Bybee, & Sullivan, 2002). Chen, Williams, Fitness, and Newton (2008) found that reliving a past socially painful event was more excruciating than reliving a past physically painful event. When asked to recall a painful event that occurred within the past five years, the authors found that the embarrassment and shame assigned to the socially painful event contributed to it being more long-lasting. Physical bruises and broken bones seem to heal quicker than continued negative views and beliefs associated with partner psychological aggression, which can last for a long time even after the

relationship may have ended, discrediting the common phrase, "*Sticks and stones may break my bones but words will never hurt me.*"

Physical symptoms are often present for individuals experiencing partner psychological aggression. Women in one study who were survivors of partner aggression mentioned that they experienced physical pain including "headaches, injuries, weight issues, immune dysfunction, and breathing problems" as well as ongoing psychological distress including "depression, anxiety, paranoia, panic attacks and flashbacks" (Cerulli, Poleshuck, Raimondi, Veale, & Chin, 2012, p. 777). In another study, Dutton (2009) found a link between partner psychological aggression and posttraumatic stress disorder (PTSD) and depression in women. Psychological distress symptoms such as PTSD and depression could also lead to suicide attempts to end the psychological pain that women experienced (Kaslow, Thompson, Okun, Price, Young, Bender, Wyckoff, Twomey, & Goldin, 2002).

In the population experiencing partner psychological aggression, it is important to examine the associations between their self-esteem and psychological distress as well as the associations between their levels of self-compassion and psychological distress. Self-esteem encompasses the way an individual feels about the self in comparison to others. Self-compassion consists of "kindness, a sense of common humanity, and mindfulness" (Germer & Neff, 2013). Self-compassion is important when considering personal inadequacy, failures, or mistakes that we make and how we treat ourselves on these occasions. The two constructs of self-esteem and self-compassion are significantly correlated and range from $r = .56$ (Leary, Tate, Adams, Batts, & Hancock, 2007) to $r = .68$ (Neff & Vonk, 2009). MacBeth and Gumley (2012) found that higher levels of self-

compassion were related to lower levels of psychological distress. Barnard and Curry (2011) suggest that future research be done to "determine the direction of the relationship between self-compassion and psychological health" and encourage that this be done in more diverse samples (p. 302). This research aimed to contribute to the body of knowledge that exists on self-compassion.

Males have often been a neglected population in terms of the impact of partner psychological aggression (Saunders, 2002; Simonelli & Ingram, 1998). Indeed, men received different levels of attention in varied studies. In one study, Simonelli and Ingram (1998) found that 90% of the men in their sample reported being a survivor of partner psychological aggression within the past year, which they note as consistent with other research findings. They also found that men who reported higher levels of partner psychological aggression and partner physical aggression also reported higher levels of psychological distress (Simonelli & Ingram, 1998). This is similar to the research on women. For both genders, partner psychological aggression is typically related to higher levels of depression and anxiety.

Saunders (2002) describes women as being equally as psychologically aggressive as men, although Saunders did not believe that violence against men by women constituted a major social problem. Saunders (2002) states that studies which claim equality of partner psychological aggression between men and women are not taking into account that women may be acting in self-defense or the aggressive behavior is due to retaliation. Hines, Brown, and Dunning (2007) looked at the characteristics of men that called an intimate partner violence helpline and found that those male survivors tended to resemble female survivors of severe partner psychological aggression. Similar to women,

men also experience control and physical aggression from their wives. Additionally, men have their own unique experiences dealing with the system that was created to help women and which can minimize a man's experience with partner psychological aggression. For example, men may run into operators on the helpline who may not take them seriously when they reveal that they are experiencing partner psychological aggression by a female partner.

In summary, partner psychological aggression is important to study because it occurs frequently by both men and women in relationships, and is often an antecedent for other forms of aggression, such as physical or sexual aggression. Even with how frequently partner psychological aggression occurs, this is still a relatively new area of study. The impact of partner physical aggression or sexual aggression on psychological distress has been explored more regularly than the impact of partner psychological aggression on psychological distress. Therefore, this study aimed to investigate how partner psychological aggression, survivor's self-esteem, and survivor's self-compassion impact the level of the survivor's psychological distress as measured by depression and PTSD. This author believed that within the population experiencing partner psychological aggression, increased levels of self-esteem and self-compassion would serve as a buffer against psychological distress for both women and men.

Statement of the Problem

The National Intimate Partner and Sexual Violence Survey (NISVS; Black, 2011) reported that partner psychological aggression is the most common form of intimate partner violence. The present study aimed to focus on partner psychological aggression and its impact on an individual's level of psychological distress within heterosexual

relationships. This study also looked at how self-esteem and self-compassion were related to psychological distress when the partner experienced psychological aggression. This author believed that higher levels of self-esteem and higher levels of self-compassion would serve as a buffer against psychological distress.

The purpose of this study was to better understand the roles of self-esteem and self-compassion for those who have experienced partner psychological aggression within heterosexual relationships and how those factors impacted a person's level of psychological distress as measured by depression and PTSD. One hope is that this clearer understanding would help guide treatment for those currently experiencing partner psychological aggression or who have experienced it in the past. Since psychological aggression tends to transcend all other types of aggression, this insight would help to enhance the therapeutic process and aid with therapeutic intervention. Additionally, since psychological aggression is strongly correlated with other types of aggression which individuals are likely to seek treatment for, this author hopes that we would be able to recognize the symptoms of partner psychological aggression so therapeutic interventions could be designed to aid with increasing psychological health and preventing negative outcomes such as suicide. It was believed that higher self-esteem and higher self-compassion would help the survivor feel less psychological distress and more empowered within the relationship if they chose to stay, or empowered to make the decision to leave. Therefore, therapeutic interventions would be aimed at helping the survivor increase their levels of self-esteem and self-compassion. Furthermore, it might prove beneficial to create a prevention program to help individuals be able to identify and recognize signs of partner psychological aggression earlier to build their resiliency and to help them be able

to make an informed decision if they encounter a partner who is psychologically aggressive.

The specific research questions this study aimed to address are as follows: 1a) Can partner psychological aggression significantly predict depression? 1b) Can partner psychological aggression significantly predict PTSD? 1c) Can partner psychological aggression significantly predict depression for women and men? 1d) Can partner psychological aggression significantly predict PTSD for women and men? 2a) For individuals experiencing partner psychological aggression, can self-esteem significantly predict depression? 2b) For individuals experiencing partner psychological aggression, can self-esteem significantly predict PTSD? 2c) For individuals experiencing partner psychological aggression, can self-esteem significantly predict depression for women and men? 2d) For individuals experiencing partner psychological aggression, can self-esteem significantly predict PTSD for women and men? 3a) For individuals experiencing partner psychological aggression, can self-compassion significantly predict depression? 3b) For individuals experiencing partner psychological aggression, can self-compassion significantly predict PTSD? 3c) For individuals experiencing partner psychological aggression, can self-compassion significantly predict depression for women and men? 3d) For individuals experiencing partner psychological aggression, can self-compassion significantly predict PTSD for women and men? 4a) Can partner psychological aggression, self-esteem, and self-compassion collectively significantly predict depression? 4b) Can partner psychological aggression, self-esteem, and self-compassion collectively significantly predict PTSD? 4c) Can partner psychological aggression, self-esteem, and self-compassion collectively significantly predict depression for women and

men? 4d) Can partner psychological aggression, self-esteem, and self-compassion collectively significantly predict PTSD for women and men?

In this study, psychological distress was measured by the variables of depression and PTSD. To answer the questions listed above, the author tested the following hypotheses: 1a) After controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression significantly predicts depression; 1b) after controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression significantly predicts PTSD; 1c) After controlling for the demographic variables of age, race, education level, and marital status, partner psychological aggression significantly predicts depression for women and men; 1d) after controlling for the demographic variables of age, race, education level, and marital status, partner psychological aggression significantly predicts PTSD for women and men; 2a) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem significantly predicts depression; 2b) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem significantly predicts PTSD; 2c) after controlling for the demographic variables of age, race, education level, and marital status, self-esteem significantly predicts depression for women and men; 2d) after controlling for the demographic variables of age, race, education level, and marital status, self-esteem significantly predicts PTSD for women and men; 3a) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion significantly predicts depression; 3b) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion

significantly predicts PTSD; 3c) after controlling for the demographic variables of age, race, education level, and marital status, self-compassion significantly predicts depression for women and men; 3d) after controlling for the demographic variables of age, race, education level, and marital status, self-compassion significantly predicts PTSD for women and men; 4a) after controlling for the demographic variables of gender, age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a statistically significant amount of variance in depression; and 4b) after controlling for the demographic variables of gender, age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a significant amount of variance in PTSD; 4c) after controlling for the demographic variables of age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a statistically significant amount of variance in depression for women and men; and 4d) after controlling for the demographic variables of age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a significant amount of variance in PTSD for women and men.

Using a sample of 153 females and males ($N = 153$), correlational analyses were conducted to determine the relationship between partner psychological aggression, self-esteem, self-compassion, and psychological distress as measured by depression and PTSD. Sixteen hierarchical linear regression analyses were run, four for each of the research questions. A hierarchical linear regression analysis was used to determine if

partner psychological aggression significantly predicted psychological distress. Since psychological distress was measured by two variables (depression and PTSD), two separate analyses were calculated for each part of the question. The data were then split by gender and the same two hierarchical linear regression analyses were run to determine if there was a difference by gender. For the second question, a hierarchical linear regression analysis was again used to determine if among the individuals experiencing partner psychological aggression, if self-esteem significantly predicted depression and then PTSD. Once again, the data were split by gender and the same analyses were run. For the third question, a hierarchical linear regression analysis was used to determine if among the individuals experiencing partner psychological aggression, if self-compassion significantly predicted depression and then PTSD. As previously done, the data were split by gender and the same analyses were conducted. For the first part of the fourth question, a hierarchical linear regression analysis was used to determine if significant variance in depression could be predicted by the collective variables of partner psychological aggression, self-esteem, and self-compassion. Another, a hierarchical linear regression analysis was used to determine if significant variance in PTSD could be predicted by the collective variables of partner psychological aggression, self-esteem, and self-compassion. Finally, each of those parts of the question was split by gender and hierarchical regression analyses were run once again.

One hundred fifty-three participants were recruited from colleges and public communities nationwide. The participant demographics were varied, given the diverse population they were sampled from. A survey including a demographic questionnaire, the Composite Abuse Scale, the Center for Epidemiologic Studies Depression Scale, the

Trauma Screening Questionnaire, the Rosenberg Self-Esteem Scale, and the Self-Compassion Scale-Short Form was completed by each participant. Hierarchical linear regression analyses were analyzed to determine the predictive effects of partner psychological aggression, self-esteem, and self-compassion on the level of psychological distress for survivors of partner psychological aggression.

CHAPTER TWO

Literature Review

Overview

There is no consensus on the formal definition of psychological aggression (Follingstad, 2007). In fact, partner psychological aggression is referred to by a multitude of terms, such as emotional abuse (Ali, 2007; Gavin, 2011; Geffner & Rossman, 1998; Sims, 2008), verbal aggression (Straus & Sweet, 1992), psychological abuse (Aguilar & Nightingale, 1994; Arias, 1999; Geffner & Rossman, 1998; Gormley & Lopez, 2010; Pipes & LeBov-Keeler, 1997), intimate partner violence (IPV; Carney & Barner, 2012; Cerulli et al., 2012; Crane & Eckhardt, 2013; Smith, 2003), interpersonal violence (Dutton, 2009), and psychological maltreatment (Jezl, Molidor, & Wright, 1996; Tolman, 1989). Follingstad (2007) advocates for the use of the term psychological aggression stating that "abuse" is difficult to identify and because psychological aggression covers a range of damaging behaviors. This paper will use the term *partner psychological aggression* to describe the abuse experienced by the survivor that is initiated by his or her intimate partner, whether verbal or nonverbal.

Loring (1994) stated that a pattern of psychologically damaging behaviors needs to be present in order to claim that it is psychological aggression. Marshall (1994) is more

liberal in her definition and declared that the potential to hurt someone by saying something that could be taken as harmful should be labeled as psychological aggression. In a qualitative study, Lammers et al. (2005) combined these two definitions to describe partner psychological aggression as:

The patterned non-physical degradation of one person by their partner through the conscious or unconscious gaining, regaining or maintaining of power through the repetitive overt or subtle acts and messages that control or attempt to control, which negatively affects the abused partner's emotions or self-value in the long term. (p. 31)

At some point in their dating lives, 20-37% of individuals will experience some kind of aggression within their relationship, but only about half of these relationships will end after the aggressive behavior has occurred (Truman-Schram, Cann, Calhoun, & Vanwallendael, 2000). In fact, many of these relationships result in marriage, and this tends to be confusing for some bystanders. Researchers have looked at partner psychological aggression and have determined that this type of aggression is often difficult to recognize and the effects tend to go unnoticed (Loring, 1994). However, since the early 1990s, some researchers have started to take a look at the different forms psychological aggression can take and how damaging it can be for the survivor.

In an effort to study and measure psychological aggression, Hart and Brassard (1990) identified six categories of psychological aggression for children, and Geffner and Rossman (1998) applied these categories to adults. These six categories include spurning; exploiting or corrupting; terrorizing; denying emotional responsiveness; isolating; and neglect of mental health, medical health, and education. Spurning is the use of verbal or nonverbal degradation. Exploiting or corrupting is encouraging behavior that is self-destructive. Terrorizing is threatening the individual or the loved ones of the individual.

Denying emotional responsiveness suggests either completely ignoring the individual or interacting with them without emotion. Isolating is preventing interaction with others outside of the home. Neglect of mental health, medical health, and education is denying access to these necessary resources.

Similarly, Murphy and Hoover (1999) identified four categories of psychological aggression: restrictive engulfment, hostile withdrawal, denigration, and dominance and intimidation. Murphy and Hoover (1999) define restrictive engulfment as:

Tracking, monitoring, and controlling the partner's activities and social contacts, along with efforts to squelch perceived threats to the relationship. This behavior pattern was consistently associated with signs of anxious and insecure attachment and a compulsive need for nurturance. (p. 49)

Hostile withdrawal involves intentionally withdrawing emotional contact in a punitive manner, similar to stonewalling. Denigration is actively humiliating and degrading the survivor. Dominance and intimidation is most like physical aggression in that it involves threats, property violence, and intense verbal aggression (Murphy & Hoover, 1999), but does not include physical violence to the individual's person.

The effects of partner psychological aggression in interpersonal relationships have profound impacts on the survivor's well-being and often coincide with other forms of aggression such as physical aggression and sexual coercion (Sims, 2008). Despite the prevalence of partner psychological aggression within intimate relationships, it is still an area that is not widely recognized and often undertreated (Carney & Barner, 2012). Jewkes (2010) claims that partner psychological aggression is important to study because it "generates fear and anxiety, removes social support, impoverishes, and undermines self esteem" (p. 851). Previous research has identified that partners who experience

psychological aggression tend to also experience lower levels of psychological well-being (Anderson & Saunders, 2003; Frieden, 2005; Murphy & Hoover, 1999), diminished self-esteem and self-worth (Sims, 2008), and lack of self-compassion (Neff, 2003a; Neff, 2003b). The role of self-compassion in the survivor's life has not been thoroughly researched at this time, however preliminary studies show that self-compassion could be a targeted area for prevention of experiencing the psychological distress associated with partner psychological aggression.

Previous research suggests that partner psychological aggression can be just as damaging as physical aggression, and may even be "the key toxic ingredient in all forms of abuse, aggression, and human oppression" (Geffner & Rossman, 1998, p. 4). Jewkes (2010) notes that partner psychological aggression takes many forms including "verbal abuse, threats of violence, engendering fear, humiliation, destruction of property, enforcement of social isolation, taking or withholding earnings, and flaunting other sexual partners" (p. 851). Partner psychological aggression has also been found to predict physical aggression in college dating relationships (Gormley & Lopez, 2010). These authors found that partner psychological aggression can result in depression and increased suicide risk, an increase in dependency, and a diminished sense of self (Gormley & Lopez, 2010).

Partner psychological aggression tends to receive less attention than partner physical aggression and partner sexual aggression. Because of this, survivors of partner psychological aggression do not often seek out counseling and frequently do not realize they have been experiencing psychological aggression (Sorsoli, 2004). When they do seek out counseling, it has been the norm for counselors to encourage the client to

address the reality of the aggression and its impact, to work on self-expression, and to empower the client to work on transforming into a new self (Loring, 1994). Ali (2007) identified partner psychological aggression as a potential catalyst for metamorphosis, aiding with leaving the harmful relationship and making life-altering changes.

As mentioned earlier, Marshall (1999) identified three ways partner psychological aggression could be displayed: obvious, overt, or subtle. Marshall explains that obvious partner psychological aggression is verbal aggression and dominating acts or statements that are easy to detect and are interpreted as harmful. An example of this is a woman putting her husband down by telling him that he is not smart enough for her. Overt partner psychological aggression is less obvious aggression and refers to those statements that are potentially harmful and may be noted by an observer. The survivor may easily identify the act or the resulting feeling, usually anger towards the partner, and it may affect their view of the relationship but may have some difficulty recognizing the act as partner psychological aggression. Subtle partner psychological aggression is more difficult for an observer to see and the survivor usually has trouble with both identifying the act as well as the resulting feeling. As Marshall describes, "acts such as undermining a woman's self-esteem and [causing] her to question her judgment" would be considered subtle partner psychological aggression (Jones, Davidson, Bogat, Levendosky, & von Eye, 2005, p. 408). Subtle partner psychological aggression may affect an individual's "sense of self and...mental health and well-being" and is dangerous because the partner tends to be oblivious to the cause of the psychological distress (Marshall, 1999, p. 71) but may recognize feelings of distress even without knowing the cause. In order to differentiate and study psychological aggression and its effects, Marshall (1999) created

the Subtle and Overt Psychological Abuse Scale (SOPAS), which assesses both subtle and overt forms of psychological aggression. Marshall (1999) found that subtle psychological aggression was more harmful than more overt forms of psychological aggression. However, one study by Jones et al. (2005) found that the SOPAS does not accurately discriminate between these forms of psychological aggression and indicated that this scale showed high convergent validity with Tolman's Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999), which measures psychological aggression as a singular variable. Jones et al. (2005) argued that the SOPAS should show a higher level of discriminant validity if it actually assessed psychological aggression as two distinct variables. This research gives an indication of how difficult partner psychological aggression is to measure, and how complex the variable actually is.

Psychological aggression may be present in relationships for a variety of reasons. Holtzworth-Munroe, Smutzler, and Bates (1997) did a comprehensive review of the literature on partner psychological aggression and found several factors that contributed to aggressive behavior within relationships, including anger, alcohol misuse, violence within the family of origin, lack of resources, difficulty in problem-solving and communication patterns, attitudes about violence, and psychopathology. Women in this study were more likely than men to experience psychologically distressing symptoms such as depression and PTSD, and children experienced a range of psychological and behavioral problems (Holtzworth-Munroe et al., 1997). This author believes that in the approximately two decades since this review article, there has been a shift in levels of psychological distress for men or at least in the reporting of these events. This present

study hypothesized that men also experience psychological distress after experiencing partner psychological aggression.

Types of Partner Aggression

Several types of partner aggression exist and the differences are worth mentioning in some detail. They include physical, sexual, and psychological aggression. The appendix will include a more thorough definition of each of these aggressive behaviors. Often, physical and sexual aggressions also include psychological aggression, which is one of the reasons why psychological aggression has been so rarely researched on its own. Among these types of aggression, psychological aggression is the most neglected in the research and therefore it is very critical that it is addressed.

Partner Psychological Aggression and Physical Aggression.

While it may be largely ignored in research, partner psychological aggression leaves its impact on the survivors. In a recent systematic review of literature, Esquivel-Santoveña, Lambert, and Hamel (2013) discovered that survivors often report the psychological and behavioral effects of aggression. Psychologically distressing symptoms include "PTSD symptomatology, stress, depression, irritability, feelings of shame and guilt, poor self-esteem, flashbacks, sexual dissatisfaction and unwanted sexual behavior, changes in eating behavior, and aggression" (p. 60). They also found that partner psychological aggression impacts the person's physical health and sleeping patterns, a mother's reproductive health, and children tend to experience diarrhea, persistent coughing, and fevers (Esquivel-Santoveña et al., 2013).

Sullivan, McPartland, Armeli, Jaquier, and Tennen (2012) established a clear link between physical and psychological aggression noting that the odds of experiencing

partner physical aggression was 64 times greater on days when the survivor also experienced partner psychological aggression. In their exhaustive literature review, Esquivel-Santoveña et al. (2013) found that worldwide, "35.8% of women and 21.7% of men report having been physically assaulted by an intimate partner at some point in their lifetime" (p. 7).

Partner Psychological Aggression and Sexual Aggression.

In a systematic review of the research, Carney and Barner (2012) found that 40% of women and 32% of men report experiencing partner psychological aggression, and 41% of women and 43% of men report experiencing some form of coercive control. They noted that for sexual coercion, 0.2% of men and 4.5% of women endorsed being sexually coerced and forced to have intercourse with their partner (Carney & Barner, 2012). The Center for Disease Control's (CDC) numbers for women are disproportionate, with 18% of women and 1% of men reporting being raped in their lifetime (Black, 2011). Sullivan et al. (2012) reported that men rarely sexually assaulted women without also concurrently utilizing psychological aggression. Despite the increase in female perpetrated aggression, research is still limited in this area.

Partner Psychological Aggression and Its Potential Consequences

The pain caused by partner psychological aggression is long-lasting and is often relived by the individual time after time, whereas it may be more difficult to "mentally re-create physical pain" (Gavin, 2011, p. 504). Sorsoli (2004) noted that much of partner psychologically aggressive experiences tend to occur in private and therefore it is difficult to prove allegations of aggression. Since the scars of psychological aggression are typically unseen, it is also easier to deny or misinterpret them (Williams, Richardson,

Hammock, & Janit, 2012). To add to this invisibility, emotional pain is not readily accepted by society, and since it is so difficult to reproduce or explain, it is sometimes viewed as exaggerated or distorted in some way (Sorsoli, 2004). Even survivors of partner psychological aggression may "often report the symptoms of abuse without ever realizing, or being able to admit, that they have been abused" (Sorsoli, 2004, p. 13). Researchers have also looked at the effects of both psychological aggression and physical violence and reported that "victims often perceive the effects of psychological abuse as more detrimental than the effects of physical violence" (Gormley & Lopez, 2010, p. 4). And, when they report the experience of psychological aggression, few subjects in one study actually identified themselves as being survivors even though more individuals had experienced psychological aggression (Goldsmith & Freyd, 2005). Follingstad (2007) made the provocative statement indicating that partner psychological aggression is more likely to occur than not occur within dating and marital relationships. Additionally, Williams et al. (2012) found that survivors of partner psychological aggression perceive its effects to be longer-lasting than partner physical aggression.

Although not studied much, men also suffer psychological distress at the hands of women. One study attempted to review the literature regarding partner psychological aggression and its consequences and found "a relative dearth of research examining the consequences of psychological abuse for male survivors, and the results of those studies have been mixed" (Lawrence, Orengo-Aguayo, Langer, & Brock, 2012, p. 406). There are a few articles that looked at the perpetration of psychological aggression by women to men, yet they are often criticized because women still suffer more partner aggression from men, and some view these studies as marginalizing to women's experiences. When

it is acknowledged that women are sometimes perpetrators of several types of aggression, it is often believed that the women are acting in self-defense (Campbell, Miller, Cardwell, & Belknap, 1994; Saunders, 2002). Another reason often cited is that women who are aggressive are usually suffering from PTSD because of the intensity and severity of the aggression they themselves endured (Bourget & Gagné, 2012; Dutton, 1992; Kemp, Rawlings, & Green, 1991; Mele, Roberts, & Wolfer, 2011; Saunders, 1986).

The effects of partner psychological aggression can exacerbate an individual's psychological distress. Psychological distress can be defined as the negative effects on a person's mental health; the opposite of psychological health and well-being. Existing research has shown that partner psychological aggression is directly correlated with psychological distress and negative mental health outcomes. There is a link between partner psychological aggression and depression (Ali et al., 1999; Arias, Lyons, & Street, 1997; Cerulli et al., 2012; Hathaway et al., 2000; Mechanic, Weaver, & Resick, 2008), suicidality (Abbott, Johnson, Koziol-McLain & Lowenstein, 1995; Gormley & Lopez, 2010; Hathaway et al., 2000), anxiety (Cerulli et al., 2012; Gormley & Lopez, 2010, Hathaway et al., 2000), posttraumatic stress disorder (Arias & Pape, 1999; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Dutton, 2009; Gormley & Lopez, 2010; Mechanic et al., 2008), and substance misuse (Coker, Davis, Arias, Desai, Sanderson, Brandt, & Smith, 2002; Kaslow et al., 2002). Depression and posttraumatic stress disorder will be measured in this study as the variables of psychological distress, yet research on all of these symptoms of psychological distress will be explained briefly.

Depression and Suicidality.

Partner psychological aggression has been strongly related to an increase in depressive symptomatology for both men and women. In an early study, Rounsaville, Weissman, Prusoff, and Herceg-Baron (1979) found that many of the women presenting for outpatient therapy had experienced marital disputes, which led to depression in 53% of them. Ali et al. (1999) specifically looked at partner psychological aggression and its role on depressive symptomatology. Their participant sample included 40 self-referred women who attended the Women's Therapy Center at an urban, university hospital. They did not necessarily need a diagnosis to attend the clinic which offered free individual counseling services. At the time of the interview, 40% of the participants were diagnosed with clinical depression and 60% were not (Ali et al., 1999). Using the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbauch, 1961; Beck, Steer, & Garbin, 1988), they found that those participants who identified as experiencing "major emotional abuse" rated themselves significantly higher on the depression scale than those who identified as experiencing "no major emotional abuse" (Ali et al., 1999, p. 9). They also noted that those participants who met the diagnostic criteria for major depressive disorder were also survivors of more severe aggression than those who did not meet the criteria (Ali et al., 1999). This is one strong indicator that partner psychological aggression may be a precipitating factor for depression.

