ABSTRACT

Title of Thesis: THE RELATIONSHIP BETWEEN PSYCHOLOGICAL PARTNER ABUSE AND DEPRESSION: SOCIAL SUPPORT AS A MODERATING VARIABLE

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The association between psychological aggression within heterosexual couples and the level of depression symptoms was explored in addition to whether or not that association was moderated by the level of perceived social support from friends. Secondary analyses were conducted on assessment data from both males and females in 406 heterosexual couples who sought conjoint therapy at the Center for Healthy Families, a university-based marriage and family therapy clinic. Psychological aggression was assessed using the Multidimensional Measure of Emotional Abuse Scale (MMEA; Murphy and Hoover, 1999); depression was assessed using the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996); and social support was assessed using the Perceived Social Support Scale (PSS; Procidano & Heller, 1983). Findings support the hypothesis that the more psychological aggression the individual received, the higher their symptoms of depression were; however there was not a significant finding that social support served as a moderator of that association. Furthermore, there were no significant findings for the research questions, which addressed gender-based differences in the degree to which social support moderates the effects of depression and psychological aggression.

THE RELATIONSHIP BETWEEN PSYCHOLOGICAL PARTNER AGGRESSION

AND DEPRESSION: SOCIAL SUPPORT AS A MODERATING VARIABLE

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CHAPTER 1: INTRODUCTION

Statement of the Problem

A large amount of research has been conducted on the negative consequences of violence within couples' relationships (Anderson, 2002; Hamel, 2009; Cocker, Smith, Bethea, King McKeown, 2000; Lafontaine & Lussier, 2005). In particular, the impact of physical aggression on victims has been investigated extensively, as it is the most recognized form of abusive behavior and has significant potential for inflicting serious injury or even resulting in death (Bergman & Brismar, 1991). Physical violence is also the easiest form of aggression to measure because it can be determined by the frequency and intensity of the violent behavior (Cocker, et. al, 2000). Studies have found an association between physical intimate partner violence and elevated levels of stress, depression, low-self esteem, and drug and alcohol problems (Anderson, 2002; Kaufman, Kantor, & Straus, 1990; Pan, Neidig, & O'Leary, 1994; Straus, 1990). Consequently, physical intimate partner violence is considered a major risk factor that negatively affects individuals' well-being, as well as the quality of couples' relationships.

However, there has been increasing attention paid by researchers to psychological forms of aggression within intimate relationships, as there is growing evidence that psychological and physical forms of aggressive behavior commonly co-occur in couple relationships (Martin, 1976; O'Leary & Maiuro, 2001; O'Leary & Woodwin, 2009), and that psychological aggression has comparable, or occasionally greater, negative effects on victims than physical violence (Follingstad et al., 1990). In their sample of 1,152 women, aged 18-65, Cocker et al. (2000) found that 88% of women who had identified their relationship as being physically abusive, also reported experiencing psychological aggression. This finding indicates that these two forms of behavior co-occur at a high

rate. In addition, the negative effects of psychological aggression on victims who have

not experienced physical abuse can include lowered self-esteem, increased symptoms of

depression, suicidal ideation, social isolation, and substance abuse (Grisso et al., 1999).

Therefore, although most of the prior research has been focused solely on physical

violence, recently there has been an increase in attention to psychological aggression and

its significant repercussions for the victim's overall level of well-being and ability to

function in daily life.

Psychologically aggressive behavior differs from physical violence in that it does

not involve direct physical contact. Although the terms emotional, psychological, and

verbal abuse or aggression have been used interchangeably in the literature, in the present

study the term *psychological aggression* was used to describe these forms of behavior.

Psychological aggression includes behaviors that individuals use to punish and control a

partner by attacking the partner's self-esteem, intimidating the partner, and increasing the

victim's dependence on the perpetrator. In their research, Murphy and Hoover (1999)

defined four different types of psychological aggression: dominance/intimidation,

denigration, hostile withdrawal, and restrictive engulfment. Dominance/Intimidation

includes verbal and nonverbal threats and damage to property; denigration involves

humiliation of the victim by his or her partner; in hostile withdrawal, the perpetrator

withholds both material items and emotional contact, including affection from the

partner; restrictive engulfment involves the perpetrator isolating the victim from family,

friends, and other social support networks (Murphy & Hoover, 1999).

Research on the negative effect of psychological aggression has shown that it can

have serious implications for the victim. In a sample of 234 women, Follingstad et al.

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(1990) found that for over 70% of women who had experienced both psychological and physical aggression, the psychological aggression had more significant negative effects. Within this 70%, who stated that psychological aggression had a more detrimental impact than physical violence, the researchers noted that the level of physical aggression was on average moderate to high, suggesting that even when victims were being physically abused they still viewed the psychological aggression as more damaging (O'Leary, 1999). This finding was consistent with results from an earlier study conducted by Walker (1979), in which it was found that a majority of the women within the sample described incidents involving psychological humiliation as their worst experiences within a battering relationship, independent of whether physical aggression was present. These studies indicate that regardless of the incidence of physical violence within the couple's relationship, psychological aggression in and of itself has significant implications for the mental health of the victims. Such findings have led researchers to acknowledge the important risks that psychological aggression in intimate relationships poses for individuals' well-being and have led to recent research designed to increase knowledge about the characteristics and consequences of psychological aggression.

Although there have been studies pointing to the negative impact of psychological aggression on victims, there is still a limited amount of research on the topic. Several factors have likely contributed to the relative lack of research on psychological aggression in comparison to physical aggression. First, there is a commonly held belief within society that physical violence causes greater psychological damage to victims than psychological aggression does, even though studies such as those already cited have indicated that the opposite is true (O'Leary, 1999). Second, psychological aggression is

not as straightforward and easy to define as physical violence. There has been a lack of consensus regarding a definition for psychological aggression or abuse that can be used uniformly for legal and formal diagnostic purposes (O'Leary, 1999). Third, forms of psychological aggression are often overlooked by victims' support systems and even by the victims themselves, because psychologically aggressive actions tend to be more difficult to identify than physical violence despite the harm that the former causes to a victim's psychological well-being (James & MacKinnon, 2010). Those who have experiences with psychologically aggressive partners may be unable to acknowledge that they are being subjected to this form of abuse, because there is an absence of a universal definition and measure.

Depending on how psychological aggression or abuse is defined within a particular study, researchers have found that members of almost all couples can qualify as being psychologically aggressive at some point in their relationship. The high incidence of psychological aggression within couples has led researchers to attempt to develop a uniform set of criteria for identifying these common behaviors, such as ridicule of the victim by the perpetrator, behaviors that involve destroying the victim's property, intimidating actions, controlling behaviors, behaviors that isolate the victim from resources such as money and social support, and the level of fear and other distress experienced by the victim (Aguilar & Nightingale, 1994; Dutton & Painter, 1993; Follingstad et al.,1990; Murphy & Hoover, 1999; O'Leary, 1999). The lack of a single definition, or set of criteria, to define psychological aggression poses a challenge for conducting research in this area, especially in developing a body of consistent findings across different studies.

Even though there have been challenges in studying psychological aggression, an increasing number of researchers have attempted to do so using valid and reliable measures that have been developed to focus on major dimensions of psychologically aggressive behavior. For the purposes of the present study the following four forms of psychological aggression, identified by Murphy and Hoover (1999) through their program of research, were examined: *denigration*, which involves verbal attacks on the victim's self esteem, *hostile withdrawal*, which involves cutting off interactions with the victim and is intended to increase the victim's level of anxiety, *dominance/intimidation*, which involves verbal and nonverbal acts of intimidation and is intended to produce fear, and *restrictive engulfment*, which involves being highly intrusive and cutting the victim off from outside resources and is intended to increase the victim's dependency on the perpetrator. As noted above, none of these behaviors involve physical contact between the aggressor and victim, but they do have significant implications for asserting power, punishing, and controlling the victim.

Now that researchers are paying more attention to the assessment of the varying forms of psychological aggression, its consequences, and clinical methods for reducing such forms of aggression in intimate relationships, research is needed to identify factors that may have the potential to *protect* individuals from the very negative impacts that psychological aggression can cause. Knowledge about factors that can protect victims from the negative effects of psychological aggression can help in designing preventive and therapeutic interventions that can enhance the protective factors. The present study was intended to investigate social support received from others as one of the potential

protective factors. The following is a description of social support and why it may have

the potential to buffer against the negative effects of psychological aggression.

The term social support, similarly to the term psychological aggression, does not

have one single measure or conceptualization with which to define it (House, 1987).

Social supports, social networks, and social relationships have all been measured

differently within the literature, but for the purposes of this study the focus will be placed

on social support. House (1981) determined four major types of social support: (1)

emotional support, which involves displaying empathy, reassurance, trust, and respect

and usually is provided by friends and family members; (2) *informational support,* which

consists of problem-solving advice; (3) *appraisal support,* which consists of feedback,

usually provided by family, friends, coworkers, or even resources in the community, that

affirms or validates the individual; and (4) *instrumental support,* which consists of

actions taken in direct support of the individual, such as providing the individual money,

time, or other resources. House (1987) proposes that in order to best measure social

support, researchers must determine the *type* of support (emotional, informational,

appraisal, or instrumental), the *source* from which the support is coming, and the *quantity

or the quality of the supportive relationship*. The present study used Procidano and

Heller's (1983) Perceived Social Support scale (PSS) to measure social support. It is

important to note that the PSS does not measure all four types of support identified by

House (1987), as a majority of the questions focus on emotional support. Additionally,

the PSS separately assesses degrees of support from two groups -- friends and family.

Despite the difficulties in finding a universal construct with which to measure

social support, it has been investigated extensively as a buffer against negative effects of

various life stressors, and the results of such studies have shown that individuals who receive strong social support have better physical and mental health (including less depression and post-traumatic stress disorder symptoms), as well as increased overall well-being (Barrera, 1986; Cohen & Wills, 1985; Lakey & Cronin, 2008; Lakey & Orehek, 2011; Uchino, 2004, 2009). In addition, social support has been studied as a buffer in lessening the negative impacts of receiving physical and/or psychological aggression in one's close relationships (Cohen & Wills, 1985).

Social support can come from a number of sources, including family, friends, coworkers, medical professionals, and community members. Research on social support in aggressive relationships has indicated that family and peer support systems produce different effects and that they should be observed independently of each other (Lyons, Perrotta, & Hancher-Kvam, 1988). For the purposes of the present study that focused on psychologically aggressive behavior occurring within couple relationships, familial support was not assessed, because an individual within the couple may view his or her abusive partner as a member of the family and therefore consider that person when responding to a questionnaire that asks about support from one's family. As a result, this study investigated whether perceived social support from non-familial friends moderates the association between psychological aggression received from one's partner and one's level of psychological distress.

There is a gap in knowledge regarding the extent to which peer social support affects the level of depression symptoms experienced by victims who are in psychologically aggressive relationships. Therapeutic treatment for individuals who are being victimized commonly focuses on increasing the victim's self esteem and reducing

depression, and it often includes examining the victim's social support networks, as they may serve as significant resources (James & MacKinnon, 2010). Because a psychologically abused individual may attribute his or her diminished sense of well-being to depression (i.e., the person focuses on the self as the source of personal problems), the individual may not seek treatment that is directly related to the abuse that has been received. Therefore, assessing the level of partner aggression that may be occurring in a depressed individual's life is an important consideration. Previous research has linked psychological aggression and depression, but there is limited research on social support as a moderator of that association (Arokach, 2006; Bergman & Brismar, 1991; Cocker, Smith, Thompson, McKeown, Bethea, Davis, 2002; Feldbau-Kohn, Heyman, & O'Leary, 1998; Gleason, 1993; O'Leary, 1999). The present study was intended to expand upon previous research on social support as a potential moderating factor that may decrease the negative association between victimization and depression.

