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Psychological Abuse in Same-Sex Couples Compared to Heterosexual Couples: Implications for Depression Outcomes

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PSYCHOLOGICAL ABUSE IN SAME-SEX COUPLES COMPARED TO HETEROSEXUAL COUPLES: IMPLICATIONS FOR DEPRESSION OUTCOMES

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ABSTRACT

Many studies have documented the mental health repercussions of intimate partner violence (IPV) on heterosexual individuals, with depression being one of the most prevalent outcomes of IPV victimization (Campbell, 2002; Golding, 1999; Mechanic, Weaver, Resick, 2008). There are very few studies that examine the mental health outcomes of IPV within same-sex relationships (Gehring & Vaske, 2017), because much research is rooted in traditional frameworks. In order to bridge gaps in the research, this project will extend work on IPV to focus on LG populations to examine the relationship between recent psychological abuse and mental health outcomes, specifically depression. Participants comprised of 176 community and undergraduate young adults who answered survey questions about sexual orientation, IPV, and depression. Results found that psychological IPV victimization significantly associated with depressive symptoms (β=.55, p<0.001). When examining gender, results indicated that males experienced higher rates of depression when they were victims of psychological IPV (β=-.16, p=0.01). Due to being underpowered, analysis could not adequately examine differences by sexual orientation. Implications of this study suggest a need for more interventions and advocacy for male individuals who are experiencing IPV as many resources are allocated to women and there is less awareness about men as victims.

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CHAPTER I

INTRODUCTION

Intimate partner violence (IPV) is a prominent issue in the United States as well as in many other countries around the world. IPV is described as aggressive acts such as physical, sexual, and psychological abuse, as well as stalking, which are committed by a current or past intimate partner (Breidling et al., 2015). Many studies have documented the mental health repercussions of IPV on heterosexual individuals, with depression one of the most prevalent outcomes of IPV victimization (Campbell, 2002; Golding, 1999; Mechanic, Weaver, Resick, 2008). Further, psychological abuse may have larger mental health implications for victims compared to other forms, such as physical abuse. For example, psychological abuse more strongly predicts depression over physical abuse (Mechanic et al., 2008).

Most IPV research began in the 1970s in response to the Women's Movement and to date most commonly focuses on heterosexual women who are victims of abuse by a male partner (Stiles-Shields & Carroll, 2015). Thus, most IPV frameworks are rooted in traditional intimate partner roles (i.e., the belief that violence was perpetrated by men against women), thus limiting empirical research with lesbian women and gay men (LG) populations (Stiles-Shields & Carroll, 2015). As a result, there are very few studies

that examine the mental health outcomes of IPV within same-sex relationships (Gehring & Vaske, 2017). In order to bridge gaps in the research, this project will extend work on IPV to also focus on LG populations to examine the relationship between recent psychological abuse and mental health outcomes, specifically depression. Therefore, this study will investigate the association between psychological abuse and depression in individuals 18 to 40 years old who identify as either heterosexual, gay, or lesbian.

Definitions and Prevalence Rates of Intimate Partner Violence (IPV)

Within the scope of IPV, there are individuals who inflict IPV, known as perpetrators, and those who are the target of IPV, or victims (Breiding et al., 2015). There are different forms of IPV that perpetrators may use, including physical, sexual, economic, stalking, and psychological or emotional abuse. Physical abuse is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm, and this may include a variety of physical behaviors such as: pushing, grabbing, biting, choking, shaking, slapping, punching, hitting, use of a weapon, and use of restraints (Breiding et al., 2015). Sexual abuse is a sexual act committed or attempted without freely given consent of the victim or against someone who is unable to consent or refuse, such as an individual who is under the influence of drugs or alcohol (Breiding et al., 2015). Economic abuse involves behaviors that control one's ability to acquire, use, and maintain economic resources, which threaten that individual's economic security and potential for self-sufficiency (Adams et al., 2008). Another form of IPV is stalking, which is a pattern of repeated, unwanted attention and contact that causes fear or concern for one's own safety. Some common stalking acts are: receiving repeated and unwanted phone calls, text messages, and emails, being watched or followed from a distance,

having one's personal property, pets or belongings damaged, and receiving threats of physical harm (Breiding et al., 2015). Psychological abuse is often referred to as verbal or emotional abuse and includes the use of verbal and non-verbal acts to harm another person mentally or emotionally or to exert control over another person (Breiding et al., 2015).

Prevalence rates for different forms of IPV vary because some manifestations are more commonly perpetrated by men compared to women due to the differing motivations. Although some studies have found that men and women perpetrate equal amounts of physical violence, the motivation behind the violence differs. This research suggests that women perpetrate due to fear and self-defense, whereas men perpetrate to control their partner (Swan et al., 2008). Additionally, men are more likely to perpetrate sexual abuse, control their partner, and engage in stalking when compared to women (Swan et al., 2008).

The lifetime prevalence rates for heterosexual women who experience sexual violence is about 9.4% compared to 2.2% of heterosexual men (Breiding, Chen, & Black, 2014). In contrast, rates for lifetime physical violence victimization for heterosexual women are approximately 32.9% compared to 28.1% for heterosexual men; whereas lifetime psychological abuse for heterosexual women (48.4%) and men (48.8%) are similar (Breiding et al, 2014). Furthermore, one study found that heterosexual females ages 18-34 generally experience higher rates of IPV with the rate declining with age (Catalano, 2012). Despite these ranges for lifetime prevalence rates of experiencing IPV in heterosexual individuals, most studies estimate between 25-33% (Seelau & Seelau,

2005). Further, psychological abuse is the most common form of IPV when compared to the other forms of abuse (Hellemans, Loeys, Buysse, Dewaele, & De Smet, 2015).

Compared to the prevalence rates for heterosexual individuals, studies on estimates of IPV for lesbian women and gay men (LG) individuals are limited. Although research on this topic has recently increased, there are still relatively few empirical studies that examine IPV in LG couples (Reuter, Newcomb, Whitton, & Mustanski, 2017). Further, lifetime prevalence rates for LG individuals show wider inconsistences with some studies finding only 1% of LG individuals experience IPV, whereas others find more than 97% of LG individuals experience IPV (Edwards, Sylaska, & Neal, 2015). One study found that lesbian women and gay men reported levels of IPV and sexual violence equal or higher than those who identified as heterosexual (Walters, Chen, and Breidling, 2013). For gay men, an estimate of 26.9% experience lifetime IPV and 12.1% have experienced IPV in the last year (Brown & Herman, 2015).