Christian, O'Leary, and Vivian (1994) used a sample of 139 couples who sought marital counseling at a clinic in New York to look at the relationship between marital discord and depression, and what variables might impact this relationship. Couples were given a set of self-report surveys that assessed variables such as marital satisfaction,

depression, and physical aggression. They found a positive correlation between marital discord and depression for both genders (Christian et al., 1994).

One study found that partner support played an interesting, somewhat counterintuitive role on depressive symptomatology for those who experienced partner psychological aggression. Arias et al. (1997) looked at how partner support affected the depression of the participant who experienced partner psychological aggression. They recruited 66 women from the community through radio advertisements and flyers. The women volunteered to help the researchers examine interactions between married couples, and were given a battery of self-report measures. In this sample, 88% of the participants endorsed partner psychological aggression and 18% endorsed partner physical aggression during the year prior to their participation in this study (Arias et al., 1997). These authors found that partner support within the aggressive relationship influenced levels of depression. The participants who "perceived more support and felt more efficacious in their relationships...experienced more depressive symptoms" (Arias & Pape, 1999, p. 206). The authors believe that participants who relied on their partners for support and intimacy responded with increased depression. This may be due to their conflicting experience with feeling supported and feeling aggressed against (Arias & Pape, 1999). Individuals who feel supported by their partners may feel more confused and therefore more depressed when their partners commit psychological aggression towards them than those individuals who do not feel supported by their partners.

Research has also focused on psychological aggression within the family of origin and its role on adult depressive symptoms. Beck (1987) hypothesized that depressive schema can originate in childhood and may be extended into adulthood. Norman,

Byambaa, De, Butchart, Scott, and Vos (2012) compiled a meta-analysis that looked at childhood psychological and physical aggression and its long-term effects on physical and psychological health. The authors, not surprisingly, found that those individuals who experienced physical or psychological aggression were at a higher risk of developing depressive disorders as adults than those who did not (Norman et al., 2012). Gibb, Alloy, Abramson, Rose, Whitehouse, Donovan, Hogan, Cronholm, and Tierney (2001) surveyed 145 students who were identified as being at high risk for depression and 152 students who were considered to be at low risk for depression, out of a total sample of 5,378 freshmen from Temple University and the University of Wisconsin who all experienced childhood aggression in some form. The authors found that childhood psychological aggression is significantly related to adult risk for depression, and that childhood psychological aggression uniquely contributed to the overall risk of depression more than childhood physical or sexual aggression, indicating that childhood psychological aggression is also harmful to the adult's psychological well-being.

The relationship between partner psychological aggression and depression has also been established, and the occurrence for suicidal ideation tends to be higher amongst those who are depressed as compared to those who are identified as having little to no symptoms of depression. In Thompson, Kaslow, and Kingree's (2002) study, a cumulative risk model was created using a sample of African American women. Risk factors for suicide attempts included "high levels of depressive symptomatology, hopelessness, and drug use, as well as... a history of childhood abuse or neglect" (Thompson et al., 2002, p. 292). Depending on the number of risk factors each individual acknowledged having, their risk for attempting suicide increased. With one risk factor,

there was no increased risk as compared to zero risk factors. With two risk factors, risk increased 10 times, 25 times with three risk factors, and an alarming 107 times for four to five risk factors. Devries, Mak, Bacchus, Child, Falder, Petzold, Astbury, and Watts (2013) conducted a meta-analysis to look at the link between partner aggression and depression and suicidality. In a review of sixteen studies, four of which included men, they found evidence relating partner aggression with depression and suicide attempts for women. They also found a relationship between partner aggression and depression for men, although there was no clear evidence to support the link between aggression and suicide attempts for men (Devries et al., 2013).

Anxiety and Posttraumatic Stress Disorder.

The National Institute of Mental Health explains that PTSD, an anxiety disorder:

Develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers. (NIMH, n.d.)

Causes of psychological trauma include experiencing natural disasters, being involved in accidents, sexual assault or rape, physical aggression, domestic violence, psychological aggression, or witnessing any of these things.

There is significant overlap between PTSD and Walker's (2006) Battered Women's Syndrome. Walker (2006) noted symptoms such as re-experiencing the aggressive events (e.g., flashbacks or nightmares), attempts to avoid the effects of the psychological aggression (e.g., with eating disorders, drug and alcohol use, avoiding people who reminded the individual about the event, numbed affect, etc.), hyperarousal

(e.g., increased startle response), problems with social relationships, and issues with intimacy or sexuality.

Some people are more vulnerable to developing symptoms of trauma than others. Some of the vulnerability factors include how severe the trauma is, how long it lasted, how close the person was to experiencing it, how dangerous it seemed, how many times the person has been traumatized, if the trauma was inflicted by other people (such as a rape), or how much negative reactions the person gets from friends and relatives (Foa, Davidson, & Frances, 1999). Arias and Pape (1999) looked at 68 women from several battered women's shelters in Atlanta, Georgia who experienced both partner physical and partner psychological aggression. All women were either married for at least one year (61%) or cohabitated with the aggressor for at least one year (39%). Using the Symptoms Checklist-90-Revised (SCL-90-R; Derogatis, 1977), the authors found that 60 women in that study (88%) met the diagnostic criteria for PTSD (Arias & Pape, 1999). PTSD was uniquely accounted for by partner psychological aggression when physical aggression was controlled for.

One study looked at the lasting effects of partner psychological aggression on women who were experiencing physical pain and psychological suffering, (e.g., anxiety, depression, and PTSD). Cerulli et al. (2012) recruited 31 women who experienced aggression within their relationship from a battered women's shelter, a domestic violence docket at family court, and community support groups. They used a biopsychosocial model to look at the woman as a whole in order to understand how physical symptoms could be related to psychological symptoms as well as social symptoms and vice versa. Cerulli et al. (2012) found a reciprocal relationship, stating that:

The inscription of pain on their bodies served as constant reminders of abuse, in turn triggering continual emotional and psychological pain and disrupting social relationships... Many women reported that pain sensations often served as triggers for retraumatization of their abuse experiences, because it reminded them of when the initial pain occurred. (p. 778)

Substance Misuse.

Psychological aggression and psychological distress might make an individual vulnerable to other variables such as substance misuse so mentioning this here is worthwhile. Substance misuse, particularly heavy alcohol use, is a risk factor for suicide attempts (Thompson et al., 2002). Coker et al. (2002) linked substance misuse, specifically heavy alcohol use, with both partner psychological aggression and partner physical aggression. When looking at the differences between men and women, they found that partner physical and partner psychological aggression were associated with recreational drug use for men, but not women (Coker et al., 2002). One study found that marijuana misuse was related to increased incidents of partner aggression, specifically insults and yelling for minorities and those with a low socioeconomic status (Stalans & Ritchie, 2007).

As a result of the existing research, this author examined the following hypotheses:

Hypothesis 1a) After controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression significantly predicts depression

Hypothesis 1b) After controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression significantly predicts PTSD

Hypothesis 1c) After controlling for the demographic variables of age, race, education level, and marital status, partner psychological aggression significantly predicts depression for women and men

Hypothesis 1d) After controlling for the demographic variables of age, race, education level, and marital status, partner psychological aggression significantly predicts PTSD for women and men

Self-Esteem Within Partner Psychological Aggression and Psychological Distress

Three types of self-esteem have been identified by Brown and Marshall (2006) including a) global self-esteem, b) feelings of self-worth, and c) self-evaluations. They described global self-esteem as *trait* self-esteem, referring to how people feel about themselves. This type of self-esteem is developed by cognitive evaluations of the self and is stable throughout the lifetime. Feelings of self-worth are a *state*-like self-esteem, which is affected by everyday occurrences and can change on a daily basis. Finally, self-evaluations are considered to be domain-specific. This means that if one is good at something (e.g., playing sports), he or she will have high athletic self-esteem. That same person could concurrently have low self-esteem when it comes to math. Taking the self into consideration, a measure of global self-esteem will be used in this study. This author believed that self-esteem would be a buffer for psychological distress for those individuals experiencing partner psychological aggression.

Much of the research that positively correlates low self-esteem with psychological distress has looked at survivors of physical violence. Cascardi and O'Leary (1992) examined 33 women in New York who sought treatment at a battered women's agency on levels of depression and poor self-esteem as it related to physical aggression. They found

that depression and low self-esteem were highly correlated with the "frequency, severity, and consequences of physical aggression" (Cascardi & O'Leary, 1992, p. 255).

Campbell et al. (1994) did a longitudinal study of 114 female survivors to look at the effects of long-term physical aggression over time. They characterized low self-esteem under the category of learned helplessness, and indicated that the women who were survivors of physical aggression experienced depression, problems with self-esteem, and inability to engage in self-care. They also identified that self-blame seemed to be more correlated with low self-esteem and depression (Campbell et al., 1994). Stets (1991) noted that those who have low self-esteem were more likely to accept physical aggression because they may feel like they deserve the aggression, and hypothesized that those who accepted partner physical aggression would likely accept psychological aggression as well especially given that they are usually experienced simultaneously.

Vissing and Bailey (1996) identified that partner psychological aggression is so devastating to the survivor because it could be done in a variety of ways and diminished the survivor's self-esteem. These authors acknowledged that partner psychological aggression could occur through jokes, blaming and belittling, ridiculing, criticizing, insulting, name-calling, making derogatory comments towards the survivor, arguing, through the use of silence or ignoring the survivor, and by making gestures or obvious threats towards the survivor (Vissing & Bailey, 1996).

Pipes and LeBov-Keeler (1997) wanted to find factors related to partner psychological aggression. They looked at 175 female college students and found that one correlate of partner psychological aggression is self-esteem. Specifically, women who reported being survivors of psychological aggression also had lower self-esteem. As with

this study, most research uses the variable of self-esteem as an outcome measure of psychological well-being but this dissertation used self-esteem as a predictor of psychological distress because this author believed that higher levels of self-esteem would help maintain psychological health and decrease psychological distress.

In more recent studies, partner psychological aggression has been shown to be harmful to one's self-esteem even after controlling for physical aggression (Gormley & Lopez, 2010; Mechanic et al., 2008). According to Gavin (2011), partner psychological aggression is defined as "any kind of behavior that is designed to psychologically subjugate, control, or harm the recipient" (p. 507). Again, they also note that partner psychological aggression can affect the individual's self-confidence and self-concept. Aguilar and Nightingale (1994) found a negative correlation between women who experience partner psychological aggression and their self-esteem. Interestingly, they found that aggression that is of a more controlling nature is more detrimental to self-esteem (Aguilar & Nightingale, 1994). Woods (1999) also found a moderate negative correlation between partner psychological aggression and self-esteem.

Follingstad, Rutledge, Berg, Hause, and Polek (1990) believed that psychologically aggressive threats to a woman's property would be the most negative form of partner psychological aggression due to the level of fear associated with these types of behaviors. In actuality, they found that ridicule was the most harmful psychologically aggressive behavior. They believe that this is because this type of partner psychological aggression impacts the woman's self-esteem and inhibits feelings of self-worth and self-compassion.

Lammers et al. (2005) conducted a qualitative study to look at women's experience of partner psychological aggression which theoretically will result in higher levels of self-distress. They surveyed seven Caucasian, lower-middle class, female participants, ages 25-60, who had experienced psychological aggression but had been out of their relationship for at least a year. Five out of the seven women in their study had been out of their relationship for about six to 11 years. They found that self-esteem was markedly reduced in all but one of the women who experienced partner psychological aggression in their study, even if the relationship ended years before (Lammers et al., 2005).

There is more evidence to show the context of partner psychological aggression. In one study, Stets (1991) found that women with low self-esteem are more likely to inflict psychological aggression on their partners than those with high self-esteem, and they are also more likely to endure partner psychological aggression. Weston (2008) found that psychological aggression had a more severe impact on self-esteem than physical aggression.

Jezl et al. (1996) looked at the relationship between self-esteem and partner psychological aggression in 257 high school dating relationships, for both males and females. Their study included 114 males and 118 females who have been in dating relationships. While 96% of the students had experienced partner psychological aggression, the authors found no relationship between self-esteem and psychological aggression for males in dating relationships, but they did find a significant relationship for females in dating relationships.

There are very few studies that look at the effects of partner psychological aggression on the self-esteem of men. One study found that males reported a higher level of partner psychological aggression than physical aggression, but hypothesized that women may not use physical violence as much due to socialization processes, meaning that women typically are the receivers of physical violence rather than the perpetrators (Kasian & Painter, 1992). This study also mentioned that women who used physical violence were probably using it in self-defense (Kasian & Painter, 1992). They also identified that males had a perception of what was appropriate female behavior that did not include psychological aggression, therefore the males may have been overestimating the degree of psychological aggression (Kasian & Painter, 1992). An earlier study found that the level of self-esteem in men who were survivors of aggression was no different than in men who were not survivors of aggression (Mills, 1984). This is contrary to another study which found "no gender differences [on self-esteem] in the percentages of males and females who reported perpetrating and receiving psychological aggression" (Hines & Saudino, 2003). This contradicting research warrants further examination. As a result of the existing research and mixed results, this author examined the following hypotheses:

Hypothesis 2a: After controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem significantly predicts depression

Hypothesis 2b: After controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem significantly predicts PTSD

Hypothesis 2c: After controlling for the demographic variables of age, race, education level, and marital status, self-esteem significantly predicts depression for women and men

Hypothesis 2d: After controlling for the demographic variables of age, race, education level, and marital status, self-esteem significantly predicts PTSD for women and men

Self-Compassion Within Partner Psychological Aggression and Psychological Distress

Barnard and Curry (2011) described the differences between self-compassion and self-esteem in their research. They acknowledge that the two measures are correlated but mention that they are also different enough to be unique constructs and measures of psychological health. These authors are supporters for more research on these measures, including mindfulness, to validate the construct of self-compassion.

Neff (2003b) advocated for using a measure of self-compassion rather than self-esteem as a measure of psychological health because self-esteem involves judgments and comparisons of the self. She also found that “self-compassion predicted more stable feelings of self-worth than self-esteem and was less contingent on particular outcomes” (Neff & Vonk, 2009, p. 23), although correlations between self-esteem and self-compassion were found to be $r = .68$ (Neff & Vonk, 2009). Smith (2003) found that in order to effectively recover from partner aggression, there are several strategies that survivors needed to learn. These included increasing social connectedness, gaining self-compassion, being assertive regarding what they want and do not want, and experiencing feelings like joy and excitement (Smith, 2003).

Self-compassion has been linked with measures of positive psychological health and well-being (Neff, 2003b). The opposite of self-compassion, self-criticism has been identified as a core component of depressive symptomatology (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1992). Self-blame has also been related to higher levels of depression in women who have left their aggressive partners (Cascardi & O'Leary, 1992), leading to the belief that those who have higher levels of self-compassion should experience greater psychological health and well-being and lower levels of self-criticism and self-blame. Self-blame is a negative emotional response whereas self-compassion promotes psychological well-being and health.

Neff, Kirkpatrick, and Rude (2007) examined the role of self-compassion on psychological health in two separate studies. The first study surveyed 91 undergraduates, both male and female, from a Southwestern university using self-report measures of self-compassion, self-esteem, negative affectivity, and anxiety. They found no gender differences on the measure of self-compassion and a significant negative correlation between self-compassion and anxiety (Neff et al., 2007). The second study surveyed 38 female and 2 male undergraduates to examine if there was a correlation between changes in self-compassion and changes in psychological health. Self-compassion was positively correlated with psychological health and negatively correlated with psychological distress (Neff et al., 2007). In a meta-analysis, MacBeth and Gumley (2012) looked at the relationship between self-compassion and psychopathology, specifically, anxiety, depression, and stress. In a review of twenty studies, they found a significant negative correlation ($r = -.54$) with a large effect size linking self-compassion with these measures of psychological distress.

Neff (2003b) described three main components for self-compassion, which includes self-kindness, common humanity, and mindfulness. Self-compassion is defined by Neff et al. (2007), as:

Being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical; perceiving one's experiences as part of the larger human experience rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them. (p. 139)

Because of this research, this author believed that self-compassion would be a buffer for psychological distress.

Neff and Germer (2013) developed a program called Mindful Self-Compassion (MSC) to teach the skills of self-compassion to the general public. This program incorporated the use of modeling by the instructors, homework assignments, and in-class experiential exercises that would elicit emotions. Sometimes, individuals experienced uncomfortable emotions, so the authors recommended that an experienced clinician run these classes. Neff and Germer (2013) then conducted a randomized controlled trial comparing MSC to a waitlist control group. They found that "MSC participants demonstrated a significant increase in self-compassion, mindfulness, compassion for others, and life satisfaction and a decrease in depression, anxiety, stress, and emotional avoidance" (Neff & Germer, 2013, p. 859). All of these factors support the hypothesis that those with higher self-compassion will experience lower psychological distress. Tesh, Learman, and Pulliam (2013) advocated for the use of MSC with survivors of partner psychological aggression. They created a set of three MSC intervention strategies that they recommended clinicians to utilize while working with survivors of partner aggression (Tesh et al., 2013). Wei, Liao, Ku, and Shaffer (2011) found in their study that

individuals who experienced greater self-compassion reported lower levels of psychological distress.

There are almost no studies that specifically look at the effects of self-compassion on the psychological distress of men. The scarcity of research does suggest, however, that men experience self-compassion more strongly than women and men have higher levels of self-compassion than women (Neff, 2003a). The little research that does exist on the effects of psychological aggression on men claim that the negative effects are less harsh for men than women (Lawrence et al., 2012). However, as a result of the dearth of existing research, this author was interested in examining the hypothesis that self-compassion is negatively associated with level of psychological distress in the survivor of partner psychological aggression for both women and men. Specifically, this author tested the following hypotheses:

Hypothesis 3a: After controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion significantly predicts depression

Hypothesis 3b: After controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion significantly predicts PTSD

Hypothesis 3c: After controlling for the demographic variables of age, race, education level, and marital status, self-compassion significantly predicts depression for women and men

Hypothesis 3d: After controlling for the demographic variables of age, race, education level, and marital status, self-compassion significantly predicts PTSD for women and men

Research on Men

Research focusing on men as survivors of aggression has been scant for several reasons. One is the frequency and severity of the aggressive behavior towards men is significantly lower than the frequency and severity of aggressive behavior towards women (Vivian and Langhinrichsen-Rohling, 1994). Another purported reason is the level of fear that is produced from male perpetrators to female survivors is higher than the level of fear from female perpetrators to male survivors given relative physical size, strength, and power. Socially, men are discouraged from disclosing if they have experienced aggression by a woman. Furthermore, one study indicated that psychological distress as measured by depression and PTSD is higher in women than in men who experience partner psychological aggression (Christian et al., 1994).

Russell and Hulson (1992) looked at correlates for partner physical aggression and psychological aggression within marital relationships. When studying the wives, they found that the wife's level of self-esteem significantly predicted psychological aggression by the wife. In this study, women with lower self-esteem tended to be more psychologically and physically aggressive towards their husbands. They also found that there is a strong causal relationship between aggression by the wife and aggression by the husbands, implicating that wives who aggress may be reacting to their husband's aggression (Russell & Hulson, 1992). This may also be a generally more reciprocal relationship suggestion that both partners in the relationship may be equally aggressive.

Basow, Cahill, Phelan, Longshore, and McGillicuddy-DeLisi (2007) looked at partner physical aggression and relational aggression in both male and female college students. They defined relational aggression as "a type of indirect aggression for which the goal is to harm peer relationships through social exclusion, gossiping, rumor spreading, and other relationship variables" (Basow et al., 2007, p. 86). They found no difference amongst gender for experiences of relational aggression, either as a perpetrator or a survivor.

Taft, O'Farrell, Torres, Panuzio, Monson, Murphy, and Murphy (2006) examined 145 male-female couples in Massachusetts to look at correlates to psychological aggression. They found that for both men and women, psychological distress was increased when the partner was a survivor of psychological aggression, and that these effects lasted even beyond the effects of physical aggression. They also found that men's psychological aggression impacted a woman's depression more than women's psychological aggression impacted a man's psychological distress (Taft et al., 2006).

In a study conducted by Magdol, Moffitt, Caspi, Newman, Fagan, and Silva (1997), findings were significant for female-perpetrated partner psychological aggression (94.6%) and male-perpetrated partner psychological aggression (85.8%). They also found that partner psychological aggression and partner physical aggression were related to the survivor's mental health symptoms such as anxiety, depression, mania, psychosis, and antisocial personality disorder.

Hines and Saudino (2003), in a study looking at psychological, physical, and sexual aggression amongst college students found that females were the perpetrators of more partner psychological aggression than males and that partner psychological and

partner physical aggression tended to co-occur. Torres, Schumm, Weatherill, Taft, Cunningham, and Murphy (2012) found that partner psychological aggression was reported by 98% of men and women. Torres et al. (2012) found that women with younger partners were more likely to be psychologically aggressive. In a recent study, Karakurt and Silver (2013) found that younger males (ages 18-34) reported the highest levels of partner psychological aggression, younger females (age 18-34) experienced higher levels of partner psychological aggression but the levels decreased with age, and older males and subsequently older females (ages 34-61) experienced the lowest levels of partner psychological aggression.

Lawrence et al. (2012) conducted a study on both male and female marital partners, looking at the nature of psychological aggression, the dynamics between psychological aggression and long-term depression and anxiety, and they wanted to clarify the influence of both psychological and physical aggression on depression and anxiety. They found that both husbands and wives were perpetrators of partner psychological aggression, even within the first year of marriage. Contrary to other research, they found that both men and women experienced psychological distress when exposed to psychological ill-treatment. Finally, they found that partner psychological aggression was at least as detrimental if not more detrimental than partner physical aggression.

In addition to the previous three hypotheses, this author wanted to determine if the three independent variables would collectively explain the variance in psychological distress. Therefore, the following hypotheses were tested:

Hypothesis 4a: After controlling for the demographic variables of gender, age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a statistically significant amount of variance in depression

Hypothesis 4b: After controlling for the demographic variables of gender, age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a significant amount of variance in PTSD

Hypothesis 4c: After controlling for the demographic variables of age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a statistically significant amount of variance in depression for women and men

Hypothesis 4d: After controlling for the demographic variables of age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a significant amount of variance in PTSD for women and men

Hypotheses

Based on the literature review, the following hypotheses were tested 1a) After controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression significantly predicts depression; 1b) after controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression significantly predicts PTSD; 1c) After controlling for the demographic variables of age, race, education level, and marital status,

partner psychological aggression significantly predicts depression for women and men; 1d) after controlling for the demographic variables of age, race, education level, and marital status, partner psychological aggression significantly predicts PTSD for women and men; 2a) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem significantly predicts depression; 2b) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem significantly predicts PTSD; 2c) after controlling for the demographic variables of age, race, education level, and marital status, self-esteem significantly predicts depression for women and men; 2d) after controlling for the demographic variables of age, race, education level, and marital status, self-esteem significantly predicts PTSD for women and men; 3a) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion significantly predicts depression; and 3b) after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion significantly predicts PTSD; 3c) after controlling for the demographic variables of age, race, education level, and marital status, self-compassion significantly predicts depression for women and men; 3d) after controlling for the demographic variables of age, race, education level, and marital status, self-compassion significantly predicts PTSD for women and men; 4a) after controlling for the demographic variables of gender, age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a statistically significant amount of variance in depression; 4b) after controlling for the demographic variables of gender, age, race, education level, and marital status, the

independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a significant amount of variance in PTSD; 4c) after controlling for the demographic variables of age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a statistically significant amount of variance in depression for women and men; and 4d) after controlling for the demographic variables of age, race, education level, and marital status, the independent variables of partner psychological aggression, self-esteem, and self-compassion collectively predict a significant amount of variance in PTSD for women and men.

CHAPTER THREE

Method

Participants

A power analysis using G-Power was conducted to determine the sample size needed to detect a significant difference for those individuals who experienced partner psychological aggression and those who did not at the .05 alpha level. The N was determined to be 153 participants ($n = 65$ who experienced partner psychological aggression and $n = 88$ who did not experience partner psychological aggression in the past 12 months) based on a power level of .80, for a medium effect size (Cohen, 1992). The Composite Abuse Scale (CAS; Hegarty, 2007) was used to identify those individuals who have been involved in a psychologically aggressive relationship. On a self-report measure in the demographic questionnaire, 84 individuals sampled in this study experienced partner psychological aggression at some point their lives (54.9%), but only 65 of those individuals (42.5%) experienced partner psychological aggression within the past 12 months, as measured by the CAS.

Two hundred fifty four individuals volunteered to participate in the study. Participants were initially selected from a convenience sample of students at national universities. In order to get a large enough sample, a snowball sampling procedure was used through an advertisement that was posted on the internet which solicited participants

from across the country. Participants who did not identify as heterosexual, who experienced other types of abuse without experiencing psychological abuse, and those who did not fully complete the necessary surveys were excluded from further analysis. Of the remaining 153 participants, 27 were male-identified (17.6%) and 126 identified as female (82.4%). Their ages ranged from 15 to 74, with the modal number of participants being between the ages of 25 to 34. Most individuals in this sample were either married ($n = 52$) or dating and cohabitating ($n = 41$). Individuals in this sample were 75.8% Caucasian, 10.5% African American, 5.2% Hispanic, 2.6% Asian or Pacific Islander, and 5.9% Biracial or Multiracial. Also, many individuals held a graduate degree ($n = 62$, 40.5%). See Table 1 for a complete outline of demographic characteristics.