Purpose

Prior research has found that psychological aggression has negative effects on individuals' mental as well as physical health (Cocker et al., 2000). However, studies have also shown that for victims of partner aggression there is an association between receiving high levels of social support and having a reduced risk of poor mental health outcomes such as depression, anxiety, posttraumatic stress symptoms, and suicidal ideation (Cocker et al., 2002). Of course, the impact of social support is likely to depend on the reactions that those individuals exhibit when the victim discloses the aggression to them. Research has indicated that it is often difficult for a victim to approach someone about his or her experience with abuse for fear that he or she will be stigmatized, judged,

or forced to confront authorities regarding the victimization (Cocker, 2002). In addition, victims of aggression may be concerned that the perpetrator will find out about the disclosure and, as a result, increase the level of aggression. Cocker et al. (2002) found that within their sample, 31% of victims never disclosed the partner aggression to anyone, whereas 32% disclosed to someone more than 10 times. This finding illustrates that just as many victims of partner aggression engage in low levels of help-seeking behavior as high levels. However, research findings indicate that if a victim does disclose the abuse, and the listener responds in a supportive and empathic manner, there is likely to be an increase in the victim's sense of well-being (Cocker et al., 2002).

A variety of factors have been shown to influence the relationship between degree of psychological aggression received and the victim's level of depression symptoms, such as the level of substance abuse by the perpetrator and the victim's level of self esteem (Anderson, 2002; Kaufman, Kantor, & Straus, 1990; Pan, Ressler, & Bradley, 1994). The present study focused on social support as a potential moderator, as prior research has found it to significantly contribute to more positive scores on mental health assessments (Cocker et al., 2002; Cocker, Watkins, Smith, & Brandt, 2003; Feldbau-Kohn, Heyman & O'Leary, 1998). Social support networks have been shown to increase depressed individuals' overall sense of well-being regardless of whether or not aggressive behavior is present within the couple relationship (Feldbau-Kohn, Heyman & O'Leary, 1998). When social support has been examined as a moderating variable between psychological aggression and the victim's mental health, no prior studies have specifically examined depression. Given that depression is one of the most common negative effects among victims of partner aggression, it is important that this gap in knowledge about the

potential buffering effect of social support be addressed, as it has implications for assessment and treatment of couples experiencing partner aggression.

The population that was used in this study consisted of couples that sought therapy for relationship issues, because there is a high likelihood that they were experiencing some degree of psychological aggression, given how common such negative behavior is among distressed couples (O'Leary, 1999). The current study contributed to knowledge regarding partner aggression by providing information on the potential role of social support in protecting the well-being of individuals who are experiencing psychological aggression in their intimate couple relationships.

The *aims of this study* were to: (1) further research on the association between psychological aggression among members of couple relationships and partners' symptoms of depression, and (2) determine whether the social support of friends acts as a moderator of that association.

CHAPTER 2: LITERATURE REVIEW

Members of couples whose relationships are in distress can experience a variety of serious negative outcomes, such as a lowered sense of well-being, lowered self esteem, and symptoms of various forms of psychopathology. Members of unhappy couples may rely on aggressive means for handling their conflicts, which tend to exacerbate their distress. Studies have found that some form of physical aggression is used in over one-third of the marriages in the United States (Murphy & O'Leary, 1989), and as noted earlier, a large majority of those couples who report physical aggression also experience psychological aggression. In addition, Cocker et al. (2002) found that 14% of women and 13% of men experience psychological aggression by a partner at some point in their lifetime. Such findings indicate that aggressive behavior is, unfortunately, very common within couple relationships in our society, but there is a limited amount known about how aggression develops in close relationships or what preventive measures can be taken to diminish these alarming statistics. Some literature suggests that there often is a gradual increase in aggression in couple relationships, beginning with forms of psychological aggression and eventually shifting to physical aggression (O'Leary, 1988). O'Leary (1988) found that psychologically coercive behaviors can precede, as well as predict, the development of later physical aggression within a marriage. Relationships in which physical aggression is present without any instance of psychological aggression are very rare, as less than 0.5% of individuals who are physically aggressive are not also verbally aggressive (O'Leary, 1999). This finding illustrates that there is a strong relationship between physical aggression and psychological aggression, although the causal

relationship between these two forms of abuse are difficult to determine because of the limited longitudinal data on couple violence (Anderson, 2002).

Although the majority of research has examined negative effects of physical aggression on the well-being of victims, more recently studies have indicated that psychologically aggressive behavior also has very negative consequences for the victims. In particular, forms of psychological aggression can have a strong effect on an individual's mental health. Murphy and O'Leary (1989) noted that the goals of physical and psychological forms of aggression may seem different in some ways (e.g., physical violence is intended to inflict physical pain), but the two forms actually have highly overlapping goals, which include gaining control and power over the victim's thoughts, emotions, and self-esteem; forcing the victim's compliance with the aggressor's desires; and punishing the victim for behavior that the aggressor dislikes. However, the function that psychological aggression serves may not be as obvious to an outside observer as those associated with physical aggression (Follingstad et al., 1990).

One reason why psychological aggression is a challenging variable to study is because the criteria for identifying it are less clear than those for physical aggression, which involve degrees of physical contact. Many individuals who are in psychologically aggressive relationships do not even realize that this is the case, because they may confuse the aggressive behavior with normal relationship conflict. Virtually all couples argue to some extent, but because there has not been emphasis placed on psychological aggression, and also because it can be less obvious, there is limited knowledge regarding the impact that this form of aggression can have on an individual. Psychological aggression often involves manipulative forms of coercion by the perpetrator, which may

not be as readily or easily recognized. Research has shown, however, that women who have experienced some form of physical aggression are also more likely to report being verbally abused. According to Walker (1984), the prevalence rate of psychological aggression in relationships that have been physically aggressive is 83%, and in the Follingstad et al. (1990) study the rate was 99%. Therefore, it is common for victims to only seek help once they are able to recognize that they have experienced some form of abuse and can no longer deny the abusive behaviors performed by the perpetrator.

The importance of measuring psychological aggression as opposed to solely looking at physical aggression was originally noted because researchers thought that it could be used as a predictor of physical violence. Researchers believed that if they were able to measure the extent to which psychological aggression was used in the initial phases of a relationship, they could then determine whether or not it would evolve into a physically aggressive relationship. Follingstad et al. (1990) found that it was possible to predict the type and severity of physical aggression based on the psychological aggression that was experienced prior to the physical battering. In addition, this same study found that the two leading predictors of physical violence were verbal threats of abuse as well as restriction and isolation tactics used by the perpetrators (Follingstad et al., 1990).

Although several studies have shown that psychological aggression can lead to physical aggression, researchers have discovered the importance of looking at psychological aggression regardless of whether or not it was related to physical violence. One study found that some women who had experienced both forms of aggression felt that psychological degradation, fear, and humiliation were more painful than the physical

battering (Walker, 1984). Researchers also found that women who were psychologically abused had higher levels of stress, were more likely to be socially isolated from family and friends, showed more symptoms of depression, had a greater chance of attempting suicide, and were more likely to abuse substances when compared to a non-abused control group (Grisso, 1999; Walker, 1984). Because psychological aggression has long-term effects on self-esteem, researchers have speculated that the recipient of the personal psychological attacks develops a decreased ability to cope with both psychological and physical forms of aggression (Follingstad et al., 1990). These findings have implications for treatment, especially if the victim has not yet identified their partner's actions as inappropriately aggressive, because the therapy may focus on the couple's presenting problem (e.g., the victim's depression) without first identifying the aggression that is occurring within the relationship.

Given that there is abundant evidence pointing to the importance of psychological aggression, both in its effects on an individual's mental health and in its ability to predict the occurrence of physical violence, the question arises as to why this construct has not been given more attention. As noted above, one reason may be that psychological aggression is a more difficult construct to define than is physical aggression. Murphy and Hoover (1999) stress that psychological aggression includes verbal and nonverbal behaviors that produce fear, lead to the victim's dependence on the perpetrator, or damage the self-esteem of the recipient. In the research by Follingstad et al. (1990), six different types of psychological aggression were assessed, including threats of abuse, ridicule, jealousy, threats to change marital status, restriction, and damage to property. In a study by Arokach (2006), psychological aggression was defined as including

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intimidation, degradation, deprivation and/or exploitation by an intimate partner. Cocker et al. (2000), who have conducted a great deal of research on the impact of partner aggression on women, defined psychological abuse as, "a process whereby one member of an intimate relationship experiences vulnerability, loss of power and control, and entrapment as a consequence of the other member's exercise of power through the patterned use psychological and/or moral force" (p. 452). This definition is somewhat different from others in that it describes a *pattern* that takes place within abusive relationships, which Cocker et al. (2000) argue is the reason why victims of violence often have great difficulty removing themselves from such situations.

Other researchers have defined psychological aggression in different ways, yielding different results, depending on how the construct was measured (Holt & Espelage, 2005). Different definitions of psychological aggression limit the degree to which one can compare findings from one study to another. If psychological aggression is not measured sufficiently, then the research may not differentiate it from more common forms of arguing (e.g., name-calling) among distressed couples. Therefore, for the purposes of this study Murphy and Hoover's (1999) definitions of psychological aggression was used, because there is sufficient evidence that the forms of psychological aggression that they identified and have measured with their questionnaire (described in detail in the Method chapter) are inclusive of the forms of aggression that other research studies identified as having serious negative effects on recipients.

Social Support

Social support is a construct regarding the strength and frequency of the resources that an individual receives from the relationships that he or she has with others. Social

support can come from various sources and can manifest in different ways, depending on what the individual receiving the support needs. As mentioned previously, social support is a difficult construct to measure, because it can be operationalized in various ways. Within the literature, different researchers have defined and measured social support in diverse ways, which makes it difficult to identify one uniform definition for how to measure this variable.

One way to measure social support is to observe supportive interactions with other people or the degree to which an individual perceives the availability of supportive others, regardless of how much he or she makes use of those resources. For example, Lyons et al. (1988) chose to measure social support through an individual's frequency and length of contact with a supportive person. Another way is to determine the type of support that is being provided to an individual. House (1981) defined four different types of social support: *emotional* in which empathy, trust, and respect are displayed; *instrumental*, in which direct action is taken in order to help the recipient of the support; *appraisal*, in which affirmative feedback is provided; and *informational* in which problem solving advice is provided. In their study, Grav et al. (2011) chose to look at instrumental support versus emotional support, which were defined similarly to House (1981), within a sample of 40,659 men and women in Norway, to determine whether or not perceived social support affected symptoms of depression. Grav et al. (2011) found that within their sample there were gender differences; mainly that men had better depression outcomes and that the social support received was more beneficial if it was instrumental support, whereas social support received by women had a greater effect on reducing depression when it was emotional support.

Some researchers have measured social support by identifying the source from which the individual is receiving the support. Sources have commonly been broken down into two categories: friends' social support and family social support. Lyons et al. (1988) determined that these two forms of support are very important, and they should be assessed independently of one another because they may have different effects on recipients depending on the population being studied. For example, in populations that suffered from chronic conditions, Lyons et al. (1988) found that there were lower levels of familial support as opposed to populations in which there was a psychiatric condition, where they found lower levels of peer support. Thus, different sources of social support may be more useful or pertinent depending on the demands of the situation. The above examples show that the quality, quantity, type, and source are all ways to operationalize social support and should be considered when conducting research on social support.