These estimates are often derived from estimates of heterosexual individuals or convenience samples of LG individuals that may not be representative of the population (Badenes-Ribera et al., 2016). Therefore, the rates of IPV for LG individuals may be less accurate compared to heterosexual individuals and may show several inconsistences across studies with LG populations. For example, the sex of the perpetrator or victim is not always asked, or worse assumed, during data collection. Further, the definition of the LG population is a persistent problem in the literature. There is no standardized way to define LG populations and not all studies examining LG relationships and IPV categorize LG relationships the same way (Badenes-Ribera et al., 2016). Further, research on IPV within LG individuals has traditionally focused on physical abuse, therefore neglecting

and minimizing the potential impact of psychological abuse (Karakurt & Silver, 2013). Despite these difficulties, estimates for LG populations experiencing any type of IPV are estimated to be between one quarter to one third of lesbian women or gay men (Stiles-Shields & Carroll, 2015).

Minority Stress Model and Intimate Partner Violence

Individuals who identify within the LG community are considered sexual minorities. Sexual minorities are individuals who do not identify as heterosexual, but are individuals attracted to their own gender, both genders, or another gender, including those who identify as lesbian, gay, or bisexual (Bostwick et al., 2014). Individuals who identify exclusively as lesbian or gay may engage in same-sex sexual behavior or have same-sex attractions, whereas bisexual individuals may be attracted to members of both genders (American Psychological Association, (APA), 2012). The minority stress model proposes that minorities experience unique stressors because they are often at a disadvantage due to their social position, (Frost & Meyer, 2009). Additionally, minority groups experience stress stemming from multiple areas, including experiences of stigma and discrimination not experienced by the majority. In turn, this additional stress increases their risk for negative mental health outcomes (McConnel et al., 2018). As a result, LG individuals likely have additional factors in relation to IPV that differ compared to heterosexual individuals. These factors include policies about IPV, access to help, stigma and stereotypes of LG individuals, internalized homophobia, and harassment.

One factor that impacts LG individuals specifically involves same sex IPV policies. IPV policies largely resulted from the antifamily violence movement, which

intended to promote safety in the household, but largely ignores victims of same sex relationship violence (Turell, 2000). Even though the movement is a big proponent of IPV awareness and providing victims with support, the movement largely ignored the LG population. As a result, same sex IPV policies are typically considered as an afterthought and these policies do not pay close attention to the specificity and meaning of violence in LG relationships (Lorenzetti, Wells, Logie, & Callaghan, 2007). In 2015, several states omitted same sex language from their IPV statues and denied individuals the right to apply for a protective order against their same sex partner (Stilles-Shields & Carroll, 2015). This type of discriminatory policy bars victims of IPV who are in a same sex relationship from receiving protection and needed resources, which in turn, may add additional stress to individuals who are LG experience IPV.

In addition to the lack of same sex protective policies, victims of same sex IPV seeking shelter have an extra layer of difficulty. IPV shelters tend to serve individuals by gender, meaning that both victims and perpetrators of IPV could be given access to the shelter at the same time. Thus, the victim may not have a guaranteed safe haven from their abuser (Stiles-Shields & Carroll, 2015). Besides shelter barriers and adequate protective policies, victims of IPV in LG relationships have uniquely different experiences that impact their access to other resources. For example, LG IPV victims have an additional barrier when seeking aid because some victims may have to disclose both victimization status and sexual orientation (Stiles-Shields & Carroll, 2015). Further, a partner may threaten to disclose the victim's sexual orientation to others, which could negatively impact the victim's life (Ard & Makadon, 2011; Stiles-Shields & Carroll, 2015). Moreover, when victims of same sex IPV do report to the authorities, their

circumstance is often mislabeled as mutual battering, instead of self-defense which is more common within heterosexual couples (Stiles-Shields & Carroll, 2015). Therefore, LG individuals experiencing IPV have more barriers in accessing help and support compared to heterosexual individuals.

Being a sexual minority creates additional strain which may further perpetuate IPV because of associated stress and stigma. These stressors include being stigmatized for their sexual orientation, living in a society that enforces traditional gender and sexuality norms, being subjected to harassment, and potential exclusion by family and friends (Lorenzetti et al, 2017). For example, in the United States, most individuals are taught about traditional values of masculinity and femininity, whereby women are supposed to be more feminine and men more masculine. Individuals are considered more feminine if they engage in activities perceived as being linked to female behavior, such as taking care of the home or being more empathetic (West & Zimmerman, 1987). On the contrary, individuals are more masculine if they engage in activities that are linked to male behavior, such as providing for their family and not expressing vulnerability (West & Zimmerman, 1987). However, these values are imposed onto LG individuals, with emphasis that there always must be a "male" and "female" in a relationship, even though the individuals in a LG relationship are both the same sex. The assumption is that one individual is more likely to act more masculine and is placed in the male role, and the other individual will be placed in the female role, even though these traditional roles do not apply in a same sex relationship (West & Zimmerman, 1987).

Another barrier involves the societal acceptance of the gender binary, which is the concept that there are only two genders, male or female (APA, 2015). Those whose

behavior is incompatible with the gender binary are referred to as gender non-conforming (APA, 2015). The gender binary is often used to explain IPV within heterosexual relationships based on the stereotype that men can handle situations on their own and do not need social support whereas women are perceived as delicate and fragile and in need of protection (Seelau & Seelau, 2005). Harmful myths promoted by acceptance of the gender binary is that only males perpetrate IPV and women are the victim and female victims need protection more than male victims (Seelau & Seelau, 2005). Unfortunately, this discredits the experience of male IPV victims because males may be viewed as weak if they disclose victimization. In contrast, there is little clarity on how the gender binary explanation for IPV can be extended to same-sex relationships (Hellemans et al., 2015).

Furthermore, the stigmatization from acceptance of the gender binary may lead to hypermasculinity, which is a man's tendency to adhere to a rigid gender role script (Guerrero, 2009). In one study, men who were hypermasculine were more likely to engage in physically and sexually coercive behavior, alcohol abuse, and exhibit lower frustration tolerance and levels of empathy (Guerrero, 2009). Additionally, other studies have found that hypermasculinity was linked to a lack of rape-related empathy and a general lack of empathy and warmth, which related to increased risk of violence (Guerrero, 2009). Along with the stigmatization of the gender binary, normalization of heterosexuality and stigma toward individuals who identify as LG from others may create a situation where LG individuals internalize this stigma. This internalized stigma may manifest as an abusive relationship (Lorenzetti et al, 2017), particularly through internalized homophobia.

Internalized homophobia is defined as when an individual who identifies as a sexual minority has negative feelings and homophobic attitudes towards themselves and others who identify as sexual minorities (Puckett et al., 2017). LG individuals face differential treatment compared to heterosexual individuals. This is important because the additional stress associated with being a sexual minority may lead to internalized homophobia. As society does not view LG relationships as the "norm," this stigmatization may lead to internalized homophobia and be evident in thoughts that LG relationships cannot maintain the same level of intimacy, last as long or be as healthy as heterosexual relationships (Frost & Meyer, 2009). These negative views about LG individuals and their relationships may cause LG individuals to feel shame and devalue their sexual identity. This, in turn, may lead individuals to experience negative views about themselves and the LG community, which may manifest in IPV and other intimacy related problems (Frost & Meyer, 2009).