Table 1*Overview of Demographic Variables*

Characteristic	Frequency (<i>n</i>)	Percentage
Total Viable Participants	153	100
Age		
15-24	33	21.6
25-34	49	32
35-44	40	26.1
45-54	19	12.4
55-64	8	5.2
65-74	4	2.6
Gender		
Female	126	82.4
Male	27	17.6
Race/Ethnicity		
White or Caucasian	116	75.8
Black or African American	16	10.5
Hispanic or Latina/Latino	8	5.2
Asian or Asian American	4	2.6
Biracial/Multiracial	9	5.9
Sexual Orientation		
Heterosexual	153	100
Highest Education Achieved		
High School	11	7.2
Technical School	2	1.3
Some College (Did not graduate)	30	19.6
Associate's	15	9.8
Bachelor's	33	21.6
Graduate Degree	62	40.5
Current Relationship Status		
Single	25	16.3
Married	52	34
Divorced	6	3.9
Separated	3	2
Widowed	1	0.7
Dating/Cohabiting	41	26.8
Dating/Not Cohabiting	25	16.3
Age in which Aggressive Relationship Started		
16-19	35	22.9
20-24	51	33.3
25-29	31	20.3
30-34	16	10.5
35-39	5	3.3
40-44	3	2

45-49	4	3.3
50-54	2	1.3
55-59	1	0.7
60+	2	1.3
Duration of Aggressive Relationship		
Less than 6 months	11	7.2
6-12 months	13	8.5
1-2 years	28	18.3
3-5 years	25	16.3
5+ years	72	47.1
Missing	4	2.6
Type of Aggression Experienced within Relationship (Self-Report)		
Psychological	84	54.9
None	69	2.6
Type of Aggression Experienced within Relationship (in past 12 months—CAS)		
Psychological	65	42.5
None	88	57.5

Measures

Demographic Questionnaire.

Participants provided information regarding their age, gender, sexual orientation, ethnicity, educational level, their current relationship status, age when the aggressive relationship began and how long they were in the aggressive relationship, as well as the type of aggressive behavior they endured. Eighty-four individuals indicated they were in a psychologically aggressive partner relationship at some point in their lives and 69 individuals reported that they have never been involved in a relationship in which they experienced partner psychological aggression.

Composite Abuse Scale.

The Composite Abuse Scale (CAS; Hegarty, 2007) was used to identify survivors of partner psychological aggression within the past 12 months. This scale was originally developed in 1995 with 74 items and had four subscales (Severe Combined Abuse, Physical Abuse, Emotional Abuse, and Harassment). It was later validated and shortened

to 30 items with 1,896 general practice patients and 345 emergency room patients. For purposes of this dissertation, only the Emotional Abuse subscale was used to identify the survivors of partner psychological aggression. This subscale consists of 11 items which cover verbal aggression, psychological aggression, dominance, and social isolation. The CAS has been used with both men and women, however there is currently limited validity with men. In this study, the reliability of the overall scale was high ($\alpha = 0.96$; $\alpha = 0.96$ for women; $\alpha = 0.94$ for men).

The CAS has an internal consistency of 0.85 or above (Hegarty, 2007; Hegarty, Bush, & Sheehan, 2005). The CAS has also demonstrated face, content, criterion, and construct validity (Hegarty, Sheehan, & Schonfeld, 1999). The CAS was developed to be compatible with the already established Conflict Tactics Scale (CTS; Straus, 1979), thereby supporting its validity.

The CAS is a 30-item self-report questionnaire and takes approximately five minutes to complete. Sample items on the Emotional Abuse subscale include: "My partner 'Told me that I was stupid,'" "Blamed me for causing their violent behavior," and "Tried to convince my family, friends, and children that I was crazy." Items are scored on a 6-point rating scale ranging from 0 = "Never" to 5 = "Daily." None of the items are weighted. Of the 11 items that identify emotional abuse, there is a total possible score of 55. However, a score of three or higher indicates that the individual has experienced partner psychological aggression during the last 12 months. According to CAS Manual (Hegarty, 2007),

There are two ways in which respondents may be misclassified on the CAS. Respondents may be classified as not experiencing abuse when in fact they are

(false negative). Alternatively, they may be classified as experiencing abuse when they are not (false positive).

Using three as a cutoff score gives a true positive rate sensitivity of 92.3%. This means that approximately 6.2% of individuals could be falsely identified as being exposed to partner psychological aggression, however all individuals who positively identified partner psychological aggression would be correctly identified. Using this cutoff score, no individuals who experienced partner psychological aggression would be missed and only a very small amount of individuals who did not experience partner psychological aggression would be incorrectly identified (< 5%). In this study, 42.5% ($n = 65$) of individuals were identified as having experienced partner psychological aggression in the past 12 months and 57.5% ($n = 88$) were identified as not having experienced any type of aggression by a partner (see Table 2).

Table 2

Type of Aggression Experienced within Relationship (in past 12 months—CAS)

<u>Type of Aggression</u>	<u>Frequency (n)</u>	<u>Percentage</u>
Psychological	65	42.5
None	88	57.5

Table 3 shows the number of women and men who endorsed experiencing partner psychological aggression on the CAS. Of the 65 individuals who experienced partner psychological aggression, 52 were women and 13 were men. Partner psychological aggression was used as a categorical variable because the data for partner psychological aggression was not normally distributed (skewness = 9.11; kurtosis = 5.48). Therefore, those individuals who scored lower than three were categorized as not experiencing psychological aggression and those who scored three or higher were coded as experiencing psychological aggression.

Table 3

Type of Aggression Experienced within Relationship by Gender using CAS

<u>Type of Aggression</u>	<u>Female (n)</u>	<u>Male (n)</u>	<u>Total (n)</u>
Psychological	52	13	65
None	74	14	88

Center for Epidemiological Studies Depression Scale.

The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) is a 20-item self-report scale that measures current psychological distress and depressive symptoms in the general population. Radloff (1977) designed this scale using "household interviews" by an "experienced lay interviewer," and it is used to study depression and its relationship among other variables (p. 386). The items on the scale were selected from previously validated scales for depression and components of the scale included "depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance" (Radloff, 1977, p. 386). The scale has been used for both males and females as well as several ethnicity groups. It has a high Cronbach's alpha value across ethnicities and gender, including Armenian ($\alpha = 0.89$ for women and $\alpha = 0.83$ for men), Dutch ($\alpha = 0.93$), English ($\alpha = 0.91$), and Spanish ($\alpha = 0.92$) (Yang, Jia, & Qin, 2015). In this study, the reliability of this scale was $\alpha = 0.80$ ($\alpha = 0.81$ for women and $\alpha = 0.71$ for men).

The CES-D was tested on several convenience samples from Kansas City, Missouri and Washington County, Maryland with randomly selected adults, aged 18 years and older. The response rates were high in both cities with 1,173 interviews completed in Missouri and 1,673 interviews completed in Maryland over a two-year time span for each city. There was about a 17% refusal rate for each city. The scale's author

acknowledges that males and lower education statuses were slightly underrepresented in the scale development.

The original scale was then revised and tested again in Washington County over the next year. The revised scale was shorter and took half of the time to complete (30 minutes instead of 60 minutes). The response rate was again high, with 75% completed interviews resulting in 1,089 interviews. Over the next six months, the respondents from Kansas City were re-interviewed using the revised scale and 343 interviews were completed. Once again, previous respondents from Washington County were re-interviewed with 1,209 respondents completing the interviews.

The CES-D scale was then validated with two psychiatric populations, one in Washington County, Maryland and the other in New Haven, Connecticut. In Maryland, the patients used the Rockliff Depression Rating Scale (Rockliff, 1971) and in Connecticut, they used the Raskin Depression Rating Scale (Raskin, Schulterbrandt, Reatig, & McKeon, 1969), the Symptoms Checklist (SCL-90; Derogatis, Lipman, & Covi, 1973), and the Hamilton Rating Scale (Hamilton, 1960). The correlations between the CES-D and these scales was moderate at admission ($r = .44$ to $.54$) and higher after four weeks of treatment ($r = .69$ to $.75$), with the correlations for the SCL-90 on the lower end of that range. The scores were also moderately correlated with the interviewer's ratings of depression (Radloff, 1977).

Internal consistency is high for the general population ($\alpha = .85$) as well as for the patient population ($\alpha = .90$), which the author acknowledges could be due to response bias although discriminant validity based by independently rated clinicians suggested otherwise. Since the test was developed to measure current symptoms, changes in

responses could affect the test-retest correlations. Test-retest correlations ranged from .45 to .70 and tended to be higher for shorter time frames. When the test used all subgroups, the coefficient alpha was over .80 and the test-retest correlations were .40 or above.

The CES-D has been revised although the revised version is rarely used as reported in the literature (Eaton, Smith, Ybarra, Muntaner, & Tien, 2004). With regards to college students, the CESD-R has also shown support for reliability and validity. Van Dam and Earleywine (2011) conducted a study with 6,971 students at a northeastern United States state university, and found a positive correlation between the CES-D and the State-Trait Inventory for Cognitive and Somatic Anxiety ($r = .065, p < .01$; STICSA; Gros, Antony, Sims, & McCabe, 2007). There was also a positive correlation between the CES-D and the Schizotypal Personality Questionnaire-Brief ($r = .0426, p < .001$; SPQ-B; Raine & Benishay, 1995) (Van Dam & Earleywine, 2011).

On the CES-D, four factors were identified: depressed affect (blues, depressed, lonely, cry sad), positive affect (good, hopeful, happy, enjoy), somatic and retarded activity (bothered, appetite, effort, sleep, get going), and interpersonal traits (unfriendly, dislike). Sample items include: "I was bothered by things that usually don't bother me," "I thought my life had been a failure," and "I felt that people dislike me." Items are scored on a 4-point rating scale, from 0 = "rarely or none of the time" to 3 = "most or all of the time" and are written to reflect the individual's current state. The scores on the CES-D range from 0-60, with higher scores showing a higher amount of depressive symptoms. In this study, 49% of individuals experienced depression ($n = 75$).

Trauma Screening Questionnaire.

The Trauma Screening Questionnaire (TSQ; Brewin, Rose, Andrews, Green, Tata, McEvedy, Turner, & Foa, 2002) is a 10-item self-report scale that measures an individual's personal reactions to trauma that happened directly to them. Brewin et al. (2002) designed this scale by administering it to 41 survivors of a railroad crash in London, England. A week later, they were given a structured clinical interview, a well-validated PTSD assessment tool called the Clinician-Administered PTSD Scale (CAPS-I; Blake, Weathers, Nagy, Kaloupek, Gusman, Charney, & Keane, 1995). According to Brewin et al. (2002), the scale had a sensitivity of .86, specificity of .93, positive predictive power of .86, negative predictive power of .93, and overall efficiency of .90.

Initially, the scale consisted of 16 items, with five measuring re-experiencing and five measuring arousal, taken from Foa's validated PTSD Symptom Scale-Self Report version (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993). The participants were asked to answer a series of questions and respond with either a yes or a no regarding whether they have experienced those emotions or beliefs in the past week (Brewin et al., 2002). Exposure to the traumatic event must have occurred at least one month prior to taking this survey. A cutoff score of six determined evidence of PTSD. In this study, the reliability of this scale was high ($\alpha = 0.92$; $\alpha = 0.91$ for women; $\alpha = 0.92$ for men).

One article by Dekkers, Olf, and Näring (2009) reported use of the TSQ with a Dutch sample to predict PTSD. These authors administered the TSQ (Brewin et al., 2002) about two weeks after the traumatic event, then used the CAPS (Blake et al., 1995) assessment four weeks later. Using a cutoff score of seven, they also found validation for the tool. The TSQ shows validity in that it is highly correlated with the CAPS and the

Structured Clinical Interview for the DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1996).

The TSQ's reliability and validity have primarily been established using foreign samples from Amsterdam. According to one study by Mouthaan, Sijbrandij, Reitsma, Gersons, and Olf (2014), the TSQ was found to be significantly correlated with the CAPS ($r = .72, p < .001$) when measuring PTSD in civilians after experiencing a traumatic injury. Using a cutoff of six, the TSQ showed a sensitivity of .86 and specificity of .93 in predicting PTSD 6-12 months after the traumatic incident.

Another study used 562 participants who presented to an emergency room following a traumatic incident. The TSQ was given to them to complete between one and three weeks following the trauma. One month later, they completed the Davidson Trauma Scale (DTS; Davidson, Book, Colket, Tupler, Roth, David, Hertzberg, Mellman, Beckham, Smith, Davison, Katz, & Feldman, 1997; Davidson, Tharwani, & Connor, 2002). At a six month interval, they completed the same scale once again. This study from the United Kingdom found that the TSQ predicted PTSD with a sensitivity of .85 and a specificity of .89 (Walters, Bisson, & Shepherd, 2007).

This scale was also used with college students at Virginia Tech. The students were sent an email to complete the questionnaire three months after the on-campus shootings. Twenty percent of the student population responded to the survey ($N = 4,639$) completing the questionnaire. Only 0.1% of the students declined to participate (Hughes, Chiu, Jones, Rothwell, Brymer, Fairbank, Pynoos, Steinberg, & Kessler, 2011). These authors were reliably able to identify those students with PTSD using the TSQ.

Sample items on the TSQ include: "Upsetting thoughts or memories about the event have come into your mind against your will," "Acting or feeling as though the event were happening again," and "Being jumpy or being startled at something unexpected." Items are scored by adding the number of "yes" responses versus the number of "no" responses. A score of six or above indicates the presence of traumatic symptoms although the authors caution against using this as a diagnostic tool. In the present study, 28.8% of individuals experienced symptoms of PTSD ($n = 44$).

Rosenberg Self-Esteem Scale.

The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1989) is a 10-item self-report scale that measures global self-esteem and is widely used in current research to measure this construct. It is used as an overall evaluation of how a person feels about themselves as a human being and has been found to be related to interpersonal problems (Rosenberg, 1979). This scale can be completed within a couple of minutes, making it very simple to use. It was initially developed using 5,000 adolescents with no disabilities, and later expanded to use with many different cultures and age ranges, including use with college students (Robins, Hendin, & Trzesniewski, 2001). The self-esteem scale is composed of two subscales: self-competence and self-liking. Schmitt and Allik (2005) defined global self-esteem as "one's overall sense of worthiness as a person," (p. 623) self-competence as "the instrumental feature of the self as causal agent, the sense that one is confident, capable, and efficacious," and self-liking as "the intrinsic feature of the self as a social object, the sense that one is a good person, is socially relevant, and contributes to the group harmony" (p. 625).

This scale is widely used to measure global self-esteem. This scale was tested across cultures and was found to have high Cronbach's alpha for internal consistency across several nations ($\alpha = .81$; Sinclair, Blais, Gansler, Sandberg, Bistis, & LoCicero, 2010). In this study, the reliability of the overall positive items was $\alpha = 0.93$ ($\alpha = 0.92$ for women and $\alpha = 0.93$ for men). The reliability of the overall negative items was $\alpha = 0.90$ ($\alpha = 0.89$ for women and $\alpha = 0.90$ for men).

One meta-analysis done by Twenge and Campbell (2001) found that self-esteem increased with age. In another study, item scale correlation across subgroups was $r = .40$ except for one subgroup which was $r = .39$ (Sinclair et al., 2010). For internal consistency reliability, Sinclair et al., (2010) noted that the "Cronbach coefficient α was .91 for the overall sample and ranged from .84 (66+ age group) to .95 (unemployed working group), with an average of .90" (p. 72). In regards to clinical validity, "the RSES scale was negatively associated with depression, anxiety, and stress" (Sinclair et al., 2010, p. 73). Crandall (1973) found a .60 correlation between this scale and the Coopersmith Self-Esteem Inventory (Coopersmith, 1967), providing evidence of support for overall validity.

The positive scale items (items 1, 2, 4, 6, 7) included sample statements such as: "On the whole, I am satisfied with myself," "I feel that I have a number of good qualities," and "I feel that I am a person of worth, at least on an equal playing field with others." Sample negative items (items 3, 5, 8, 9, 10) include: "I feel I do not have much to be proud of," "I certainly feel useless at times," and "I wish I could have more respect for myself." Items are scored on a 4-point rating scale from 0 = "strongly disagree" to 3 = "strongly agree" and has an equal number of positive and negative items. The total scale

ranges from 0 to 30, which indicates the highest score possible. Scores below 15 suggest low self-esteem while scores between 15-25 are considered within the normal range. In this study, 22.2% of individuals experienced low self-esteem ($n = 34$).

Self-Compassion Scale-Short Form.

Neff (2003a, 2003b) identified three major components of self-compassion: self-kindness, common humanity, and mindfulness. Neff also stated that self-compassion may be an important protective factor when evaluating psychological distress, with more self-compassion indicating better psychological well-being (Neff, 2009). The Self-Compassion Scale-Short Form (SCS-SF; Raes, Pommier, Neff, & VanGucht, 2011) is a 12-item scale that measure self-compassion which is nearly perfectly correlated ($r \geq .97$) with the full 26-item scale. The scale was validated using two Dutch samples and then one English sample. Neff and Vonk (2009) state that the scale "demonstrates concurrent validity (e.g., correlates with social connectedness), convergent validity (e.g., correlates with therapist ratings), discriminant validity (e.g., no correlation with social desirability), and test-retest reliability" (p. 32), although the authors did not report the validity coefficients in this article. Neff (2003a) reported that construct validity was supported by correlation with the Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti, & Quinlan, 1976) and the Social Connectedness Scale (Lee & Robbins, 1995). The SCS "was found to have a significant negative correlation with the Self-Criticism subscale of the DEQ, $r = -.65, p < .01$ and a significant positive correlation with the Social Connectedness scale, $r = .41, p < .01$ " (Neff, 2003a, p. 233). Barnard and Curry (2011) encourage more research to be conducted in order to "develop the construct validity of self-compassion, its component elements, how these are associated with various aspects

of distress and well-being, and how self-compassion and its various aspects can be fostered, cultivated, and raised in treatment" (p. 302).

The same six subscales from the original form were also identified in the shorter version, including: self-kindness (e.g., "When I'm going through a very hard time, I give myself the caring and tenderness I need"), self-judgment (e.g., "I am disapproving of my own flaws and inadequacies"), common humanity (e.g., "I try to see my failings as part of the human condition"), isolation (e.g., "When I fail at something that is important to me, I tend to feel alone in my failure"), mindfulness (e.g., "When something upsets me, I try to keep my emotions in balance"), and over-identification (e.g., "When I'm feeling down, I tend to obsess and fixate on everything that is wrong") (Neff, 2003a).

The SCS has also been used with a college student sample. One study looked at the subjective well-being and attachment style of college students as compared to the adult community population with self-compassion as a mediator. These authors found that "self-compassion was a significant mediator between attachment anxiety and subjective well-being" for both college students and community adults (Wei et al., 2011, p. 216).

Items are scored on a 5-point rating scale, from 1 = "almost never" to 5 = "almost always." A total self-compassion score is calculated by calculating the mean of the subscale scores and reversing the scores for the negative subscales, which includes self-judgment, isolation, and over-identification. Higher scores indicate higher levels of self-compassion (See Table 4 for descriptive statistics for the SCS for this study). Internal consistency for the total score was high ($\alpha \geq .86$). Test-retest reliability was also high ($\alpha = .93$). In this study, the reliability of the overall positive items was $\alpha = 0.86$ ($\alpha = 0.87$ for

women and $\alpha = 0.74$ for men). The reliability of the overall negative items was $\alpha = 0.89$ ($\alpha = 0.88$ for women and $\alpha = 0.87$ for men).

Raes et al. (2011) found that in the Dutch sample,

Correlations between the corresponding subscales for the long and short form were as follows: $r = 0.91$ for Self-Kindness, $r = 0.93$ for Self-Judgment, $r = 0.84$ for Common Humanity, $r = 0.86$ for Isolation, $r = 0.87$ for Mindfulness and $r = 0.88$ for Over-Identification. (p. 252)

In the English sample, the internal consistency was high ($\alpha = .86$) and Cronbach's alpha for subscales varied from .54 to .75. Again on the English sample, (Raes et al., 2011,) note that the

Correlations between the long- and short-form subscales (on corresponding dimensions) were also excellent: $r = 0.89$ for Self-Kindness, $r = 0.90$ for Self-Judgement, $r = 0.91$ for Common Humanity, $r = 0.93$ for Isolation, $r = 0.89$ for Mindfulness and $r = 0.89$ for Over-Identification. (p. 254)

Sample items on the SCS included: "When I fail at something important to me, I become consumed by my feelings of inadequacy," "I tend to be understanding and patient towards those aspects of my personality I don't like," and "When something painful happens, I try to take a balanced view of the situation."

Table 4

SCS

<u>Self-Compassion Score</u>	<u>Frequency (<i>n</i>)</u>	<u>Percentage</u>
1	1	0.7
2	38	24.8
3	64	41.8
4	36	23.5
5	14	9.2

Procedure

An online survey was approved by the University of Denver's Institutional Review Board (IRB). The link to the online survey was then sent to student organizations, professors, and online list-serves to be forwarded to students. In order to obtain a larger sample size, the survey was opened up to the larger community through email and internet recruitment by using a snowball sampling procedure. The questionnaire included a demographic survey to help identify female and male individuals who have been in relationships with an opposite sex partner. All data were collected through the use of structured online surveys. Participants who responded to the email or internet request had access to the online survey. They were asked to review and complete an informed consent in order to participate in the study and were also informed of their right to refuse participation at any time during the study. The informed consent included information about the study and potential risks of participating. It explained that this research project was for a dissertation and therefore the primary researcher was under the supervision of a licensed psychologist and contact information for the student's advisor was listed in case the participant needed to follow up with treatment services. Participants were given a number of surveys to complete. None of the participants requested counseling services, but referral information was available upon request.

Once participants agreed to participate and signed the informed consent, the survey guided them to answer a demographic questionnaire. Next, participants completed a series of five surveys including the Composite Abuse Scale, the Center for Epidemiological Studies Depression Scale, the Trauma Screening Questionnaire, the Rosenberg Self-Esteem Scale, and the Self-Compassion Scale-Short Form. A total of about 20-30 minutes was needed to complete all of these questionnaires. All survey results were coded and de-identified. At the completion of the survey, each participant was offered a chance to enter a raffle to win one of five \$50 Visa gift cards. If they chose to enter the raffle, they were prompted to give an email address where the researcher could reach the winners. They could also choose to receive the results of this dissertation by entering their email address. Their contact information was kept separately from their survey results.

General Procedures for the Statistical Analyses.

Data were initially reviewed to identify which cases had missing data. These cases were then reviewed to determine if data were missing at random or if they were missing because individuals did not complete the survey. Cases where individuals did not complete the survey were excluded from continued analysis. Otherwise, there were no missing data that would have led to exclusion from further analysis. Next, data were examined to separate all individuals who identified as heterosexual and individuals who identified as other than heterosexual were excluded from further analysis.

Using the demographic questionnaire as a guide, some possible confounding variables that could affect results were identified. These included variables such as age, ethnicity, education level, and marital status. According to existing research, younger

couples tend to be at a higher risk for engaging in physically and psychologically aggressive behaviors (Pan, Neidig, & O'Leary, 1994). The older the person gets, the less likely it is that they will be involved in a relationship that is aggressive, psychologically or physically (Holtzworth et al., 1997; Kaukinen, 2004). There is a low negative correlation between number of years in the relationship and age of the husband, although this could be because newlyweds tend to be younger (MacEwen & Barling, 1988). Kaukinen (2004) note that women who are of a minority race are 72% more likely to be involved in a psychologically aggressive relationship than non-minority women. Straus and Gelles (1986) found that risk of violence was higher amongst African Americans than amongst Caucasians. Moss, Pitula, Campbell, and Halstead (1997) mentioned that 90% of female homicides are caused by men, and among African American women ages 15-35, homicide is the leading cause of death. Steinmetz (1977) found a negative correlation between aggressive behavior and both husband and wife's education level, suggesting that individuals who have higher levels of education were less likely to be involved in an aggressive relationship. Cohabiting couples also tend to exhibit more aggressive behavior than married couples (Lewis, 1987; Roberts, 1987; Yllo, 1981) and cohabitation is a risk factor for intimate partner homicide (Reckdenwald & Parker, 2010; Shackelford & Mouzos, 2005).

The data were examined to ensure they met the regression assumptions of normality, linearity, and homoscedasticity (Cohen, Cohen, West, & Aiken, 2003). In the multiple regression analyses, the covariates (gender, age, ethnicity, education level, and marital status) were controlled to isolate effects of the independent variables of primary interest (partner psychological aggression, self-esteem, and self-compassion) on the

dependent variables (psychological distress as measured by depression and PTSD). To determine whether the dependent variables varied as a function of participant's gender, this author conducted a *t*-test analysis for gender with the dependent variables (see Table 5). This study found that there was no statistically significant difference between females and males with regard to experiencing depression or PTSD. Since there was no statistically significant difference between males and females in this study on psychological distress, gender was added as a control variable in half of the subsequent regression analyses.

Table 5

Depression Experienced by Gender (Range 0-55)

Gender	Participants (<i>n</i>)	Mean	SD	<i>t</i>	<i>p</i>
Female	126	19.45	14.35		
Male	27	13.89	11.66		
Equal Variances Assumed				-1.89	.06

PTSD Experienced by Gender (Range 0-10; cutoff score = 6)

Gender	Participants (<i>n</i>)	Mean	SD	<i>t</i>	<i>p</i>
Female	126	3.52	3.54		
Male	27	2.33	3.21		
Equal Variances Assumed				-1.61	.11

Note. Male = 1 Female = 0

Given the previous information, the following hypotheses were tested: 1a) After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), partner psychological aggression (Step 2) significantly predicts depression; 1b) after controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), partner psychological aggression (Step 2) significantly predicts PTSD; 1c) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), partner psychological aggression (Step

2) significantly predicts depression for women and men; 1d) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), partner psychological aggression (Step 2) significantly predicts PTSD for women and men; 2a) after controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts depression; 2b) after controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts PTSD; 2c) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts depression for women and men; 2d) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts PTSD for women and men; 3a) after controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts depression; 3b) after controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts PTSD; 3c) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts depression for women and men; 3d) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts PTSD for women and men; 4a) after controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) collectively predict a statistically significant amount of variance in depression; and 4b) after controlling for the

demographic variables of gender, age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) collectively predict a significant amount of variance in PTSD; 4c) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) collectively predict a statistically significant amount of variance in depression for women and men; and 4d) after controlling for the demographic variables of age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) collectively predict a significant amount of variance in PTSD for women and men.