Despite the challenges that researchers face in terms of identifying a uniform way to measure social support, there has been a vast amount of research literature indicating that it is beneficial to individuals. Social support has been widely identified in the research literature as a buffer between stressful life events and individuals' overall psychological well-being (Cohen & Wills, 1985; Price, Price, & McKenry, 2010). Social support has also been found to have a positive impact on coping with stressful life events as well as mental and physical health (Lyons, Perrotta, & Hancher-Kvam, 1988). Psychological aggression is one type of stressful life event that can have a very detrimental impact on an individual's overall well-being for which social support can also serve as a buffer. Although the research has shown that social supports can help in psychologically aggressive situations, several studies have found that many victims of

partner aggression tend to distance themselves from others, even those individuals who are closest to them, and that they tend to deny that they are abused because they are afraid that the abuser will find out, and/or they are experiencing feelings of shame and hopelessness because of the abuse (Arokach, 2006). The same study by Arokach (2006) also found that those who have been abused utilize distancing and denial techniques more often than the general population, as a means of coping with their particular life circumstances.

Although some studies have focused on victims who did not turn to their social supports as a way to cope with partner aggression, others have looked at those who did decide to disclose their abuse. Results of such studies have shown that social supports are a central factor in helping victims to cope with aggression from their partners. Cocker et al. (2003) found that an increased level of social support could help in countering common characteristics of psychological aggression such as alienation from personal relations and a reduced sense of worth, value, or self-esteem. By having someone to talk to about their experiences who will listen without making judgments, the victim is able to utilize his or her personal resources and develop coping mechanisms that can eventually lead them to remove themselves from the abusive relationship.

Within psychologically aggressive relationships, perpetrators may recognize that with social supports in place victims will have resources and a heightened sense of self-esteem, which will reduce their likelihood of remaining in the couple relationship. Perpetrators are motivated by the need to exert power and control over their victims, and a major aspect of obtaining that power involves manipulating the victim and pushing them away from their traditional support networks until the victim feels that they can

depend solely on the perpetrator (Cocker et al., 2000; Murphy & Hoover, 1999). Cocker et al.'s (2003) study found that receiving emotional support was associated with better physical as well as mental health among victims of partner aggression.

Gender Differences in Social Support

Within the literature, there have been gender differences found in the degree to which women and men develop and use social support networks. One study, which had a sample of 1,020 Puerto Rican men and women from the Boston area, looked at social support as a moderator of the association between psychological distress and stress level (Falcon, Todorova, & Tucker, 2009). They found that tangible or instrumental support, which consists of providing money, time, or resources, was more protective against depression symptoms in men, whereas emotional support, which consists of empathy and affirmation, was more protective for women. In addition, Wheeler, Reis, and Nezlek (1983) found that relationships among women were more intimate and self-disclosing than those among men, which meets the criteria for the emotional type of support. Therefore, prior research has commonly found that because emotional support is more beneficial for women than for men, women are also the main providers of emotional support, whereas men provide more instrumental support (Cutrona, 1996).

There has also been research done on the source from which support is derived. This can consist of friends, family, peers, co-workers, community resources, and even health providers. Falcon et al. (2009) found that women's social support groups mainly consisted of other women, family, and neighborhood friends, whereas men's support groups consisted of coworkers and friends; they did not have as many familial supports. This finding that women are more likely to find support from other women and family

members has been consistent across several studies. For example, Powers, Ressler, and Bradley (2009) looked at how gender was related to familial versus peer social supports among individuals who had experienced childhood abuse. They found that for both men and women, those who had a higher level of familial support were better able to manage their past experiences with the abuse. They also found that for women, a higher level of support from friends was significantly correlated with lower depression, but these results were not significant for men (Powers et al., 2009). Therefore, there are gender differences in perceived social support as well as differences between support from friends and family. For the purposes of the present research, only observed support from friends was examined, for reasons that are explained in the Method chapter.

The present study observed whether higher levels of perceived social support from friends reduced the strength of the association between receipt of psychological aggression from a partner and the level of depression symptoms in the victim of aggression. If that is the case, it has implications for clinical assessment and treatment, as intervention with victims of partner aggression may involve strengthening the individual's access to social support as well as attempting to modify the aggressive behaviors directly.

Depression

Depression is characterized by low mood, low self-esteem, loss of interest or pleasure in activities that are normally enjoyable, and a variety of other cognitive, emotional, physiological, and behavioral symptoms described in the Diagnostic and Statistical Manual of Mental Health Disorders (American Psychiatric Association, 2000). According to the National Institutes of Mental Health, depression is a serious mental

health disorder that affects almost 7% of adults in the United States each year (NIMH, 2008). In addition to the alarming rates at which depression is prevalent, studies have consistently found that women experience depression symptoms more often than men do. One study found that women have a 70% higher chance of experiencing depression throughout their lifetime than men (NIMH, 2008). Another study found that, in general, women are two times more likely than men to be diagnosed with clinical depression (Fincham et al., 1997). When considering possible reasons for this gender difference, women are said to be more in touch with their emotions, so it may be easier for them to recognize, accept, and seek help when they are feeling depressed.

In addition to the prevalence rate of depression being higher in women than in men, the literature indicates that there are also gender differences in the types of symptoms exhibited by depressed individuals. Men who have been diagnosed with depression frequently exhibit behaviors such as anger, difficulty in controlling their impulses, irritability, aggression, substance abuse, risk taking behaviors, and emotional numbness (Cochran & Rabinowitz, 2003). Women, tend to display their symptoms of depression through more internalizing symptoms such as lowered self-esteem and self worth, sadness, anxiety, fatigue, uncontrollable crying, restlessness, and irritability (Kendler, Thornton, & Prescott, 2001). These gender differences in how depression is manifested contribute to the common finding that men report less depression than women, which may be due to the symptoms that typically are assessed with depression questionnaires, as well as to gender-related response biases by the participants (Oliffe et al., 2011).

Various studies have looked at the causes and predictive factors for depression. One study reported that in women who had no prior history of depression, 36% of them met the criteria for clinical depression shortly after having experienced a negative marital event (Fincham et al., 1997). There also are findings suggesting a bi-directional relationship between partner aggression and depression. For example, a study by Pan, Neidig, and O'Leary (1994), which focused on the link between depression and aggression in men, found that for every 20% increase in depression symptoms the odds of the male engaging in moderate physical aggression (e.g., pushing) increased by 30% and for severe aggression (e.g., beating) the odds were increased by 74%. These results suggest that gender differences may affect how depression symptoms are exhibited; for men, it may be more likely that the depression will manifest itself as anger or aggression, whereas for women it may be more internalized. These gender differences must be considered when working with samples from clinical populations. Therefore the present study explored gender differences in the relationships among psychological aggression, depression, and social support.

Depression has also been examined in samples that have experienced both physical and psychological forms of abuse. Studies have shown that women who have been subjected to any type of partner aggression are more likely to state on self-report measures, that they have lower levels of physical and mental health (Cocker et al., 2000). Women who had experienced aggression from a male partner were more likely to visit doctors and to have emergency room visits for ailments including irritable bowel syndrome, chronic pain, migraines, sexually transmitted infections, and urinary tract infections than a control group that had not been physically or psychologically abused

(Cocker et al., 2000). In addition, battered women were shown to seek psychiatric care more often than the control group, and the most common reasons for being admitted into an inpatient treatment facility included substance use, depression, and suicide attempts (Bergman & Brismar, 1991). These findings suggest that women who are in psychologically or physically aggressive relationships may display symptoms of physical and mental illnesses, which they may not even recognize as being linked to their victimization. This has implications for treatment, because many individuals are unaware that aggression, even if it is "only" verbal, can have such a large impact on one's body and lead to so many adverse health outcomes.

Powers, Ressler, and Bradley (2009), in their study on childhood abuse, found that in a sample of 378 men and women the effect of psychological aggression was more significant than that of reported sexual or physical abuse when measuring for depression. This finding points to the importance of studying psychological aggression and creating treatment strategies to best assist victims. Abused women tend to report higher levels of anxiety and depression as compared to women whose partners are not aggressive, because they constantly live in fear that they will not be able to please their partner or prevent the cycle of partner aggression from escalating (Dutton-Douglas & Dionne, 1991). Because depression symptoms are common among individuals experiencing partner aggression, it is essential to expand upon the research that has already been done in order to be able to identify coping techniques and intervention strategies that can assist individuals who live in abusive situations.

A Family Stress Theory Framework for the Present Study

Family stress theory has frequently been used in looking at the dynamics that occur when families are dealing with stressful situations. This framework proposes that the occurrence of stress in families is unavoidable, but that the way in which a family copes with the stressors that they face, including how they use appropriate resources and how they perceive the stressors, will determine the likelihood that they will restore themselves to their previous state of functioning (Smith, Hamon, Ingoldsby & Miller, 2009). The ABC-X model, initially developed by Hill (1949) has been the preeminent form of family stress theory in the field. In the ABC-X model, the *A* represents the event(s) that causes the stress by placing pressure on the family and individuals within it, *B* are the resources or strengths that the family has available to them, *C* are their perceptions of the stressor (e.g., as a manageable challenge that can be overcome through effort or as an insurmountable aversive condition), and *X* is the resulting level of disruption in individual and family functioning, which may reach a crisis state of significant deterioration (Smith et al., 2009).

Lipman-Blumen (1975) defined seven criteria for the *A* portion of the ABC-X model, or the stressful event(s) that affect the degree to which the stressor will influence a family. These criteria include whether the stressor is internal or external to the family, whether it is focused on one member of the family or several, if it has a sudden or gradual onset, the severity of the stressor, how long the family has to adjust to the stressor, if the stressor is expected to occur (i.e., predictable), and the family members' perceptions of whether or not they will be able to solve the stressful situation (Lipman-Bulmen, 1975). Within this model, a stressful situation is not viewed as inherently positive or negative,

because all events can be considered neutral until each individual has evaluated it as positive or negative. Therefore, the ABC-X theory acknowledges that each family may react differently to a similar situation. For example in one couple, the victim of the psychological aggression may view the behavior as normative, maybe because that person grew up in a psychologically aggressive household and was accustomed to that treatment, whereas in another couple the victim of the aggression may recognize it as unacceptable right away and take steps toward altering that pattern.

The *B* component of the model represents the resources that the family has available to cope with the stressful event. These can fall into three categories: individual, family, and community resources (Lavee, McCubbin & Patterson, 1985). A victim of psychological partner aggression may turn to his or her family or community for assistance in coping with the stressor. Family supports can be helpful in providing a home or shelter for the victim to escape, as well as access to community resources such as doctors, mental health professionals, or a domestic violence shelter. The ABC-X model proposes that the more resources an individual, couple, or family has available, the better they will be able to cope with life stressors, including partner aggression. In addition, social supports are considered to be the most important resources that people can access because they help to increase individuals' sense of self-worth (Smith et al., 2009).

The *C* component of the model represents the way that the members of a family think about or interpret the stressful event. For example, if a person has an optimistic belief that a stressful situation can lead to positive outcomes, it gives the individual motivation to move forward in a positive way and not give up as quickly (Smith et al.,

2009). Members of families may engage in cognitive reappraisal, a process through which they attempt to decrease the intensity of the distressing emotions elicited by the stressor events by focusing on positive aspects (Smith et al., 2009). In a severely abusive relationship, cognitive reappraisal may be difficult to achieve because it may be challenging for a victim of partner aggression to focus on positives, but if the victim can focus on advantages of using available resources, then that cognitive reappraisal can be constructive.

Lastly, the *X* in the model represents the degree to which the stressors have resulted in deterioration in the functioning of the individual, couple, or family. A crisis state may be reached if the family can no longer maintain its usual functioning or balance due to the stressful event (Smith et al., 2009). A crisis state is more likely to occur when there are few resources available (or the family fails to use available resources) and when the family members' interpretations or appraisals of the stressors and their ability to overcome them are negative. However, a family may develop an enhanced ability to cope with a crisis after having overcome it, potentially increasing their resilience so that they are able to function better than they did prior to experiencing the crisis (Smith et al., 2009). Although a crisis state can be a very difficult time in individuals' lives, the outcome can cause the family to unite and form stronger bonds than they had previously.