Individuals who are LG also have higher rates of harassment, especially verbal harassment, which is defined as hearing verbal slurs that are used to intimidate and hurt another individual (McCabe, Dragowski, & Rubinson, 2013). As many as 80% of LG individuals have experienced some type of harassment in their lifetime (Lick, Durso, & Johnson, 2013). There has been extensive research to examine the effect of harassment on individuals LG (Heubner, et al., 2004; Lick et al., 2013; McCabe, et al., 2013). As LG individuals have an increased risk for harassment due to their sexual orientation, they may also be at an increased risk for numerous mental health conditions (Lick et al., 2013). LG individuals are at higher risk for experiencing harassment because they are sexual minorities, and therefore are also at increased risk for mental health problems, like

major depression (Lick et al., 2013). Verbal harassment has been shown to be linked to negative mental health outcomes (McCabe, et al., 2013).

In sum, individuals in LG relationships may experience additional stressors that heterosexual couples do not, such as experiencing discrimination or reduced access to services. The added stress of discrimination, as well as typical relationship stress, may make LG relationships more vulnerable to increased conflict which may in turn increase risk for IPV (Hellemans et al., 2015). Additionally, the oppressive system of the gender binary (i.e., male and female) is problematic because it promotes oppressive gender myths and enforces conformity (Lorenzetti et al, 2017). Therefore, this paper will focus on LG individuals and examine IPV to better understand how IPV outcomes differ between heterosexual and LG individuals. Specifically, this paper will examine how psychological IPV in these relationships is related to various poor mental health outcomes, specifically depression.

Intersectionality

The model of intersectionality theory was rooted in Black feminist thought; however, it provides a very critical lens for understanding individuals who fall into multiple categories of marginalization and how that may adversely affect them (McConnell et al., 2018). Moreover, the theory of intersectionality highlights how multiple social identities (e.g., gender, race, sexual orientation) work together to exploit how the experience of privileged and marginalized groups are interdependent and co-constructed. Individuals who are privileged and those who are oppressed interlock together in society and give rise to our social identities (Bowleg, 2008). The purpose behind using this theory in research is to reduce intersectional invisibility, which happens

when individuals who are in multiple marginalized groups have their experiences excluded from prominent issues because they do not fit into one single category of marginalization (Purdie-Vaughns & Eilbach, 2008). These individuals who are marginalized across multiple areas often become marginalized members of an already marginalized group. This leaves them in a position of social invisibility (Purdie-Vaughns & Eilbach, 2008). There is a lack of research in the areas of multiple minority stress and on individuals who fall into this category (i.e., multiple marginalized groups) (Bowleg, 2008; McConnell et al., 2018; Purdie-Vaughns & Eilbach, 2008;). For example, when looking at different groups of individuals (e.g., Caucasian heterosexual women compared to Black sexual minority women), individuals from multiple minority groups (e.g., Black sexual minority women) are going to experience more minority stress because they are a social minority in three different groups (Calabrese et al., 2015). These women not only face discrimination within their racial community because of their sexual orientation, but also in the LGBT+ community because of their race. Additionally, as women, these individuals face discrimination in society as women are "less than" men (Calabrese et al., 2015). This multiple layered form of aggression on Black women who are sexual minorities increases risk for negative mental health outcomes compared to individuals who only experience one form of oppression (Bowleg, 2008; Calabrese et al., 2015). Therefore, it is important to consider multiple minorities (e.g., gender, race) to understand the intersection between heterosexism and sexual minority status to better understand risk for mental health disorders (Balsam et al., 2011). Additionally, if these individuals are also a racial or ethnic minority the interplay between multiple identities may lead them experience greater psychopathology.

Intimate Partner Violence and Mental Health

IPV is associated with a plethora of associated secondary problems related to experiencing IPV. Additional complications from IPV victimization include serious long-term physical health consequences from obtained injuries with the most serious being death (Black, 2011). Furthermore, victims of IPV may experience high rates of mental disorders that include depression and suicidality; these high rates of mental disorders have been assumed to be related to violence the victim endures (Kessler et al., 2001).

LG individuals deal with minority stress, where they are subjected to stigma and harassment due to their sexual orientation (Frost & Meyer, 2009). As described above, one proposed reason that the prevalence of mental health disorders is higher in LG individuals compared to heterosexual individuals is because of minority stress (Meyer & Frost, 2013). In a meta-analysis by Meyer and Frost (2013), they found that studies have shown that LG individuals are at a higher risk for major depression. In a study done comparing LG individuals to heterosexual individuals, they found that gay or bisexual men had higher rates of depression, panic attacks, and overall psychological distress when compared to their heterosexual counterpart (Cochran, Sullivan, & Mays, 2003). In contrast, lesbian women or bisexual individuals have higher rates of generalized anxiety disorder compared to heterosexual individuals (Cochran et al., 2003). This study will specifically examine the impact of psychological IPV victimization on depression.

Depression. Depression is a debilitating disorder that affects about 4.4% of individuals worldwide (World Health Organization (WHO), 2017). Depression is characterized by persistent low mood, loss of pleasure or interest, trouble eating and sleeping, and trouble concentrating throughout the day (Diagnostic and Statistical Manual

of Mental Disorders Fifth Edition (DSM-5), 2013). A plethora of research on heterosexual individuals who experience IPV has shown a strong association between IPV and depression, with many studies reporting that depression is the most prevalent mental health outcome of IPV (Black, 2011, Campbell, 2002; Gehring & Vaske, 2017; Howard et al., 2010). Studies utilizing this population have found that experiencing IPV has been linked to an increased risk for depression and depressive symptoms for both men and women (Coker et al., 2002; Gehring & Vaske, 2017; Golding, 1999). Additionally, other studies have found a link between IPV and depression, such that experiencing IPV is related to increases in depressed mood (Gehring & Vaske, 2017; Mechanic et al, 2008). Unfortunately, very few studies took sexual orientation into account and there is a dearth of research that examines the mental health outcomes of IPV in same-sex couples (Gehring & Vaske, 2017). The few studies that have looked at IPV in same-sex couples have found that LG individuals have similar mental health outcomes, such as higher levels depression, compared to heterosexual individuals (Eaton et al., 2008; Gehring & Vaske, 2017; Walters et al., 2013).