Testing Hypothesis One.

To test the first hypothesis, the researcher used a hierarchical multiple regression analysis to determine if partner psychological aggression can significantly predict psychological distress after controlling for gender, age, race, education, and marital status. Since psychological distress was measured by the separate variables of depression and PTSD, two separate analyses were conducted. In the first analysis, depression was used as the dependent variable. PTSD was used as the dependent variable in the second analysis. In step one of the regression analysis, gender, age, ethnicity, education level, and marital status were entered. In step two, partner psychological aggression was entered. The data were then split by gender for the next two parts of the question and the exact same analyses were run, but gender was removed as a control variable.

Testing Hypothesis Two.

To test the second hypothesis, the researcher used a hierarchical multiple regression analysis to investigate the relationship between self-esteem and psychological distress. As above, since psychological distress was measured by the separate variables of depression and PTSD, two separate analyses were conducted. In the first analysis, depression was used as the dependent variable. PTSD was used as the dependent variable in the second analysis. In step one of the regression analysis, gender, age, ethnicity, education level, and marital status were entered. In step two, self-esteem was entered. The data were then split by gender for the next two parts of the question and the exact same analyses were run, but gender was removed as a control variable.

Testing Hypothesis Three.

To test the third hypothesis, the researcher again used a hierarchical multiple regression analysis to investigate the relationship between self-compassion and psychological distress. Once again, since psychological distress was measured by the separate variables of depression and PTSD, two separate analyses were conducted. In the first analysis, depression was used as the dependent variable. PTSD was used as the dependent variable in the second analysis. In step one of the regression analysis, gender, age, ethnicity, education level, and marital status, were entered. In step two, self-compassion was entered. The data were then split by gender for the next two parts of the question and the exact same analyses were run, but gender was removed as a control variable.

Testing Hypothesis Four.

To test the fourth hypothesis, the researcher used a hierarchical multiple regression analysis to investigate the relationship between partner psychological aggression, self-esteem, and self-compassion and psychological distress. Since psychological distress was measured by the separate variables of depression and PTSD, two separate analyses were conducted. In the first analysis, depression was used as the dependent variable. PTSD was used as the dependent variable in the second analysis. In step one of the regression analysis, gender, age, ethnicity, education level, and marital status, were entered. In step two, all three independent variables (e.g., partner psychological aggression, self-esteem, and self-compassion) were entered. The data were then split by gender for the next two parts of the question and the exact same analyses were run, but gender was removed as a control variable.

CHAPTER FOUR

Results

Overview

Data analysis included data preparation, analysis of missing data and exclusion of participants who did not identify as heterosexual, preliminary analyses yielding descriptive statistics, and an analysis of the data relevant to the four hypotheses. All statistical tests utilized one-tailed tests with alpha of $p < .05$. Typically, when running multiple statistical tests, the researcher will adjust the alpha level by the number of variables of interest in order to reduce the chances of committing a Type I error. Daniel O'Keefe (2003) argues against doing this, explaining,

Type I error is a risk undertaken whenever significance tests are conducted, and the chances of committing a Type I error increase as the number of significance tests increases. But adjusting the alpha level because of the number of tests conducted in a given study has no principled basis, commits one to absurd beliefs and practices, and reduces statistical power. The practice of requiring or employing such adjustments should be abandoned. (p. 431)

Therefore, in this study, no control for familywise Type I error was implemented. Given the relative standard in the field, some may believe that there is a possibility of inflation of Type I error across the hierarchical regression analyses.

Data Preparation

Once the survey was closed in Qualtrics, the data were downloaded into a Statistical Package for the Social Sciences (SPSS) data file. Data were reviewed to determine which participants needed to be eliminated from the sample. Some individuals ($n = 66$) started, but did not complete all of the surveys which were necessary for the study, including the CAS, CES-D, TSQ, RSES, and SCS-SF. Individuals who had experienced sexual assault by their partners, child maltreatment, or physical aggression, but did not report psychological aggression ($n = 6$), were excluded from continued analysis as well, even though it is likely that they experienced partner psychological aggression but did not specifically identify this. Data were then reviewed to determine which individuals self-identified as heterosexual. All individuals who identified as other than heterosexual ($n = 39$) (e.g., homosexual, bisexual, questioning, pansexual, or not sure) were excluded from further data analysis. Of the initial 254 participants who volunteered to participate in the study, 101 were eliminated leaving 153 participants included in the final analysis.

Analysis of Missing Data

The SPSS data file was reviewed to determine if there were any missing data. Several participants did not fully complete the necessary surveys, which made those data unusable. A listwise deletion of these cases was applied to any data missing values for the dependent or independent variables. This reduced the sample size; however, there were enough participants to be able to achieve statistical significance. Each survey represented a variable of interest that would be measured in this study, therefore all surveys needed to be mostly complete.

Initial Data Exploration

Preliminary analyses were conducted to examine the descriptive statistics and correlations among partner psychological aggression, depression, PTSD, self-esteem, and self-compassion (see Table 6). This table shows the means, standard deviations, correlations, ranges of scores, and significance levels. The correlations between variables showed that partner psychological aggression (PPA) was significantly positively correlated to depression ($r = .55, p < .01$) and PTSD ($r = .51, p < .01$). PPA was significantly negatively correlated to self-esteem ($r = -.30, p < .01$) and self-compassion ($r = -.29, p < .01$). Depression was significantly positively correlated with PTSD ($r = .76, p < .01$). Depression was also significantly negatively correlated to self-esteem ($r = -.69, p < .01$) and self-compassion ($r = -.64, p < .01$). PTSD was significantly negatively correlated to self-esteem ($r = -.57, p < .01$) and self-compassion ($r = -.53, p < .01$). While not specifically tested as a hypothesis in this study, these data also provided evidence of the relationship between self-esteem and self-compassion, which were significantly positively correlated ($r = .70, p < .01$). Neff and Vonk (2009) found correlations between these two variables to be as high as $r = .68$, and these data support that finding.

Table 6*Correlations, Ranges, Means, Standard Deviations, and Significance Levels*

Variable	1	2	3	4	5
1. PPA	1	.55**	.51**	-.30**	-.29**
2. Depression		1	.76**	-.69**	-.64**
3. PTSD			1	-.57**	-.53**
4. Self-Esteem				1	.70**
5. Self-Compassion					1
Range	0-55	0-60	0-10	0-30	12-60
Mean	7.95	18.47	3.31	19.97	37.14
SD	12.69	14.04	3.51	6.92	10.27

Note. ** Correlation is significant at the .01 level (1-tailed)

A one-way between subjects analysis of variance was conducted to compare the effect of partner psychological aggression on depression, PTSD, self-esteem, and self-compassion. Table 7 shows the means, standard deviations, skewness, and kurtosis on all measures. Results of this analysis indicate that individuals who experienced partner psychological aggression also experienced higher levels of depression and PTSD as well as lower levels of self-esteem and self-compassion when compared to individuals who did not experience partner psychological aggression.

Table 7*Overview of Variables by Experience of Partner Psychological Aggression: Means, Standard Deviations, Skewness (S), and Kurtosis (K)*

Variable	Experienced PPA (<i>n</i> = 65)			Did not Experience PPA (<i>n</i> = 88)		
	M (SD)	S	K	M (SD)	S	K
1. Depression	25.71 (14.38)	.23	-.83	13.13 (11.14)	1.02	.10
2. PTSD	4.72 (3.56)	.16	-1.40	2.27 (3.10)	1.26	.40
3. Self-Esteem	17.92 (6.74)	.24	-.77	21.48 (6.70)	-.77	.36
4. Self-Compassion	33.03 (8.91)	.39	-.14	40.18 (10.19)	.02	-.79

The data were then split into female and male in order to determine the correlations between each variable by gender (see Table 8). Partner psychological aggression was significantly positively correlated to depression and PTSD and

significantly negatively correlated to self-esteem and self-compassion for women, but not for men. Depression was significantly positively correlated to PTSD and significantly negatively correlated to self-esteem and self-compassion for both genders. PTSD was significantly negatively correlated to self-esteem and self-compassion for both genders. And, self-esteem was significantly positively correlated to self-compassion for women, but not for men.

Table 8

Correlational Analysis of all Variables by Experience by Gender

Variable	1	2	3	4	5
1. PPA					
Female	1	.50**	.24**	-.25**	-.40**
Male	1	.11	.13	-.22	-.27
2. Depression					
Female		1	.51***	-.55**	-.58**
Male		1	.43*	-.29	-.68**
3. PTSD					
Female			1	-.53**	-.37**
Male			1	-.52**	-.43*
4. Self-Esteem					
Female				1	.42**
Male				1	.34
5. Self-Compassion					
Female					1
Male					1

Note. ** $p \leq .01$; * $p < .05$

The data were then prepared for the regression analyses. Each of the demographic variables that would be used as control variables was coded as a dichotomous variable. Given previous research, the following variables were used as control variables: gender, age, ethnicity, education level, and marital status. Specifically, gender was coded as “male” and “female;” ethnicity was coded as “White” and “non-White;” education was coded as “at least a Bachelor’s degree” and everything else; and marital status was coded as “married or cohabitating” versus everyone else. Age was already categorical, so that

was left untouched for this analysis. The age groups were “15-24,” “25-34,” “35-44,” “45-54,” “55-64,” and “65-74.”

Independent samples t-tests were then conducted to determine if gender had an effect on the dependent variables of depression and PTSD. With regards to depression, there was no significant difference for gender $t(151) = -1.89, p = 0.06$. Similarly, for PTSD, no significant differences were found $t(151) = -1.61, p = 0.11$. Of the 153 participants, only 27 were male, and therefore no significant findings were expected given this limited sample size.

Analysis of the Assumptions of Multiple Regression

Several tests of assumptions for multiple regression were conducted in order to ensure that the data did not violate any initial assumptions. The data were checked to determine if they met the assumptions for linearity, normality, and homoscedasticity, and they met all three assumptions. The linearity assumption was tested with scatter plots for both depression and PTSD, and both showed linearity. All variables were normal, according to the Q-Q Plot that was conducted and visually inspected. When testing homoscedasticity, a P-P Plot was conducted and visually inspected as well, and the variance around the regression line was normal. Additionally, multicollinearity was examined. The independent variables of self-esteem and self-compassion were very highly correlated. Both were included because of the robustness of the hierarchical regression test and because these variables are still considered to be separate enough variables.

Analysis of the Primary Research Hypotheses

Hypothesis 1a: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), partner psychological aggression (Step 2) significantly predicts depression. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variable of partner psychological aggression entered in Step two (Table 9). After controlling for Step one, analysis of the regression equation indicated that partner psychological aggression significantly predicted depression. Specifically, for those individuals who experienced partner psychological aggression, their levels of depression were significantly higher than those who did not experience partner psychological aggression.

In Step one, which did not include partner psychological aggression, 11% of the variance was explained by the control variables ($R^2 = .11, p < .001$). In Step two, when partner psychological aggression was added to the equation, an additional 15% of the variance of depression was significantly explained ($R^2 = .25, p < .001$).

Table 9*Hierarchical Multiple Regression of Depression on Partner Psychological Aggression (PPA)*

	b	(SE)	β	R^2	PPA				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	.01	.03	.02		.03	.03	.06		
Age	-.09	.10	-.07		-.12	.10	-.10		
Race	.00	.09	.00		-.03	.09	-.03		
Education	-.28	.08	-.27***		-.21	.08	-.20**		
Marital Status	-.13	.08	-.13		-.11	.08	-.11		
				.11***					
Step 2									
PPA					.40	.07	.40***	.25***	.15***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; ** $p < .01$

Hypothesis 1b: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), partner psychological aggression significantly (Step 2) predicts PTSD. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variable of partner psychological aggression entered in Step two (Table 10). After controlling for Step one, analysis of the regression equation indicated that partner psychological aggression did not significantly predict PTSD beyond the variance accounted for by Step one. In Step one, which did not include partner psychological aggression, 21% of the variance was significantly explained by the control variables ($R^2 = .21, p < .001$). Adding partner psychological aggression in Step two did not explain statistically significant additional variance in

PTSD ($R^2 = .23, p = .06$), although an additional 2% of the variance was accounted for by adding PTSD. In summary, partner psychological aggression did not significantly predict PTSD. It appears that this one variable does not account for PTSD since this type of psychological distress variable is a complex construct and many factors contribute to its development in certain people.

Table 10

Hierarchical Multiple Regression of PTSD on Partner Psychological Aggression (PPA)

	b	(SE)	β	R^2	PPA			R^2	ΔR^2
					b	(SE)	β		
Step 1									
Gender	-.21	.09	-.18*		-.22	.09	-.19*		
Age	-.04	.03	-.11		-.03	.03	-.09		
Race	.09	.08	.08		.08	.08	.07		
Education	-.38	.07	-.41***		-.36	.07	-.38***		
Marital Status	-.06	.07	-.06		-.05	.07	-.05		
				.21***					
Step 2									
PPA					.13	.07	.14	.23	.02

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; * $p < .05$

Hypothesis 1c: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), partner psychological aggression (Step 2) significantly predicts depression for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variable of partner psychological aggression entered in Step

two (Table 11). After controlling for Step one, analysis of the regression equation indicated that partner psychological aggression significantly predicted depression for women, but not for men. Specifically, for women who experienced partner psychological aggression, their levels of depression were significantly higher than those who did not experience partner psychological aggression. There was no statistical significance for men.

In Step one for women, which did not include partner psychological aggression, 15% of the variance was significantly explained by the control variables ($R^2 = .15, p < .001$). In Step two for women, when partner psychological aggression was added to the equation, an additional 20% of the variance of depression was significantly explained ($R^2 = .35, p < .001$). In Step one for men, which did not include partner psychological aggression, only a non-significant 8% of the variance was explained by the control variables ($R^2 = .08, p = .75$). In Step two for men, when partner psychological aggression was added to the equation, an additional 4% of the variance of depression was explained ($R^2 = .12, p = .35$) but this was not significant.

Table 11

Hierarchical Multiple Regression of Depression on Partner Psychological Aggression (PPA) by Gender

	b	(SE)	β	R^2	PPA				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.02	.04	-.04		-.01	.03	-.02		
Race	-.05	.10	-.04		-.07	.09	-.06		
Education	-.36	.09	-.35***		-.29	.08	-.28***		
Marital Status	-.11	.09	-.11		-.05	.08	-.05		
				.15***					
Step 2 (Female)									
PPA					.46	.08	.45***		
								.35***	.20***
Step 1 (Male)									
Age	.03	.09	.07		.05	.09	.14		
Race	.20	.29	.16		.12	.30	.09		
Education	.02	.24	.02		.10	.26	.10		
Marital Status	-.21	.24	-.18		-.28	.25	-.25		
				.08					
Step 2 (Male)									
PPA					.23	.24	.23		
								.12	.04

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
Race: 1 = "White"; 0 = "Non-White"
Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
*** p < .001

Hypothesis 1d: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), partner psychological aggression significantly (Step 2) predicts PTSD for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variable of partner psychological aggression entered in Step two (Table 12). After controlling for Step one, analysis of the regression equation indicated that partner

psychological aggression significantly predicted PTSD for women, but not for men. Specifically, for women who experienced partner psychological aggression, their levels of PTSD were significantly higher than those who did not experience partner psychological aggression. There was no statistical significance for men.

In Step one for women, which did not include partner psychological aggression, 22% of the variance was significantly explained by the control variables ($R^2 = .22, p < .001$). In Step two for women, when partner psychological aggression was added to the equation, an additional 3% of the variance of PTSD was significantly explained ($R^2 = .25, p < .05$). In Step one for men, which did not include partner psychological aggression, a non-significant 23% of the variance was explained by the control variables ($R^2 = .23, p = .20$). In Step two for men, when partner psychological aggression was added to the equation, an additional 2% of the variance of PTSD was explained ($R^2 = .25, p = .47$) but this was not significant.

Table 12

Hierarchical Multiple Regression of PTSD on Partner Psychological Aggression (PPA) by Gender

	b	(SE)	β	R^2	PPA				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.05	.03	-.12		-.04	.03	-.11		
Race	.09	.09	.08		.08	.09	.08		
Education	-.45	.08	-.47***		-.43	.08	-.44***		
Marital Status	-.03	.08	-.03		-.01	.08	-.01		
				.22***					
Step 2 (Female)									
PPA					.16	.08	.17*		
								.25*	.03*
Step 1 (Male)									
Age	-.08	.05	-.34		-.07	.05	-.29		
Race	-.07	.17	-.08		-.10	.18	-.13		
Education	.03	.14	.05		.06	.15	.10		
Marital Status	-.27	.14	-.38		-.30	.15	-.42		

		.23				
Step 2 (Male)						
PPA		.10	.14	.16		
					.25	.02

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed,

Dating/Not Cohabiting)

*** $p < .001$; * $p < .05$

Hypothesis 2a: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts depression. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variable of self-esteem entered in Step two (Table 13). After controlling for Step one, results indicated that self-esteem significantly predicted depression. In Step one, which did not include self-esteem, 11% of the variance was significantly explained by the control variables ($R^2 = .11, p < .01$). In Step two, when self-esteem was added to the equation, an additional 20% of the variance of depression was significantly explained ($R^2 = .31, p < .001$).

Table 13*Hierarchical Multiple Regression of Depression on Self-Esteem*

	b	(SE)	B	R^2	Self-Esteem				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	-.09	.10	-.07		-.04	.09	-.03		
Age	.01	.03	.02		.01	.03	.02		
Race	.00	.09	.00		.03	.08	.03		
Education	-.28	.08	-.27***		-.17	.08	-.17*		
Marital Status	-.13	.08	-.13		-.10	.07	-.10		
				.11**					
Step 2									
Self-Esteem					-.56	.09	-.47***		
								.31***	.20***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45=54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; ** $p < .01$; * $p < .05$

Hypothesis 2b: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts PTSD for women and men. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variable of self-esteem entered in Step two (Table 14). After controlling for Step one, the regression indicated that self-esteem significantly predicted PTSD. In Step one, which did not include self-esteem, 21% of the variance was explained by the control variables ($R^2 = .21$, $p < .001$). In Step two, when self-esteem was added to the equation, an additional 19% of the variance of PTSD was significantly explained ($R^2 = .40$, $p < .001$).

Table 14*Hierarchical Multiple Regression of PTSD on Self-Esteem*

	b	(SE)	β	R^2	Self-Esteem				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	-.21	.09	-.18*		-.17	.08	-.15*		
Age	-.04	.03	-.11		-.04	.02	-.10		
Race	.09	.08	.08		.11	.07	.11		
Education	-.38	.07	-.41***		-.29	.06	-.31***		
Marital Status	-.06	.07	-.06		-.03	.06	-.03		
				.21***					
Step 2									
Self-Esteem					-.49	.07	-.45***	.40***	.19***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; * $p < .05$

Hypothesis 2c: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts depression for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variable of self-esteem entered in Step two (Table 15). After controlling for Step one, analysis of the regression equation indicated that self-esteem significantly predicted depression for women, but not for men. Specifically, women who experienced higher levels of self-esteem reported less symptoms of depression. There was no statistical significance for men.

In Step one for women, which did not include self-esteem, 15% of the variance was significantly explained by the control variables ($R^2 = .15, p < .001$). In Step two for women, when self-esteem was added to the equation, an additional 20% of the variance of self-esteem was significantly explained ($R^2 = .35, p < .001$). In Step one for men, which did not include self-esteem, only a non-significant 8% of the variance was explained by the control variables ($R^2 = .08, p = .75$). In Step two for men, when self-esteem was added to the equation, an additional 9% of the variance of self-esteem was explained ($R^2 = .17, p = .15$) but this was not significant.

Table 15

Hierarchical Multiple Regression of Depression on Self-Esteem by Gender

	b	(SE)	β	R^2	Self-Esteem				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.02	.04	-.04	.15***	-.01	.03	-.01		
Race	-.05	.10	-.04		-.02	.09	-.02		
Education	-.36	.09	-.35		-.22	.08	-.21		
Marital Status	-.11	.09	-.11***		-.07	.08	-.07**		
Step 2 (Female)									
Self-Esteem					-.56	.09	-.48	.35***	.20***
Step 1 (Male)									
Age	.03	.09	.07	.08	.01	.09	.03		
Race	.20	.29	.16		.27	.28	.21		
Education	.02	.24	.02		-.02	.24	-.02		
Marital Status	-.21	.24	-.18		-.20	.23	-.18		
Step 2 (Male)									
Self-Esteem					-.42	.28	-.31	.17	.09

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45=54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
Race: 1 = "White"; 0 = "Non-White"
Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
*** $p < .001$; ** $p < .01$

Hypothesis 2d: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-esteem (Step 2) significantly predicts PTSD for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variable of self-esteem entered in Step two (Table 16). After controlling for Step one, analysis of the regression equation indicated that self-esteem significantly predicted PTSD for women and men. Specifically, women and men with higher levels of self-esteem experienced less PTSD than women and men with lower levels of self-esteem.

In Step one for women, which did not include self-esteem, 22% of the variance was significantly explained by the control variables ($R^2 = .22, p < .001$). In Step two for women, when self-esteem was added to the equation, an additional 17% of the variance of PTSD was significantly explained ($R^2 = .39, p < .001$). In Step one for men, which did not include self-esteem, a non-significant 23% of the variance was explained by the control variables ($R^2 = .23, p = .20$). In Step two for men, when self-esteem was added to the equation, an additional 33% of the variance of PTSD was significantly explained ($R^2 = .56, p = .001$).

Table 16*Hierarchical Multiple Regression of PTSD on Self-Esteem by Gender*

	b	(SE)	β	R^2	Self-Esteem				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.05	.03	-.12		-.04	.03	-.09		
Race	.09	.09	.08		.11	.08	.11		
Education	-.45	.08	-.47***		-.33	.07	-.34***		
Marital Status	-.03	.08	.03		.00	.07	.00		
				.22***					
Step 2 (Female)									
Self-Esteem					-.48	.08	-.43***		
								.39***	.17***
	b	(SE)	β	R^2	Self-Esteem				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Male)									
Age	-.08	.05	-.34		-.10	.04	-.43*		
Race	-.07	.17	-.08		.02	.13	.02		
Education	.03	.14	.05		-.02	.11	-.04		
Marital Status	-.27	.14	-.38		-.27	.11	-.37*		
				.23					
Step 2 (Male)									
Self-Esteem					-.52	.13	-.59***		
								.56***	.33***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
Race: 1 = "White"; 0 = "Non-White"
Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
*** p < .001; * p < .05

Hypothesis 3a: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts depression for women and men. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variable of self-compassion entered in Step two (Table 17). After controlling for Step one, the regression indicated that self-compassion significantly predicted depression. In Step one, which did not include self-compassion, 11% of the variance was significantly explained by the control

variables ($R^2 = .11, p < .01$). In Step two, when self-compassion was added to the equation, an additional 31% of the variance of depression was significantly explained ($R^2 = .41, p < .001$).

Table 17

Hierarchical Multiple Regression of Depression on Self-Compassion (SC)

	b	(SE)	β	R^2	Self-Compassion				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	-.09	.10	-.07		.11	.09	.09		
Age	.01	.03	.02		.04	.03	.10		
Race	.00	.09	.00		-.06	.08	-.05		
Education	-.28	.08	-.27***		-.18	.07	-.17**		
Marital Status	-.13	.08	-.13		-.07	.07	-.07		
				.11**					
Step 2									
SC					-.32	.04	-.60***		
								.41***	.31***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed,

Dating/Not Cohabiting)

*** $p < .001$; ** $p < .01$

Hypothesis 3b: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), self-compassion (Step 2) will significantly predict PTSD. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variable of self-compassion entered in Step two (Table 18). After controlling for Step one, the regression indicated that self-compassion significantly predicted PTSD. In Step one, which did not include self-compassion, 21% of the variance was significantly explained by the control variables (R^2

= .21, $p < .001$). In Step two, when self-compassion was added to the equation, an additional 8% of the variance of PTSD was significantly explained ($R^2 = .30$, $p < .001$).

Table 18

Hierarchical Multiple Regression of PTSD on Self-Compassion (SC)

	b	(SE)	β	R^2	Self-Compassion				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	-.21	.09	-.18*		-.12	.09	-.10		
Age	-.04	.03	-.11		-.02	.03	-.06		
Race	.09	.08	.08		.06	.08	.05		
Education	-.38	.07	-.38		-.34	.07	-.36***		
Marital Status	-.06	.07	-.06		-.02	.07	-.03		
				.21***					
Step 2									
SC					-.15	.04	-.31***		
								.30***	.08***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; * $p < .05$

Hypothesis 3c: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts depression for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variable of self-compassion entered in Step two (Table 19). After controlling for Step one, analysis of the regression equation indicated that self-compassion significantly predicted depression for both women and men. Specifically, both women

and men with higher levels of self-compassion experienced less depression than those with lower levels of self-compassion.

In Step one for women, which did not include partner psychological aggression, 15% of the variance was significantly explained by the control variables ($R^2 = .15, p < .001$). In Step two for women, when self-compassion was added to the equation, an additional 27% of the variance of self-compassion was significantly explained ($R^2 = .42, p < .001$). In Step one for men, which did not include partner psychological aggression, only a non-significant 8% of the variance was explained by the control variables ($R^2 = .08, p = .75$). In Step two for men, when self-compassion was added to the equation, an additional 50% of the variance of self-compassion was significantly explained ($R^2 = .58, p < .001$.)

