The role of hopelessness depression in women's decision to leave a violent relationship

Heather N. Paluso
The University of Montana

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The Role of Hopelessness Depression in Women's Decision to Leave a Violent Relationship

Heather N. Paluso, M.A.
B.A. University of San Francisco, San Francisco, California, 1996
M.A. University of Montana, Missoula, Montana, 1999
Presented in partial fulfillment of the requirements for the degree of
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The University of Montana
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Approved by:

Christine Fiore, Ph.D.
Chair, Doctoral Committee

Dean, Graduate School

Date

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The purpose of this study was to contribute to our understanding of how stage of change, social support, and hopelessness depression influence women's decision to leave a violent relationship. There is strong evidence that traumatic experiences, such as domestic violence, play a large role in the etiology of depression. Specifically, the Hopelessness model of depression suggests that the experience of hopelessness results in the development of this particular subtype of depression (Abramson, Metalsky, and Alloy, 1989). Also, social support has been found to be one of the strongest predictors of depression and appears to have an important influence on the development of depression (Campbell, 1996). The Transtheoretical model proposes that a woman's decision to leave her relationship will involve movement from the stage of precontemplation through action, into maintenance.

Participants were a community sample of 100 women who experienced severe physical violence in a current or past romantic relationship. Participants completed an individual interview and series of questionnaires that assessed variables related to demographic information, severity of violence, stage of change, social support, and depression.

The results of multiple regression analyses indicate that stage of change, social support, severity of violence, length of relationship, and number of previous violent relationships significantly predict hopelessness depression. Further, social support was found to moderate the relationship between stage of change and hopelessness depression. An additional multiple regression analysis demonstrated that the HDSQ and BDI significantly predict stage of change.

The results of this study expand our knowledge base in a previously unexplored area in the field of domestic violence. The findings provide support for addressing hopelessness depression in women as they negotiate the decision-making process. The results of this study have clinical implications for those developing treatment interventions with battered women.
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Chapter One

Introduction

Several studies have reported that a primary mental health response to battering and a common reason that battered women seek mental health care is depression (McCauley, Kern, Kolodner, Dill, Schroeder, et al., 1995; Saunders, Hamberger, & Hovey, 1993). Research that has examined etiology of the high rate of depression in women have found that the frequency and severity of physical abuse, as well as stress, predict depression more strongly than prior history of mental illness or other demographic information (Campbell, Kub, Belknap, & Templin, 1997).

There is strong evidence that traumatic experiences play a large role in the etiology of depression (Kendler, et al., 1993). Trauma presents both distal and proximal risk for depression. Past traumatic events, as well as current life stressors, influenced the risk of depression in a sample of women. In fact, recent stressful events were the most powerful risk factor for developing major depression (Kendler, Kessler, Neale, Heath, Eaves, 1993).

Interpersonal relationships also play a role in the development of depression in women. Low social support and recent interpersonal difficulties have been found to increase the likelihood of developing depression during the one-year study period (Kendler, et al., 1993). This finding has been supported in other research, as well (Parker, Barrett, Hickie, 1992).

The current proposal seeks to further understand a woman's decision to leave a violent relationship. The Transtheoretical model proposes that a woman's decision to leave her relationship will involve movement from the stage of precontemplation through action, into maintenance. This model suggests that change is a process in which a woman may move through these stages and back.
again throughout her leaving the violent relationship. This model provides a useful approach to conceptualizing women's experience in making the difficult decision to leave a violent relationship. This conceptualization of leave-taking can be particularly important for the helping professionals who become frustrated when a woman returns to her abuser after leaving. From the perspective of this model, each time a woman leaves her violent relationship, she gains skills that may help her be better prepared for future decisions. Viewing the decision to leave in this manner may help to avoid pejorative judgements and increase understanding of the dynamics when a woman returns to her abuser.

Research has begun to explore the Transtheoretical model as applied to battered women (Brown, 1996; Lerner & Kennedy, 2000; Kennedy, 1999). The current project hopes to further the understanding of the role of depression, particularly Hopelessness Depression, in women's decision to leave her violent relationship. Although much research has focused on learned helplessness in regard to domestic violence, the component of hopelessness has yet to be examined. This piece may provide useful information to guide intervention strategies. A woman who is experiencing Hopelessness Depression may need a different intervention than a woman who is not depressed. Perhaps treating the depression and then addressing the violent relationship may be more appropriate than expecting a depressed woman to have the ability to undertake the difficult task of leaving her abusive partner. Addressing the depression before the decision to leave the violent relationship may assist women in achieving greater success in maintaining the change over time.

An additional benefit of the proposed research is to gain a greater understanding of battered women's experience of depression. The comparison of Beck's cognitive model of depression with the Hopelessness Depression model
may provide information regarding the appropriateness of each in describing battered women's experience of depression. Because the hopelessness model of depression stems from learned helplessness theory, it may more strongly describe battered women's experience of depression.

**Domestic Violence Statistics and Background**

Domestic violence is a serious and stressful life event for women. Studies attempting to measure the prevalence of domestic violence report that between 3.2% and 4.1% of women had been victims of severe domestic violence within the past year (Wilt & Olson, 1996). These are thought to be underestimates of the actual prevalence of violence for several reasons, but most importantly is that many women fear disclosing their abuse. A violent relationship is maintained by a cycle of power and control, from which many women have difficulty escaping. Women may not disclose their abuse and seek assistance because they fear their abuser will hurt or kill them if they come forward.

In the lifetime of a marital relationship, estimates suggest that 30% of women will be physically abused by their husbands (Straus, 1983). This rate has been found to be higher, proportionally, in clinical samples. Herman (1986), in a sample of female outpatients, found that one-third of women reported physical or sexual victimization by their intimate partners or in intimate relationships.