CHAPTER II

CURRENT STUDY

The current study aims to examine the effect of sexual orientation (i.e., lesbian women, gay men, and heterosexual) on the association between psychological IPV victimization on depression. This study will add to the growing literature on IPV in LG populations, where research is limited. This research will also examine mental health outcomes in LG populations as well, which is important because few studies consider sexual orientation when examining mental health effects of IPV (Gehring & Vaske, 2017). By specifically comparing these associations in both heterosexual and LG individuals, an association can be made between whether same-sex couples have similar mental health effects due to IPV as heterosexual couples. The overarching model is presented in Figure 1. The specific hypotheses are: 1: Psychological IPV victimization will be positively related to higher levels of depression symptoms, 2. Prevalence of psychological IPV victimization and corresponding levels of depression symptoms will differ by sexual orientation (i.e., lesbian women, gay men, heterosexual). Specifically, based on previous research, levels of depression symptoms in conjunction with psychological IPV victimization are expected to be highest in gay men, then lesbian

women, and lastly heterosexuals, 3. Internalized homophobia will moderate the relationship between psychological IPV victimization and depression such that depressive symptoms will be higher for those with higher levels of internalized homophobia. As internalized homophobia is specific to sexual minorities, this hypothesis will only be examined in lesbian and gay individuals.

CHAPTER III

METHOD

Participants and Procedures

Participants comprised of community dwelling individuals and college students who identify as either heterosexual, lesbian, or gay. For participants to be considered for the study they had to be either heterosexual, lesbian, or gay and in a current romantic relationship that has lasted at least three months. This requirement ensured measurement of psychological IPV in relationships that are stable and steady.

Individuals who do not identify as heterosexual, a lesbian woman, or a gay man were excluded in order to keep the sample as representative to these groups as possible. The decision to utilize a sample that only focused on the gender binary (i.e., cisgender male and female) was decided in order to make the study more generalizable to these specific groups. Furthermore, although there are a limited number of studies examining individuals who identify as transgender, the experiences of transgender individuals are different from cisgender sexual minority individuals. Therefore, a decision was made to exclude this population.

In order to recruit individuals, an advertisement was posted to Research Match, Tumblr, Reddit, and the CSU Psychology Department's Research Participation System,

SONA. On Research Match, we filtered by age to only recruit those who were 18-40 years old. The remaining sites were used to increase the sample of LG individuals. On Tumblr, a blog post created through the HEART Lab (PI: Goncy) account was shared. This blog described the study and provided a link to the survey. The blog post was tagged at the bottom with research and LGBT+ related words in attract individuals interested in LGBT+ research studies. Further, LGBT+ blogs were searched, and direct messages sent to those bloggers asking to advertise this study on their blog. Five bloggers agreed to re-blog the post to their followers. Reddit and SONA were used to saturate LGBT+ specific populations to increase the LG sample. On Reddit, a post was made to an LGBT+ server; however, it gained minimal attention as it was posted on the very bottom. Additional participants who identified as lesbian or gay were recruited using the Psychology subject pool through Cleveland State University (i.e., SONA). As a result, those individuals received 0.5 credits upon the completion of the survey. There was no compensation for other participants.

Two hundred ninety-six participants began the study; however, there were 115 participants that were excluded from the study. Out of the 115 who were excluded: 46 participants stopped answering the survey at various points leading to incomplete data, 44 individuals self-identified as bisexual, 1 individual identified as a man but was born a woman, 1 participant identified as a lesbian/gay individual in a heterosexual relationship, 7 individuals identified their sexual orientation as other (4 as pansexual, 2 as acesexual, and 1 as unsure), 12 participants identified their gender as either transgender, non-binary, or queer, and 4 participants were ruled out because their partners identified as either transgender or non-binary.

The final sample was comprised of 176 community dwelling individuals and undergraduate students. Of the remaining 176 participants, two identified as gay males and six identified as lesbian women. This sexual minority sample had a mean age of 24.14 years (*SD*=4.84). Due to the low sample size of lesbian and gay individuals, these subsamples were aggregated to a combined sample of eight. There was a total of 161 heterosexuals for the study with a M_{age}=30.37 years, *SD*=5.46. By gender across all participants, there were 152 female participants (M_{age}=30.13 years, *SD*=5.51) and 24 male participants (M_{age}=29.92 years, *SD*=5.62).

The final sample mainly comprised of Caucasian individuals (79%) with all other races comprising of frequencies below ten. Out of the remaining races, 3.4% were African American, 4.5% Asians, 0.6% American Indian or Alaskan Natives, 3.4% LatinX, and 8.5% other races, including individuals identifying as two or more races. Most of this sample had a graduate degree (74.4%), 14.8% a 4-year degree, 2.8% a 2-year college degree, 3.4% had some college, and 2.8% only received a high school diploma. Regarding employment, 39.2% were employed working part time, 33.5% individuals were employed working full time, 6.8% were not employed, but looking for work, 153% were unemployed but not looking for work, and 3.4% were disabled or not able to work.

Measures

Individuals completed an online survey and were asked about their sexual and romantic orientation and whether they were currently with a romantic partner. The study also asked about their partner's sexual orientation and gender to better identify the type of relationship. Additionally, individuals were asked about their age, gender, sex, education history, race/ethnicity, and job status. Individuals were asked to complete surveys that

asked them about IPV and depression, and if they identified as lesbian or gay, internalized homophobia.

Psychological IPV Victimization (see Appendix A). The Conflict in Adolescent Dating Relationships Inventory (CADRI) was used to assess IPV victimization (Wolfe et al., 2001). The CADRI is comprised of thirty-five questions with subscales (sexual abuse, physical abuse, threatening behavior, relational aggression, and emotional/verbal abuse) that count for diverse types of abuse victimization within the past year. An additional ten items ask about positive conflict resolution. The response choices for these questions are: 0=*never*, 1=*seldom* (1-2 conflicts), 2=*sometimes* (3-5 conflicts), 3=*often* (6 or more conflicts). For this study, only the emotional/verbal victimization subscale was used (e.g., "He/she did something to try to make me jealous") (Wolfe et al., 2001).

In prior psychometric work, a modest Cronbach's alpha coefficient was reported for the emotional and verbal abuse subscale (α=.62); however, in this study, the alpha was much higher (α=.89). Some evidence exists for criterion validity among heterosexual respondents (Wolfe et al., 2001). However, this measure has no currently published psychometric evidence for LG individuals as it was created and implemented originally with heterosexual individuals. As this measure was developed using heterosexual language, the measure was modified using a stem question to link participants to their partner's preferred pronouns, therefore tailoring the measure for same-sex and heterosexual relationships.