The ABC-X family stress and coping theory proposes that in response to stressful events a family will experience a period of disorganization as they attempt to cope and deal with the situation (Smith et al., 2009). The more difficulty the family has coping with the stressful event, the more difficult it will be for them to recover. The recovery process requires the family to reorganize themselves in order to return to their normal

level of family functioning. For some, the level of reorganization can be better than it was before, but for others it may be worse; this all depends on how the family is able to cope with overcome the stressful event.

The present study used the family stress theory framework as the basis for posing hypotheses regarding the relationships among psychological aggression, depression, and social support. Within the theory, psychological aggression is considered a non-normative stressful occurrence, and individuals who are victims of partner aggression are at risk of experiencing deteriorated personal functioning, such as depression; the exposure to psychological aggression would be considered the *A* in the theory. To the extent that a victim of partner aggression has resources such as a social support network, he or she should be less susceptible to the negative effects of the aggression; this would be considered the *B* in the theory. Thus, the theory postulates that social supports are important resources that can buffer against the negative effects of stressors, thereby allowing the victim to be able to better cope with the stresses of being in a psychologically aggressive relationship. The outcome, in terms of the individual's level of psychological functioning, would be considered the *X* in the theory.

CHAPTER 3: METHODS

Conceptual Definitions of Variables

Independent Variable

Degree of psychologically aggressive behavior received. There is no single

commonly used definition of psychological aggression in the literature, as it encompasses

a variety of actions and behaviors. However, there are some key elements that appear

throughout the research literature on this topic (Murphy & Hoover, 1999). Psychological

aggression includes both coercive and aversive behaviors that are enacted with the intent

to produce emotional harm or threat of harm to the recipient. As a result of those

behaviors, the victim will often feel some degree of fear, experience dependence on the

perpetrator, and have a damaged self-concept (Murphy & Cascardi, 1999; Murphy &

Hoover, 1999). Murphy and Hoover (1999) developed a four-factor model of

psychological aggression after examining several existing assessment instruments to the

capture major forms of this construct. The Multidimensional Measure of Emotional

Abuse (MMEA) is based on that four-factor model. Consistent with Murphy and

Hoover's (1999) work, four subcategories of psychological aggression were examined in

the current study. The first category is *Dominance/Intimidation*, which includes acts such

as verbal threats, damage to personal property, and intense levels of verbal aggression. In

this category the intent is to, "produce fear or submission" and it is the form of

psychological aggression that is most closely related to physical aggression (Murphy &

Hoover, 1999). *Denigration* is characterized by humiliation or degradation of an individual with the intent to reduce the person's self-esteem. The third category, *Hostile Withdrawal,* consists of withholding emotional contact or affection toward the partner with the intention of increasing his or her anxiety and insecurity. Finally, *Restrictive Engulfment* is characterized by isolation and restriction of another person's activities, and the intent is to increase the victim's dependency on the perpetrator of the psychological aggression (Murphy & Hoover, 1999). In the current study, all four types of psychological aggression were assessed.

Moderator Variable

  Social support from friends. Peer support has been shown to increase psychological well-being (McCreary, Slavin, & Berry, 1996). In Luster and Small's (1997) study, they found that individuals who had been subjected to partner aggression and who reported high levels of social support experienced lower levels of negative outcomes when compared to those who had lower levels of support. Friendships are created and maintained by choice and not by obligation, and they commonly provide a major source of social support such as emotional support, tangible aid in solving problems, and esteem support, among several others. The goal of the present study was to determine whether social support obtained from close relationships outside of the couple's relationship served as a buffer against negative effects that partner aggression may have had on a victim's well-being in the form of depression.

Dependent Variable

  Depression. Depression is a form of psychopathology (DSM; American Psychiatric Association, 2000) that is characterized by emotional, cognitive,

physiological, and behavioral symptoms such as the following: feeling sad for most of the day, loss of weight or appetite, loss of pleasure in activities that were previously enjoyable, lack of energy, irregular sleeping patterns (insomnia or hypersomnia), suicidal thoughts, feelings of worthlessness, and difficulty in thinking or concentrating. Although there are categorical psychiatric diagnoses for forms of depression that require that an individual meet a set of criteria for types and severity of symptoms experienced, depression also is commonly assessed along a continuum of symptom severity. In other words, individuals can be assessed as having degrees of depression severity without meeting criteria for a full diagnosis. Individuals who experience high levels of stress in their lives, such as being in distressing intimate relationships, are more often depressed than those who do not have such experiences. Depression occurs more often in women than in men, especially in the context of marital dissatisfaction, and this gender difference has been attributed to women being more relationship oriented than men (Fincham et al., 1997). This is not to say that men do not experience depression due problems in their relationships, but only that studies have shown a greater prevalence of depression symptoms in women who are in distressed relationships. As described earlier, there is substantial evidence that women whose partners subject them to aggressive behavior are likely to experience depression as one of several negative effects on their personal well-being. However, there is an absence of research examining the degree to which men who are victims of partner aggression experience depression. The present study explored whether there was a gender difference in the association between receiving psychological partner aggression and experiencing depression symptoms. In addition, the present study

investigated whether there was a gender difference in the degree to which social support from friends served as a moderator of that relationship.

Hypotheses & Research Questions

Based on the literature regarding the consequences that psychological aggression can cause within couple relationships, in particular depression as a common experience for victims, and the literature on the role of social support as a buffer against the negative impacts of stress, the following hypotheses were tested in the present study:

1. Individuals who receive more psychologically aggressive behavior from their intimate partner will report higher levels of depression symptoms.

2. Women will report higher levels of perceived social support from friends than men report.

3. The greater the individual's perceived social support from friends, the lower his or her level of depression symptoms will be.

    a. The association between greater perceived social support and lowered depression symptoms will be stronger for women than for men.

4. Perceived social support from friends will moderate the association between psychological aggression received from a partner and the recipient's level of depression symptoms, such that when social support is higher the association between receiving more psychological aggression and being more depressed will be weaker.

In addition, based on prior literature regarding gender differences in depression and in use of social support networks, the following *research questions* were investigated:

1. Is there a gender difference in the strength of the association between amount of psychological aggression received from a partner and the recipient's level of depression symptoms?

2. Is there a gender difference in the degree to which level of perceived social support from friends moderates the association between amount of psychological aggression received from a partner and the recipient's level of depression symptoms?

Sample

This study involved a secondary analysis of data previously collected in standard pre-therapy assessments of clients attending the Center for Healthy Families (CHF) outpatient couple and family therapy clinic at the University of Maryland, College Park. The sample for this study were members of couples who sought couple therapy at the CHF and who completed a set of questionnaires assessing a variety of aspects of their individual and relationship functioning. The data that were used in this study were from all couples that completed measures of psychological aggression, depression, and social support. The clients who come to this clinic are from diverse cultural, ethnic, and racial backgrounds. They vary in socio-economic status, from individuals who have minimal or no income to those who have high incomes. The sample that was used for this study was drawn from the assessments done with partners who come to therapy together as a couple.

The pre-therapy assessments at the CHF are administered at the client's first meeting with their therapist and generally take a few hours to complete. Each person who is a client of the Center for Healthy Families must complete all of the assessments before beginning therapy. Prior to participating in the assessment and beginning therapy, clients

read and sign a CHF informed consent form that provides information about the assessment and treatment procedures at the Center. By signing the consent form, clients also give permission for their data to be used in research, with strict protection of confidentiality. Because the present study was a secondary analysis of numerical scores in a password-protected database in the Center for Healthy Families, the data file contains no information that would reveal the clients' identities, and the present investigator conducted no new procedures with the original clients; there was no additional informed consent procedure used in this study.

Couples' data were included in this study if the couples had completed the necessary self-report measures as part of the standard process of beginning couples therapy at the Center for Healthy Families. The sample analyzed in the present study was comprised of 406 heterosexual couples. The characteristics in the current sample are similar to the overall population that seeks treatment at the CHF. There were demographic data missing for some of the participants, so the n is lower than 406 on most variables. The mean ages for the male ($n = 393$) and female ($n = 395$) participants were 33.6 ($SD = 9.27$) and 31.9 ($SD = 8.84$), respectively. The men ($n = 337$) reported a mean number of 6.59 ($SD = 6.30$) years spent with their partner, whereas the females ($n = 341$) reported a mean number of 6.77 years with their partner ($SD = 6.41$). Men ($n = 366$) reported a mean yearly gross income of \$37,304 ($SD = 30,536$), and women reported a mean yearly gross income of \$26,597 ($SD = 22,881$). See Tables 1-6 for the distributions of the participants' relationship status, race, and education levels.

In summary, the sample was largely currently married (over 50%), either African American (approximately 40%) or Caucasian (approximately 35%), and highly educated (over 70% had at least some college education).

Table 1: *Men's Current Relationship Status*

	Frequency	Percent
Currently married, living together	204	50.2
Currently married, separated	33	8.1
Divorced	1	0.2
Living together, not married	67	16.5
Separated	7	1.7
Dating, not living together	62	15.3
Single	20	4.9
Missing	12	3.0
Total	394	100.0

Table 2: *Women's Current Relationship Status*

	Frequency	Percent
Currently married, living together	205	50.5
Currently married, separated	35	8.6
Divorced	3	0.7
Living together, not married	61	15.0
Separated	5	1.2

	Frequency	Percent
Dating, not living together	70	17.2
Single	14	3.4
Missing	13	3.2
Total	406	100.0

Table 3: *Men's Race*

	Frequency	Percent
Native American	7	1.7
African American	167	41.1
Asian/Pacific Islander	12	3.0
Hispanic	31	7.6
White	152	37.4
African	1	0.2
Other	19	4.7
Missing	17	4.2
Total	406	100.0

Table 4: *Women's Race*

	Frequency	Percent
Native American	0	0
African American	172	44.0
Asian/Pacific Islander	12	3.1
Hispanic	36	9.2
White	150	36.9

	Frequency	Percent
African	0	0
Other	21	5.2
Missing	15	3.7
Total	391	100.0

Table 5: *Men's Highest Level of Education*

	Frequency	Percent
Some High School	23	5.7
High School Diploma	64	15.8
Some College	109	26.8
Associate's Degree	33	8.1
Bachelor's Degree	44	10.8
Some Graduate Education	35	8.6
Master's Degree	38	9.4
Doctoral Degree	26	6.4
Trade School	21	5.2
Missing	13	3.2
Total	406	100.0

Table 6: *Women's Highest Level of Education*

	Frequency	Percent
Some High School	17	4.2
High School Diploma	41	10.1
Some College	102	25.1

Associate's Degree	41	10.1
Bachelor's Degree	50	12.3
Some Graduate Education	49	12.1
Master's Degree	58	14.3
Doctoral Degree	19	4.7
Trade School	18	4.4
Missing	11	2.7
Total	395	100.0

Procedure

The procedure that was used in this study required that the researcher access the

previously collected coded data that were stored in a password-protected computer file in

the Center for Healthy Families. This data file included individuals' scores on the

assessment instruments, measures of psychological aggression, depression, and social

support, as well as demographic information, but no information that revealed the clients'

identities.

This study used the subscale of the Perceived Social Support scale (PSS) that

assesses the individual's social support involving friends only. The total score on the

Beck Depression Inventory (BDI) was used to assess depression, as is standard practice

with the BDI. Higher scores indicate higher levels of depression symptoms. Each

individual's total score for the set of four subscales of the Multidimensional Measure of

Emotional Abuse (MMEA) was computed as the index of psychological aggression

received within the couple relationship. Higher scores indicate higher levels of

psychological aggression. The following are descriptions of the measures that were used in the study.