The battered woman syndrome has been proposed to describe the effects of domestic violence on women. There are thought to be three major components to the syndrome: traumatic effects of the victimization by violence, learned helplessness as a result of the violence, and the self-destructive coping responses to the violence (Dutton & Painter, 1993). Other aspects of the syndrome may include idealization of the abuser and denial of the danger of the situation. These types of symptoms are thought to be coping responses that
appear under stress. Of particular interest in the present study is the experience of helplessness that occurs as a result of domestic violence. The hopelessness model of depression proposes that the helplessness in the face of negative life events results in the experience of hopelessness, which results in depression. Women who experience a sense of helplessness as a result of abuse may then be more likely to experience depression.

**Etiology of Depression**

Theories of the etiology of depression suggest several ways in which depression may occur in women. Models include behavioral and cognitive-behavioral, psychodynamic, as well as interpersonal models. Each of these models presents a unique mechanism by which depression is caused and maintained.

**Psychosocial Factors**

Identifying psychosocial factors that may cause depression has been difficult as a result of the problems associated with demonstrating causal relationships in naturalistic research (Barnett & Gotlib, 1988). Most of the research on depression has been cross-sectional. This type of research has been successful in identifying differences between depressed and non-depressed individuals, but cannot determine causality. Causality can be determined by prospective research, although this type of research also has its difficulties. Participants in these studies need to be screened carefully to rule out a history of depression. Once a sample is chosen, it needs to be followed for a lengthy period of time so that a sufficient number of participants will become depressed (Barnett & Gotlib, 1988). As with all longitudinal research, the investment of time, money, and other resources often limits researchers' ability to carry out the project.
Biological Theories

Over the past 30 years, support for a genetic component of depression has emerged (Campbell, et.al., 1996). Earlier theories in this area utilized the deficiency model. The neurotransmitter norepinephrine was believed to be deficient in those with depression. Most recent theories, however, recognize the complexity of the brain and support more integrated theories. Lately, the dysregulation hypothesis has gained attention in the field, as the role of cortisol in response to stress has been discovered (Campbell, et.al., 1996).

Research considering the contribution of genetics to depression has found four general etiologic categories: genetic effects, traumatic experiences, temperament, and interpersonal relationships (Kendler, Kessler, Neale, Heath, Eaves, 1993). In their study, the findings support the hypothesis that genetic factors influence the one year prevalence of depression. Genetic predisposition was the second leading risk factor in the study, surpassed only by recent stressful life events. The leading risk factor found in this study was the recent occurrence of stressful life events. Those participants who had recently experienced a stressful life event were more likely to experience depression.

Hypothalamic-pituitary-adrenal Axis

As early as the 1930's, Cannon and colleagues (as cited in Shulman, Tohen, & Kutcher, 1996) identified that the adrenal glands were involved in the body's response to stress. In patients with major depression, hyperactivity of the HPA axis is one of the most robust findings (Shulman, et.al., 1996). The abnormalities that have been discovered include increased secretion of cortisol, increased 24-hour urinary excretion of cortisol, resistance to suppression of cortisol, and hyper-secretion of corticotrophin-releasing factor (CRF).

When an individual experiences an actual or perceived threat, counter-
regulatory processes are activated, including the hypothalamic-pituitary-adrenal axis (HPA axis). This system begins in the central nervous system and results in the synthesis and secretion of adrenocortical steroids. This has many effects on body systems, including metabolism, reproduction, inflammation, and immune functioning. The HPA axis is self-regulating system (Plotsky, Owens, & Nemeroff, 1998). Recent research has suggested that CRF plays a central role in the regulation of stress. Specifically, it has been shown to be the primary positive regulator of the HPA axis and the primary mediator of the stress response, an important mediator of fear and anxiety, and a major regulator of nervous system activity (reported by Plotsky, et al., 1998). The implication of this finding is that although the central nervous system follows a specific genetically-driven plan for development, it is also shaped by the individual’s interactions with the environment (Plotsky, et al., 1998).

Research has demonstrated that patients who do not return to normal levels of suppression on the dexamethasone suppression test (DST) after treatment may be at increased risk for relapse to depression (Ribeiro, Tandon, Grunhaus, & Greden, 1993). Further, it has been demonstrated that the degree of cortisol non-suppression on the DST correlates with the severity of the depressive episode (Carroll, 1982). This theory together with the circumstances surrounding domestic violence may contribute to a partial understanding of depression in this population.

**Interpersonal Model**

The interpersonal model of depression and its treatments is based on psychodynamic formulations of depression, which emphasize the importance of interpersonal relationships (Klerman, Weissman, Rounsaville, & Chevron, 1984). The interpersonal model does not emphasize the linear direction of etiology.
between interpersonal functioning and depression. Rather, it conceptualizes depression as occurring within the interpersonal context and impairing interpersonal functioning. The decrease in interpersonal functioning is not necessarily viewed as the cause of the depression, however. In fact, etiological statements are avoided in this model of depression. Rather, the depression is conceptualized as relating to loss or lack of meaningful relationships. Establishing stronger relationships with others is believed to play an important role in the treatment of depression.

This model emphasizes the importance of relationships in the maintenance of depression. A battered woman may not have a social support system due to the isolation that frequently occurs in violent relationships. Her previous interpersonal ties may have been severed, leaving her without social relationships. Her only relationship may be with her abuser. This loss of interpersonal relationships may contribute to battered women’s experience of depression.