Depression (see Appendix B). To measure depression, this study used the Center for Epidemiologic Studies - Depression Scale (CESD; Radloff, 1977). The CESD is a twenty-item self-report measure for depression that includes various symptoms such as:

depressed mood, feelings of guilt/worthlessness, feelings of helplessness/hopelessness, psychomotor retardation, loss of appetite, and sleep disturbances. Individuals were asked to rate how often they have experienced these symptoms during the past week. Some examples of the questions that individuals were asked are: "I was bothered by things that usually don't bother me", "I had trouble keeping my mind on what I was doing," and "My sleep was restless," (Radloff, 1977). The response choices regarding symptom frequency in the past week were on a four point scale: 0=*rarely or none of the time* (less than 1 day), 1=*some or a little of the time* (1-2 days), 2=*occasionally or a moderate amount of time* (3-4 days), and 3=*most or all of the time* (5-7 days). The CESD has strong internal consistency (α=.85) when used with the general population, and with higher internal consistency within a clinical sample (α=.90). The internal consistency for this measure for this study showed a lower alpha (α=.75), which is slightly lower than the internal consistency used with the general public. Along with strong internal consistency, the CESD had adequate test-retest reliability and very good concurrent validity as well as substantial evidence of construct validity (Radloff, 1977).

Internalized Homophobia Scale (see Appendix C). To measure internalized homophobia, the Revised Internalized Homophobia Scale (IHP-R) was used. The IHP-R is a self-report measure that is a shorter version of the Internalized Homophobia Scale (Herek, Gillis, & Cogan, 2009). This measure assesses participants attitudes towards their own sexual orientation. The original Internalized Homophobia Scale was designed specifically for use with gay men; however, the revised version was developed to include lesbian women. The IHP-R is a five-item measure to examine if negative attitudes are integrated into an individual's self-image and identity as being lesbian women or gay

men. This measure was only given to participants who identify as LG since the measure is assessing internalized homophobia in sexual minority. Individuals were asked to rate how much they agreed with each statement. Examples are: “I wish I weren’t lesbian/bisexual [gay/bisexual],” “I have tried to stop being attracted to women [men] in general” and “If someone offered me the chance to be completely heterosexual, I would accept the chance” (Herek et al., 2009). The response choices are on a five-point scale: 1=*strongly disagree*, 2=*disagree*, 3=*neither disagree or agree*, 4=*agree*, and 5=*strongly agree*. The IHP-R has strong internal reliability (α=.82) and the score that individuals had on the IHP-R were highly correlated with the original IHP for all sexual orientation groups (all *rs* >.90) (Herek et al., 2009). The alpha for this study (α=.77) was consistent to the original instrument alpha.

CHAPTER IV

ANALYSIS PLAN

First, descriptive statistics were calculated to examine how the data appeared and to make any changes to the data set if there were any outliers or if skewness and kurtosis were present. After the dataset was examined and cleaned, bivariate correlations were calculated to assess the associations among the constructs being examined. Correlations were calculated for depression, age, sex, and IPV victimization for lesbian women, gay men, and heterosexual individuals independently. The bivariate correlations dictated the final models for the univariate analysis. If variables were not statistically significant via bivariate correlations, the variables were considered for removal in the univariate analysis.

To determine the sample size, G Power (Faul et al., 2009) was utilized to determine how many individuals per groups were needed for the multiple group regression. The calculated sample size was based off prior effect size research with depression with the most complex model (sex and internalized homophobia) and a moderate effect size (Cohen's $d = 0.3$). A moderate effect was used as research has been mixed about the exact effect size of the association between depression and psychological IPV. In order to be sufficiently powered, 158 participants total were required with each

group, lesbian women, gay men, and heterosexual individuals, having 58 individuals.

Analyses

To examine if psychological IPV victimization increases the risk of depression (Hypothesis 1), a linear regression was run (see Figure 2 model) after controlling for sex. To assess whether sexual orientation impacts depression after experiences of psychological IPV (Hypothesis 2), a multiple group regression was used (Figure 3). The different groups were lesbian women, gay men, and heterosexual individuals. This analysis assessed if the effect (i.e., β) between IPV and depression is statistically equivalent across the groups. This is tested using multi-group analyses, such that the effects between depression and psychological IPV victimization were constrained as equal in a path analysis. Fit indices were evaluated to determine whether these imposed constraints worsened the model fit. These analyses indicate whether the magnitude of the effects of depression and psychological abuse is similar across lesbian women, gay men, or heterosexual individuals. A statistically significant chi-square difference indicates that the effects were statistically different from each other and stronger for one group, whereas a non-statistically significant chi-square difference indicates no differences between the groups. To assess whether internalized homophobia moderates the association between psychological victimization and depression symptoms (Hypothesis 3), a regression of depression on psychological IPV victimization moderated by internalized homophobia was run (Figure 4). This hypothesis was only assessed for lesbian women and gay men as internalized homophobia is only relevant to examine in those individuals.

CHAPTER V

RESULTS

Descriptive

Upon examination of the data, missing data was minimal at the item level being less than .01%. for participants retained in the final analyses. Notably, two participants did not provide their age, four individuals did not answer one question from the CESD, and two participants did not answer two questions from the CADRI. There were six outliers in the data; however, all were retained. Four of the six were high on both psychological victimization and depression (i.e., *Z*=3.28, *Z*=3.68, *Z*=3.52, *Z*=3.37) and not too far over the cutoff of three. The other two participants were only high on victimization; however, they were retained because they both had the same Z-score only slightly above the cutoff of three (i.e., *Z*=3.22).

Skewness and kurtosis were examined for each variable (see Table 1). The average age of participants for the overall sample was 30.1 years (*SD*=5.51) with a skewness of -.02 (*SE*=.18) and kurtosis of -.86 (*SE*=.37), meaning that age was normally distributed. When examining the internalized homophobia scale, the scale average was 8.5 (*SD*=2.73) with the skewness of .14 (*SE*=.75) and a kurtosis of -1.59 (*SE*=1.48). This variable was normally skewed, but the shape of the distribution was not. For all other

variables there were problems with skewness. The average score for participants on the CESD was 21.19 (*SD*=7.56) with skewness of 1.2 (*SE*=.18) and kurtosis of 1.3 (*SE*=.37). This means this data were positively skewed, denotating that individuals in this sample tended to score higher on this measure. Based off the standard cutoff of 16 for clinical depression, this sample had 137 individuals who either had a CESD score of 16 or above. Therefore, this sample had overall higher scores of depression, with more than three-quarter of the sample at or above the clinical cutoff threshold for depression. Lastly, the psychological victimization scores on the CADRI had a mean response of 7.1 (*SD*=6.51), skewness of 1.37 (*SE*=.18), and kurtosis of 1.89 (*SE*=.37), meaning this measure was positively skewed. The positive skewness for the CADRI suggests that individuals in this sample have higher scores on this measure.