Measures

Psychological Aggression

    Multidimensional Measure of Emotional Abuse (MMEA). The MMEA (Murphy & Hoover, 1999) has 28 two-part items that ask the individual to report both about specific forms of psychologically aggressive behavior perpetrated by his or her partner and the same forms of psychological aggression perpetrated by the self during the past four months. A copy of the MMEA appears in Appendix A. The MMEA has four subscales: dominance/intimidation, restrictive engulfment, hostile withdrawal, and denigration. In this study each individual's total MMEA score was calculated, in order to test the association between psychological aggression and depression. For each item, the respondent uses a 6-point Likert scale to report the amount of psychological aggression that he or she has received, with 0 meaning that the behavior has not occurred in the past four months, but it has occurred previously; 1 meaning that the behavior has occurred once; 2 meaning that the behavior has occurred twice; 3 meaning that the behavior has occurred 3-5 times; 4 meaning that the behavior has occurred 6-10 times; 5 meaning that the behavior has occurred 11-20 times; and 6 meaning that the behavior has occurred more than 20 times in the past four months. In addition, there is a response option to indicate that the behavior has never occurred within the duration of their couple relationship. The higher the MMEA subscale score, the more the individual is reporting

that she or he has experienced. Each item also asks the respondent how often he or she has perpetrated the type of psychologically aggressive behavior. The possible range of scores for each individual person, whether it was the individual's report aboiut his or her own behavior or perceptions of the partner's behaviors, was between 0 and 168.

Ro and Lawrence (2007) found that the overall internal consistency of the MMEA was high. However, they also found that the subscales' reliability was varied and therefore concluded that this measure is more reliable when used as a uni-dimensional scale rather than multidimensional (Ro and Lawrence, 2007). The total MMEA has a Cronbach alpha of .91 and is valid as an index of psychological aggression (Murphy & Hoover, 1999). In order to minimize degrees to which individuals may have biases in reporting about their own or about a partner's aggression, the index of an individual's degree of received psychological aggression that was used in this study was an average of the two partners' reports about each individual's level of aggression.

Social Support

Perceived Social Support scale (PSS). The PSS (Procidano & Heller, 1983) is a 45-item scale that includes two subscales, regarding social support that the respondent perceives receiving from family and from friends. The family subscale was not used in this study because the individual may view his/her partner as included in this category, making it impossible to identify which members of the family are providing support and which ones are possibly causing stress for the individual. Thus, each partner's friends' social support system was assessed using the PSS, meaning that only questions 1-20 were used for this study. For each item the respondent uses a 5-point Likert scale (1 = "Yes" and 5 = "No"). The possible range of scores for this measure was between 0 and 100.

This scale has questions that pertain mostly to emotional support and, as mentioned previously, this form of support is commonly more beneficial for women than for men. Therefore, in using the Perceived Social Support scale a limitation of this study may be that males score lower on this measure because it does not offer nearly as many examples of instrumental or tangible support (male support preference) as it does items tapping aspects of emotional support.

The PSS measures the quality and significance of social support networks in the individual's life. It has been demonstrated to have high test-retest reliability, which was .83 over a one-month period for both friend and familial supports, and a high internal consistency of .90 (Procidano & Heller, 1983).

Depression

Beck Depression Inventory (BDI). In this study depression was measured using the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) that is administered to each member of the couple during the assessment at the Center for Healthy Families. The BDI consists of 21 items that are used to rate the level of depression symptoms in individuals (Powers, Ressler, & Bradley, 2009). The possible range of scores for this measure is between 0 and 63. Although there are recognized cut-off scores indicating levels of depression (e.g., individuals scoring 14 or above on the scale are considered at least mildly depressed), the BDI is typically used as a measure of a continuum of depression severity. The BDI was used in the present study to measure the extent to which the individual is experiencing symptoms of depression; i.e., it measures depression severity, not whether or not an individual warrants a psychiatric diagnosis of depression.

The BDI has been demonstrated to be highly reliable, with a Cronbach alpha of .91, and valid as an index of depression severity (Beck, Steer, Ball, & Ranieri, 1996).

Gender

> *Couple Information & Instructions.* Gender in this study was determined by what the individual indicated on his or her Center for Healthy Families Couple Information and Instructions form. There is an option for male or female, but there is no transgendered option, so those were the only two subgroups for this variable. The study included only heterosexual couples, because a fairly small number of gay and lesbian couples seek couple therapy at the Center for Healthy Families, resulting in too small a sample to allow statistical analyses that take sexual orientation into account.

CHAPTER 4: RESULTS

Findings Regarding the Hypotheses

This study was designed to determine the relationships among psychological aggression, depression, and perceived social support received from friends. Social support from friends was tested as a moderating variable of the association between psychological aggression in couples and level of depressive symptoms. As described earlier, the following hypotheses and research questions were tested, and the following results were obtained:

Hypothesis 1 stated that there would be a positive relationship between the level of psychologically aggressive behavior received and level of depression symptoms. First, a Pearson correlation was computed between the amount of psychological aggression received by men ($n = 271$) and their level of depression. The correlation was .17, $p = .003$, which supported the hypothesis. Similarly, the Pearson correlation between the level of psychological aggression received by women ($n = 264$) and their level of depression was computed. The correlation was .30, $p = .001$, which also supported the

hypothesis. Thus, the Pearson correlations for men and for women supported the hypothesis linking receipt of psychological aggression and depression. This finding is consistent with previous research that found that psychological aggression can have negative effects on a recipient's overall well-being and mental health.

Hypothesis 2 stated that the female participants would report greater perceived social support than males. A paired sample t-test was completed to compare the total scores of men and women on the PSS friends subscale. The results indicated that for men the mean score was 48.96 and for women the mean score was 41.35, and t (340) = 7.12, p < .001. Thus, the test of the group comparison indicated a significant difference in the opposite direction, such that within the current clinical sample men reported significantly higher levels of perceived social support from friends than women did.

Hypothesis 3 stated that there would be a negative association between social support that an individual receives from friends and the level of his or her depression symptoms. First, a Pearson correlation was completed between men's (n = 336) level of perceived social support from friends and their level of depression. The correlation was .181, p =.001, which is a significant association that is in the opposite direction to the hypothesis. The correlation between women's (n = 349) level of perceived social support from friends and depression was .159, p = .003, which also was significant and opposite to the hypothesized direction. Thus, for both the men and the women, the results indicated that there is a positive association between perceived social support from friends and level of depression, a finding that is inconsistent with prior research findings indicating that receipt of social support fosters positive mental health and well-being.

In addition, hypothesis 3a, which stated that the association between social support from friends and level of depression would be stronger for women than for men was not supported by the data, because within the current sample the men's correlation was slightly higher than that of the women, but the test for the difference between two correlations (using r-to-z transformations) indicated that the gender difference was not significant; $z = .30$, $p = .76$.

Hypothesis 4 stated that social support from friends would serve as a moderator of the association between psychological aggression received from a partner and the recipient's level of depression symptoms. Specifically, it was expected that when social support was higher, the association between the degree of psychological aggression received and level of depression would be weaker. In order to test this hypothesis, a separate stepwise multiple regression analysis was conducted for each gender. In the first step of each analysis, the amount of social support received from friends was entered, in the second step the amount of psychological aggression received from the partner was entered, and in the third step the interaction term (product of social support and psychological aggression received) was entered, to predict the dependent variable of depression symptoms.

In the analysis for the males, which is summarized in Table 7.1, at step one, the social support received significantly predicted their depression level; $F(1, 251) = 8.22$, $p = .004$. The standardized Beta was .178, indicating that higher support was associated with greater depression, was reported earlier for the Pearson correlation results for hypothesis 3. The R^2 was .032. At the second step, the change in R^2 was .027, which was significant; $F(1, 250) = 7.22$, $p = .008$, indicating that the amount of psychological

aggression received accounted for additional variance in depression scores. The standardized Beta for aggression received was .165, indicating that the more aggression received, the greater the depression, as reported earlier for the Pearson correlation results for hypothesis 1. Finally, at step three the addition of the interaction term (regarding moderation) resulted in an increase in R^2 of .002, which was not significant; F (1, 249) = 0.53, p = .469. Thus, for men hypothesis 4 that support would moderate the association between aggression received and depression was not supported.

In the stepwise multiple regression analysis for women, which is summarized in table 7.2, at step one social support received by the females significantly predicted their level of depression; F (1, 254) = 5.52, p = .020. The standardized Beta was .146, indicating that higher support was associated with greater depression, as was noted in the Pearson correlation findings for hypothesis 3. At the second step, the change in R^2 was .085, which was significant; F (1, 253) = 24.03, p < .001, indicating that the amount of psychological aggression received accounted for additional variance in depression. The standardized Beta for aggression received was .291, indicating that the more aggression received, the greater the depression, as reported earlier for the Pearson correlation findings regarding hypothesis 1. Finally, at step three the addition of the interaction term (regarding moderation) resulted in an increase in R^2 of .000, which was not significant; F (1, 252) = 0.00, p = .986. Thus, hypothesis 4 that support would moderate the association between aggression received and depression was not supported for either females or males.

Table 7.1: *Multiple Regression Results Regarding Hypothesis 4 -- Males*

Model	Variables Entered	R	R^2	R^2 Change	F Change	Degrees of Freedom 1	Degrees of Freedom 2	Significant F Change
1	Male Social Support from Friends (SSFr)	.178	.032	.032	8.221	1	251	.004
2	Male Psychological Aggression (PA) Received	.243	.059	.027	7.221	1	250	.008
3	Male SSFr x PA	.247	.061	.002	.527	1	249	.469

Table 7.2: *Hypothesis 4-- Multiple Regression Results Regarding Females*

Model	Variables Entered	R	R^2	R^2 Change	F Change	Degrees of Freedom 1	Degrees of Freedom 2	Significant F Change
1	Female Social Support from Friends (PSSFr)	.146	.021	.021	5.515	1	254	.020
2	Female Psychological Aggression (PA) Received	.326	.106	.085	24.029	1	253	.000
3	Female PSS x PA	.326	.106	.000	.000	1	252	.986

Research Questions

Research question 1 asked whether there was a gender difference in the association between psychological aggression received from a partner and the recipient's level of depression symptoms. Correlations were computed separately for women and men, and as was reported for hypothesis 1, there was an association between psychological aggression and depression for both genders. However, as described previously, there was not a significant difference between genders for this association.

Research question 2 asked whether or not there was a gender difference in the degree to which perceived social support from friends would moderate the association between psychological aggression and depression. As described regarding the analyses for hypothesis 4, the multiple regression analyses that were computed separately for women and men indicated that social support from friends did not moderate the association between psychological aggression and depression for either gender. Therefore, due to the lack of significance for either gender, there was no support for the hypothesized gender difference for research question 2.

CHAPTER 5: DISCUSSION

Summary of Findings

The purpose of this study was to determine the relationships among psychological aggression, depression, and social support from friends. Because there has been a limited amount of research on psychological aggression, it is important to determine the factors that influence its impact on the individual. In particular, this study looked at the association between the amount of psychological aggression that individuals receive from their intimate partner and their level of depression symptoms, as well as the degree to which social support from friends may moderate that association. Previous research has demonstrated a relationship between each pair of these variables (i.e., psychological aggression and social support, psychological aggression and depression, depression and social support), the degree to which the common buffering effects that social support has on the effects of life stressors has not been investigated in the context of negative impacts of psychological aggression. Table 8 summarizes the study's findings regarding the hypotheses and research questions.