Cognitive Theories

Seligman draws a connection between depression in humans and learned helplessness in animals. He describes learned helplessness as a response to events that are painful and inescapable, which teach an individual that he or she lacks control over the environment (Seligman, 1975). The result of this perceived lack of control is a reduction in response to the aversive event, rather than attempting an adaptive response. The theory of learned helplessness has been expanded to include hopelessness, which is the belief that negative events will continue to occur. Another component of hopelessness is that individuals who blame themselves for uncontrollable events are more likely to be chronically depressed than those who blame external causes (Abramson, Metalsky, & Alloy,
One of the most prevalent model of depression is the cognitive model suggested by Beck (1976). This model is proposed to have three main components: negative cognitive triad, negative schemas, and cognitive distortions. The cognitive triad refers to the negative pattern of thinking found in depression including negative views of the self, the world, and the future. Schemas are stable thought patterns that represent how a person has generalized thinking about past experiences. Schemas organize information from these past experiences and influence how events are perceived, remembered, and recalled.

Individuals with depression tend to view the world in a fixed, negative manner and experience distortions in how they perceive and interpret new experiences. This results in cognitive errors, or distortions. For example, one may tend to make internal, stable, and global attributions for negative events. Rather than blame aspects of the environment for the negative, event a depressed person is more likely to blame themselves. The implications of this self-blame for battered women are enormous. Women who blame themselves for the violence in their relationship may be more likely to stay in the relationship longer than women who make external attributions for the violence. A central aspect of an abusive relationship involves power and control of the woman by her abuser. One tactic abusers use to increase control is to blame the victim for her abuse. The combination of this coercive tactic used by abusers and a woman's tendency to make internal attributions for the violence may be a powerful influence in a woman's decision to stay in or leave a violent relationship.

**Hopelessness Model of Depression**

The hopelessness model of depression was initially proposed to address
limitations of the learned helplessness model of depression (Abramson, Metalsky, and Alloy, 1989). This theory-based model proposes Hopelessness Depression to be a sub-type of depression, characterized by motivational difficulties and sad affect. Other proposed symptoms of Hopelessness Depression include suicidal ideation and attempts, lack of energy, psychomotor retardation, sleep disturbance, and difficulty with concentration (Abramson, Metalsky, & Alloy, 1989). Hopelessness is an important part of depressive cognitions and research has found that it predicts up to 44% of the variance in depression (Bonner & Rich, 1988). A study found that 94% of participants who were hopeless were also depressed while only 56% of depressed participants were also hopeless (Stockum, 1999). This finding supports the hypothesis that Hopelessness Depression is an unique subtype of depression.

In contrast to Major Depression, Hopelessness Depression is hypothesized to intersect current diagnostic categories of depression, as well as include individuals with anxiety and personality disorders. Therefore, Hopelessness Depression may be most easily identified in a mixed outpatient sample, rather than a sample of individuals with a diagnosis of Major Depression (Abramson, Alloy, & Hogan, 1997). Rather than identify a single type of depression, recent research has suggested that depression is, instead, a group of heterogeneous disorders that differ in etiology, symptoms, course, treatment, and prevention (Abramson, et. al., 1997).

While most other approaches to depression use symptom-based classifications, hopelessness theory examines causal factors leading to depression (Abramson, Alloy, & Metalsky, 1990). Specifically, the model identifies distal and proximal causes that are believed to result in a proximal sufficient cause of depressive symptoms. Abramson and colleagues (1990) distinguish
between necessary, sufficient, and contributory causes. A necessary cause is an etiological factor that is present and leads to the occurrence of symptoms. Sufficient cause refers to an etiological factor whose presence assures the occurrence of symptoms. If symptoms do not occur, then the etiological factor cannot be present. However, the symptoms can occur without the sufficient cause. Finally, a contributory cause is one which increases the likelihood of symptom occurrence, but does not guarantee the occurrence of symptoms.

In hopelessness theory, a series of distal and proximal contributory causes are proposed to result in proximal sufficient cause for the symptoms of Hopelessness Depression (Abramson, et.al., 1990). A key proximal sufficient cause is the presence of hopelessness. This is defined as the expectation that highly desired outcomes will not occur or that aversive outcomes will occur, unrelated to any response that is given. Because hopeless is considered a proximal sufficient cause rather than a necessary cause of depression, the theory allows for other causal pathways to depressive symptoms. Hopelessness Depression is believed to be one sub-type of depression, rather than the only explanation for the onset of depression.

The causal pathway to Hopelessness Depression is believed to begin with the occurrence of negative life events. These events “set the stage” for the development of hopelessness. Three attributions that might be made after the occurrence of negative life events include stable, global attributions to the event, inferred negative consequences of the event, and inferred negative characteristics about the self as a result of the event (Abramson, et.al., 1990).

A distal contributory cause that may lead to Hopelessness Depression is cognitive styles. For example, attributional style has been proposed to influence the development of depression. “Depressogenic” individuals may tend to attribute
causes of negative events to stable, global factors which may increase the likelihood of becoming hopeless and developing Hopelessness Depression. Positive events, or lack of negative events, should not result in increased hopelessness in either depressogenic or non-depressogenic individuals. The diathesis-stress model conceptualizes this component of Hopelessness Depression theory. The depressogenic attributional style may operate as the diathesis and a distal contributory cause of Hopelessness Depression during the occurrence of the stress of negative life events (Abramson, et.al., 1990). For example, a person might have a depressogenic attributional style characterized by internal, stable, and global attributions. This inherent style would be described as the diathesis. The stress component of the model might be losing one's job. The occurrence of this stressor increases the risk that the depressogenic person will develop depressive symptoms.

Several studies have demonstrated that Hopelessness Depression is qualitatively different from other types of depression. Research by Spangler, Simons, Monroe, and Thase (1993) found that depressed patients with negative attributional style and a negative life event had higher levels of hopelessness and a different constellation of symptoms compared to other depressed patients. Research by Alloy, Just, and Panzarella (1997) found that attributionally high-risk people (those who had negative attributions) had higher levels of Hopelessness Depression symptoms, but not other depression symptoms, than non-attributionally high-risk people. Another study found that attributional and stress interaction predicted Hopelessness Depression symptoms, but not other depressive symptoms (Metalsky & Joiner, 1997).