In order to examine if there were any significant differences in the data based on demographics, chi-square analyses were run. The results showed more females (n = 152, 86.4%) participated than males (n = 24, 13.6%), χ=13.66, p=.001. When examining the overall sample using bivariate correlations between age, depression, and psychological victimization (Table 2), depressive symptoms and psychological victimization were positively correlated, $r(170)$=.56, p<0.001. For women (Table 3), there was a positive relationship between psychological IPV victimization and depression, $r(148)$=.60, p<0.001. For men, psychological IPV victimization and depression trended toward significance, $r(22)$=.40, p=.06. Descriptively, both women and men who experienced psychological victimization also reported higher levels of depression. Age of females and psychological IPV victimization were unrelated, $r(148)$=-.12, p=.14, however, age of females and depression trended toward significance, $r(148)$=-.15, p=.08. For men, age

was not related to psychological IPV victimization, $r(22)=-.07$, $p=.74$, or depression, $r(22)=-.01$, $p=.95$. For heterosexual individuals, psychological IPV victimization and depression were significantly related, $r(165)=.56$, $p<0.001$, indicating that as psychological abuse increased, so did depressive symptomology.

Correlations based on the aggregated sexual orientation group are shown in Table 4. All results for lesbian and gay individuals between psychological victimization and age, $r(5)=-.01$, $p=.99$, depression and age, $r(6)=-.43$, $p=.33$, and psychological IPV victimization and depression, $r(6)=.18$, $p=.67$, were not statistically insignificant. Further, internalized homophobia and depression, $r(6)=.37$, $p=.36$, and internalized homophobia and psychological IPV victimization, $r(6)=-.21$, $p=.62$, were statistically insignificant. Internalized homophobia and age were also not related, $r(5)=-.14$, $p=.77$; the relationship between gender and internalized homophobia trended toward significance, $r(6)=.68$, $p=.06$. As none of the variables for the sexual minority groups were statistically significant at the bivariate level, this sample was dropped from regression analysis. Consequently, this prevented the ability to test Hypothesis 2 and 3.

Hypothesis 1

Hypothesis 1 stated that higher rates of psychological IPV victimization would be related to increased depression symptoms after covarying for sex. Regression results are presented in Table 5. Sex and psychological IPV victimization explained 34.1% of the variance in the model ($p<0.001$). Psychological victimization significantly predicted depressive symptoms ($\beta=.56$, $p<0.001$), whereby more psychological victimization was related to higher ratings on depressive symptoms. This provided evidence consistent with hypothesis 1. Additionally, there was a significant effect for sex in predicting depressive

symptoms (β=-3.53, *p*=0.01). Specifically, male individuals were more likely to be depressed. To more closely examine gender differences in depression, an additional regression examined female and male participants separately. Results (Table 6) showed that males trended toward being more likely to experience higher rates of depression when they also endorsed higher levels of psychological IPV victimization (β=.40, *p*=0.06).

Hypothesis 2 and 3

Due to insufficient power, analyses for Hypothesis 2 and 3 could not be completed. This was further evidenced in the lack of bivariate correlations for this subsample.

CHAPTER VI

DISCUSSION

This study set out to examine the effect of sexual minority orientation (i.e., lesbian women, gay men) on the association between psychological IPV victimization and depression. One benefit of this study was its intention to add to the growing literature on IPV in LG populations, where research is limited. However, as the sexual minority sample was highly underpowered, the hypotheses for this subsample and for internalized homophobia were unable to be conducted. Results did demonstrate support for Hypothesis 1, that psychological IPV victimization was associated with higher levels of depression symptoms. Levels of depression were higher when participants indicated that they also experienced psychological IPV.

Results from this study, specifically the correlation between sex and depression, and that females who have experienced IPV have higher rates of depression, support previous literature (Gehring & Vaske, 2017; Coker et al., 2000; Black, 2011). As females are typically the victims of IPV, they are at a higher risk for depression and other mental disorders when experiencing IPV. However, one unique result in this study was that the men in this sample were experiencing more depressive symptoms then females. Typically, from early adolescence through adulthood, women are twice as likely to

experience depression compared to men (Nolen-Hoeksema, 2001). The expectation was that women would evidence higher levels of depressive symptoms; however, this study showed men experiencing higher levels of depression. Further, men who experienced IPV had higher levels of depression; however, it was at the trend level. One reason that may explain the relationship between men and depression, may be related to education not being as much as a protective factor for men compared to women. This sample was highly educated, and previous research has shown that education is a protective factor for depression (Erickson et al., 2016). Furthermore, in a longitudinal study examining the effects of education on different psychiatric disorders, they found that individuals who had a graduate degree were the most protected against developing a psychiatric disorder, whereas those who reported having less than a college degree were at a higher risk of experiencing depression (Erickson et al., 2016). However, contrary to the findings of education being a protective factor for depression, this sample, on average, reported higher levels of depression and were highly educated as well. Education may have only been a protective factor for some of the individuals (i.e., females) in this sample and not others (i.e., males). This may be particularly true as the relationship between depression and males persisted even though the male sample was noticeably smaller than the female sample.

As for women, education it is a protective factor for IPV (Abramsky et al, 2011; Jewkes, 2002), especially when they and their partner have similar educational attainment as one another (Abramsky et al, 2011). When there is a difference between a women's level of education and her partner's level of education, power differentials and jealousy may ensue, leading to higher levels of abuse (Abramsky et al, 2011; Jewkes, 2002).

However, higher levels of education for women is a protective factor as shown in one study that demonstrated that secondary education indicated a reduction in IPV risk whereas only primary education was not a protective factor (Abramsky et al, 2011).

Limitations to this study were that many of the recruited sexual minority participants identified as bisexual which disqualified many potential participants. Additionally, several participants identified as transgender and were also disqualified as a gender minority. Recruitment for lesbian and gay individuals proved to be an impediment for this project as there were very few individuals who identified themselves as lesbian or gay and not as another part of the LGBT+ community. Additionally, when individuals were completing the survey, there were no attention checks to ensure that individuals were not randomly clicking through the survey. Therefore, individuals could have finished the survey by random responding. Furthermore, this study relied solely on self-report data from participants and there were no measures to substantiate participants' responses. It was estimated that participants would complete the survey in about a half hour; however, the average time participants spent taking the survey was about fifteen minutes. This average was based around individuals who started the survey and completed it, individuals who started the survey but did not finish it completely were not accounted for in the average. This suggest that participants were not taking the full estimated time to complete the survey, which may have resulted in individuals not fully reading the questions in the survey or simply randomly responding to the questions in order to complete the survey faster.