Table 8.1: *Summary of Findings-- Hypotheses*

Hypothesis	Men	Women
1. Individuals who receive more psychologically aggressive behavior from their intimate partner will report higher levels of depression symptoms.	Supported	Supported
2. Women will report a higher level of perceived social support than men.	Not Supported (Opposite Found)	Not Supported (Opposite Found)
3. The greater the individual's perceived social support from friends, the lower his or her level of depression symptoms will be. a. The association between perceived social support and lower depression symptoms will be stronger for women than for men.	Not Supported Not Supported	Not Supported Not Supported
4. Perceived social support from friends will moderate the association between psychological aggression received from a partner and the recipient's level of depression symptoms, such that when social support is higher the association between receiving more psychological aggression and being more depressed will be weaker.	Not Supported	Not Supported

Table 8.2: *Summary of Findings—Research Questions*

Research Questions	Outcome
1. Is there a gender difference in the strength of the association between amount of psychological aggression received from a partner and the recipient's level of depression symptoms?	No significant difference
2. Is there a gender difference in the degree to which level of perceived social support from friends moderates the association between amount of psychological aggression received from a partner and the recipient's level of depression symptoms?	No significant difference

The first hypothesis was supported within the current sample, in which a relationship between higher levels of psychological aggression and high levels of depression was found. This finding has several implications for research in helping to support the notion that psychological aggression is associated with a lower level of the recipient's well-being. These correlational results cannot determine the direction of causality between receiving psychological aggression and experiencing depression, but there might be other variables that lead to both partner aggression and depression (e.g., relationship distress on the parts of both members of a couple). Nevertheless, these findings do indicate that receipt of partner psychological aggression and depression symptoms commonly co-occur, and therapists need to be aware of that during their assessments and interventions with clinic couples.

Regarding gender differences in responses to forms of social support, prior studies have found that women have more positive outcomes when they receive emotional support, whereas men attain more positive outcomes from instrumental support (Falcon, Todorova, & Tucker, 2009; Wheeler, Reis, & Nezlek, 1983). The Perceived Social

Support scale used in the present study asks questions mainly related to emotional support (i.e., "I rely on my friends for emotional support" or "My friends are sensitive to my personal needs"). The second hypothesis set out to determine whether the gender difference found in past research was applicable to the current clinic sample of couples. However, within this sample there was a significant gender difference that was opposite to what had been expected. The results show that men had significantly higher scores on the Perceived Social Support scale as compared to women. Possible explanations for this unexpected finding are discussed in the next section.

Hypothesis 3 predicted that the higher an individual scored on perceived social support from friends, the lower his or her symptoms of depression would be. This hypothesis was based on a substantial amount of prior research indicating that social support facilitates positive mental and physical well-being. However, in the present study there was a significant *positive* association between amount of perceived social support received from friends and symptoms of depression. This finding is, again, opposite of the hypothesized association, and possible reasons for this unexpected finding are discussed in the next section. Furthermore, hypothesis 3a stated that the relationship between social support and depression would be stronger for women than for men. However, within the current sample, even though the relationship between the variables was positive instead of negative, the *males* in the sample had a significantly higher positive correlation than the females. Again, possible explanations for this finding are considered in the next section.

Finally, hypothesis 4 examined whether social support served as a moderating variable for the relationship between psychological aggression received and the

recipient's depression. The findings were not significant, and therefore the hypothesis was not supported. This finding means that in the present sample of clinic couples psychological aggression and depression are positively correlated regardless of the amount of perceived social support received from friends. Again, the buffering effect that has been demonstrated for social support in prior studies did not operate in this clinic sample. Possible reasons why this was so are considered in the next section.

In addition to the hypotheses that were tested, there were also two gender-based research questions that yielded no significant results within the current study. First, as already reported, there was no significant gender difference in the association between the amount of psychological aggression received and the recipient's level of depression. Second, there was no gender difference in the degree to which social support moderates the association between psychological aggression and depression, because in the present sample there was no evidence of such a moderation effect for either females or males.

Discussion of Findings

This study was conducted in an attempt to better understand the degree to which psychological aggression in heterosexual couple relationships has an effect on symptoms of depression, using social support as a potential moderator of that association. It was hypothesized that the more psychological aggression that was received by an individual, the higher their level of depression would be. This study focused on depression associated with psychological aggression, because much less research has been conducted with psychological aggression than with physical aggression/violence. The moderation hypothesis was tested because past research found that social support networks can have a moderating effect on the relationship between a stressor and the

level of distress that the individual experiences (Fortin, Guay, Lavoie, Boisvert, & Beaudry, 2011). In addition to the predicted moderating effect of social support, it was further hypothesized that there would be a direct positive effect between social support and depression, such that the more social support an individual had, the lower their depression symptoms would be, independent of any psychological aggression that was received from a partner. In terms of gender, women were hypothesized to perceive higher levels of social support from their friends than men do, given prior evidence that women develop and use social support networks more than men. Based on that same rationale, two research questions addressed whether or not there was a gender difference in the association between social support as a moderating variable of psychological aggression and depression as well as the strength of the association between psychological aggression received and depression. As described above, the hypothesized positive association between receipt of psychological aggression and experiencing depression symptoms was supported by the findings of this study, but the other hypotheses were not supported, and in fact two findings were in the opposite direction of the hypothesized relationship. In the following sections each of these findings is discussed further.

    Psychological aggression and depression. Historically, psychological aggression was only looked at as a predictive variable for physical abuse, whose effects were said to be incredibly detrimental to the individual experiencing the abuse. However, there is a growing body of literature pointing to the effect of psychological aggression on an individual, which can include social isolation, depression, stress, and substance abuse (Walker, 1984). Consistent with this research, the current study found that those who reported higher scores on the combined subscales of the Multidimensional Measure for

Emotional Abuse, indicating that they had been exposed to various forms of psychologically aggressive behavior from their intimate partner, also had higher scores on the Beck Depression Inventory. This finding is consistent with the notion that psychological aggression can have a negative impact on an individual's level of wellbeing, although these cross-sectional results do not demonstrate that the psychological aggression caused the recipients' depression.

For professionals who are treating individuals who have been exposed to psychological aggression, it is important to remember that one of the results of being abused in such a way can be depression. Many individuals who seek therapy initially present with the issue of depression, and it is the role of the therapist to begin to explore this problem. The results of this study point to the importance of exploring with a depressed individual whether he or she has been experiencing aggressive behavior in relationships with others, in order to identify whether or not the depression may be a residual effect of aggression. Thus, this finding of the present study was consistent with prior research and adds to the growing body of evidence that aggressive behavior within close relationships can have negative effects on the individuals as well as on the quality of their relationship. As will be discussed further in the section on implications for research, there is a need for further studies to identify the causal path linking psychological aggression and depression.

Perceived social support and women. Social support has been found to have positive effects for buffering various different life stressors including daily stress, transitional periods, and even trauma (Luster & Small, 1997). The source through which social support was provided within the present study was through friendships. Friendship

networks provide support to individuals in various different ways, which House (1987)

defined in his work as emotional, instrumental, appraisal, and instructional. When

measuring the impact of each of those four types of support, past research has found

significant gender differences in how they are utilized within friend relationships. Studies

have indicated that men show better outcomes when instrumental support is provided,

and women show better outcomes with emotional support (House, 1987; Cocker et. al,

2002; Kinard 2006). Surprisingly, the findings did not support the hypothesis that women

would score higher on the Perceived Social Support scale than men, in spite of the fact

that the scale's items primarily assess aspects of emotional support, with little attention to

instrumental support. In fact, the opposite was true, in that men scored significantly

higher than women on the Perceived Social Support scale. This finding is inconsistent

with previous research that found that emotional support is more helpful to women than

to men.

One possible explanation for this finding may be that only friend social supports

were assessed in this study. Prior research found that women mainly turn to family

support groups and other women when they are looking for emotional support (Falcon,

Todorova, & Tucker, 2009). Because this study did not include an assessment of how

much support individuals received from family members, it may have underestimated the

degree of emotional social support that the women in the sample were receiving.

Although this also would be true of the men, if the men were obtaining proportionally

more support from friends than from family members, whereas the women may have

received more of their emotional support from family, the PSS scale may have

overestimated the total amount of social support that men received compared to the

amount that the women received. This finding could account for why the men in the current study had significantly higher scores than women on the Perceived Social Support scale.

In addition, Antonucci and Akiyama (1987) found in their sample of 380 men and women, aged 50-95 years old, that the quality and the quantity of the social support received had a greater effect on women's overall level of well-being in comparison to men. Within the present study, the sample consisted of individuals who were coming to therapy to work on a couple issue. Due to the aforementioned point that within this study only friend supports were examined, the outcome may have occurred because the women in the sample believed that the quality and quantity of their friendships were not helpful in solving their couple issues. This finding supports previous research that women are more dependent on support networks than men, and that they rely more heavily on the support that they are receiving as a measure of their overall level of well-being (Cocker et. al, 2002). It is possible that the women had already sought out their support networks for assistance in solving their couple issues and found that they were not helpful, therefore turning to therapy as an outside form of support that could serve to repair the couple relationship. Consequently, if women depend more on the quality and quantity of their support networks and do not feel as though those supports are helping to assist them with their problems, there is a strong possibility that they may have given up on their current supports, therefore leading them to get a lower score on the PSS than men.

Perceived social support and depression. In addition to serving as a buffer against life stressors, social support has also been shown to lead to increased levels of overall psychological well-being (Luster & Small, 1997). The current study produced no

significant findings to support this statement. In the present study, it was found that there was a significant *positive* association between social support and depression, in that those who scored higher on the Beck Depression Inventory also had higher levels of social support. One explanation for this finding could be that those who were feeling more depressed turned to their social support networks more often, and as a result, felt like they were getting more support in return due to the depression they were experiencing. The cross-sectional design of this study leaves that causal direction a distinct possibility.

Furthermore, the hypothesis that women would have a stronger association between social support and depression was not supported, and in fact the opposite was true. Men had a significantly higher association between levels of depression and perceived social support. This finding may have been influenced by the previously described finding that, overall, women reported less perceived social support from friends than men. One reason for this finding could be that the couples within this sample are likely to have been experiencing distress within their relationship for an extended period of time and therefore have already exhausted their use of the social support networks that they have available. Women tend to utilize and depend more on their support networks than men, and due to the troubles within their relationship, the women may have felt as though they were not getting the amount of support that they needed. In contrast, perhaps the men, who do not rely as heavily on social supports to enhance their quality of life, may have felt as though they were receiving a higher level of support due to their elevated levels of depression symptoms (Antonucci & Akiyama, 1987).

Psychological aggression, depression, and perceived social support. There has been no prior research that observed the association between psychological aggression

and depression using social support as a moderator. Despite all of the previous literature indicating that social support buffers against negative effects of various life stressors, the current study did not find a significant moderation effect for either females or males who experienced degrees of psychological aggression from their partner. Mainly, what the current study did find was that there is an association between psychological aggression and depression regardless of the level of social support that the individual is receiving. This means that, at least in the present sample, the level of social support received from friends was not a significant protective measure to help reduce the residual effects of psychological aggression. This finding is surprising given that perceived social support was higher among those with elevated symptoms of depression.

One reason for this finding could be that individuals have different expectations, criteria, experiences, and evaluations of their support systems (Antoucci & Akiyama, 1987). Therefore, although there was an association found between psychological aggression and depression, the social support networks did not influence that relationship perhaps because each person, regardless of their sex, has different needs and uses for their social support networks. Within the current sample, none of the tests regarding social support resulted in significant findings, and this could be due to the clinical sample that was used. It is likely that the individuals within this study decided to come to therapy because they were not getting the outside help that they felt they needed in order to repair their relationship issues, and therefore scores on the social support scale did not prove to buffer against the negative effects of psychological aggression and depression. It could be that a different form of support, such as the inclusion of familial supports, or the use of an assessment that measured each form of social support (emotional, appraisal, instrumental,

and informational) could have changed the outcome of the study. This issue is discussed in the limitations section of this document.