The hopelessness theory of depression has several implications for therapy and prevention of depression. According to Abramson and colleagues
Hopelessness Depression (1989), any intervention that attempts to increase hopefulness and reduce hopelessness should be effective in reducing the symptoms of Hopelessness Depression. Another helpful approach might be to modify the hopelessness-inducing environment or encourage behavior change that might serve to decrease hopelessness. Hopelessness theory of environmental contributions to depression contributes a unique perspective to the treatment of depression that is not considered in other cognitive approaches. The increased focus on the environment rather than on only cognitive structures may provide increased relief to those suffering from Hopelessness Depression. Hopelessness theory considers the influence of the environment in the development of hopelessness, which may lead to Hopelessness Depression.

Abramson and colleagues (1989) compare their hopelessness theory of depression to Beck's cognitively-based theory of depression. Several similarities are noted between the two models of depression. For example, both theories emphasize the importance of maladaptive inferences in depression and include hopelessness as an important factor. Also, both theories contain a diathesis-stress component for explaining the development of depressive symptoms. Despite some similarities, there are key differences between the two models of depression. The first is that Hopelessness Depression is proposed as a sub-type of depression, whereas Beck’s model has not proposed a cognitive sub-type of depression. Beck’s model focuses on negative bias in depressive thinking, while the hopeless model considers the possibility of distortion in depressive and non-depressive cognitions. While Beck focuses on the cognitive processes that result in depression, hopelessness theory considers the environment in addition to the cognitive factors that may lead to depression. Finally, the hopelessness model specifies invulnerability factors of depressive symptoms, such as the tendency to
make unstable, specific, attributions for events) that Beck’s model does not consider. When faced with negative life events, making an unstable, specific attribution may decrease the risk of developing depressive symptoms. For example, if a person does poorly on an exam, there are several ways to describe the situation. A stable and general attribution might be “I am stupid and can’t do well in school.” This type of attribution may increase the likelihood of developing depression. On the other hand, the student can say, “I failed the exam because I didn’t prepare well. I need to study harder next time.” This attribution is specific to the situation (referring to this test) and is unstable (preparation for the exam is under the student’s control). This type of attribution is less likely to result in depressive symptoms.

Research by Dixon, Heppner, Burnett, and Lips (1993) examined the relationship between stress, hopelessness, and the onset of depression. Their study found support for hopelessness as a moderator between stress and depression. This suggests that the effects of stress and hopelessness on depression are interactive. This implies that the effects of stress on depression depend on the level of hopelessness present. When levels of negative life stress are high, individuals with high levels of hopelessness are also likely to report high level of depression.

A study by Clements and Sawhney (2000) examined Hopelessness Depression in a sample of battered women who had left their relationship and were staying in a battered women’s shelter. The hopelessness model of depression suggests that women who attribute the cause of their abuse to internal, stable, and global factors will be more likely to expect negative experiences in the future. Their findings regarding hopelessness were rather surprising: the researchers concluded that women in the study did not report
Hopelessness Depression and Battered Women

Depression is a common psychological disorder, particularly among women. The prevalence of major depression in women ranges from 5-9%, with a lifetime risk of 10-25% (APA, 1994). Furthermore, there are higher rates of depression in women than men, with a ratio of three to one. This finding is consistent across studies, but an adequate explanation for the finding has not been found (Campbell, et.al., 1996).

The relationship between domestic violence and depression has been documented for 20 years, but has received limited attention in the depression literature (Campbell, Kub, Rose, 1996). A study by Watson and colleagues
(1997) examined the prevalence of psychiatric disorders in women who report a history of domestic violence. The most common disorders that were identified in these women was Post Traumatic Stress Disorder and Major Depression. The prevalence of PTSD reported in this study is 78% of the sample and was about three times as prevalent as that found in the non-abused comparison group. The second largest prevalence of psychiatric sequelae was Major Depression, of which 65% of the sample met criteria of abused women.

Lenore Walker was one of the first to apply learned helplessness to depression in battered women (1984). She suggested that the lack of control that is associated with domestic violence created the conditions described in learned helplessness theory. Some characteristics of learned helplessness include depression, low self-esteem, apathy, and difficulties problem solving. These characteristics are also associated with women who have been in abusive relationships. Although her proposal that domestic violence results in learned helplessness was generally supported, her hypothesis that women who had left abusive relationships would be less depressed was not supported (Walker, 1984).

Learned helplessness, as related to domestic violence, has received mixed support in the literature. Research by Campbell (1989) provided some support for the learned helplessness model. However, both battered and non-battered women reported similar levels of self-blame, which was found to be unrelated to depression. In the study, many women were able to leave their abusive partner, which was seen as reasserting control rather than becoming increasingly helpless. A relationship has been found between intensity of abuse and levels of learned helplessness (Wilson, Vercella, Brems, Benning, & Renfro, 1992). Thus, only limited support has been found for learned helplessness as
related to domestic violence.

In a study of 394 adult women treated at a family practice medical center, depression was found to be the strongest indicator of adult relationship abuse (Saunders, Hamberger, & Hovey, 1993). Research by Gleason (1993) found a higher prevalence of major depression in battered women than in an age and sex matched NIMH catchment study. Research by Cascardi and O'Leary (1992) found that depressive symptomatology increased as the level and frequency of battering increased.