Table 19*Hierarchical Multiple Regression of Depression on Self-Compassion (SC) by Gender*

	b	(SE)	β	R^2	Self-Compassion				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.02	.04	-.04		.01	.03	.03		
Race	-.05	.10	-.04		-.10	.08	-.09		
Education	-.36	.09	-.35***		-.27	.078	-.26***		
Marital Status	-.11	.09	-.11		-.05	.07	-.05		
				.15***					
Step 2 (Female)									
SC					-.30	.04	-.54***		
								.42***	.27***
	b	(SE)	β	R^2	Self-Compassion				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Male)									
Age	.03	.09	.07		.11	.06	.28		
Race	.20	.29	.16		.06	.20	.05		
Education	.02	.24	.02		.07	.17	.07		
Marital Status	-.21	.24	-.18		-.04	.17	-.04		
				.08					
Step 2 (Male)									
SC					-.44	.09	-.75***		
								.58***	.50***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
Race: 1 = "White"; 0 = "Non-White"
Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
*** p < .001

Hypothesis 3d: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), self-compassion (Step 2) significantly predicts PTSD for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variable of self-compassion entered in Step two (Table 20). After controlling for Step one, analysis of the regression equation indicated that self-compassion significantly predicted PTSD for women, but not for men. Specifically, women who had

lower levels of self-compassion experienced higher levels of PTSD than those who had higher levels of self-compassion. There was no significance for men.

In Step one for women, which did not include self-compassion, only a non-significant 4% of the variance was explained by the control variables ($R^2 = .04, p < .27$). In Step two for women, when self-compassion was added to the equation, an additional 13% of the variance of PTSD was significantly explained ($R^2 = .17, p < .001$). In Step one for men, which did not include self-compassion, a non-significant 27% of the variance was explained by the control variables ($R^2 = .27, p = .12$). In Step two for men, when self-compassion was added to the equation, only an additional 4% of the variance of PTSD was explained ($R^2 = .31, p = .27$), which was not significant.

Table 20*Hierarchical Multiple Regression of PTSD on Self-Compassion (SC) by Gender*

	b	(SE)	β	R^2	Self-Compassion				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.02	.04	-.06		-.00	.03	-.01		
Race	.05	.10	.04		.02	.10	.02		
Education	-.15	.09	-.15		-.09	.09	-.09		
Marital Status	-.11	.09	-.11		-.08	.09	-.08		
				.04					
Step 2 (Female)									
SC					-.21	.05	-.37***		
								.17***	.13***
Step 1 (Male)									
Age	-.11	.08	-.29		-.09	.08	-.23		
Race	.39	.26	.30		.34	.26	.27		
Education	-.32	.22	-.32		-.31	.22	-.30		
Marital Status	.32	.22	.28		.37	.22	.33		
				.27					
Step 2 (Male)									
SC					-.13	.11	-.22		
								.31	.04

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
Race: 1 = "White"; 0 = "Non-White"
Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
*** p < .001

Hypothesis 4a: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) will collectively explain significant variance in depression. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variables of partner psychological aggression, self-esteem, and self-compassion entered in Step two (Table 21). After controlling for Step one, the regression indicated that all three independent

variables significantly predicted depression. In Step one, which included only the control variables, 11% of the variance was significantly explained ($R^2 = .11, p < .01$). In Step two, when the independent variables were added to the equation, an additional 40% of the collective variance of depression was significantly explained ($R^2 = .51, p < .001$).

Table 21
Hierarchical Multiple Regression of Depression

	b	(SE)	β	R^2	PPA, SE, SC				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	-.09	.10	-.07		.06	.08	.05		
Age	.01	.03	.02		.04	.02	.10		
Race	.00	.09	.03		-.04	.07	-.04		
Education	-.28	.08	-.27**		-.11	.06	-.11		
Marital Status	-.13	.08	-.13		-.06	.06	-.06		
				.11**					
Step 2									
PPA					.21	.07	.21**		
SE					-.31	.08	-.26***		
SC					-.23	.04	-.42***		
								.51***	.40***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; ** $p < .01$

Hypothesis 4b: After controlling for the demographic variables of gender, age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) will collectively explain significant variance in PTSD. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., gender, age, race, education level, and marital status) and the independent variables of partner

psychological aggression, self-esteem, and self-compassion entered in Step two (Table 22). After controlling for Step one, the regression indicated that all three independent variables significantly predicted PTSD. In Block one, which included only the control variables, 21% of the variance was significantly explained ($R^2 = .21, p < .001$). In Step two, when the independent variables were added to the equation, an additional 21% of the collective variance of PTSD was significantly explained ($R^2 = .42, p < .001$). In particular, individuals who experienced partner psychological aggression who also had significantly lower levels of self-esteem and self-compassion were more vulnerable to endorsing symptoms of PTSD than those with higher levels of self-esteem and self-compassion.

Table 22

Hierarchical Multiple Regression of PTSD

	b	(SE)	β	R^2	PPA, SE, SC				
					b	(SE)	β	R^2	ΔR^2
Step 1									
Gender	-.22	.09	-.18		-.14	.08	-.11		
Age	-.04	.03	-.11*		-.03	.02	-.08		
Race	.09	.08	.08		.10	.07	.09		
Education	-.38	.07	-.41***		-.28	.06	-.30***		
Marital Status	-.06	.07	-.06		-.01	.06	-.02		
				.21***					
Step 2									
PPA					.01	.06	.01		
SE					-.43	.08	-.39***		
SC					-.07	.04	-.15		
								.42***	.21***

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.

Gender: 1 = "Male"; 0 = "Female"

Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"

Race: 1 = "White"; 0 = "Non-White"

Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"

Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)

*** $p < .001$; * $p < .05$

Hypothesis 4c: After controlling for the demographic variables of age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) will collectively predict significant variance in depression for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital status) and the independent variables of partner psychological aggression, self-esteem, and self-compassion entered in Step two (Table 23). After controlling for Step one, analysis of the regression equation indicated that partner psychological aggression, self-esteem, and self-compassion significantly predicted depression for both women and men. Specifically, women who experienced partner psychological aggression who also had higher levels of self-esteem and self-compassion had lower levels of depression. However, men who experienced partner psychological aggression who had lower levels of self-esteem and higher levels of self-compassion endorsed less symptoms of depression. This is consistent with the earlier finding that men's self-esteem was not predictive of depression.

In Step one for women, which did not include partner psychological aggression, self-esteem, or self-compassion, 15% of the variance was significantly explained by the control variables ($R^2 = .15, p < .001$). In Step two for women, when all three independent variables were added to the equation, an additional 41% of the variance was significantly explained ($R^2 = .55, p < .001$). In Step one for men, which did not include partner psychological aggression, self-esteem, or self-compassion, only a non-significant 8% of the variance was explained by the control variables ($R^2 = .08, p = .75$). In Step two for

men, when all three independent variables were added to the equation, an additional 50% of the variance was significantly explained ($R^2 = .58, p < .01.$) In particular, women who experienced partner psychological aggression who also had significantly lower levels of self-esteem and self-compassion were more vulnerable to endorsing symptoms of PTSD. For men, those who experienced partner psychological aggression and had lower levels of self-compassion endorsed more symptoms of PTSD. Men's self-esteem level was not predictive of depression when all three independent variables were combined.

Table 23*Hierarchical Multiple Regression of Depression by Gender*

	B	(SE)	β	R^2	PPA, SE, SC				
					b	(SE)	β	R^2	ΔR^2
Step 1 (Female)									
Age	-.02	.04	-.04	.15***	.02	.03	.04		
Race	-.05	.10	-.04		-.08	.07	-.07		
Education	-.36	.09	-.35***		-.17	.07	-.17*		
Marital Status	-.11	.09	-.11		-.02	.06	-.02		
Step 2 (Female)									
PPA					.28	.07	.28***	.55***	.41***
SE					-.34	.08	-.29***		
SC					-.18	.04	-.33***		
Step 1 (Male)									
Age	.03	.09	.07	.08	.12	.07	.30		
Race	.20	.29	.16		.04	.23	.03		
Education	.02	.24	.02		.09	.19	.09		
Marital Status	-.21	.24	-.18		-.05	.19	-.05		
Step 2 (Male)									
PPA					.04	.19	.04	.58**	.50**
SE					.05	.25	.04		
SC					-.44	.10	-.76***		

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45-54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
Race: 1 = "White"; 0 = "Non-White"
Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
*** p < .001; ** p < .01; * p < .05

Hypothesis 4d. After controlling for the demographic variables of age, race, education level, and marital status (Step 1), the independent variables of partner psychological aggression, self-esteem, and self-compassion (Step 2) will collectively explain significant variance in PTSD for women and men. The data were split and analyzed by gender. A hierarchical multiple regression analysis was conducted with the demographic variables entered in Step one (e.g., age, race, education level, and marital

status) and the independent variables of partner psychological aggression, self-esteem, and self-compassion entered in Step two (Table 24). After controlling for Step one, analysis of the regression equation indicated that partner psychological aggression, self-esteem, and self-compassion significantly predicted PTSD for both women and men.

In Step one for women, which did not include partner psychological aggression, self-esteem, or self-compassion, 22% of the variance was significantly explained by the control variables ($R^2 = .22, p < .001$). In Step two for women, when all three independent variables were added to the equation, an additional 19% of the variance was significantly explained ($R^2 = .41, p < .001$). In Step one for men, which did not include partner psychological aggression, self-esteem, or self-compassion, only a non-significant 23% of the variance was explained by the control variables ($R^2 = .23, p = .20$). In Step two for men, when all three independent variables were added to the equation, an additional 34% of the variance was significantly explained ($R^2 = .57, p < .01$.) In particular, women who experienced partner psychological aggression who also had lower levels of self-esteem and self-compassion were more vulnerable to endorsing symptoms of PTSD. For men, those who did not experience partner psychological aggression and had lower levels of both self-esteem and self-compassion endorsed more symptoms of PTSD, which is confusing. This may be a result of not having a lot of men who endorsed PTSD in this study.

Table 24

Hierarchical Multiple Regression of PTSD by Gender

	b	(SE)	β	R^2	PPA, SE, SC				
					b	(SE)	B	R^2	ΔR^2
Step 1 (Female)									
Age	-.05	.03	-.12		-.03	.03	-.08		
Race	.09	.09	.08		.10	.08	.09		
Education	-.45	.08	-.47***		-.32	.07	-.33***		
Marital Status	-.03	.08	-.03		.02	.07	.02		
				.22***					
Step 2 (Female)									
PPA					.04	.07	.05		
SE					-.41	.09	-.37***		
SC					-.07	.04	-.14		
								.41***	.19***
Step 1 (Male)									
	b	(SE)	β	R^2	b	(SE)	B	R^2	ΔR^2
Age	-.08	.05	-.34		-.11	.05	-.44*		
Race	-.07	.17	-.08		.04	.15	.05		
Education	.03	.14	.05		-.05	.12	-.08		
Marital Status	-.27	.14	-.38		-.23	.12	-.32		
				.23					
Step 2 (Male)									
PPA					-.08	.12	-.13		
SE					-.53	.16	-.60**		
SC					-.03	.07	-.08		
								.57**	.34**

Note. b values denote unstandardized regression coefficients and standard errors are shown in parentheses; β values denote standardized coefficients.
 Age: 1 = "15-24"; 2 = "25-34"; 3 = "35-44"; 4 = "45=54"; 5 = "55-64"; 6 = "65-74"; 7 = "75+"
 Race: 1 = "White"; 0 = "Non-White"
 Education: 1 = "Bachelors or Graduate Degree"; 0 = "Less than Bachelors Degree"
 Marital Status: 1 = "Married/Cohabiting"; 0 = "Other" (Single, Divorced, Separated, Widowed, Dating/Not Cohabiting)
 *** p < .001; ** p < .01; * p < .05

CHAPTER FIVE

Discussion

Overview and Discussion of Hypotheses

The effects of partner psychological aggression on an individual's mental health can be devastating. However, there is emerging research that shows that the distressing effects such as depression and PTSD can be mitigated by other factors. This research provides evidence for increasing self-esteem and self-compassion for those individuals who have experienced partner psychological aggression. Each hypothesis in this study will be examined in further detail, and implications discussed. Moreover, the cycles of aggression experienced from childhood to adulthood is explored in further detail to help provide a rationale for developing a treatment program that incorporates elements of self-esteem and self-compassion.

Hypothesis 1a stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression would significantly predict depression. This hypothesis was supported by the regression analysis which indicated that individuals who experienced partner psychological aggression also experienced significantly higher levels of depressive symptomatology than those who did not experience partner psychological aggression. This is consistent

with previous research in this area that shows the link between psychological health and partner psychological aggression. In a study that looked at the effects of physical and psychological aggression on the psychological health of women, the authors found that partner psychological aggression contributed to increased levels of depression after controlling for the effects of physical aggression (Theran, Sullivan, Bogat, & Stewart, 2006). They also found that physical aggression contributed to a woman's level of depression. This means that both physical and psychological aggression independently contribute to feelings of increased depression for women who are currently experiencing partner psychological aggression. While previous studies have found that depression is higher amongst male perpetrators (Johnson & Leone, 2005; Sugarman, Aldarondo, & Boney-McCoy, 1996), the present study did not account for perpetrators of aggression. One previous study has found that male survivors of partner aggression, both physical and psychological, also suffer from depression (Stets & Straus, 1990), yet the present study did not have enough male participants to account for any differences in gender.

Hypothesis 1b stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression would significantly predict PTSD. This hypothesis was not supported by the regression analysis, which was not completely surprising given the mixed outcomes in previous studies. Some previous research showed a positive correlation between partner psychological aggression and PTSD (Arias & Pape, 1999; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Dutton, 2009; Gormley & Lopez, 2010; Mechanic et al., 2008) whereas others only showed a positive correlation between partner psychological aggression and anxiety (Gormley & Lopez, 2010, Hathaway et al., 2000). In this study, partner

psychological aggression did not significantly predict PTSD, although it came very close to doing so. According to statistician Sir Ronald Fisher, a significance level of 5% is set in order to reduce the chances of determining an incorrect hypothesis to be true (Cowles & Davis, 1982) but this relationship showed a significance level of 6% instead of the generally accepted 5%.

There are many reasons why partner psychological aggression may not significantly predict PTSD. Previous research has found that PTSD is a common outcome for individuals who have experienced partner psychological aggression (Cavanaugh, Messing, Petras, Fowler, LaFlair, Kub, Agnew, Fitzgerald, Bolyard, & Campbell, 2012; Stuart, Moore, Gordon, Ramsey, & Kahler, 2006; Woods, 2000), however there were not enough participants endorsing PTSD in this study to identify any significance. One previous study looked at the effects of both physical aggression and psychological aggression and found that while they are both correlated, psychological aggression did not account for higher levels of PTSD beyond the effects of physical aggression (Babcock, Rosman, Green & Ross, 2008). It may be that by definition, people who suffer from PTSD have had to witness or personally experience "physical harm or the threat of physical harm" in order to confirm that they have experienced PTSD, and with the many forms of psychological aggression, there might not always be a threat of physical harm to the survivor. Therefore, physical or sexual aggression may be better predictors of PTSD than partner psychological aggression, although it is well-known that psychological aggression exists in those relationships where other forms of aggression are also taking place (Carney & Barner, 2012; Loring, 1994; Sullivan et al, 2012).

However, Arias and Pape (1999) found in their study that partner psychological aggression could predict PTSD even after physical aggression was controlled for, which presents conflicting evidence. It is well-researched that partner psychological aggression has damaging effects on an individual's psychological health, contributing to symptoms of depression, anxiety, and in some cases, PTSD, especially when the psychological aggression is combined with physical or sexual aggression as it so commonly is. Future research to determine the impact that partner psychological aggression could have on psychological health, specifically PTSD, is necessary to clarify that relationship.

Hypothesis 1c stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression would significantly predict depression for women and men. The regression analysis supported this hypothesis for women, but not for men. Previous research has primarily established a positive correlation between partner psychological aggression and depression for women, so this result adds to this finding. However, partner psychological aggression was not predictive of depression for men. This may be due to the lack of men in this study who endorsed partner psychological aggression.

Hypothesis 1d stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, partner psychological aggression would significantly predict PTSD for women and men. Again, results indicated support for this hypothesis with regards to women, but not for men. It seems that women are more likely to endorse symptoms of PTSD. It may also be that the fear implicitly associated with men being aggressive due to their relative size and physical strength may lead women to be more at risk for fearing for their safety.

Hypothesis 2a stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem would significantly predict depression. This hypothesis was supported by the regression analysis, indicating that individuals with higher levels of self-esteem experienced significantly less depressive symptomatology than individuals with lower levels of self-esteem. This is supported by previous research that gives evidence for a vulnerability model in which low self-esteem has been shown to contribute to depression (Orth & Robins, 2013). The vulnerability model has held true regardless of gender and age (Sowislo & Orth, 2013). One study examined the causal relationship between self-esteem and depression and found that "low self-esteem predicted subsequent depressive symptoms, but depressive symptoms did not predict subsequent levels of self-esteem" and that this held true for individuals between the ages of 18 and 96 (Orth, Robins, Trzesniewski, Maes, & Schmitt, 2009, p. 472).

Very little is known regarding the causes of self-esteem across the lifespan. However, there is some emerging research that shows that self-esteem is lowest during adolescence and then again in old age, but highest around age 50, irrespective of gender (Orth & Robins, 2014; Orth, Robins, & Widaman, 2012). One study found that "self-esteem was prospectively related to higher levels of relationship satisfaction, job satisfaction, occupational status, salary, and physical health" (Orth et al., 2012, p. 1283). Furthermore, when specifically looking at relationship satisfaction, another study found that "initial level of self-esteem of each partner predicted the initial level of the partners' common relationship satisfaction, and change in self-esteem of each partner predicted changes in the partners' common relationship satisfaction" (Erol & Orth, 2014, p. 2291).

With regards to psychological aggression within intimate partner relationships, it has been shown that individuals with higher self-esteem do not typically engage in aggression with their partners, (Stets, 1991). Given the dearth of information related to self-esteem and its development, we can only speculate as to why self-esteem is so strongly predictive of depressive symptomatology. We know that individuals who endorse higher levels of depression tend to engage in negative self-talk (Beck, Rush, Shaw, & Emery, 1979). Repeatedly engaging in such behavior has been associated with low self-esteem, and it seems that individuals who have low self-esteem are more vulnerable to being self-critical and interpreting events around them in a more negative light. This likely leads them to be increasingly more susceptible to being around others who confirm their negative beliefs about themselves. These individuals may have an inherent belief that they are bad and therefore deserving of aggressive behavior (Stets, 1991). These are the individuals who may confuse partner interest, even when it's aggressive, with love. For example, if individuals have the belief that they will never be good enough for anyone, when a prospective partner shows interest in them, even if that partner turns out to be aggressive, they may be likely to stay in the relationship longer because they believe they cannot do any better or that all relationships are aggressive like this.

Contrastingly, if individuals consistently hear negative comments about themselves, they may start to believe them and therefore internalize those critical voices. This is an example of what happens to children who experience psychological aggression at the hands of their caretakers (Forward & Buck, 1989). These individuals may be more susceptible to later getting involved in a psychologically aggressive relationship or

staying in one longer because they may believe that they deserve to be treated in such an abusive manner and they are used to it. One study looked at children who experienced aggression by their caretakers, their levels of self-esteem, and the amount of internalizing behaviors they exhibited later on in life (such as depression, anxiety, and PTSD). This study found that individuals with higher levels of self-esteem displayed much less internalizing behaviors than those who started off with lower levels of self-esteem, suggesting that lower levels of self-esteem can predict the vulnerability to internalizing behaviors (Sachs-Ericsson, Gayman, Kendall-Tackett, Lloyd, Medley, Collins, Corsentino, & Sawyer, 2010).

Hypothesis 2b stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem would significantly predict PTSD. This hypothesis was supported by the regression analysis, indicating that individuals with higher levels of self-esteem experienced significantly fewer symptoms of PTSD than individuals with lower levels of self-esteem. There is very little research that examines the role of self-esteem as being predictive of PTSD. Kashdan, Uswatte, Steger, and Julian (2006) note that "the inability to regulate affective responses to internal or external stimuli perceived as threats are prominent features of PTSD and suggest the examination of self-esteem and affective instability might be valuable" (p. 1610). They found that veterans with greater self-esteem instability are more likely to exhibit symptoms of PTSD (Kashdan et al., 2006). Since global self-esteem incorporates how a person views themselves, if they have an unstable sense of self, it is reasonable to assume that when they experience a trauma, they would be more likely to exhibit symptoms of that trauma. On the other hand, since psychological aggression is so difficult to identify

even by the survivor themselves, it may be even more difficult to interpret whether they have developed PTSD as related to their experiences with psychological aggression. This writer believes that individuals who experience physical or sexual aggression, since those types of aggression are more publicly accepted as "real" forms of aggression, are more likely to report symptoms of PTSD than those who solely experience psychological aggression. All in all, this study will contribute to the research that self-esteem is predictive of PTSD for individuals who have experienced partner psychological aggression, even with such a small sample size.

Hypothesis 2c stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem would significantly predict depression for women and men. The regression analysis supported this hypothesis for women but not for men. This finding is consistent with previous research (Mills, 1984).

Hypothesis 2d stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-esteem would significantly predict PTSD for women and men. Results indicated that self-esteem could significantly predict PTSD for both women and men.

Hypothesis 3a stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion would significantly predict depression. This hypothesis was supported by the regression analysis, indicating that individuals with higher levels of self-compassion experienced significantly less depressive symptomatology than individuals with lower levels of self-compassion. This is supported by previous research that shows a significant negative relationship between

self-compassion and depression (Marshall & Brockman, 2016). Self-criticism, the opposite of self-compassion, has also been shown to be correlated with increased levels of depression and negative emotions (Irons, Gilbert, Baldwin, Bacchus, & Palmer, 2006). Gilbert, Birchwood, Gilbert, Trower, Hay, Murray, Meaden, Olsen, and Miles (2001) found that individuals who engaged in powerful self-criticism experienced more symptoms of depression. They noted that individuals need to not only be able to counteract their own negative thoughts and self-appraisals, but they have to be able to generate warmth towards themselves, which might explain why individuals can understand how to use cognitive therapy and re-evaluate negative self-criticism but may not experience a lasting change in their negative feelings (Gilbert et al., 2001). Using self-compassion, an individual learns how to practice experiencing warmth and compassion towards themselves, which seems to be more useful in decreasing symptoms of depression and therefore provides evidence for the use of improving self-compassion in order to reduce depressive symptomatology.

Hypothesis 3b stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion would significantly predict PTSD. This hypothesis was supported by the regression analysis, indicating that individuals with higher levels of self-compassion experienced significantly less PTSD symptoms than individuals with lower levels of self-compassion. While research is limited in the area of self-compassion and its impact on PTSD, Neff (2003a, 2003b) found that self-compassion is negatively related to anxiety. In one study, Thompson and Waltz (2008) found that higher levels of self-compassion were associated with lower levels of the avoidance symptoms of PTSD. When looking at war veterans who

experienced PTSD, self-compassion was also shown to predict lower levels of PTSD for each symptom cluster in two separate studies (Hiraoka, Meyer, Kimbrel, DeBeer, Gulliver, & Morissette, 2015; Kearney, Malte, McManus, Martinez, Felleman, & Simpson, 2013). On the other hand, there is a growing body of research that shows the relationship between self-criticism with PTSD (Cox, MacPherson, Enns, & McWilliams, 2004). When looking at female survivors of domestic violence in Israel, one study found that a personality style that was more self-critical was positively associated with increased intensity of PTSD (Sharhabani-Arzy, Amir, & Swisa, 2005).

Recent studies have also established a link between self-compassion and attachment with secure attachment relating to higher levels of self-compassion (Neff & McGehee, 2010). Neff and McGehee (2010) found that adolescents learn to model their self-compassion based on their relationships with their parents. Neff and McGehee (2010) noted,

How individuals treat themselves in times of suffering or failure may be modeled on family experiences. If parents are angry, cold or critical to their children, they may be colder and more critical towards themselves. If parents are warm, caring and supportive, this may be reflected in children's inner dialogues. (p. 235)

Gilbert et al. (2006) affirmed that "it may be difficult to develop self-soothing if one has not experienced others being soothing and compassionate to the self" (p. 186). Children need to learn empathic responses from their caregivers in order to be able to respond empathically towards others and ultimately, towards themselves. Furthermore, research also shows the individuals who experienced childhood maltreatment and have higher levels of self-compassion are more capable of coping with upsetting events (Vettesse, Dyer, Li, & Wekerle, 2011).

Hypothesis 3c stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion would significantly predict depression for women and men. Results of the regression analysis showed support for this hypothesis.

Hypothesis 3d stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, self-compassion would significantly predict PTSD for women and men. The regression analysis showed support for this hypothesis with regards to women but not for men. The limited research on self-compassion and men show that self-compassion tends to be less affected for men who experience partner psychological aggression than for women who experience partner psychological aggression (Lawrence et al., 2012), so this finding is consistent with that research.

Hypothesis 4a stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, all independent variables of partner psychological aggression, self-esteem, and self-compassion would collectively predict significant variance in depression. This hypothesis was supported by the regression analysis, indicating that individuals who experienced partner psychological aggression, lower levels of self-esteem, and lower levels of self-compassion also experienced higher levels of depressive symptomatology. Hypothesis 4b stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, all independent variables of partner psychological aggression, self-esteem, and self-compassion would collectively predict significant variance in PTSD. This hypothesis was also supported by the regression analysis, indicating that individuals who experienced

partner psychological aggression, lower levels of self-esteem, and lower levels of self-compassion also experienced increased amounts of PTSD symptoms.

Hypothesis 4c stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, all independent variables of partner psychological aggression, self-esteem, and self-compassion would collectively predict significant variance in depression for women and men. Hypothesis 4d stated that after controlling for the demographic variables of gender, age, race, education level, and marital status, all independent variables of partner psychological aggression, self-esteem, and self-compassion would collectively predict significant variance in PTSD for women and men. Both of these hypotheses were supported by the regression analyses.