 Gender differences. One of this study's research questions focused on a possible gender difference in the strength of the association between psychological aggression received and level of depressive symptoms, and the other focused on whether there was a gender difference in the amount that social support serves as a moderator of the association between psychological aggression and depression. In neither case did the findings indicate a gender difference, in spite of prior research indicating that women make more use of social support networks than men.

 The lack of significant gender differences could, again, be due to the sample that was used. In seeking assistance from the Center for Healthy Families, both members of the couple had decided or acknowledged that they needed extra support and help in working through their relationship issues, which could explain why the receipt of psychological aggression had similar effects on the individual, regardless of their gender. As was mentioned previously, when couples are in constant conflict with one another, they may be using forms of psychological aggression against their partner without realizing or accepting the detrimental effects that it may have on the individual. Many couples who are seeking therapy to work through their issues have developed negative patterns that involve behaviors such as name calling, screaming, throwing items, withdrawing from their partner, and lack of intimacy, all of which fit into Murphy and Hoover's (1999) descriptions of psychologically aggressive behavior. Therefore, the strongly bidirectional nature of psychologically aggressive behavior in couples who are in conflict have resulted in the absence of gender differences within the current sample.

Limitations

The current study had some limitations that may have affected the results that were obtained. To begin, the sample originally consisted of 406 couples, but there was a great deal of information missing which limited the sample to about half, depending on which measure was examined. The assessments are all completed in the initial assessment session for all of the couples, and this significant amount of missing data could be reduced if the therapist assigned to check the assessments made sure that couples had completed all of the questions on each assessment form. Unfortunately, this study relied on a subsample of the couples who attended the clinic, potentially reducing the generalizability of the findings, as well as reducing the statistical power for the analyses.

The sample used was also a clinical sample of couples that attended the Center for Healthy Families to work on their relationship issues. This included a vast range of presenting problems such as infidelity, communication, parenting, working through trauma, and addiction among others. A clinical sample can be useful when measuring variables such as depression and psychological aggression, but it is important to acknowledge that this is a sample that has already identified that there is a problem that they are unable to fix using their own resources. Therefore, levels of depression and psychological aggression may be higher and significantly more common within the current sample as opposed to in the general population. If the sample was different, perhaps if there was a non-clinical sample, then the results may have been different.

In addition, all of the measures used within this study were standardized self-report measures. As a measure of psychological aggression, the Multidimensional

Measure of Emotional Abuse asked each question twice, one asked whether or not the individual had committed that act against their partner, and the other asked whether or not the partner had committed that act against the individual who was answering the questionnaire. In order to control for possible response biases, both the individuals' description of their own behavior, and that of their partner of were averaged. For example, the male's scores for himself were averaged with the female's scores for the male.

Despite averaging each individual's answers, the current study did not specifically analyze scores from each subscale. All of the subscales were summed together in order to measure the total psychological aggression score for each individual. The current study may have yielded different results had each subscale been observed to further note which form of psychological aggression was most closely tied to depression and social support. Conceptually, restrictive engulfment is the form of psychological aggression that is more closely tied to individuals' use of their social support systems, because it involves the perpetrator limiting the victim's interactions with the resources that he or she has available to provide them with support (Murphy & Hoover, 1999). Had this index been extracted from the total measure, there could have potentially been a significant finding. This is because there may have been perpetrators who have already been implementing the restrictive engulfment form of psychological aggression with their partners, leading to lowered levels of social support to begin with.

In addition, if the four MMEA subscales had been examined independently, there could have been a potential gender difference in the amount that each type of psychological aggression was displayed. Previous research has indicated that

psychological aggression is often bi-directional, meaning that both members of the couple are likely to be engaging in some or all of the behaviors defined by Murphy and Hoover (1999). Future studies should consider separating the four subscales and removing those individuals who scored high on restrictive engulfment, in addition to using a more refined assessment of forms of psychological aggression.

All self-report measures used, including the MMEA, assess respondents' subjective views, and couples may have different memories or perceptions of how they behave toward one another, which could lead to a reporting bias. During the time of the assessment, a couple could have engaged in a major argument or recently experienced a crisis in which one or both individuals felt hurt or unappreciated, leading to higher scores on the MMEA, as opposed to another couple who may have come into therapy during a time when they were experiencing relatively lower-level aggression, leading to lower scores on the MMEA. These differences in circumstances can greatly affect how an individual responds on any given assessment and is a limitation of using all self-report measures, as they are influenced by circumstances that cannot be controlled.

In addition, perpetrators of physical and psychological aggression generally tend to underreport such behaviors, because the behavior is socially undesirable and they minimize the impact that their behavior may have on the victim, and victims experiencing aggressive behavior may over report it (Murphy & O'Leary, 1989). In future research it would be interesting to analyze the results separately for recipients' ratings of their partner's aggression toward them rather than combining the scores, to determine whether the results are different.

The Beck Depression Inventory was the only measure used in this study to assess depression levels. In future studies it would be helpful to use additional assessments in order to achieve a broader index of depression. Depression can be displayed differently across genders as was discussed previously, with men being more likely to demonstrate anger and violence when depressed and women displaying more internalizing responses (Fincham et. al, 1997). Women also tend to report higher levels of depression due to this gender difference because most measures of depression, including the Beck Depression Inventory, focus more on internalizing responses such as inability to get out of bed, uncontrollable crying, and erratic changes in emotion. Therefore, depression could have possibly been measured using different instruments that would provide a more comprehensive assessment for both genders.

In relation to House's (1987) four different types of social support, the Perceived Social Support scale was limited in that it did not assess all of these forms of social support. The study could have yielded different results had a measure been used that focused specifically on each of these four forms of social support. In addition, the social support scale was even more limited by the fact that in the present study, only support received from friends was examined.

There could have been some follow-up analyses that would have been helpful in providing a better picture of the potential moderating affect of social support on the association between psychological aggression and depression. For example, the exclusion of the restrictive engulfment subscale in the Multidimensional Measure of Emotional Abuse, separating each of the subscales within the MMEA, the addition of the family subscale in the Perceived Social Support scale, and the inclusion of a depression measure

that assesses externalizing behaviors, as is commonly displayed by males would provide more information about the relationships among psychological aggression, social support, and depression.

Implications

The results of the present study have several important implications. They suggest that social support from friends can be more beneficial for men than for women in protecting against the effects of depression. This is an important finding that should be further explored because men are commonly thought to have better outcomes when it came to instrumental support, and the Perceived Social Support scale measures mostly emotional support. A better measure, which specifically looks at instrumental versus emotional support could be used in future studies to further explore this association. It would also be important, when measuring social support, to use a measure that looks at the quality and the quantity of interaction between the individual and their social support network and who is providing the support in addition to the type of support that is being provided. Depending on what the presenting issue is, social supports have been found to lead to various outcomes, and in order to obtain a more accurate description of the benefits that social support can provide, additional assessments should be used.

There were a few findings within this study that did not support previous findings, mainly that the higher an individual's level of depressive symptoms, the more support they were receiving from friends. In past research, social support was shown to prove as a buffer against mental health issues and this study went against these findings (Luster & Small, 1997). This is a finding that deserves closer observation because it could mean that supports are not serving their purpose, perhaps that friends become closer only once

an individual has identified that he or she has a serious problem as opposed to being a constant source of support. Future researchers should also consider using a control group, or a non-clinical sample, to measure the effectiveness of social support systems. This is because many clients who attend therapy have a limited social support network and limited resources to turn to in terms of helping with the specific presenting problem. The reasons for this can be multifaceted and can range from shame regarding being in a struggling couple relationship, to not feeling comfortable talking about couple issues with members of their current support network, to perhaps lacking support in general. A non-clinical population may be making better use of their supports so that they feel as though they do not need to seek treatment, and therefore may yield better outcomes on the social support measures and lower depression scores.

This study also found that, contrary to past research on the topic, there was no significant gender difference in the association between the amount of psychological aggression received and recipients' levels of depression. It was hypothesized that women would be more affected by psychological aggression and as a result demonstrate elevated levels of depression symptoms, but within this sample there was no significant result to support this. Future researchers should investigate gender differences in how psychological aggression is defined within a couple relationships. It might be that men are more likely to report psychologically aggressive behaviors committed against them by their partners because there is less guilt and shame surrounding this phenomena than with physical aggression. In addition, due to cultural perceptions, women may be more likely to excuse a male's aggressive or dominant behavior, leading them to minimize the psychological aggression they are receiving. Depression is a construct that also needs to

be considered as a gendered construct, because in past research men have displayed very different depression symptoms than women, and researchers need to make sure to keep this in mind when finding an appropriate measure to assess depression for *both* genders.

Summary

Overall, this study was relevant for couple and family therapists because the results suggest that social support networks did not play a significant role in protecting against the residual effects of psychological aggression within this clinic sample of couples who had sought therapy for relationship problems. This finding may change the way that a treatment plan is set up in relation to inquiring about social supports and bringing in additional members of the family. The therapist may wish to look at the type of support an individual is receiving, as well as the quality of their relationships with those supports and the quantity with which they utilize them. Psychological aggression can have a significant impact on levels of depression, as was shown in this study, and therefore further research needs to be done in order to identify protective factors that may reduce its impact. Although previous studies have found that social support networks can serve this purpose, the current study did not, and therefore these contradicting findings support the notion that these constructs need to be researched more extensively in the future.

Multidimensional Measure of Emotional Abuse

center for healthy families
UNIVERSITY OF MARYLAND

MMEA

Gender: _____   Date of Birth: _____

Therapist Code: _____   Family Code: _____

Directions: No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things IN THE PAST 4 MONTHS, and how many times your partner did them in the **IN THE PAST 4 MONTHS**. If you or your partner did not do one of these things in the past 4 months, but it happened before that, circle 0.

(0) Not in the past four months, but it did happen before

(1) Once   *(2) Twice*   *(3) 3-5 times*

(4) 6-10 times   *(5) 11-20 times*   *(6) More than 20 times*

(9) This has never happened

	Never in PAST 4 MONTHS	Once	Twice	3-5	6-10	11-20	20+	Never in relationship
	0	1	2	3	4	5	6	9

How Often in the last 4 months?

1. Asked the other person where s/he had been or who s/he was with in a suspicious manner.	**You:** 0 1 2 3 4 5 6 | 9

	Your partner: **0 1 2 3 4 5 6** **9**
2. Secretly searched through the other person's belongings.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
3. Tried to stop the other person from seeing certain friends or family members.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
4. Complained that the other person spends too much time with friends.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
5. Got angry because the other person went somewhere without telling him/her.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
6. Tried to make the other person feel guilty for not spending enough time together.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
7. Checked up on the other person by asking friends where s/he was or who s/he was with.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
8. Said or implied that the other person was stupid.	**You:** **0 1 2 3 4 5 6** **9** **Your partner:** **0 1 2 3 4 5 6** **9**
9. Called the other person worthless.	**You:** **0 1 2 3 4 5 6** **9**

	Your partner: **0 1 2 3 4 5 6**	**9**
10. Called the other person ugly.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
11. Criticized the other person's appearance.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
12. Called the other person a loser, failure, or similar term.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**

13. Belittled the other person in front of other people.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
14. Said that someone else would be a better girlfriend or boyfriend.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
15. Became so angry that s/he was unable or unwilling to talk.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
16. Acted cold or distant when angry.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**

17. Refused to have any discussion of a problem.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
18. Changed the subject on purpose when the other person was trying to discuss a problem.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
19. Refused to acknowledge a problem that the other felt was important.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
20. Sulked or refused to talk about an issue.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
21. Intentionally avoided the other person during a conflict or disagreement.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
22. Became angry enough to frighten the other person.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
23. Put her/his face right in front of the other person's face to make a point more forcefully.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**
24. Threatened to hit the other person.	You: **0 1 2 3 4 5 6**	**9**
	Your partner: **0 1 2 3 4 5 6**	**9**

25. Threaten to throw something at the other person.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: 0 1 2 3 4 5 6	**9**
26. Threw, smashed, hit, or kicked something in front of the other person.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: 0 1 2 3 4 5 6	**9**
27. Drove recklessly to frighten the other person.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: 0 1 2 3 4 5 6	**9**
28. Stood or hovered over the other person during a conflict or disagreement.	**You:** **0 1 2 3 4 5 6**	**9**
	Your partner: 0 1 2 3 4 5 6	**9**

Beck Depression Inventory

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BDI

Gender: _____   **Date of Birth:** _____

Therapist Code _____   **Family Code** _____

Directions: On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the *PAST WEEK,* **INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.