There has been evidence to suggest that battered women are at increased risk for depression. (Campbell, 1989). A study by Cascardi, O'Leary, and Schlee (1999) found 32% of their sample of recently battered women met criteria for Major Depression. Studies have found high rates of depression in samples of battered women (Prescott & Letko, 1977; Rounsaville & Lifton, 1983). Along with increased risk for depression, battered women also have an increased risk for suicide. Research by Pagelow (1984) found that 50% of battered women had thought about suicide and 23% had attempted suicide. Because of the severity of the consequences for depression in this population, Sato and Helby (1992) stress the importance of learning more about the role of depression in domestic violence, specifically how it affects the stay-leave decision. For example, they discuss how depressive symptoms such as self-blame and guilt complicate battered women's stay-leave decisions. As a result, women may have difficulty accurately assessing that the precipitant of the violence is the abuser and they underestimate the danger of their violent relationship.

Research suggests that depressed individuals tend to make internal attributions for events that are beyond their control (Abramson, Metalsky, and Alloy, 1989). Clearly, battering is one situation which is out of the women's
immediate control. Further, women who realize their abusers are to blame for violence are more likely to leave the relationship, temporarily or permanently, than women who blame themselves for the violence in their relationship (Frieze, 1979). Considering the high prevalence of depression in battered women and the impact depression may have on a woman's decision to leave a violent relationship, increased research interest in this area is crucial. Understanding the role that depression plays in the decision-making process may inform interventions developed for depressed battered women. For example, in addition to interventions that provide shelter and other basic needs, counseling interventions may be provided with the goal of reducing depressive symptoms or those cognitive attributions contributing to the depressive symptomatology.

Sato and Helby (1992) found four factors that were associated with depressive symptoms in a sample of battered women. These include: a history of depression, realistic assessment of their abusive relationship, poor self-reinforcement skills, and loss. Women who have been in a violent relationship may suffer from chronic depressive symptoms related to the learned helplessness and hopelessness perpetuated by the cycle of violence. Holding a realistic view of the violent relationship may further increase helplessness and hopelessness about the situation, in turn increasing the risk of suffering a future depressive episode. Battered women who lack the skills for self-reinforcement are less likely to have positive, pleasurable experiences in their lives, which in the presence of negative life events, may increase the likelihood of developing depression. Finally, loss contributes to the development of depression in battered women in terms of the loss of her social network. As her abuser increases her isolation from family and friends, she experiences the loss of a significant source of social support, which may result in depression.
Brown and Harris (1978) state that loss plays an important role in the development of depression. They believe that loss results in the inability to have positive thoughts about oneself and one's life, therefore having implications far beyond the actual loss itself. In their view, loss is a likely cause of hopelessness, which is a key factor in depression. An immediate response to a loss is likely to be a feeling of hopelessness, that when generalized, forms the core of depression. A sense of self-efficacy is thought to reduce the risk for the development of hopelessness. The implications for this hypothesis of loss and depression for battered women is enormous. When a woman leaves a violent relationship, she suffers many losses. She loses the relationship itself, her status as wife or girlfriend, suffers emotional losses, and financial losses. These significant losses place her at risk for developing a sense of hopelessness. According to Brown and Harris (1978), the more a woman has taken on a certain identity, the greater the severity of crisis when she gives it up.

Battered women's feelings of being out of control can also contribute to the development of Major Depression. A study by Campbell, Sullivan, and Davidson (1995) examined the level of depression in a sample of shelter women over time. Women were assessed immediately post-shelter, 10 weeks post-shelter, and a 6-month follow-up. Immediately following the shelter stay, 19% were mildly depressed, 28% were moderately depressed, and 36% were severely depressed. At ten weeks, 10% were mildly depressed, 38% reported moderate depression, and 20% reported severe depression. At six months, the percentages were 14% mild, 34% moderate, and 23% severe depression. The study also examined factors that predicted the depressive symptoms. Of most importance, women who felt they had little control over their lives tended to report increased levels of depression. At all three data collection times, most women in
this study reported experiencing depression.

Other research has also supported that depression is temporally related to battering. A study by Surtees (1995) found that depression declined from 28.1% in the six months before a shelter stay to 9.2% during the six months following admission to the shelter. Another study found a negative association between depression and the length of time in the shelter (Orava, McLeod, & Sharpe, 1996).

Comorbidity of Depression and PTSD

PTSD is a common sequelae of interpersonal violence. A review of the literature by Golding (1999) found that the prevalence of PTSD ranged from 33% to 84.4% for battered women. This is a very important mental health issue for women, as suggested by the high prevalence of PTSD in battered women. Research has demonstrated comorbidity between depression and anxiety disorders (Clark & Beck, 1989). Further research has shown that hopelessness is associated with depressive symptoms, rather than anxiety symptoms. When anxiety is controlled for, hopelessness predicts depressive symptoms; however, when depression is controlled for, hopelessness does not predict anxiety symptoms. This lends support to the helplessness-hopelessness model (Alloy, Kelly, Mineka, & Clements, 1990) that hypothesizes that an individual's symptoms of anxiety are replaced by depressive symptoms once one makes a negative attribution about future negative life events (Alloy & Clements, 1998). Helplessness is an integral component of hopelessness, which provides additional support for the comorbidity of anxiety and depressive disorders. Swendsen (1997) describes anxiety as an initial mood response to negative life events, which results in the development of helpless attributions and subsequent Hopelessness Depression. In this view, depression is a progression from
symptoms of anxiety and a transition from helplessness to hopelessness (Swendsen, 1998).

The literature on traumatic stress suggests that women who have been in physically violent relationships experience a recovery process from trauma symptoms (Dutton, 1992). Lenore Walker (1984) described "battered women's syndrome" as the psychological sequelae following abuse. Some symptoms include: anxiety, depression, memory loss, dissociation, helplessness, re-experiencing of traumatic event, and fatigue (Astin, Lawrence, & Foy, 1993). A study by Saunders (1994) further supports the existence of post-traumatic stress disorder in battered women. In this study, a sample of battered women staying in a shelter experienced more severe PTSD than a sample of women who were not recently involved in a violent relationship.