Given the previous findings in this study, these results are not surprising. Collectively, all of these variables predicted increased levels of depression and PTSD showing that while each one is significant on its own, it is also significant together and experiencing that combination of partner psychological aggression, and lower levels of self-esteem and self-compassion can be detrimental to the overall level of psychological health of a person. In this equation, PTSD was significantly predicted even with the smaller sample size and the relatively limited amount of individuals endorsing PTSD. This provides evidence and support to developing higher levels of self-esteem and self-compassion for those individuals who experience partner psychological aggression in order to mitigate the effects of this type of aggression on the individual's psychological health.

Clinical Implications

Taking a look at the covariates of age, ethnicity, education level, and marital status that were identified as possible confounding variables, there are clinical implications that are related to these. First, younger individuals tend to be more likely to get involved in a psychologically aggressive relationship; therefore it would be important to develop a prevention program to help adolescents learn how to identify psychological aggression within relationships. If they are able to identify these types of relationships early, the risk of getting involved in a psychologically aggressive relationship might reduce and long-term impacts of partner psychological aggression on psychological health could be mitigated. Next, since previous research has shown that minority women are 72% more likely to become involved in a psychologically aggressive relationship (Kaukinen, 2004) and a lower-educated population are also more at risk to get involved in this type of relationship (Steinmetz, 1977), it would be beneficial to identify these groups as a primary target for education and prevention related to psychological aggression within relationships. Finally, another group that would benefit from early intervention and prevention would be those individuals who are unmarried but cohabitating since they are at the highest risk of getting involved in a violent relationship (Lewis, 1987; Reckdenwald & Parker, 2010; Roberts, 1987; Shackelford & Mouzos, 2005; Yllo, 1981).

Many individuals involved in a psychologically aggressive relationship with their partner may not even be aware of it. In fact, they may have experienced psychological aggression in their childhood and be unaware of how it may be impacting their current relationship. It is not uncommon for individuals who have experienced psychological

aggression or neglect in childhood to choose partners who may also be psychologically aggressive or to become an aggressor in their adult lives because this is what they are familiar with. Individuals who experienced psychological aggression in their childhood typically do not recognize when they are involved in a relationship that is psychologically aggressive because they may believe that “all couples fight as they do or that all women (or men) are treated as they are” (Engel, 2002, p. 10). According to Engel (2002), “very few people put up with emotional abuse as an adult unless they were abused as a child. And nearly every person who becomes emotionally abusive has a history of such abuse in childhood” (p. 58). People learn from their caregivers what appropriate responses in relationships are, and they repeat them. If they learned that controlling, dominating, screaming at, ridiculing, or threatening their partner is “normal,” then it would not be atypical to continue that pattern when they become adults and are involved in their own relationships. It becomes common and acceptable to them, and so repeating those behaviors do not seem out of the ordinary.

Some people unconsciously pick partners who treat them as they were treated as a child in order to experience or create a change in that relationship as an adult. They try to conquer or resolve issues from their past, however they are ill-equipped with the adequate resources or the modeling to make such a significant change. Sigmund Freud (1914) termed this “repetition compulsion,” noting that individuals may have experienced something in “very early childhood [that was] not understood at the time but were *subsequently* [italics in original] understood and interpreted” (p. 149). Freud (1914) clarified that

The patient does not *remember* anything of what he has forgotten or repressed [from childhood], but *acts* it out. He reproduces it not as a memory but as an action; he *repeats* it, without, of course, knowing that he is repeating it. (p. 150)

In the context of psychological aggression, this means that an individual may repeat the behaviors they were exposed to and become aggressive in their relationships or they may become involved with a partner who treats them in the same way. Since these actions are unconscious, it is very common to hear individuals say that they keep getting involved in the same type of relationship or choosing the same type of partner, then feel very confused or disillusioned by this. They may even start to believe that all partners will be this way.

Engel (2002) notes that “you are desperately—albeit unconsciously—attempting to find someone like your emotionally abusive parent so you can replay the relationship and get it right this time” (p. 64). Levine (2015) reminds us of the 2004 movie *Eternal Sunshine of the Spotless Mind*, in which Joel and Clementine, after being involved in a destructive relationship with one another each independently decide to have their memories erased. However, we learn that they meet each other again and are automatically attracted to each other and similarly repelled by one another, developing what feels like a familiar relationship. This is due to their unconscious memories that connect them. As Levine (2015) further explains,

An even deeper subterranean attractor derives from each of their individual, unresolved implicit and procedural childhood memories—the *imago* (the imprint, or engram) from their early childhood attachment relationships with their parents, as well as other childhood and adolescent traumas.... [They] select a partner like their parent—or turn their partner into that parent. (p. 153)

Bessel van der Kolk has been advocating since 2005 for the use of a new diagnosis, which he termed Developmental Trauma Disorder, to capture the complexities

of the repeated traumatic experiences that children and adolescents experience when younger that continue to affect them and influence them in their adult lives. He describes the importance of secure attachments being developed with infants in order to allow individuals to learn how to trust their own emotions and thoughts as they grow up. The children who have healthy, secure attachments will then learn how to trust their own instincts when they become involved in an aggressive relationship and rely on those instincts to guide them to making a healthy decision about whether or not to continue on in that relationship. Van der Kolk does not believe that a diagnosis of PTSD would accurately describe what these individuals are experiencing, and this likely holds true for the results of this study as well.

Beverly Engel (2002) suggested an eight-step program for individuals who have experienced partner psychological aggression, based on the theory that these individuals may be acting out a repetition compulsion in order to create a new ending. In her book, she suggests the following steps (Engel, 2002):

1. Admit to yourself that you are being emotionally abused and acknowledge the damage you've experienced because of it.
2. Understand why you chose an abusive partner.
3. Understand why you have put up with the abuse.
4. Understand your pattern and work on completing your unfinished business.
5. Confront your partner on his or her abusive behavior.
6. Pay attention to your feelings.
7. Take your power back by setting and enforcing your boundaries.
8. Continue to speak up.

Similarly, Engel (2002) also suggests a seven-step program for the partner who is aggressive:

1. Admit to yourself that you are emotionally abusive and acknowledge the damage you've done.

2. Understand why you abuse.
3. Understand your pattern and work on your unfinished business from the past.
4. Admit to your partner that you have been emotionally abusive.
5. Apologize to your partner and work on developing empathy for her [or him] and for others.
6. Learn and practice ways to identify and constructively release your anger, pain, and stress.
7. Identify your triggers and false beliefs.

Similarly to the cycles of aggression theory listed earlier, we can identify the same types of problems for individuals who experience low self-esteem. We know that people who feel good about themselves may be less likely to become involved in an aggressive relationship or to stay in one for a long time because they will not allow their partners to treat them in that manner. There is also a lot of embarrassment and shame that is experienced by an individual who experiences partner psychological aggression, and therefore, they may not reach out for support from others in their lives. Given how invisible this issue is, they may have difficulty explaining to someone else what they have been experiencing, and may expect to be invalidated even if they do share their experiences. Someone with low self-esteem may also feel deserving of the pain associated with psychological aggression and hence, not even know they should be asking for help or seeking support.

For individuals who have experienced partner psychological aggression and those who have been perpetrators of aggression, Engel (2002) suggests that recovery includes building self-esteem and being able to understand and honor their own emotions. She indicated that in order to build self-esteem, individuals should look at how often they are self-critical, reframe their thoughts to focus on more positive attributes, set realistic goals and standards for themselves, stop comparing themselves with other people, accept that

other people (including their abusers) can be both good and bad, and begin to nurture themselves (Engel, 2002). By honoring their own feelings, Engel (2002) means to not push down your emotions to avoid or deny them anymore, but rather accept them, pay attention to them, and experience them in the body. By learning to identify and experience all of your emotions, the individual will begin to fully experience life and to feel more in control of their emotions and bodily sensations.

Taking care of the self becomes extremely critical for any individual who is feeling alone, unsupported, uncared for, and misunderstood. This supports arguments for increasing self-compassion after experiencing psychological aggression. Neff (2004) noted that “when we apply [concepts of compassion] to the self, it means that self-compassion requires that we are touched by our own suffering. We don’t ignore it or repress our pain, but stop to realize ‘this is really difficult, I’m going through a lot right now’” (p. 29). If we can accept that we are experiencing pain, that everyone experiences pain sometimes, and that we can help to heal ourselves, we are less likely to be self-critical and harsh on ourselves. This accepting attitude towards the self helps us to minimize the effects of the pain we are experiencing by removing the power associated with the suffering that we could cause ourselves from being judgmental towards ourselves or setting higher standards for ourselves than we would for others. Additionally, “because self-compassionate individuals can to a large extent meet their own needs for comfort, kindness, and belonging, they should be able to grant their partners more freedom in their relationships without being overly controlling” (Neff & Beretvas, 2012, p. 3), a common characteristic of partner psychological aggression.

According to Peter Levine (2015), “What most of us struggle with is that we are unable to create efficacious relationships with others while we still maintain a deeply wounded relationship with ourselves” (p. 154). Many individuals may try to forget past history of aggression, but recent developments on traumatic memory has shown us that even if we consciously forget something, our bodies still hold onto the memories and react as if we are experiencing the trauma again. This is true for all types of aggression, including psychological aggression. When we experience psychological aggression, there is a physiological response that we also experience that is similar to a stress response. Our bodies start to prepare us for fighting or fleeing. Our sympathetic nervous system kick starts, "our metabolic processes (including digestion, respiration, circulation, and energy production) shut down...[and this] is mediated by the so-called primitive (unmyelinated) branch of the parasympathetic nervous system" (Levine, 2015, p. 45).

Knowing that the types of partner psychological aggression that seem to be the most harmful are those related to control (Aguilar & Nightingale, 1994) and ridicule (Follingstad, et al., 1990), increasing awareness of these two types of behaviors should be a targeted area of focus in treatment for individuals who enter therapy. These seem to be so detrimental because they can be very subtle forms of aggression, which might be overlooked by the survivor or easily dismissed by the survivor. However, repeatedly being controlled or ridiculed takes its toll on an individual's level of self-esteem and by extension, their level of self-compassion. Since these individuals may probably not self-identify into therapy, clinicians will have to be mindful of these two types of psychological aggression and assess for them when clients present for other reasons. These areas can then be addressed as part of the overall treatment plan with the client.

Since higher levels of self-esteem and self-compassion are related to greater psychological health, they would be beneficial to incorporate into any therapy. Even more importantly, it would be beneficial to develop a prevention and education program to help adolescents learn to identify these types of behavior younger so they could become aware of it and not get involved in these types of relationships or at least know what to do if they do choose partners who are psychologically aggressive or if they themselves become psychologically aggressive.

There is some hesitation in the field, especially more recently, regarding the efficacy of building self-esteem in the client. There is new research that shows a correlation between self-esteem and greater levels of narcissistic traits (Leary et al., 2007; Neff, 2003b). It is not a stretch to see how those two concepts might be related. It may be that individuals are not necessarily starting to feel better about themselves but rather are starting to overcompensate in order to hide their feelings of inadequacy, which promotes narcissistic traits. Relatedly, Brummelman, Thomaes, and Sedikides (2016) explain that the two constructs of self-esteem and narcissism are different in phenotype, consequences, development, and origins. They assert that the core beliefs of narcissism is that "one is superior to others" whereas for self-esteem, there is a belief that "one is worthy" (p. 11) and these two concepts may be getting confused. This writer advocates for building self-compassion since there is enough overlap between the two concepts to show improvement in both if one is addressed, and since there is less of a chance of inadvertently promoting qualities and traits of narcissism as we are helping clients to feel better.

Limitations

Several limitations should be acknowledged in this research. Overall, in this study, there were not enough individuals who endorsed coping with PTSD to account for significant findings for individuals who experienced partner psychological aggression. Starting off by using a college student and graduate student population also led to the bias that individuals would have experienced less partner psychological aggression. Given previous research in the area, graduating from college seems to be a protective factor against experiencing partner psychological aggression therefore PTSD would be less likely to be a factor (Steinmetz, 1977). There are several differences between individuals with more education than those with less education. Typically, they have more access to resources, both financially and through support. For example, these individuals usually have access to counseling services, they might have more family support, and they may experience more social support as well. A higher level of education is also associated with a higher socioeconomic status also, so we can assume that with more finances, they can afford to secure other resources, such as childcare or marital counseling, if necessary.

Furthermore, the majority of the sample identified themselves as being Caucasian (75%), so it would be difficult to generalize these results to other racial or ethnic populations. Within a higher educated sample, it is common to see the overrepresentation of Caucasian participants.

Using more of a community sample would have been justified to obtain a higher number of individuals that would endorse PTSD. Another limitation in this study was that all data were collected via self-report surveys. It is possible that individuals who may have experienced PTSD and were triggered by the topic may have self-selected out of the

study. Additionally, PTSD may have been more likely to be identified if looking at a sample which also included partner physical abuse and controlling for that variable as previous research has done (Arias & Pape, 1999).

Similarly, there were a limited number of men in the study, which as mentioned earlier, made it difficult to account for gender differences in this sample. It is possible that, given the topic, more women than men would self-select to complete surveys that are related to partner psychological aggression. Previous research has acknowledged the gender disparities when it comes to admitting an individual has experienced partner psychological aggression, and it can be assumed that the shame and embarrassment around admitting this might be increased for men. Also, the CAS which was the scale used to identify experience of aggression has been shown to have limited validity with men (Hegarty, 2007). This research hoped to extend validity to this subpopulation, but was unable to do so given the relatively small sample size.

When running statistical analyses, married couples and unmarried, cohabitating couples were lumped into one group. Though not formally tested, it would have been interesting to note if there was a significant difference in those two groups with regards to levels of partner psychological aggression since previous research has shown that unmarried cohabitating couples are at a higher risk for violence and even homicide (Lewis, 1987; Reckdenwald & Parker, 2010; Roberts, 1987; Shackelford & Mouzos, 2005).

Future Research

In light of the results that were found in this study, there are several directions that this author has identified as areas to pursue further research. Generally, more research is needed in the following areas: the development of self-esteem, increasing self-esteem and the risk of contributing to narcissistic tendencies, and more information and possibly DSM inclusion of the Developmental Trauma Disorder.

This research also identified specific areas related to the generalization of this study, which would be beneficial to address in the future as well. Since some individuals who experienced psychological aggression as children also grow up to be either involved in similar types of relationship or become perpetrators of psychological aggression, it would be interesting to look at the levels of self-esteem and self-compassion in both the survivors and the perpetrators to determine if there are any differences and to note if either of those variables would be predictive of becoming a perpetrator of partner psychological aggression.

Furthermore, this dissertation looked at individuals who experienced partner psychological aggression within the past 12 months. Because of this, some participants were not identified as experiencing current psychological aggression and may have been excluded from analysis. For future research, it might be useful to take a look at individuals who have experienced partner psychological aggression at any point in their lives, thereby including more participant experiences.

Another modification of this study would be to include more men in order to diversify the sample and to generalize the results. Given the dearth of information on men with all three independent variables of partner psychological aggression, self-esteem, and

self-compassion on psychological distress as well as the protective factor of being a college graduate, this author would be interested in using a community sample to examine the effects of these variables on psychological distress as measured by depression and PTSD in order to obtain more men and less individuals with a higher education level.

Alternatively, since there is overlap between PTSD and Battered Woman's Syndrome, it might be beneficial to utilize a measure like the revised version of the Battered Woman Syndrome Questionnaire (BWSQ; Walker, 2006) in order to identify the subpopulation that specifically experienced symptoms related to partner aggression rather than the TSQ that was used in this study. However, this writer recognizes the limits of the BWSQ, given that it would take approximately three hours to administer by trained professionals.

With regards to future research as it relates to creating a prevention program for individuals identified to be at-risk for experiencing partner psychological aggression, there is some support for Forgiveness Therapy, which encourages individuals to forgive the harmful behavior of others but not necessarily condone it, in order to release the hold on anger and resentment that may impede the survivor's psychological health (Reed & Enright, 2006). As mentioned throughout this paper, increasing levels of self-compassion has also been shown to be useful. There are several programs already designed that incorporate mindfulness and self-compassion, such as Mindful Self-Compassion (MSC; Neff & Germer, 2012) and Compassionate Mind Training (CMT; Gilbert & Procter, 2006). Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1990) also offers some suggestions incorporating mindfulness to help cope with stress, which can be a general

side-effect of having to cope with partner psychological aggression. The MBSR program has quite a bit of research showing its efficacy, and has been shown to improve the functioning of the brain (Farb, Segal, Mayberg, Bean, McKeon, Fatima, & Anderson, 2007; Hölzel, Cramody, Vangel, Congleton, Yerramsetti, Gard & Lazar, 2010)

Finally, since people with lower levels of self-esteem are more likely to endorse symptoms of PTSD, there are some arguments for increasing self-esteem, but this writer would caution clinicians to be mindful to monitor the increase of narcissistic traits as well because of the relationship between self-esteem and narcissism. It would be interesting to note if building self-compassion would also increase self-esteem as a by-product and to notice if one variable seems more or less beneficial to target.

Concluding Remarks

This research unequivocally provides evidence for the efficacy of increasing self-esteem and self-compassion for all individuals, whether they are experiencing symptoms of psychological distress or not, however there seems to be benefit in increasing these for individuals who experience depression and PTSD as well. Even though there is some research on Forgiveness Therapy, there is also the contrary belief that forgiving the perpetrator is not necessary in order to recover from the effects of partner psychological aggression. Incorporating interventions based on mindfulness and increasing self-esteem and self-compassion would be beneficial to reducing the harmful effects of partner psychological aggression. Since partner relationships tend to start during middle school or high school, this age group could be targeted for prevention and intervention programs to help reduce the impact of psychological distress one may experience as an adult.

REFERENCES

- Abbott, J., Johnson, R., Koziol-McLain, J. & Lowenstein, S.R. (1995). Domestic violence against women: Incidence and prevalence in an emergency department population. *Journal of American Medical Association*, 273, 1763-1767.
- Aguilar, R.J. & Nightingale, N.N. (1994). The impact of specific battering experiences on the self-esteem of abused women. *Journal of Family Violence*, 9(1), 35-45.
- Ali, A. (2007). Where is the voice of feminism in research on emotional abuse? *Journal of Gender Studies*, 16:1, 73-77, doi: 10.1080/09589230601116224
- Ali, A., Oatley, K., & Toner, B.B. (1999). Emotional abuse as a precipitating factor for depression in women. *Journal of Emotional Abuse* 1(4), 1-13.
- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, DC: American Psychiatric Association.
- Anderson, D. & Saunders, D.G. (2003). Leaving an abusive partner: An empirical review of predictors, the process of leaving, and psychological well-being. *Trauma, Violence, & Abuse*, 4(2), 163-191.
- Arias, I. (1999). Women's responses to physical and psychological abuse. In X.B. Arriaga & S. Oskamp (Eds.), *Violence in Intimate Relationships* (pp. 139-161). Thousand Oaks, CA: Sage.
- Arias, I., Lyons, C.M., & Street, A.E. (1997). Individual and marital consequences of victimization: Moderating effects of relationship efficacy and spouse support. *Journal of Family Violence*, 12(2), 193-210.
- Arias, I. & Pape, K.T. (1999). Psychological abuse: Implications for adjustment and commitment to leave violent partners. *Violence and Victims*, 14(1), 55-67.

- Babcock, J.C., Roseman, A., Green, C.E., & Ross, J.M. (2008). Intimate partner abuse and PTSD Symptomatology: Examining mediators and moderators of the abuse-trauma link. *Journal of Family Psychology, 22*, 809-818.
- Barnard, L.K. & Curry, J.F. (2011). Self-compassion: Conceptualizations, correlates, and interventions. *Review of General Psychology, 15*(4), 289-303.
- Basow, S.A., Cahill, K.F., Phelan, J.E., Longshore, K., & McGillicuddy-DeLisi, A. (2007). Perceptions of relational and physical aggression among college students: Effects of gender of perpetrator, target, and perceiver. *Psychology of Women Quarterly, 31*, 85–95.
- Beck, A. T. (1987). Cognitive models of depression. *Journal of Cognitive Psychotherapy, 1*, 5–37.
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.
- Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.
- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbauch, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.
- Black, M.C, Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

- Blake, D. D., Weathers, F.W., Nagy, L. M., Kaloupek, D.G., Gusman, F.D., Charney, D.S., & Keane, T.M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75-90.
- Blatt, S. J., D’Afflitti, J., & Quinlan, D. (1976). Experiences of depression in young adults. *Journal of Abnormal Psychology, 65*, 383–389.
- Blatt, S.J., Quinlan, D.M., Chevron, E.S., McDonald, C. & Zuroff, D. (1992). Dependency and self-criticism: Psychological dimensions of depression. *Journal of Consulting and Clinical Psychology, 30(1)*, 113-124.
- Bourget, D. & Gagné, P. (2012). Women who kill their mates. *Behavioral Sciences and the Law, 30*, 598-614.
- Breiding, M.J., Basile, K.C., Smith, S.G., Black, M.C., & Mahendra, R.R. (2015). Intimate partner violence surveillance: Uniform definitions and recommended data elements, Version 2. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S., and Foa, E. B. (2002). Brief screening instrument for post-traumatic stress disorder. *The British Journal of Psychiatry, 181*, 158-162.
- Brown, J. D., & Marshall, M. A. (2006). The three faces of self-esteem. In M. Kernis (Ed.), *Self-esteem: Issues and answers* (pp. 4-9). New York: Psychology Press.
- Brummelman, E., Thomaes, S., & Sedikides, C. (2016). Separating narcissism from self-esteem. *Current Directions in Psychological Science, 25(1)*, 8-13.
- Campbell, J.C., Miller, P., Cardwell, M.M., & Belknap, R.A. (1994). Relationship status of battered women over time. *Journal of Family Violence, 9(2)*, 99-111.

- Carney, M.M. & Barner, J.R. (2012). Prevalence of partner abuse: rates of emotional abuse and control. *Partner Abuse, 3*(3), 286-335.
- Cascardi, M., & O'Leary, K.D. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence, 7*(4), 249-259.
- Cascardi, M., O'Leary, K.D., Lawrence, E.E., & Schlee, K.A. (1995). Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict. *Journal of Consulting and Clinical Psychology, 63*(4), 616-623.
- Cavanaugh, C.E., Messing, J.T., Petras, H., Fowler, B., LaFlair, L., Kub, J., Agnew, J., Fitzgerald, S., Bolyard, R., & Campbell, J.C. (2012). Patterns of violence against women: A latent class analysis. *Psychological Trauma, 4*, 169-176.
- CDC. (1999). Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements. Atlanta, GA: U.S. Department of Health and Human Services, CDC. Retrieved May 3, 2014, from https://www.cdc.gov/ncipc/pub-res/ipv_surveillance/11_section34.htm
- CDC. (2013). Definitions: Self-directed violence. Atlanta, GA: U.S. Department of Health and Human Services, CDC. Retrieved August 16, 2014, from <http://www.cdc.gov/violenceprevention/suicide/definitions.html>
- Cerulli, C., Poleshuck, E., Raimondi, C., Veale, S., & Chin, N. (2012). "What fresh Hell is this?" Victims of intimate partner violence describe their experiences of abuse, pain, and depression. *Journal of Family Violence, 27*, 773-781, doi:10.1007/s10896-012-9469-6

- Chen, Z., Williams, K.D., Fitness, J., & Newton, N.C. (2008). When hurt will not heal: Exploring the capacity to relive social and physical pain. *Psychological Science, 19*(8), 789-795.
- Christian, J.L., O'Leary, K.D., & Vivian, D. (1994). Depressive symptomatology in maritally discordant women and men: The role of individual and relationship variables. *Journal of Family Psychology, 8*, 3242.
- Cohen, J. (1992). A power primer. *Psychological Bulletin, 112* (1), 155-159.
- Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). Applied multiple regression for the behavioral sciences (2nd ed.). Hillsdale, NJ: Erlbaum.
- Coker, A.L., Davis, K.E., Arias, I., Desai, S., Sanderson, M., Brandt, H.,M., & Smith, P.G. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*, 260-268.
- Coopersmith, S. (1967). The antecedents of self-esteem. San Francisco: W.H. Freeman & Co.
- Cowles, M. & Davis, C. (1982). On the origins of the .05 level of statistical significance. *American Psychologist, 37*(5), 553-558.
- Cox, B.J, MacPherson, P.S.R., Enns, M.W., & McWilliams, L.A. (2004). Neuroticism and self-criticism associated with posttraumatic stress disorder in a nationally represented sample. *Behavior Research and Therapy, 42*(1),105-114.
- Coyle, C. T., & Enright, R. D. (1997). Forgiveness intervention with postabortion men. *Journal of Consulting and Clinical Psychology, 65*, 1042–1046.

- Crandall, R. (1973). The measurement of self-esteem and related constructs. In J. Robinson & P. Shaver (Eds.), *Measures of social psychological attitudes* (rev. ed.). Ann Arbor Institute for Social Research, University of Michigan.
- Crane, C.A. & Eckhardt, C.I. (2013). Negative affect, alcohol consumption, and female-to-male intimate partner violence: A daily diary investigation. *Partner Abuse, 4*(3), 332-355.
- Davidson, J. R., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J. C., Smith, R. D., Davison, R. M., Katz, R. & Feldman, M. E. (1997). Assessment of a new self-rating scale for post-traumatic stress disorder. *Psychological Medicine 27*, 153–160.
- Davidson, J. R., Tharwani, H. M. & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety 15*, 75–78.
- Dekkers, A.M.M, Olf, M. & Näring, G.W.B. (2009). Identifying persons at risk for PTSD after trauma with TSQ in the Netherlands. *Community Mental Health Journal, 46*, 20-25.
- Derogatis, L.R. (1977). SCL-90 administration, scoring and procedure manual for the R (Revised) version. Johns Hopkins University School of Medicine, Baltimore, MD.
- Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric scale: Preliminary report. *Psychopharmacology Bulletin, 9*, 13-27.
- Devries, K.M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., Astbury, J., & Watts, C.H. (2013). Intimate partner violence and incident depressive

symptoms and suicide attempts: A systematic review of longitudinal studies.
PLoS Medicine, 10(5), 1-11.