Individuals within the LGBT+ communities occasionally overlap between their sexual minority status, as well as gender minority status, making them prime candidates

for intersectionality research. Future research should explore individuals who have multiple labels that lead them to be marginalized in more than one way. The marginalization for transgender individuals may be greater than that of bisexual individuals because often transgender individuals may also identify as a sexual minority as well. This multiple marginalization may even lead these individuals to experience more types of victimization because they fall outside of the gender binary, but they also do not align themselves with the sexual majority either.

Transgender and bisexual individuals may also be at a higher risk for mental health disorder because of the stigma that they face in society. Within the context of IPV research, one study found that when examining bisexual women and men, both groups of individuals experienced a higher prevalence rate of IPV. Notably, they were 1.8 times more likely to report ever experiencing IPV than heterosexual women (Brown & Herman, 2015). When focusing specifically on transgender individuals, they report rates of physical abuse at about 34.6% over their lifetime, compared to a 14% lifetime prevalence for gay and lesbian individuals (Ard & Makadon, 2011). Bisexual individuals are also more likely to experience IPV at a higher rate than any other sexual orientation (Turell, Brown, & Herrmann, 2018). One study suggested that the reason for this increased risk for bisexual individuals compared to other sexual minorities, is that there are specific stereotypes for bisexual individuals and a lot of bi-negativity both inside the LGBT+ community and in society overall (Turell et al., 2018). Additionally, much like with sexual minority individuals, transgender individuals also have the added fear of being forced out by their partner as another form of abuse (Ard & Makadon, 2011). If they had disclosed only to their partner that they were transgender but no one else, their

partner could use that as a form of control or threaten to "out" them if they told anyone about the abuse. These individuals also face the same barriers to adequate IPV services as well because they are a gender minority and do not often get the same quality of care either (Brown & Herman, 2015).

There were recruitment issues highlighted after the study reached completion. As most of the recruitment took place via online social media, few sites provided the option to advertise to individuals based on their sexuality. This may have led to the over inflation of heterosexuals in this sample. Additionally, when the survey was made, individuals who identified as anything other than heterosexual, lesbian, or gay were immediately ruled out from completing the survey. If these individuals had been allowed to finish the survey, even those who had identified as bisexual or transgender could have been coded as heterosexual, lesbian, or gay depending on their current partner. Both bisexual and transgender populations are underrepresented in research in this area and this could be an important area to examine in future research studies.

Additionally, there were few free places to recruit specifically for lesbian and gay individuals. Recruitment was done on the CSU campus and flyers were emailed to LGBT+ center. Blog posts were posted on Tumblr and messages were sent to specifically LGBT+ blogs who agreed to post the survey. However, these places may not have yielded high traffic as there may not be many people on campus who use or know about the LGBT+ center. Further, individuals who use Tumblr for the LGBT+ forums may be systematically different from those who do not. On Tumblr, there was no way of checking to see who frequented this site, thus limiting information on the population. Future research could consider recruitment at Pride events over the summer to increase

the LGBT+ sample. These events may yield a higher percentage of lesbian and gay individuals since attendance of these individuals is typically very higher at these events.

Future directions for this study would be to include bisexual and transgender individuals to examine theses associations among these individuals. There would also be various other forms of recruitment to gain a wider sample of men and sexual minorities as well, such as recruiting from Pride events as well as possibly posting the survey in other popular sexual minority sites. Additionally, future research could examine the differences of psychological IPV among sexual minorities to determine whether there are differences in IPV prevalence for these groups. Another possibility for research in this field would be to more broadly define sexual minority status, rather than relying on labels, and examine actual sexual behavior differences (e.g., men having sex with men) and whether that differentially predicts IPV.

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Appendix A

Table 1

Variables Means, Standard Deviations, Skewness, and Kurtosis

Variable	N	*M*	*SD*	Skew	Kurtosis
Age	174	30.1	5.51	-.02	-.86
Psychological IPV Victimization	174	7.1	6.51	1.37	1.89
Depression Symptoms	172	21.2	7.56	1.2	1.3
Internalized Homophobia	8	8.5	2.73.	.14	-1.59
Total	176				

Table 2

Bivariate Correlations for Overall Sample

Variable	1	2
1. Age	-	
2. Psychological IPV Victimization	-.12	-
3. Depression Symptoms	-.13	.56**

**correlation is significant at the 0.01 level

Table 3

Bivariate Correlations for Female and Male Participants

Variable	1	2	3
1. Age		-.12	-.15^{+}
2. Psychological IPV Victimization	-.07	-	.60**
3. Depression Symptoms	-.01	.40^{+}	-

Note. Females are above the diagonal, males are below
$^{+}$ correlation is significant at the 0.10 level
**correlation is significant at the 0.01 level

Table 4

Bivariate Correlations for Sexual Minority Participants

Variable	1	2	3
1. Age	-		
2. Psychological IPV Victimization	-.01	-	
3. Depression Symptoms	-.43	.18	-
4. Internalized Homophobia	-.14	-.21	.37

Table 5

Regression Results for Psychological Victimization on Depression

Variables	*B*	*SE B*	β	*t*	*p*
Sex	-3.53	1.39	-0.16	-2.54	.01
Psychological Victimization	0.65	0.07	0.56	8.85	<.001

Note. R^2=34.1% (*N*=170, *p*=<.001)

Table 6

Regression Results for Males on Depression

Variables	*B*	*SE B*	β	*t*	*p*
Males	0.54	0.27	0.4	1.97	0.06

Note. R^2=34.1% (*N*=23, *p*=.06)