Features of PTSD include responding to the traumatic experience(s) with alternating intrusions and avoidance (Goodman, Koss, & Russo, 1993). Intrusions refer to the re-living of the traumatic experience through nightmares, vivid recollections, and intense anxiety about the recurrence of the trauma. Avoidance occurs when the survivor tries to avoid reminders of the trauma by avoiding stimuli associated with trauma, withdrawal from others, and dissociation. Increased arousal, irritability, and sleep disturbance may also be present.

Goodman and colleagues (1993) discuss the limitations of the PTSD diagnosis for women who experience ongoing abuse. They suggest that the PTSD diagnosis is best suited for describing the sequelae of a single traumatic incident, rather than ongoing trauma such as battering. Also, the DSM-IV describes the traumatic event as "outside the range of usual human experience" (APA, 1987, p.247). As Goodman and colleagues (1993) indicate, physical and sexual violence towards women do not fit this criteria because of their high
Despite the limitations, there are some advantages of using the diagnostic label PTSD. It can be helpful to battered women to hear that the symptoms they experience are not at all unusual considering the trauma of being involved in a violent relationship. By sharing information about PTSD with battered women, their anxiety and sense of powerlessness may be reduced (Saunders, 1994) and they learn that their responses are normal and understandable (Goodman, et. al., 1993). Also, it is helpful to clinicians and researchers to have an established framework for understanding and describing women's experience of trauma.

According to Astin and colleagues (1993), there is limited research that examines the development of PTSD symptoms related to battering. The authors note only two published studies that use standardized measures to assess PTSD in this population. There research study hoped to contribute to the knowledge of PTSD following interpersonal violence. The research by Astin and colleagues (1993) found that the intensity and duration of physical violence was associated with the severity of PTSD symptoms. PTSD symptoms were greatest as the length of relationship and the level of violence increased. Further, PTSD symptoms decreased as the time from the last violent incident increased. This suggests that PTSD symptoms tend to decrease over time.

Social support has been found to be significantly related to PTSD, mostly in research with combat veterans. Social support and positive life events have been found to be negatively related to the intensity of PTSD symptoms (Butler, Foy, Snodgrass, Hurwicz, & Goldfarb, 1988). This suggests that social support may play a similar role in the etiology of both PTSD and Major Depression. Social support may act as a protective factor in the development of these disorders.
Depression, Chronic Stress, and Coping

Stress is believed to play a role in the etiology of depression. Individuals with depression report almost three times as many life changes in the previous six months before the onset of depression as those in control groups (Stuart & Sundeen, 1995).

Domestic violence seems to be a stressor by itself, as well as contributing to other stressors. Everyday stressors have been found to be the strongest predictor of depression, surpassing other strong predictors such as childhood physical abuse and relationship abuse. Daily hassles correlate significantly with physical abuse (Campbell, 1996). This suggests that the experience of physical abuse acts as a daily stressor for the victims of the abuse. Since daily stressors are strong predictors of depression, it seems likely that women experiencing physical abuse are more likely to be depressed.

During periods of stress, an individual’s coping resources assists in the adaptation to this stress (Folkman & Lazarus, 1985). Coping is also proposed to be related closely to self-efficacy (Bandura, 1982). There are several ways in which people cope with stress: problem-focused coping and emotion-focused coping. Women who have been out of their violent relationship for less than six months tend to use more emotion-focused coping strategies than women who have been out of the violent relationship for over one year (Lerner & Kennedy, 2000).

Stressful life events have been found to influence the development of depression. However, they account for only a small amount of the variance in the prediction of depression. Research has demonstrated that coping mediates the relationship between stressful life events and depression (Folkman & Lazarus, 1986). Individuals with high levels of depressive symptoms tend to use more...
avoidance and emotion-focused coping, rather than problem-focused coping (Billings & Moos, 1981). Problem-focused coping has been found to be associated with less depressive symptoms, while emotional discharge tends to be related to greater dysfunction (Billings & Moos, 1984). When stress is high, personal resources (such as confidence) and social resources (such as social support) were related indirectly to future stressors. Under these conditions, the mediating factor seems to more adaptive coping strategies. When stress is low, however, these resources have a more direct, causal role, in maintaining psychological health (Kuyken & Brewin, 1994). Research by Avison and Turner (1988) suggest that a single negative life event does not have a significant effect on outcome. However, chronic adversity, such as domestic violence, may have a greater influence on the individual than acute stressors.

Lazarus and Folkman (1984) propose a model of coping in which an individual's appraisal of the stressful situation and the coping resources available determine the type of coping that is used. They suggest that individuals who have more depressive symptoms are more vulnerable to threat in stressful situations (Folkman & Lazarus, 1986). According to Bandura (1977), appraisals of threat tend to lead to more use of avoidance coping behavior. For example, if a battered woman is depressed and perceives her situation as more threatening than her available coping resources, then she may use more avoidance coping. Avoidance coping may serve a cathartic function and relieve stress in the short-term (Kuyken & Brewin, 1994). However, in depressed individuals, the tendency to engage in avoidance coping may interfere with action, cause emotional numbness, result in the intrusion of threatening material, and lead to a lack of awareness between the trauma and symptoms (Roth & Cohen, 1986).

There are several proposed ways in which the relationship between
coping and depression may function. The first is that depressive symptoms may provoke or maintain life stressors. As a result, personal relationships may suffer. Because of this, avoidance coping may increase (Fennell & Teasdale, 1987). Another explanation for the relationship between coping and depression is that life stressors, poor coping, and inadequate social support intensifies depressive symptoms (Kuyken & Brewin, 1994).