Domestic violence protection orders. (n.d.) In Women'sLaw.org. Retrieved from:
http://www.womenslaw.org/laws_state_type.php?id=11333&state_code=CO#content-7763.

Dutton, M. A. (1992). Assessment and treatment of PTSD among battered women. In D. Foy (Ed.), *Treating PTSD: Procedure for combat veterans, battered women, adult and child sexual assaults*. New York: Guilford Press.

Dutton, M.A. (2009). Pathways linking interpersonal violence and posttraumatic disorder. *Trauma, Violence, & Abuse*, 10, 211-224.

Eaton, W.W., Smith, C., Ybarra, M., Muntaner, C., & Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: Review and revision (CESD and CESD-R). In: Maruish, M.E. (Ed.), *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment*, 3rd ed.: Instruments for Adults, 3. Lawrence Erlbaum, Mahwah, NJ, pp. 363–377.

Engel, B. (2002). *The emotionally abusive relationship*. New Jersey: John Wiley & Sons, Inc.

Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive: An empirical guide for resolving anger and restoring hope*. Washington, DC: American Psychological Association.

Erol, R.Y., & Orth, U. (2014). Development of self-esteem and relationship satisfaction in couples: Two longitudinal studies. *Developmental Psychology*, 50(9), 2291-2302.

Esquivel-Santoveña, E.E., Lambert, T.L., & Hamel, J. (2013). Partner abuse worldwide.

Partner Abuse, 4(1), 6-75.

Family Violence Prevention Fund. (1999). Preventing domestic violence: Clinical

guidelines on routine screening. San Francisco, CA: Family Violence Prevention

Fund.

Farb, N.A.S., Segal, Z.V., Mayberg, H., Bean, J., McKeon, D., Fatima, Z., & Anderson,

A.K. (2007). Attending to the present: Mindfulness meditation reveals distinct

neural modes of self-reference. *Social Cognitive and Affective Neuroscience, 2,*

313-322.

First, M.B., Spitzer, R.L., Gibbon, M. & Williams, J.B.W. (1996) Structured Clinical

Interview for DSM-Axis I Disorders, Clinician Version (SCID-CV). Washington,

DC: American Psychiatric Press, Inc.

Foa, E., Davidson, J.R.T., & Frances, A. eds. (1999). Expert Consensus Guideline Series:

Treatment of Posttraumatic Stress Disorder. *The Journal of Clinical Psychiatry,*

60 (16).

Foa, E. B., Riggs, D. S., Dancu, C.V., & Rothbaum, B.O. (1993). Reliability and validity

of a brief instrument for assessing post-traumatic stress disorder. *Journal of*

Traumatic Stress, 6, 459-473.

Follingstad, D.R. (2007). Rethinking current approaches to psychological abuse:

Conceptual and methodological issues. *Aggression and Violent Behavior, 12, 439-*

458.

- Follingstad, D.R., Rutledge, L.L., Berg, B.J., Hause, E.S., & Polek, D.S. (1990). The role of emotional abuse in physically abusive relationships. *Journal of Family Violence, 5*(2), 107-120.
- Forward, S. & Buck, C., (1989). Toxic parents: Overcoming their hurtful legacy and reclaiming your life. New York: Bantam Books.
- Freud, S. (1914). Remembering, repeating, and working-through. In J. Strachey (Editor & Translator). *The Standard Edition of the Complete Psychological Works of Sigmund Freud, 12*, (pp. 145-156). London: Hogarth Press.
- Frieden, J. (2005). Emotional abuse may raise risk of mental illness. *Clinical Psychiatry News, 33*(3), 53.
- Gavin, H. (2011). Sticks and stones may break my bones: The effects of emotional abuse. *Journal of Aggression, Maltreatment & Trauma, 20*(5), 503-529, doi:10.1080/10926771.2011.592179
- Geffner, R. & Rossman, B.B.R. (1998). Emotional abuse. *Journal of Emotional Abuse, 1*(1), 1-5.
- Germer, C.K., & Neff, K.D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology: In Session, 69*(8), 856-867.
- Gibb, B.E., Alloy, L.B., Abramson, L.Y., Rose, D.T., Whitehouse, W.G., Donovan, P., Hogan, M.E., Cronholm, J., & Tierney, S. (2001). History of childhood maltreatment, cognitive styles, and episodes of depression in adulthood. *Cognitive Therapy and Research, 25* (4), 425-446.
- Gilbert, P., Birchwood, M., Gilbert, J., Trower, P., Hay, J., Murray, B., Meaden, A., Olsen, K., & Miles, J.N.V. (2001). An exploration of evolved mental mechanisms

- for dominant and subordinate behaviour in relation to auditory hallucinations in schizophrenia and critical thoughts in depression. *Psychological Medicine*, 31, 1117-1127.
- Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, 13, 353-379.
- Goldsmith, R.E. & Freyd, J.J. (2005). Effects of emotional abuse in family and work environments: Awareness for emotional abuse. *Journal of Emotional Abuse*, 5(1), 95-123.
- Gormley, B. & Lopez, F. (2010). Correlates of psychological abuse perpetration in college dating relationships. *Journal of College Counseling*, 13, 4-16.
- Gros, D.F., Antony, M.M., Simms, L.J., & McCabe, R.E. (2007). Psychometric properties of the state-trait inventory for cognitive and somatic anxiety (STICSA): Comparison to the state-trait anxiety inventory (STAI). *Psychological Assessment*, 19, 369-381.
- Hamilton. M. A. (1960). A rating scale for depression. *Journal of Neurologic Neurosurgical Psychiatry*, 23, 56-62.
- Hart, S. N., & Brassard, M. R. (1990). Psychological maltreatment of children. In R. T. Ammannan & M. Hersen (Eds.), *Treatment of family violence: A source-book* (pp. 77-112). New York: Wiley & Sons.
- Hathaway, J.E., Mucci, L.A., Silverman, J.G., Brooks, D.R., Mathews, R., & Pavlos, C.A. (2000). Health status and health care use of Massachusetts women reporting partner abuse. *American Journal of Preventive Medicine*, 19(4), 302-307.

- Hegarty, K. (2007). Composite Abuse Scale Manual. Department of General Practice at the University of Melbourne, Australia.
- Hegarty, K., Bush, R., & Sheehan, M. (2005). The Composite Abuse Scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims, 20*:5, 529-547.
- Hegarty, K.L., Sheehan, M., & Schonfeld, C. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the Composite Abuse Scale. *Journal of Family Violence, 14*:4, 399-414.
- Hines, D.A., Brown, J., & Dunning, E. (2007). Characteristics of callers to the domestic abuse helpline for men. *Journal of Family Violence, 22*, 63-72.
- Hines, D.A. & Saudino, K.J. (2003). Gender differences in psychological, physical, and sexual aggression among college students using the revised conflict tactics scales. *Violence and Victims, 18*(2), 197-215.
- Hiraoka, R., Meyer, E.C., Kimbrel, N.A., DeBeer, B.B., Gulliver, S.B., & Morissette, S.B. (2015). Self-compassion as a prospective predictor of PTSD symptom severity among trauma-exposed U.S. Iraq and Afghanistan war veterans. *Journal of Traumatic Stress, 28*, 127-133.
- Holtzworth-Munroe, Smutzler, N., & A., Bates, L. (1997). A brief review of the research on husband violence: Part III: Sociodemographic factors, relationship factors, and differing consequences of husband and wife violence. *Aggression and Violent Behavior, 2*(3), 285-307.
- Holzel, B.K., Carmody, J., Vangel, M., Congleton, C., Yerramsetti, M., Gard, T., Lazar, S.W. (2010). Mindfulness practice leads to increases in regional brain gray matter

density. *Psychiatry Research Neuroimaging*.

doi:10.1016/j.psychresns.2010.08.006.

Hughes, M., Chiu, W.T., Jones, R.T., Rothwell, V., Brymer, M., Fairbank, J.A., Pynoos, R.S., Steinberg, A.M., & Kessler, R.C. (2011). Posttraumatic stress among students after the shootings at Virginia Tech. *Psychological Trauma: Theory, Research, Practice, and Policy* 3(4), 403-411.

Irons, C., Gilbert, P., Baldwin, M.W., Baccus, J., & Palmer, M. (2006). Parental recall, attachment relating and self-attacking/self-reassurance: Their relationship with depression. *British Journal of Clinical Psychology*, 12, 297-308.

Jewkes, R. (2010). Emotional abuse: A neglected dimension of partner violence.

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Jezl, D.R., Molidor, C.E., & Wright, T.L. (1996). Physical, sexual, and psychological abuse in high school dating relationships: Prevalence rates and self-esteem issues. *Child and Adolescent Social Work Journal*, 13(1), 69-87.

Johnson, M.P. & Leone, J.M. (2005). The differential effects of intimate terrorism and situational couple violence: Findings from the national violence against women survey. *Journal of Family Issues*, 26(3), 322-349.

Jones, S., Davidson II, W.S., Bogat, G.A., Levendosky, A., & von Eye, A. (2005).

Validation of the subtle and overt psychological abuse scale: An examination of construct validity. *Violence and Victims*, 20 (4), 407-416.

Kabat-Zinn, J. (1990). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness. New York: Bantam Books.

- Karakurt, G. & Silver, K.E. (2013). Emotional abuse in intimate relationships: The role of gender and age. *Violence and Victims, 28*(5), 804-821.
- Kashdan, T.B., Uswatte, G., Steger, M.F., & Julian, T. (2006). Fragile self-esteem and affective instability in posttraumatic stress disorder. *Behavior Research and Therapy, 44*, 1609-1619.
- Kasian, M. & Painter, S.L. (1992). Frequency and severity of psychological abuse in a dating population. *Journal of Interpersonal Violence, 7*(3), 350-364.
- Kaslow, N. J., Thompson, M. P., Okun, A., Price, A., Young, S., Bender, M., Wyckoff, S., Twomey, H., & Goldin, J. (2002). Risk and protective factors for suicidal behavior in abused African American women. *Journal of Consulting and Clinical Psychology, 70*, 311-319.
- Kaukinen, C. (2004). Status compatibility, physical violence, and emotional abuse in intimate relationships. *Journal of Marriage and Family, 66*, 452-471.
- Kearney, D.J., Malte, C.A., McManus, C., Martinez, M.E., Felleman, B. & Simpson, T.L. (2013). Loving-kindness meditation for posttraumatic stress disorder: A pilot study. *Journal of Traumatic Stress, 26*, 78-83.
- Kemp, A., Rawlings, E.I. & Green, B.L. (1991). Post-traumatic stress disorder (PTSD) in battered women: A shelter example. *Journal of Traumatic Stress Studies, 4*, 137-148.
- Lammers, M., Ritchie, J., & Robertson, N. (2005). Women's experience of emotional abuse in intimate relationships: A qualitative study. *Journal of Emotional Abuse, 5*(1), 29-64.

- Lawrence, E., Orengo-Aguayo, R., Langer, A., & Brock, R.L. (2012). The impact and consequences of partner abuse on partners. *Partner Abuse, 3*(4), 406-428.
- Leary, M.R., Tate, E.B., Adams, C.E., Batts, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92*, 887–904.
- Lee, R. M., & Robbins, S. B. (1995). Measuring belongingness: The social connectedness and social assurance Scales. *Journal of Counseling Psychology, 42*, 232–241.
- Levine, P. A. (2015). Trauma and memory. Berkeley, CA: North Atlantic Books and Lyons, CO: ERGOS Institute Press.
- Lewis, B.Y. (1987). Psychosocial factors related to wife abuse. *Journal of Family Violence, 2*(1), 1-10.
- Lin, W. F., Enright, R. D., Mack, D., Krahn, D., & Baskin, T. (2004). Effects of forgiveness therapy on anger, mood, and vulnerability to substance use among inpatient substance-dependent clients. *Journal of Consulting and Clinical Psychology, 72*, 1114–1121.
- Loring, M. T. (1994). Emotional abuse. New York: Lexington.
- MacBeth, A. & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*, 545-552.
- MacEwen, K.E., & Barling, J. (1988). Multiple stressors, violence in the family of origin, and marital aggression: A longitudinal investigation. *Journal of Family Violence, 3*, 73-87.

- Magdol, L., Moffitt, T.E., Caspi, A., Newman, D.L., Fagan, J., & Silva, P. (1997). Gender differences in partner violence in a birth cohort of 21-year-olds: Bridging the gap between clinical and epidemiological approaches. *Journal of Consulting and Clinical Psychology, 65*(1), 68-78.
- Marshall, E.J., & Brockman, R.N. (2016). The relationships between psychological flexibility, self-compassion, and emotional well-being. *Journal of Cognitive Psychotherapy: An International Quarterly, 30*(1), 60-72.
- Marshall, L. L. (1994). Physical and psychological abuse. In W.R. Cupach & B.H. Spitzberg (Ed.), *The dark side of interpersonal communication* (pp. 281 – 311). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Marshall, L.L. (1999). Effects of subtle and overt psychological abuse on low-income women. *Violence and Victims, 14*(1), 69-88.
- Mechanic, M.B., Weaver, T.L., & Resick, P.A. (2008). Mental health consequences of intimate partner abuse: A multidimensional assessment of four different forms of abuse. *Violence Against Women, 14*(6), 634-654.
- Mele, M., Roberts, J.C., & Wolfer, L. (2011). Men who seek protection orders against female intimate partners. *Partner Abuse, 2*(1), 61-75.
- Merriam-Webster. (n.d.). Retrieved on August 16, 2014, from <http://www.merriam-webster.com/dictionary/meditate>
- Mills, T. (1984). Victimization and self-esteem: On equating husband abuse and wife abuse. *Victimology: An International Journal, 9*, 254-261.
- Moss, V.A., Pitula, C.R., Campbell, J.C., & Halstead, L. (1997). The experience of terminating an abusive relationship from an Anglo and African American

- perspective: A qualitative descriptive study. *Issues in Mental Health Nursing*, 18, 433-457.
- Mouthaan, J., Sijbrandij, M., Reitsma, J.B., Gersons, B.P.R., & Olf, M. (2014). Comparing screening instruments to predict posttraumatic stress disorder. *PLoS One*, 9(5), e97183. doi:10.1371/journal.pone.0097183
- Murphy, C. & Hoover, S. (1999). Measuring emotional abuse in dating relationships as a multifactorial construct. *Violence and Victims*, 14(1), 39-53.
- National Institute of Mental Health. (n.d.). Retrieved from:
<http://www.nimh.nih.gov/health/publications/anxiety-disorders/nimhanxiety.pdf>
- Neff, K.D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.
- Neff, K.D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85-101.
- Neff, K.D. (2004). Self-compassion and psychological well-being. *Constructivism in the Human Sciences*, 9(2), 27-37.
- Neff, K.D. (2009). Self-compassion. In M.R. Leary & R.H. Hoyle (Eds), *Handbook of individual differences in social behavior* (pp. 561–573). New York: Guilford Press.
- Neff, K.D. & Beretvas, S.N. (2012). The role of self-compassion in romantic relationships. *Self and Identity*, 1-21.
- Neff, K.D. & Germer, C.K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology*, 69, 28–44.

- Neff, K.D., Kirkpatrick, K.L., & Rude, S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality, 41*, 139-154.
- Neff, K.D. & McGehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and Identity, 9*(3), 225-240.
- Neff, K.D. & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality, 77*(1), 23-50.
- Norman, R.E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Medicine, 9*(11), 1-31.
doi:10.1371/journal.pmed.1001349
- O'Keefe, D. (2003). Colloquy: Should familywise alpha be adjusted? Against familywise alpha adjustment. *Human Communication Research, 29*(3), 431-447.
- Orth, U. & Robins, R.W. (2013). Understanding the link between low self-esteem and depression. *Current Directions in Psychological Science, 22*(6), 455-460.
- Orth, U. & Robins, R.W. (2014). The development of self-esteem. *Current Directions in Psychological Science, 23*(5), 381-387.
- Orth, U., Robins, R.W., Trzesniewski, K.H., Maes, J., & Schmitt, M. (2009). Low self-esteem is a risk factor for depressive symptoms from young adulthood to old age. *Journal of Abnormal Psychology, 118* (3), 472-478.
- Orth, U., Robins, R.W., & Widaman, K.F. (2012). Life-span development of self-esteem and its effects on important life outcomes. *Personality Processes and Individual Differences, 102*(6), 1271-1288.

- Pan, H.S., Neidig, P.H., & O'Leary, K.D. (1994). Predicting mild and severe husband-to-wife physical aggression. *Journal of Consulting and Clinical Psychology, 62*, 975-981.
- Pipes, R.B. & LeBov-Keeler, K. (1997). Psychological abuse among college women in exclusive heterosexual dating relationships. *Sex Roles, 36*(9/10), 585-603.
- Radloff, L.S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385-401.
- Raes, R., Pommier, E., Neff, K.D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy, 18*, 250-255.
- Raine, A. & Benishay, D. (1995). The SPQ-B: A brief screening instrument for schizotypal personality disorder. *Journal of Personality Disorders, 9*, 346-355.
- Raskin, A., Schulterbrandt, J., Reatig, N., & McKeon, J. (1969). Replication of factors of psychopathology in interview, ward behavior, and self-report ratings of hospitalized depressives. *Journal of Nervous and Mental Disease, 148*, 87-96.
- Reckdenwald, A., & Parker, K. F. (2010). Understanding gender-specific intimate partner homicide: A theoretical and domestic service-oriented approach. *Journal of Criminal Justice, 38*, 951-958.
- Reed, G.L. & Enright, R.D. (2006). The effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women after spousal emotional abuse. *Journal of Consulting and Clinical Psychology, 74*(5), 920-929.
- Roberts, A.R. (1987). Psychosocial characteristics of batterers: A study of 234 men charged with domestic violence offenses. *Journal of Family Violence, 2*(1), 81-93.

- Robins, R.W., Hendin, H.M., & Trzesniewski, K.H. (2001). Measuring global self-esteem: Construct validation of a single-item measure and the Rosenberg self-esteem scale. *Personality and Social Psychology Bulletin*, 27, 151-161.
- Rockliff, B.W. (1971). A brief rating scale for anti-depressant drug trials. *Comprehensive Psychiatry*, 12, 122-135.
- Rosenberg, M. (1979). *Conceiving the self*. New York: Basic Books.
- Rosenberg, M. (1989). *Society and the adolescent self-image: Revised Edition*. Middletown, CT: Wesleyan University Press.
- Rounsaville, B.J., Weissman, M.M., Prusoff, B.A., & Herceg-Baron, R.L. (1979). Marital disputes and treatment outcome in depressed women. *Comprehensive Psychiatry*, 20(2), 483-490.
- Russell, R.J.H. & Hulson, B. (1992). Physical and psychological abuse of heterosexual partners. *Personality and Individual Differences*, 13(4), 457-473.
- Sachs-Ericsson, N., Gayman, M.D., Kendall-Tackett, K., Lloyd, D.A., Medley, A., Collins, N., Corsentino, E., & Sawyer, K. (2010). The long-term impact of childhood abuse on internalizing disorders among older adults: The moderating role of self-esteem. *Aging and Mental Health*, 14(4), 489-501.
- Saunders, D.G. (1986). When battered women use violence: Husband-abuse or self-defense? *Victims and Violence*, 1(1), 47-60.
- Saunders, D.G. (2002). Are physical assaults by wives and girlfriends a major social problem?: A review of the literature. *Violence Against Women*, 8, 1424-1448.
- Schmitt, D.P. & Allik, J. (2005). Simultaneous administration of the Rosenberg self-esteem scale in 53 nations: Exploring the universal and culture-specific features

- of global self-esteem. *Journal of Personality and Social Psychology*, 89(4), 623-642.
- Schumacher, J.A., Slep, A.M.S., & Heyman, R.E. (2001). Risk factors for male-to-female partner psychological abuse. *Aggression and Violent Behavior*, 6, 255-268.
- Shackelford, T. K., & Mouzos, J. (2005). Partner killing by men in cohabiting and marital relationships. *Journal of Interpersonal Violence*, 20, 1310–1324.
- Sharhabani-Arzy, R., Amir, M., & Swisa, A. (2005). Self-criticism, dependency and posttraumatic stress disorder among a female group of help-seeking victims of domestic violence in Israel. *Personality and Individual Differences*, 38, 1231-1240.
- Simonelli, C.J. & Ingram, K.M. (1998). Psychological distress among men experiencing physical and emotional abuse in heterosexual dating relationships. *Journal of Interpersonal Violence*, 13(6), 667-681.
- Sims, C. (2008). Invisible wounds, invisible abuse: The exclusion of emotional abuse in newspaper articles. *Journal of Emotional Abuse*, 8(4), 375-402.
- Sinclair, S.J., Blais, M.A., Gansler, D.A., Sandberg, E., Bistis, K., & LoCicero, A. (2010). Psychometric properties of the Rosenberg Self-Esteem Scale: Overall and across demographic groups living within the United States. *Evaluation and the Health Professions*, 33(1), 56-80.
- Smith, M.E. (2003). Recovery from intimate partner violence: A difficult journey. *Issues in Mental Health Nursing*, 24, 543-573.

- Sorsoli, L. (2004) Hurt feelings: emotional abuse and the failure of empathy. *Journal of Emotional Abuse, 4(1)*, 1-26, doi: 10.1300/J135v04n01_01
- Sowislo, J.F. & Orth, U. (2013). Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. *Psychological Bulletin, 139*, 213-240.
- Stalans, L.J. & Ritchie, J. (2007). Relationship of substance use/abuse with psychological and physical intimate partner violence: Variations across living situations. *Journal of Family Violence, 23*, 9-24.
- Steinmetz, S.K. (1977). The cycle of violence: Assertive, aggressive, and abusive family interaction. New York: Praeger.
- Stets, J.E. (1991). Psychological aggression in dating relationships: The role of interpersonal control. *Journal of Family Violence, 6(1)*, 97-114.
- Stets, J.E. & Straus, M.A. (1990). Gender differences in reporting marital violence and its medical and psychological consequences. In M.A. Straus & R.J. Gelles (Eds.), *Physical violence in American families* (pp. 151-165). New Brunswick, NJ: Transaction.
- Straus, M.A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scale. *Journal of Marriage and the Family, 41:1*, 75-79.
- Straus, M.A. & Gelles, R. J. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of Marriage and the Family, 48*, 465-479.
- Straus, M.A. & Sweet, S. (1992). Verbal/symbolic aggression in couples: Incident rates and relationships to personal characteristics. *Journal of Marriage and the Family, 54(2)*, 346-357.

- Stuart, G.L., Moore, T.M., Gordon, K.C., Ramsey, S.E., & Kahler, C.W. (2006). Psychopathology in women arrested for domestic violence. *Journal of Interpersonal Violence, 21*, 376-389.
- Sugarman, D.B., Aldarondo, E., & Boney-McCoy, S. (1996). Risk marker analysis of husband-wife violence: A continuum of aggression. *Journal of Applied Social Psychology, 26*(4), 313-337.
- Sullivan, T.P., McPartland, T.S., Armeli, S., Jaquier, V., & Tennen, H. (2012). Is it the exception or the rule? Daily co-occurrence of physical, sexual, and psychological partner violence in a 90-day study of substance-using, community women. *Psychology of Violence, 2*(2), 154-164.
- Sutherland, C.A., Bybee, D.I., & Sullivan, C.M. (2002). Beyond bruises and broken bones: The joint effects of stress and injuries on battered women's health. *American Journal of Community Psychology, 30*(5), 609-636.
- Taft, C.T., O'Farrell, T.J., Torres, S.E., Panuzio, J., Monson, C.M., Murphy, M., & Murphy, C.M. (2006). Examining the correlates of psychological aggression among a community sample of couples. *Journal of Family Psychology, 20*(4), 581-588.
- Tesh, M., Learman, J., & Pulliam, R.M. (2013). Mindful self-compassion strategies for survivors of intimate partner abuse. *Mindfulness*, doi: 10.1007/s12671-013-0244-4
- Theran, S.A., Sullivan, C.M., Bogat, G.A., & Stewart, C.S. (2006). Abusive partners and ex-partners: Understanding the effects of relationship to the abuser on women's well-being. *Violence Against Women, 12*(10), 950-969.

- Thompson, M.P., Kaslow, N.J., & Kingree, J.B. (2002). Risk factors for suicide attempts among African American women experiencing recent intimate partner violence. *Violence and Victims, 17*(3), 283-295.
- Thompson, B.L. & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress, 21*, 556-558.
- Tolman, R.M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4*(3), 159-177.
- Tolman, R.M. (1999). The validation of the psychological maltreatment of women inventory. *Violence and Victims, 14*(1), 25-37.
- Torres, J.G., Schumm, J.A., Weatherill, R.P., Taft, C.T., Cunningham, K.C., & Murphy, C.M. (2012). Attitudinal correlates of physical and psychological aggression perpetration and victimization in dating relationships. *Partner Abuse, 3*(1), 76-88.
- Truman-Schram, D.M., Cann, A., Calhoun, L., & Vanwallendael, L. (2000). Leaving an abusive dating relationship: An investment model comparison of women who stay versus women who leave. *Journal of Social and Clinical Psychology, 19*(2), 161-183.
- Twenge, J. M., & Campbell, W. K. (2001). Age and birth cohort differences in self-esteem: A cross-temporal meta-analysis. *Personality and Social Psychology Review, 5*, 321-344.
- Types of abuse. (n.d.) In Department of Health and Human Services. Retrieved from: http://ncea.aoa.gov/FAQ/Type_Abuse/

- Van Dam, N.T. & Earleywine, M. (2011). Validation of the center for epidemiologic studies depression scale-revised (CESD-R): Pragmatic depression assessment in the general population. *Psychiatry Research, 186*, 128-132.
- Vettesse, L., Dyer, C., Li, W., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood maltreatment and later regulation difficulties? A preliminary investigation. *International Journal of Mental Health and Addiction, 9*(5), 480-491.
- Vissing, Y., & Bailey, W. (1996). Parent-to-child verbal aggression. In D. D. Cahn & S. A. Lloyd (Eds.), *Family violence from a communication perspective* (pp. 85–107). London: Sage.
- Vivian, D. & Langhinrichsen-Rohling, J. (1994). Are bi-directionally violent couples mutually victimized? A gender-sensitive comparison. *Violence and Victims, 9*, 107-123.
- Walker, L.E.A. (2006). Battered woman syndrome: Empirical findings. *Annals of the New York Academy of Sciences, 1087*(1), 142-157.
- Walters, J.T.R., Bisson, J.I., & Shepherd, J.P. (2007). Predicting post-traumatic stress disorder: Validation of the Trauma Screening Questionnaire (TSQ) in victims of assault. *Psychological Medicine, 37*, 143-150.
- Webster's Concise English Dictionary. (1992). P.H. Colin (Ed.). New York: Harrap Publishing Group Ltd.
- Wei, M., Liao, Y., Ku, T., & Shaffer, P.A. (2011). Attachment, self-compassion, empathy, and subjective well-being among college students and community adults. *Journal of Personality, 79*(1), 191-221.