Appendix B

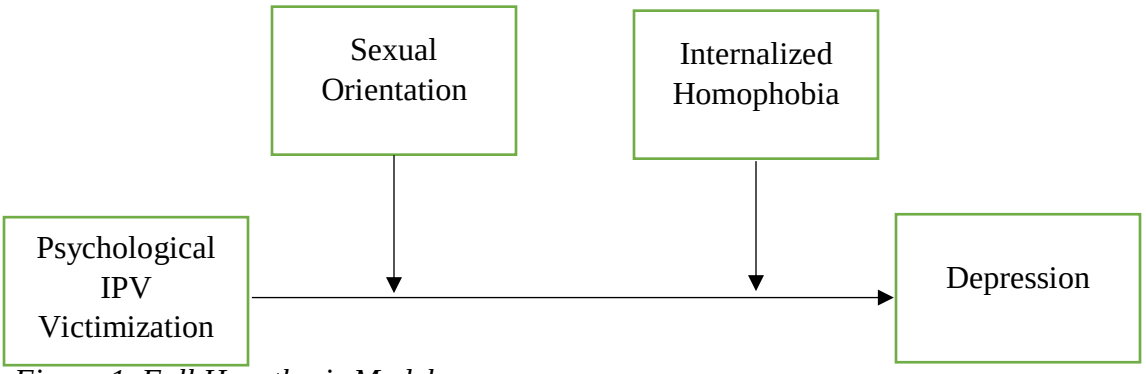

Figure 1. Full Hypothesis Model

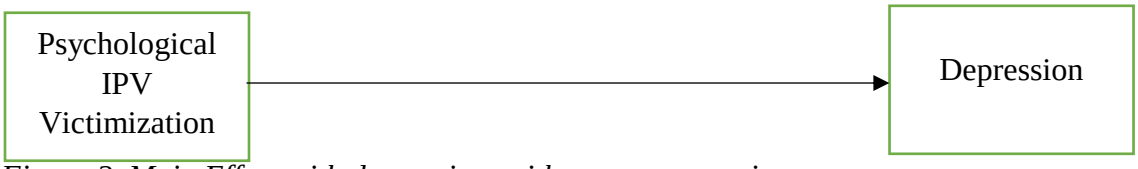

Figure 2. Main Effect with depression, with sex as a covariate

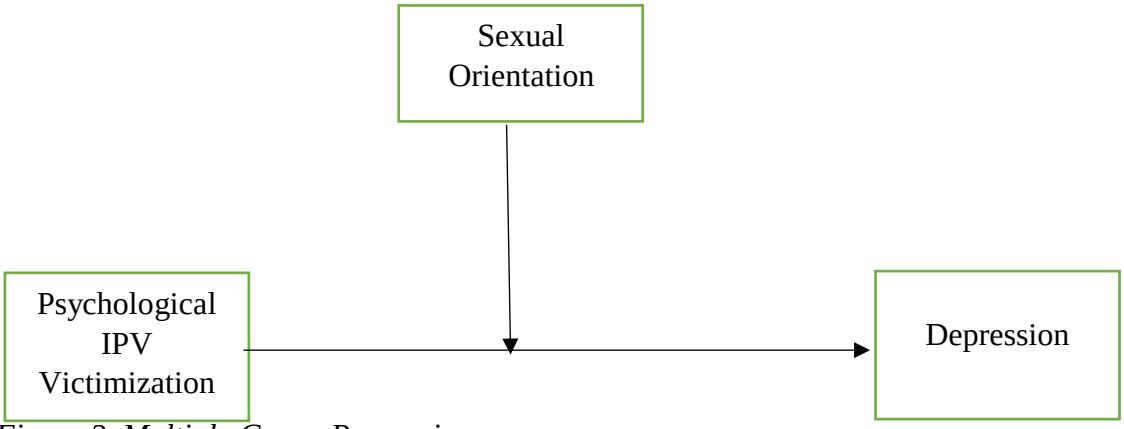

Figure 3. Multiple Group Regression

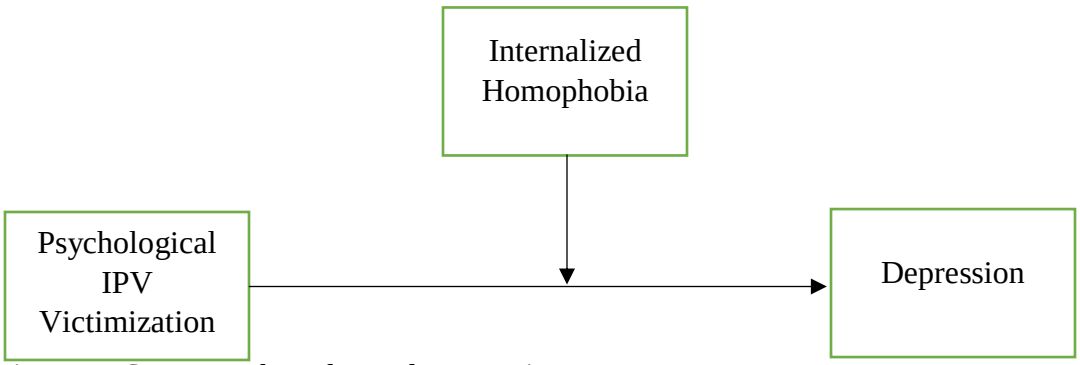

Figure 4. Conceptual Moderated Regression

Appendix C

Scales & Measures

The Conflict in Adolescent Relationships Inventory (CADRI)

RESPONSE FORMAT

The following questions ask you about things that may have happened to you with your boyfriend/girlfriend while you were having an argument. Check the box that is your best estimate of how often these things have happened with your current or ex-boyfriend/ex-girlfriend in the past year. Please remember that all answers are confidential. As a guide use the following scale:

1 = Never: this has never happened in your relationship

2 = Seldom: this has happened only 1-2 times in your relationship

3 = Sometimes: this has happened about 3-5 times in your relationship

4 = Often: this has happened 6 times or more in your relationship

Emotional and Verbal Abuse Perpetration

I did something to make him/her feel jealous.
I brought up something bad that he/she had done in the past.
I said things just to make him/her angry.
I spoke to him/her in a hostile or mean tone of voice.
I insulted him/her with put-downs.
I ridiculed or made fun of him/her in front of others.
I kept track of who he/she was with and where he/she was.

I blamed him/her for the problem.
I accused him/her of flirting with someone else.
I threatened to end the relationship.

Emotional and Verbal Abuse Victimization

He/she did something to make me feel jealous.
He/she brought up something bad that I had done in the past.
He/she said things just to make me angry.
He/she spoke to me in a hostile or mean tone of voice.
He/she insulted me with put-downs.
He/she ridiculed or made fun of me in front of others.
He/she kept track of who I was with and where I was.
He/she blamed me for the problem.
He/she accused me of flirting with someone else.
He/she threatened to end the relationship.

Appendix D

Scales & Measures

Center for Epidemiological Studies-Depression Scale (CES-D)

RESPONSE FORMAT:

During the past week:

1 = Rarely or None of the Time (Less than 1 Day)

2 = Some or a Little of the Time (1-2 Days)

3 = Occasionally or a Moderate Amount of Time (3-4 Days)

4 = Most or all of the time (5-7 Days)

During the past week:

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.

14. I felt lonely.

15. People were unfriendly.

16. I enjoyed life.

17. I had crying spells

18. I felt sad.

19. I felt that people dislike me.

20. I could not get “going.”

Appendix E

Scales & Measures

Internalized Homophobia

RESPONSE FORMAT: Use the numbers below to indicate how much you agree or disagree with each statement.

1 = Strongly Disagree

2= Disagree

3= Neither disagree or agree

4= Agree

5 = Strongly agree

Items

1. I wish I weren't lesbian/gay.

2. I have tried to stop being attracted to women [men] in general.

3. If someone offered me the chance to be completely heterosexual, I would accept the chance.

4. I feel that being lesbian/gay is a personal shortcoming for me.

5. I would like to get professional help in order to change my sexual orientation from lesbian/gay to straight.