Involvement in an abusive relationship is considered to be a major life stressor (Campbell, Miller, Cardwell, & Belknap, 1994). Oddly, a study comparing women who had been abused in the past with women currently abused found that most of the women with past abuse had lower rates of depression. Yet, a few women in this group had higher, stable rates of depression, suggesting that they experienced chronic depression. The women who were still involved in their violent relationship had stable rates of depression (Campbell, et al., 1994). This data seems to suggest that the relationship between depression, stress, and domestic violence is complex. Women currently in abusive relationships have higher rates of depression than those whose relationships have ended, yet some women out still had more chronic, stable depression. One goal of the present study is to examine how women's experience of depression differs during and in the process of leaving abusive relationships, particularly with regard to their level of hopelessness.

Social Support, Domestic Violence, and Depression

Social support is an important issue for women in abusive relationships. Further, it may interact with stress or hopelessness to moderate the relationship with depression. A definition of social support, proposed by Ellis (1992) states that social support includes actions taken by another person that result in actual or perceived reduction of negative experiences or events, as well as the
attainment of positive outcomes or events. Several different types of social support have been proposed in the literature. Two prominent models are Lazarus’ (1981) model of resource equalization and Brown’s (1981) model of contextual threat reduction.

In the model proposed by Lazarus (1981), social support is described as social interactions with others that provide the perception to an individual that the resources of the support are greater or equal to the perceived stressor. In this way, the social support functions to equalize the perception of coping resources available. Social support reduces the gap between perceived stress and the available resources. This model suggests that the influence of social support is greatest when the type of support provided matches the need for support. However, it assumes that the needs of the individual are relatively stable over time (Jacobsen, 1986).

The model of contextual threat reduction (Brown, 1981) proposes that stressful life events involve change that threatens stable, contextual meanings. Social support involves social interactions that create stable meanings for the individual that result in an improved adjustment to life transitions and changes. This model conceptualizes the need for support as a dynamic process, in which needs change over time. Because the individual’s needs are changing, the timing of social support is as important as the match between type of support and need.

Research has found that people with high levels of Hopelessness Depression evidenced greater social dysfunction, such as poor social support and social adjustment (Whisman, Miller, Norman, & Keitner, 1995). Therefore, there is an important relationship between Hopelessness Depression and social support.

There are several ways to examine the influence of social support:
perceived support, occurrence of helping behaviors, and structure of the social support system (Mitchell & Hodson, 1986). Perceived social support refers to the degree of support that the woman perceives that she receives from her support network. The actual occurrence of support measures the actual supportive actions that occur from the woman’s social network. The structure of the social support network examines the connectedness of the woman in various domains of support (family, friends, work). Research suggests that perceived support may be most important when considering the effects of social support on psychological health (Mitchell & Hodson, 1986).

Research on stress implicates social support as an important component of the stress and coping response. Having access to social support resources may have a protective effect and increase coping responses in a stressful situation, including domestic violence (Walker, 1983). Individuals with high levels of social support may be less likely to experience psychological maladjustment in response to stress (Cassel, 1974). Effective social support modifies the effect of stress on psychological distress. Those with higher levels of social support experience less psychological distress. Specifically, women who have marital strain and less social support are more likely to be depressed than women with good social support (Aneshensel, 1986). The proposed benefits of social support are providing assistance, promote active coping, and maintain self-esteem (Heller & Swindle, 1983). In domestic violence, the woman is often isolated from her friends and family by her partner, which decreases her resources and social support network (Mitchell & Hodson, 1986).

Studies examining the role of social support in battered women may not account for these control issues in why women have small social support networks. A complication in the research on social support and domestic violence...
is that many abusers isolate their partners during the relationship. The result of this isolation is that women in abusive relationships may not have a lot of social support that they can draw upon in times of need (Campbell, 1996).

The varied needs of women at different times after leaving their abusive relationship is discussed by Ellis (1992). Two critical points have been identified for intervention with women: the first few months after the separation and again between 18 and 24 months. The initial few months after leaving a relationship have been called the "crisis stage" by Weiss (1975) and the "adjusting to the dissolution stage" by Spanier and Casto (1979). During this time, helpful interventions might be aimed at safety and basic needs (housing, food, clothing). During the second critical phase, the woman most likely has her own residence and her basic needs taken care of, so useful interventions might take the form of encouraging her to report threats by her former partner and also to take care of her own psychological needs (Ellis, 1992).

The type of stressor may shape the responses of the social support network. For example, in cases of domestic violence, many people in the woman’s social support network may be uncomfortable with the issue and be less helpful than they might be in another circumstance. Other life transitions, such as the birth of a child or illness may initiate greater demonstrations of support from family and friends (Mitchell & Hodson, 1986). A woman’s social support network may also become frustrated if the woman returns to an abusive partner and their support may decline over time. This may also be true of community supports, such as those providing counseling, medical, or legal interventions. It may be difficult for them to understand why the woman may return to her partner.

As the level of battering increases in a relationship, the woman may be
isolated more by her partner and have less access to social support. Also, the woman may distance herself from family and friends because of discomfort talking about the issue (Campbell, 1996; Ellis, 1992; Mitchell & Hodson, 1986). She may feel ashamed or guilty about her relationship. Also, friends and family may be uncomfortable with the issue and avoid the topic. For these reasons, women are at increased risk for becoming isolated from social support at a time when they need it most.

Since coping responses have been associated with psychological outcomes of stress, this is an important area to examine. Social support is an important aspect of the coping response and may even determine how a person copes with stress. Research has begun to examine how women cope with abuse and the effects coping has on psychological health. In general, women tend to use more avoidant and dependent coping strategies (Claerhout, Elder, & Janes, 1982; Walker, 1979). These strategies may be employed in an attempt to placate the abuser and try to reduce violence (Mitchell & Hodson, 1986). Other research has demonstrated that women who use more active coping responses (such as considering alternatives or talking with a friend) and less avoidant responses (keeping feelings to self) reported less depression (Mitchell & Hodson, 1983).