- Weston, R. (2008). Insecure attachment mediates effects of partners' emotional abuse and violence on women's relationship quality. *Journal of Family Violence, 23*, 483-493.
- Williams, C., Richardson, D.S., Hammock, G.S., & Janit, A.S. (2012). Perceptions of physical and psychological aggression in close relationships: A review. *Aggression and Violent Behavior, 17*, 489-494.
- Woods, S.J. (1999). Normative beliefs regarding the maintenance of intimate relationships among abuse and nonabused women. *Journal of Interpersonal Violence, 14*, 479-491.
- Woods, S.J. (2000). Prevalence and patterns of posttraumatic stress disorder in abused and postabused women. *Mental Health Nursing, 3*, 309-324.
- Yang, L., Jia, C., and Qin, P. (2015). Reliability and validity of the center for epidemiologic studies depression scale (CES-D) among suicide attempters and comparison residents in rural China. *BMC Psychiatry 15:76*, 1-8. DOI 10.1186/s12888-015-0458-1.
- Yllo, K. (1981). Interpersonal violence among married and cohabitating couples. *Family Relations, 30(3)*, 339-347.

APPENDIX A

Glossary

1. Partner (domestic partner):

Partner or domestic partner can be defined as an interpersonal relationship where parties may or may not be married or joined in a civil union. The term may be interchangeable with intimate partner, since this is often used in the literature. In this dissertation, domestic partners are limited to adult, heterosexual couples who have been involved in a relationship for at least six months.

2. Abuse:

Webster's Concise English Dictionary (1992) defines abuse as "to insult" or "to mistreat." In therapy, abuse can be defined as anything that is used in excess, taken advantage of, or misused with intent to harm. In this dissertation, the term abuse is used as interchangeable with aggression.

3. Emotional abuse:

According to the Department of Health and Human Services (n.d.), emotional abuse is defined as "the infliction of anguish, pain, or distress through verbal or nonverbal acts." In this dissertation, the term emotional abuse is used as interchangeable with psychological aggression. These two terms encompass the same behaviors, including insults, belittling, name-calling, controlling behaviors, intimidation, humiliation, and harassment.

4. Psychological abuse:

Psychological abuse is another term used to describe emotional abuse or psychological aggression. Since there is no consistent phrase used to describe

psychological abuse, this dissertation will attempt to limit multiple phrases and solely use the term psychological aggression.

5. Psychological aggression:

The term "psychological aggression" is varied in the literature, with much of the existing literature using the term "emotional abuse." This dissertation will use the term "partner psychological aggression" to describe the trauma experienced by the victim by his or her intimate partner. Follingstad (2007) advocates for the use of the term psychological aggression stating that "abuse" is more difficult to identify and because psychological aggression covers a range of damaging behaviors.

The Centers for Disease Control (CDC, 1999) defines psychological aggression as "trauma to the victim caused by acts, threats of acts, or coercive tactics" including but not limited to humiliating the survivor, controlling the survivor, withholding information from the survivor, feeling annoyed due to disagreement with the survivor, deliberate attempts at making the survivor feel diminished or embarrassed, using the survivor's money or taking advantage of the survivor, disregard of the survivor's wants, isolating the survivor, prohibiting the survivor to access transportation or the telephone or money, encouraging the survivor to engage in illegal activities, using the survivor's children to control the survivor's behavior, threatening the loss of child custody, smashing objects or destroying property, or disclosing tarnishing information on the survivor's reputation (p. 61). While there is no agreed-upon formal definition for psychological aggression, researchers agree that this type of aggression is the

most deleterious form of aggression as well as the most widely used form of aggression within interpersonal relationships.

6. Partner psychological aggression:

Partner psychological aggression is defined as non-physical, verbal aggression, perpetrated by one's intimate partner. This could include overt means of psychological aggression such as ridiculing, saying demeaning words, or insulting another person. The goal of partner psychological aggression is to attempt to control, suppress, or harm the recipient. Partner psychological aggression could also be covert. Often times, partner psychological aggression is difficult to recognize, even by the survivor, because it feels more like a microaggression. For example, a husband might say to his wife, "You are beautiful and would look even better in that dress if you lost 15 pounds." While this may not be intentionally harmful, the effects from hearing this message can be quite devastating to the survivor who then feels inadequate.

7. Domestic violence:

Women's Law of Colorado (Women'sLaw.org, n.d.) informs us that domestic violence is defined as "any act, attempted act, or threatened act of violence, stalking, harassment, or coercion." In this dissertation, this term is used as interchangeable with intimate partner violence. Domestic violence encompasses all types of aggression, such as physical aggression, sexual aggression, and psychological aggression.

8. Intimate partner violence:

According to the Family Violence Prevention Fund (1999), intimate partner violence (IPV) is defined as "a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion." In this dissertation, intimate partner violence includes not only psychological aggression, but physical and sexual aggression as well.

9. Survivor:

A survivor is referred to as anyone who has experienced abuse or aggression in the past and are living through it or moving on. In previous literature, survivors of aggression were referred to as "victims" however, in this dissertation, a strength-based approach has been taken, recognizing the difficulties and struggles the recipient has experienced as well as acknowledging their resilience.

10. Sexual abuse:

Sexual abuse is defined as the "non-consensual sexual act of any kind" (Department of Health and Human Services, n.d.). This definition includes rape, molestation, sodomy, unwanted touching, or coerced nudity. Taking sexually-explicit photography of an individual who does not consent to it would also be considered sexual abuse.

11. Sexual coercion:

Women's Law of Colorado (n.d.) defines coercion as "using force, the threat of force, or intimidation to make you do something that you have the right

not to do, or to make you **not** do something that you have the right to do." With regards to sexual coercion, this means the individual is forced to either perform a sexual act or is the survivor of a sexual act being performed against them without their permission. In this dissertation, the term sexual coercion will be used interchangeable with sexual aggression.

12. Sexual aggression:

Sexual aggression is the same as sexual coercion and sexual abuse. This dissertation will use the term sexual aggression instead of sexual abuse or sexual coercion to be consistent with the other types of aggressive behavior noted.

13. Physical abuse:

The Department of Health and Human Services (n.d.) defines physical abuse as "the use of physical force that may result in bodily injury, physical pain, or impairment." Physical abuse includes behaviors such as spitting, punching, kicking, slapping, hair-pulling, burning, shoving, pushing, shaking, and beating. Physical abuse may also include use of physical force to restrain a person. Physical abuse often results in bruises, skin-breakages, broken bones, or lacerations. This is the most commonly noticed form of abuse. In this dissertation, physical abuse will be used interchangeably with physical aggression.

14. Physical aggression:

Physical aggression is the same as physical abuse. This dissertation will use the term physical aggression instead of physical abuse to be consistent with the other types of aggressive behavior noted.

15. Psychological distress:

Psychological distress is the pain caused by any type of aggression which is long-lasting and is often relived by the individual time after time. Psychological distress can include symptoms related to shame, depression, anxiety, posttraumatic stress disorder, suicidality, and substance abuse. For the purposes of this dissertation, the author measured the psychological distress variables of depression and PTSD.

16. Depression:

Depression refers to feeling blue or sad for an extended period of time. The DSM-5 (APA, 2013) identifies several categories or types of depression. For purposes of this dissertation, this writer used Major Depressive Disorder. The DSM-5 (APA, 2013) defines Major Depressive Disorder as:

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day.
2. Markedly diminished interest or pleasure in all, or almost all activities.
3. Significant unintentional weight loss when not dieting or weight gain.
4. Insomnia or hypersomnia.
5. Psychomotor agitation or retardation (observable by others).
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive or inappropriate guilt.
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

17. Posttraumatic Stress Disorder:

The DSM-5 (APA, 2013) defines Posttraumatic Stress Disorder as:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic experience occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state.
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance.

F. Duration of the disturbance (symptoms in Criteria B, C, D, and E) is more than one month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance or another medical condition.

18. Suicidality:

Webster's Concise English Dictionary (1992) refers to suicide as the act of "killing yourself." Suicide is defined as "death caused by injurious behavior with any intent to die as a result of the behavior" (CDC, 2013). The CDC (2013) includes the definition for suicidal ideation, which includes "thinking about, considering, or planning for suicide."

19. Substance abuse/Substance Use Disorder:

The DSM-5 (APA, 2013) explains that substance use disorder encompasses 11 criteria:

1. The individual may take the substance in larger amounts or over a longer period that was originally intended.
2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use.
3. The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.
4. Craving is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used.
5. Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home.
6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational, or recreational activities may be given up or reduced because of substance use.
8. Recurrent substance use in situations in which it is physically hazardous.
9. The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.
11. Withdrawal is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance.

20. Self-esteem:

Webster's Concise English Dictionary (1992) defines self-esteem as "pride in yourself." Self-esteem is the way a person feels about self and views self in comparison to others. Three types of self-esteem has been identified including: a) Global Self-Esteem (a.k.a. Trait Self-Esteem), b) Feelings of Self-Worth (a.k.a.

State Self-Esteem), and c) Self-Evaluations (a.k.a. Domain Specific Self-Esteem) (Brown & Marshall, 2006). Global self-esteem is relatively stable over time, from childhood to adulthood. When self-esteem is used in terms of being self-evaluative of our emotional reactions, we call it self-worth. This is seen as a state because it changes with each situation we experience. When people evaluate their various abilities and attributes in specific areas, it is described more as a self-evaluation. A measure of global self-esteem was used in this study since it is the most stable. Self-esteem could act as a buffer for partner psychological aggression and may help limit the negative effects of this type of aggression.

21. Self-compassion:

Self-compassion is defined by Neff et al. (2007) as:

Being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical; perceiving one's experiences as part of the larger human experience rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them (p. 139).

These different aspects were identified within three components including self-kindness, common humanity, and mindfulness. Neff (2007) believes that self-compassion could act as a buffer for partner psychological aggression and may help limit the negative effects of this type of aggression. Research on self-compassion originated in Western philosophies where meditation and mindfulness are practiced.

22. Mindfulness:

Merriam-Webster's online dictionary defines mindfulness as "the quality or state of being conscious or aware of something" and "a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations." This second definition is the one practiced as a therapeutic technique in counseling.

23. Mindfulness-Based Stress Reduction

The Mindfulness-Based Stress Reduction (MBSR) program was created in 1979 by Dr. Jon Kabat-Zinn at the Stress Reduction Clinic at the University of Massachusetts Medical Center in Worcester, Massachusetts. It is an eight-week course that teaches

People to engage more fully in their own movement toward greater levels of health and well-being as a complement to whatever medical treatments they may be receiving, starting of course from where they are at the moment they decide to take up this challenge: namely, to do something for themselves that no one else on the planet can do for them (Kabat-Zinn, 1990, pp. xlvii-xlviii).

24. Mindful Self-Compassion:

Mindful Self-Compassion (MSC) is an eight-week program designed to help individuals become more self-compassionate and has been shown to be effective to increase self-compassion, mindfulness, and well-being (Neff & Germer, 2013). The program teaches mindfulness skills in one session, which contributes to the development of self-compassion, and was developed to be an adjunct to MBSR or Mindfulness-Based Cognitive Therapy (MBCT). The program is structured similarly to MBSR in that it meets weekly for eight weeks

over 2.5 hours each week. Individuals are asked to participate in experiential exercises and to complete homework which involves being more compassionate towards the self.

25. Compassionate Mind Training

"Compassionate mind training (CMT) was developed for people with high shame and self-criticism, whose problems tend to be chronic, and who find self-warmth and self-acceptance difficult and/or frightening" (Gilbert & Procter, 2006). It has shown efficacious for individuals who suffer from traumatic experiences and who have difficulty with self-soothing.

26. Forgiveness Therapy

Forgiveness Therapy (FT) has become important because of the research that shows it's relationship between forgiveness and reduction in anxiety and depression and increases in self-esteem (Coyle & Enright, 1997; Enright & Fitzgibbons, 2000; Lin, Enright, Mack, Krahn, & Baskin, 2004). FT makes the clarification that forgiving someone does not excuse the harmful behavior and it does not condone it. Forgiveness is for the individual to let go of the anger and resentment that might be contributing to their psychological distress. For partners who have experienced psychological aggression, FT helps them to:

Examine the injustice of the abuse, consider forgiveness as an option, make the decision to forgive, do the hard work of forgiving (grieve the pain from the injustice, reframe the wrongdoer, relinquish resentment, and develop goodwill), find meaning in the unjust suffering, and discover psychological release and new purpose (Reed & Enright, 2006).

APPENDIX B

Demographic Information

If you would like to be entered into an anonymous drawing for one of five \$50 gift card and/or receive the results of this dissertation, please enter your email address here (this information will be kept separately from your answers and will not be linked to your results in any way):

Age:

15-24 25-34 35-44 45-54 55-64 65-74 75 +

Gender:

Male Transgender Transgender Heterosexual Homosexual Bisexual
Female (*FtM*) (*MtF*) Questioning Not Sure Other

Sexual Orientation:

Race/Ethnicity:

White/Caucasian Black/African American Hispanic/Latino/Latina
Asian/Pacific Islander Biracial/Multiracial American Indian/Alaskan Native
Other _____

What, in years, is your educational level?

Grade school (up to 8th grade) High School (9-12th grade) Technical School
Some college Associate's degree Bachelor's degree Graduate degree

What is your occupation, if applicable? _____

What state do you live in? _____

What is your current relationship status:

Single Divorced Dating/Cohabiting Widowed
Married Separated Dating/Not-Cohabiting

How long have you been in your current relationship?

> 1 year 1-5 years 5-10 years 11+ years

Please answer the following questions about the relationship with the partner you are describing in the study:

Age when your relationship began _____

Duration of the relationship _____

Type of experience you had with your partner (Please note all that apply):

Physical aggression Emotional or psychological aggression
Sexual aggression/assault Maltreatment of child(ren)
None Other _____

APPENDIX C

Composite Abuse Scale (CAS; Hegarty et al., 2005)

Used with author's permission

In this section, you will be asked about your relationships because it is an important part of your life that may influence your health. I ask you about your experiences in adult intimate relationships. By adult intimate relationship, I mean husband/wife, partner, or boy/girl friend for longer than one month.

1. Have you ever been in an adult intimate relationship?

(Since you were 16 years of age)

Yes _____ No _____

2. Have you been in an adult intimate relationship in the last 12 months?

(Since you were 16 years of age)

Yes _____ No _____

3. Are you currently in an intimate relationship?

Yes _____ No _____

4. Are you currently afraid of your partner?

Yes _____ No _____

5. Have you been afraid of any partner in the last 12 months?

Yes _____ No _____

6. Have you ever been afraid of any partner?

Yes _____ No _____

Please read each question carefully, then answer each item by indicating how often it happened during the last 12 months. If you were not with a partner in the past 12 months, could you please answer for the last partner that you had.

0-----1-----2-----3-----4-----
5
NEVER ONLY ONCE SEVERAL TIMES ONCE/MONTH ONCE/WEEK
DAILY

In the past 12 months, my partner:

- _____ 1. Told me that I wasn't good enough
- _____ 2. Kept me from medical care
- _____ 3. Followed me
- _____ 4. Tried to turn my family, friends, and children against me
- _____ 5. Locked me in the bedroom
- _____ 6. Slapped me
- _____ 7. Raped me
- _____ 8. Told me that I was ugly
- _____ 9. Tried to keep me from seeing or talking to my family
- _____ 10. Threw me
- _____ 11. Hung around outside me house
- _____ 12. Blamed me for causing their violent behavior
- _____ 13. Harassed me over the telephone
- _____ 14. Shook me
- _____ 15. Tried to rape me
- _____ 16. Harassed me at work
- _____ 17. Pushed, grabbed, or shoved me
- _____ 18. Used a knife or gun or other weapon
- _____ 19. Became upset if dinner/housework was not done when they thought it should be
- _____ 20. Told me I was crazy
- _____ 21. Told me that no one would ever want me
- _____ 22. Took my wallet and left me stranded

- _____ 23. Hit or tried to hit me with something
- _____ 24. Did not want me to socialize with my female friends
- _____ 25. Put foreign objects in my vagina/anus
- _____ 26. Refused to let me work outside the home
- _____ 27. Kicked me, bit me, or hit me with a fist
- _____ 28. Tried to convince my friends, family, or children that I was crazy
- _____ 29. Told me that I was stupid
- _____ 30. Beat me up

<i>Scoring</i>	<i>Never</i>	<i>Only Once</i>	<i>Several Times</i>	<i>1x/mo</i>	<i>1x/wk</i>	<i>Daily</i>	<i>Cut off Scores</i>
<i>EA items:1, 4, 8, 9, 12, 19, 20, 21, 24, 28, 29</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>3 or 4</i>
<i>Harassment items:3, 11, 13, 16</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>2</i>

APPENDIX D

Center for Epidemiologic Studies Depression Scale (CES-D Scale; Radloff, 1977)

This scale is available publicly; no permission from author is needed

Please read each question carefully, then answer each item by indicating how you have felt or behaved during the past week, including today, according to the following scale.

1-----	2-----	3-----	4-----
RARELY OR OR NONE OF THE TIME (<small>< THAN 1 DAY</small>)	SOME OR A LITTLE OF THE TIME (<small>1-2 DAYS</small>)	OCCASIONALLY OR A MODERATE AMOUNT OF TIME (<small>3-4 DAYS</small>)	MOST OR ALL OF THE TIME (<small>5-7 DAYS</small>)

In the past week:

- _____ 1. I was bothered by things that don't usually bother me
- _____ 2. I did not feel like eating; my appetite was poor
- _____ 3. I felt that I could not shake off the blues, even with help from my family or friends
- _____ 4. I felt that I was just as good as other people
- _____ 5. I had trouble keeping my mind on what I was doing
- _____ 6. I felt depressed
- _____ 7. I felt that everything I did was an effort
- _____ 8. I felt hopeful about the future
- _____ 9. I thought my life had been a failure
- _____ 10. I felt fearful
- _____ 11. My sleep was restless
- _____ 12. I was happy
- _____ 13. I talked less than usual
- _____ 14. I felt lonely
- _____ 15. People were unfriendly
- _____ 16. I enjoyed life
- _____ 17. I had crying spells
- _____ 18. I felt sad
- _____ 19. I felt that people disliked me
- _____ 20. I could not "get going"

Scoring	<i>Rarely</i>	<i>Some</i>	<i>Occasionally</i>	<i>Most</i>	<i>16 points or more is considered depressed. Do not score if more than 4 questions are missing answers.</i>
<i>4, 8, 12, 16</i>	<i>3</i>	<i>2</i>	<i>1</i>	<i>0</i>	
<i>All other</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	

APPENDIX E

Trauma Screening Questionnaire (TSQ; Brewin et al., 2002)

Used with author's permission

Please consider the following reactions which sometimes occur after a traumatic event such as physical abuse, sexual abuse, being bullied, being assaulted, or being a survivor of or witness to a serious accident. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please write YES or NO to whether or not you have experienced any of the following **at least *twice* in the past week.**

- _____ 1. Upsetting thoughts or memories about the event that have come into your mind against your will
- _____ 2. Upsetting dreams about the event
- _____ 3. Acting or feeling as though the event were happening again
- _____ 4. Feeling upset by reminders of the event
- _____ 5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event
- _____ 6. Difficulty falling or staying asleep
- _____ 7. Irritability or outbursts of anger
- _____ 8. Difficulty concentrating
- _____ 9. Heightened or increased awareness of potential dangers to yourself or others
- _____ 10. Being jumpy or being startled at something unexpected

Scoring:

<i>Six or more positive responses mean that the client is at risk of having PTSD according to the DSM-IV (American Psychiatric Association, 1994) and requires a more detailed assessment. The traumatic event must have occurred at least one month prior to taking the survey. It only assesses current symptoms and should not be used as a diagnostic tool.</i>

APPENDIX H

PROJECT INFORMATION SHEET

Approval Date: 03/30/2015

Valid for Use Through: 03/30/2016

Project Title: Invisible effects of partner psychological aggression

Principal Investigator: Galana Chookolingo, M.A.

Faculty Sponsor: Ruth Chu-Lien Chao, Ph.D.

DU IRB Protocol #: 658100-1

You are being asked to participate in a research study about factors that assist with decreasing the negative effects of partner psychological aggression (PPA). This form provides you with information about the study. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part.

Invitation to participate in a research study

You are invited to participate in a research study about partner psychological aggression. In other words, this study is about emotional abuse within adult intimate partner relationships. The goal of this study is to understand how certain factors such as self-esteem and self-compassion impact the survivor's mental health.

You are being asked to be in this research study because you may have been or are currently involved in a heterosexual romantic relationship. Within this relationship, you may have experienced PPA. Even if you have not experienced PPA, your responses would also be beneficial for this study because the researcher is interested in finding out if PPA is predictive of psychological distress for both men and women.

Description of subject involvement

If you agree to be part of the research study, you will be asked to complete a demographic questionnaire and 88 additional questions. The questions will cover topic areas such as type of relationship abuse, your experiences with depression or trauma, self-esteem, and self-compassion. This will take about 10-15 minutes of your time. Approximately 200 participants are needed to complete the survey.

Possible risks and discomforts

The researcher has taken steps to minimize the risks of this study. Even so, you may still experience some risks related to your participation, even when the researcher is careful to avoid them. Since the subject of psychological aggression can be sensitive to some, it is possible to experience mild to moderate discomfort while answering the questions pertaining to abuse on these surveys. If you experience discomfort, you may choose to skip questions or discontinue the survey at any time. The researcher respects your right not to answer any questions that may be uncomfortable.

If you experience discomfort during the survey, you may contact your local emergency room or call 911. There are also several national hotlines that are available, such as the National Mental Health Association Hotline (800) 273-8255; the National Hopeline Network (800) 784-2433; the National Domestic Violence Hotline (800) 799-7233; Rape, Abuse, and Incest National Network (800) 656-4673; Safe Horizon's Rape, Sexual Assault, and Incest Hotline (800) 621-4673; or the National Institute of Mental Health Information Center (866) 615-6464.

Possible benefits of the study

This study is designed for the researcher to learn more about the factors that guard against psychological distress when experiencing PPA. As such, there may not be any direct benefits to you, however this information can be used to later develop prevention programs to help others who may be involved in abusive relationships. By understanding how the factors of self-esteem and self-compassion contribute to level of psychological distress, this researcher hopes to develop interventions that could be used within counseling centers that could contribute to more favorable outcomes for individuals experiencing PPA.

Study compensation

Individuals who wish to participate in and complete this study will be entered into a raffle to win one of five \$50 VISA gift cards by providing their email addresses at the start of the survey and at the end of this consent form. If you choose to provide your email address to enter into the raffle, it will be stored separately from the rest of the data and will not be used to identify you in any way aside from contacting you if you win. **Completion of the survey will be required for compensation and withdrawing early from the survey will not enable you to be entered into the raffle.**

Study cost

There are no costs associated with completing this survey, other than the time that it will take you to complete it.

Confidentiality, Storage, and Future use of data

To keep your information safe, your name will not be attached to any data, but a study number will be used instead. The data will be collected via a secure online survey tool that will be password-protected and will be stored on a password-protected computer using a password-protected file. The researcher will retain the de-identified data or make it available to other researchers for other studies following the completion of this research study, however the data will not contain information that could be used to identify you.

The results from the research may be shared at a meeting. The results from the research may be in published articles. Your individual identity will be kept private when information is presented or published.

Who will see my research information?

Although I will do everything I can to keep your records a secret, confidentiality cannot be guaranteed. Both the records that identify you and the consent form signed by you may be looked at by the following: Federal agencies that monitor human subject research and the Human Subject Research Committee.

All of these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

Also, if you tell me something that makes me believe that you or others have been or may be physically harmed, I may report that information to the appropriate agencies. Some things cannot be kept private: If you mention that you are going to physically hurt yourself or someone else, I have to report that to your local police department. Also, if I get a court order to turn over your study records, I will have to do that.

Voluntary Nature of the Study

Participating in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. If you decide to withdraw early, the information or data you provided will be destroyed.

Contact Information

The researcher carrying out this study is Galana Chookolingo, M.A., Doctoral Candidate in the Counseling Psychology program at the University of Denver. If you have questions, you may email Galana directly at galana.chookolingo@du.edu. This research is being supervised by a licensed psychologist, Dr. Ruth Chu-Lien Chao, Ph.D. You may contact her at 303-871-2556 or cchao3@du.edu.

If Galana cannot be reached, or if you would like to talk to someone other than the researcher about; (1) questions, concerns or complaints regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects issues, you may contact the Chair of the Institutional Review Board for the Protection of Human Subjects, at 303-871-4015 or by emailing IRBChair@du.edu, or you may contact the Office for Research Compliance by emailing IRBAdmin@du.edu, calling 303-871-4050 or in writing (University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121).

Agreement to be in this study:

I have read this paper about the study or it was read to me. I understand the possible risks and benefits of this study. I know that being in this study is voluntary. I choose to be in this study: I will print out a copy or save a copy of this consent form on my computer.

____ I have read the above statement and agree to participate in this study.

____ I decline participation in this study.