    1 I feel sad.

    2 I am sad all the time and I can't snap out of it.

    3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.

    1 I feel discouraged about the future.

    2 I feel I have nothing to look forward to.

    3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.

    1 I feel I have failed more than the average person.

    2 As I look back on my life, all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.

   1 I don't enjoy things the way I used to.

   2 I don't get real satisfaction out of anything anymore.

   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.

   1 I feel guilty a good part of the time.

   2 I feel quite guilty most of the time.

   3 I feel guilty all the time.

6. 0 I don't feel I am being punished.

   1 I feel I may be punished.

   2 I expect to be punished.

   3 I feel I am being punished.

7. 0 I don't feel I am worse than anybody else.

   1 I am disappointed in myself.

   2 I am disgusted with myself.

   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.

   1 I am critical of myself for my weaknesses or mistakes.

   2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.

    1 I have thoughts of killing myself, but I would not carry them out.

    2 I would like to kill myself.

    3 I would kill myself if I had the chance.

 10. 0 I don't cry any more than usual.

    1 I cry more than I used to.

    2 I cry all the time now.

    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I have ever been.

    1 I get annoyed or irritated more easily than I used to.

    2 I feel irritated all the time now.

    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.

    1 I am less interested in other people than I used to be.

    2 I have lost most of my interest in other people.

    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.

    1 I put off making decisions more than I used to.

    2 I have greater difficulty in making decisions than before.

3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel that there are permanent changes in my appearance that make me look

unattractive.

3 I believe that I look ugly.

15. 0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I cant' do any work at all.

16. 0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to an cannot get back to sleep.

17. 0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired more doing almost anything.

3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.

1 I have lost more than 5 pounds.

2 I have lost more than 10 pounds.

3 I have lost more than 15 pounds.

I am purposely trying to lose weight. Yes ___ No ___

20. 0 I am no more worried about my health than usual.

1 I am worried about physical problems such as aches, pains, an upset stomach or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

BDI.Rev. .Rev.7/11

Perceived Social Support Scale

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PSS

Gender: _____   **Date of Birth:** _____

Therapist Code: _____   **Family Code:** _____

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with **FRIENDS**. When thinking about friends, please do not include family members. For each statement there are five possible answers (1 through 5) ranging from "Yes" to "No." Please check the answer you choose for each item.

Yes   No

1   2   3   4   5

__   __   __   __   __   1.   My friends give me the moral support I need.

__   __   __   __   __   2.   Most other people are closer to their friends than I

                                             am.

__   __   __   __   __   3.   My friends enjoy hearing about what I think.

__   __   __   __   __   4.   Certain friends come to me when they have

                                             problems or need advice.

__   __   __   __   __   5.   I rely on my friends for emotional support.

__   __   __   __   __   6.   If I felt that one or more of my friends were upset

                                             with me, I'd just keep it to myself.

__   __   __   __   __   7.   I feel that I'm on the fringe in my circle of friends.

__   __   __   __   __   8.   There is a friend I could go to if I were just feeling

down, without feeling funny about it later.

— — — — — 9. My friends and I are very open about what we think about things.

— — — — — 10. My friends are sensitive to my personal needs.

— — — — — 11. My friends come to me for emotional support.

— — — — — 12. My friends are good at helping me solve problems.

— — — — — 13. I have a deep sharing relationship with a number of friends.

— — — — — 14. My friends get good ideas about how to do things or make things from me.

— — — — — 15. When I confide in friends, it makes me feel uncomfortable.

— — — — — 16. My friends seek me out for companionship.

— — — — — 17. I think that my friends feel that I'm good at helping them solve problems.

— — — — — 18. I don't have a relationship with a friend that is as intimate as other people's relationships with friends.

— — — — — 19. I've recently gotten a good idea about how to do something from a friend.

— — — — — 20. I wish my friends were much different.

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with **FAMILIES.** When thinking about family, please do not include friends. For each statement there are five possible answers (1 through 5) ranging from "Yes" to "No". Please check the answer you choose for each item.

Yes   No

1   2   3   4   5
—   —   —   —   —   1.   My family gives me the moral support I need.

—   —   —   —   —   2.   I get good ideas about how to do things or make

things from my family.

—   —   —   —   —   3.   When I confide in the members of my family who

are closest to me, I get the idea that it makes them

uncomfortable.

—   —   —   —   —   4.   Most other people are closer to their families than I

am.

—   —   —   —   —   5.   My family enjoys hearing about what I think.

—   —   —   —   —   6.   Members of my family share many of my interests.

—   —   —   —   —   7.   Certain members of my family come to me when

they have problems or need advice.

—   —   —   —   —   8.   I rely on my family for emotional support.

—   —   —   —   —   9.   There is a member of my family I could go to if I

were just feeling down, without feeling funny about

it later.

—   —   —   —   —   10.   My family and I are very open about what we think

about things.

___ ___ ___ ___ ___   11.   My family is sensitive to my personal needs.

___ ___ ___ ___ ___   12.   Members of my family come to me for emotional

support.

___ ___ ___ ___ ___   13.   Members of my family are good at helping me

solve problems.

___ ___ ___ ___ ___   14.   I have a deep sharing relationship with a number of

members of my family.

___ ___ ___ ___ ___   15.   Members of my family get good ideas about how to

do things or make things from me.

___ ___ ___ ___ ___   16.   When I confide in members of my family, it makes

me uncomfortable.

___ ___ ___ ___ ___   17.   Members of my family seek me out for

companionship.

___ ___ ___ ___ ___   18.   I think that my family feels that I'm good at helping

them solve problems.

___ ___ ___ ___ ___   19.   I don't have a relationship with a member of my

family that is as close as other people's

relationships with family members.

___ ___ ___ ___ ___   20.   I wish my family were much different.

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Couple Information & Instructions

Gender: _____   **Date of Birth:** _____

Therapist Code: _____   **Family Code:** _____

Directions: This is a first in a series of questionnaires you are being asked to complete that will contribute to the knowledge about couple therapy. In order for our research to measure progress over time we will periodically re-administer questionnaires. Please answer the questions at a relatively fast pace, usually the first that comes to mind is the best one.

There are no right or wrong answers.

The following information is gathered from each partner separately.

Name: (Print)   **Address:**

_____   _____

E-mail address: _____   _____zip____

Phone Numbers: (h) _____   (w) _____

          (cell) _____   (fax) _____

5. Gender: M F   **6. SS#** _____

7.   Age (in years) _____

8. You are coming for: a.) Family _____   b.) Couple _____   c) Individual Therapy _____

9. **Relationship status** to person in couple's therapy with you:

10. Total Number of **Years** Together: _____

   1. Currently married, living together
      a. **If married**, number of years married: _____

2. Currently married, separated, but not legally divorced
3. Divorced, legal action completed
4. Engaged, living together
5. Engaged, not living together
6. Dating, living together
7. Dating, not living together
8. Domestic partnership

11. What is your **occupation** ?_____   12. What is your **current employment status** __

1. Clerical sales, bookkeeper, secretary
2. Executive, large business owner
3. Homemaker outside
4. None – child not able to be employed
5. Owner, manager of small business
6. Professional - Associates or Bachelors degree
7. Professional – master or doctoral degree
8. Skilled worker/craftsman
9. Service worker – barber, cook, beautician
10. Semi-skilled worker – machine operator
11. Unskilled Worker
12. Student

1. Employed full time
2. Employed part time
3. Homemaker, not employed

4. Student
5. Disabled, not employed
6. Unemployed
7. Retired

13. Personal **yearly gross income**: $_____   14. **Race**: _____

   (i.e., before taxes or any deductions)

1. Native American

2. African American

3. Asian/Pacific Islander

4. Hispanic

5. White

6. Other (specify)_____

15. What is **your country of origin**? _____

What was **your parent's country of origin**?

   16. _____(father's)
   17. _____(mother's)

How many years have you lived in the USA? _____

18. Highest Level of **Education** Completed: _____

                           1. Some high school (less than 12 years)
                                   5. Associate degree
                           2. High school diploma (12 years) 6.
Bachelors degree (BA, BS)
                           3. Some college   7.
Some graduate education
                           4. Trade School (mechanic, carpentry,
                      8. Masters degree (MA, MS, etc.)
                    beauty school, etc.)   9.
Doctoral degree (PhD, MD, EDD, etc.)

19. Number of people in household: _____
20. Number of **children** who **live in home** with you: ____
21. Number of children who **do not live** with you: _____

Names and phone number of **contact people** (minimum 2):

_____

_____

22. What is your **religious** preference? ____

                1. Mainline Protestant (e.g., Episcopal, Lutheran,

                     Methodist, Presbyterian, Unitarian)

                2. Conservative Protestant(e.g., Adventist, Baptist,

                     Pentecostal)

                3. Roman Catholic

                4. Jewish

                5. Other(e.g., Buddist, Mormon, Hindu)

                6. No affiliation with any formal religion

23. How often do you **participate in organized activities of a church or religious group?** _____

        1. several times per week   5. several times a year
        2. once a week   6. once or twice a year
        3. several times a month   7. rarely or never
        4. once a month

24. How **important is religion or spirituality** to you in your daily life?_____

        1. Very important   2. Important   3. Somewhat important
        4. Not very important   5. Not important at all

25. **Medications**: _____ Yes _____ No If yes, please list the <u>names</u>, <u>purpose</u>, and <u>quality</u> of **medication**(s) you are currently taking. Also list the name and phone number of the medicating physician(s) and primary care physician:

 Medications: _____

Primary Care Physician: _____ **Phone:** _____

 Psychiatrist? Yes/No   Name & Phone, if yes.

_____ **Phone:** _____

Legal Involvement:

26. A. Have you ever been involved with the police?   Yes/No (circle)

   If yes, what happened?   Explain: _____

_____

27. B. Have formal, legal procedures (i.e., ex-parte orders, protection orders, criminal charges, juvenile offenses) been brought against you?   Yes/No (circle)

   If yes, what happened?   Explain: _____

_____

28. If formal procedures were brought, what were the results (e.g., eviction, restraining orders?) _____

_____

Many of the questions refer to your "family". It will be important for us to know what individuals you consider to be your family. Please list below the names and relationships of the people you will include in your responses about your family. <u>Circle yourself in this list</u>.

29. (Number listed in family) _____.

Name	Relationship

_____

List the concerns and problems for which you are seeking help. <u>Indicate which is the most important by circling it</u>. For each problem listed, note the degree of severity by checking (√) the appropriate column.

		4-Severe	3-Somewhat Severe	2 – Moderate	1 - Mild
30.	31.				
32.	33.				
34.	35.				
36.	37				

38. The most important concern (circled item) is # _____

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