The literature on social support has also begun to consider the timing of social support to best serve women's needs at varying times in their abusive relationship. For example, when women are ready to leave their relationship, they may be more successful if provided with the type and timing of social support to increase their independence and make them less available to their abusive partner (Ellis, 1992). When initially leaving the relationship, effective support might take the form of housing, food, and transportation. These types of support would assist battered women in successfully establishing themselves in
their own residences and taking care of their basic needs for food and shelter. Once these needs are addressed, supports such as counseling and job training can be provided. These types of support begin to assist the battered women in establishing jobs that provide a steady income and taking care of their emotional needs through support groups and counseling.

In summary, several studies have examined the role of social support in depression. Research by Sato and Helby (1992) found that social support was not a significant predictor of depression. Other research, however, has found support for such a relationship. In one study, social support was found to be one of the two strongest predictors of depression, along with fear and anxiety (Campbell, 1996). Other research has found social support to be negatively correlated with depression (Mitchell & Hodson, 1983). These findings highlight the importance of social support in the study of depression. It appears to have a significant relationship to depression and should be included in studies of depression. This study is interested in the moderating role that social support plays in the relationship between Hopelessness Depression and stage of change, according to the Transtheoretical Model.

Transtheoretical Model of Change

Previous research in this area (Lerner & Kennedy, 2000; Kennedy, 1996; Kennedy, ) has examined how the Transtheoretical Model of Change influences women's leave-taking behavior and this study hopes to extend that research by exploring how depressed women differ from non-depressed women in their stage of change regarding violent relationships.

The transtheoretical model of change is concerned with how people are able to alter their behavior and the process by which this occurs. Rather than simply consider the outcome of the behavior change, this model examines the
process of decision making that is involved in behavioral change. The transtheoretical model is also interested in how people change, on their own, without the intervention of a mental health professional (Prochaska, 1992).

Often, when change does not occur, factors such as inadequate motivation, resistance, or defensiveness are blamed for the lack of success. Instead, the transtheoretical model approaches change as a process, in which people cycle through stages from precontemplation to maintenance. In this way, the process of change is viewed as active, dynamic, and intentional.

At the precontemplation stage, there is no intention to change behavior at any time in the future. In fact, many people in this stage do not believe that they have a problem. Family, friends, or co-workers may see the problem, but the individual has yet to gain awareness of the issue. If precontemplators do enter treatment, they usually have been pressured to do so by others in their life. They are not usually interested in making a behavioral change. They may begin to change under this pressure from their environment, but once left on their own again, they typically return to their previous behavior (Prochaska, 1992). There are times in which a precontemplator wishes to change, but they are differentiated from a contemplator if they do not intend to change within the next six months. The main quality of a precontemplator is that they are resistant to recognizing or modifying the problem.

The next stage in the model is contemplation, in which a person is aware that a problem exists and they begin to seriously consider making a change. However, they have not yet committed to taking any action on the problem. A person can remain in the contemplation stage for a long time. A study of smokers followed 200 participants in the contemplation stage for two years (DiClemente & Prochaska, 1985). The primary characteristic of the contemplation stage is to
know that a change is desired, but not quite yet. Weighing the pros and cons of an issue is an essential component of the contemplation stage. People in this stage typically struggle with their positive views of the issue and the amount of effort it will take to overcome the problem (DiClemente, 1991). People in the contemplation stage are seriously considering making a change within the next six months. They are seriously considering alternatives for resolution of the problem (Prochaska, 1992).

The preparation stage is comprised of both intention to change and behavioral criteria of change. In this stage, an individual intends to take action in the next month and has also unsuccessfully taken action in the past year. Individuals in this stage also report small behavioral changes. For example, a smoker might smoke less each day or wait longer between cigarettes (DiClemente, Prochaska, Fairhurst, Velicer, Velasquez, & Rossi, 1991). Although individuals in this stage are taking small steps toward their goal, they have yet to meet criteria for the complete behavioral change.

The action stage is characterized by attempts to modify behavior, experiences, and environment with the goal of overcoming the problem. The action stage requires a large commitment of time and energy in order to accomplish overt behavioral change. Because of the level of behavior change in this stage, the changes are usually readily visible to outside observers (Prochaska, 1992). Many people associate this stage, then, with change and overlook the earlier hard work the individual has put in to achieve action. An individual is considered to be in the action stage if a behavioral change has occurred from a period of time of one day to six months. The primary feature of the action stage is modification of the problem behavior and significant, obvious efforts to change (Prochaska, 1992).
Once the significant behavioral change has been made for six months, the individual moves into the maintenance stage. In this stage, the goal is to prevent relapse and maintain the gains that have been attained. The maintenance stage is not static, however, it is a continuation of change for the individual (Prochaska, 1992). This stage can last from six months to an indefinite period of time. Once maintenance is achieved, the individual is not necessarily free from the problem behavior. Maintenance may last indefinitely, but most people cycle back through the stages of change many times as part of their learning process.

Achieving change in many behaviors, ranging from smoking to weight loss to leaving a violent relationship, is very difficult. The transtheoretical model increases understanding about the process of change and views it as a process, rather than a linear event. The implications of this viewpoint for the field of domestic violence is enormous. Rather than becoming frustrated when a woman returns to her partner, the transtheoretical model allows for compassion and understanding. Further, the role of Hopelessness Depression in the leave-taking process may further conceptualize the difficulties women face in leaving a violent relationship. The current study hypothesizes that women suffering from Hopelessness Depression may be less likely to leave a violent relationship than women who are not hopelessly depressed. One important component of Hopelessness Depression is a lack of motivation, which may impact a woman’s self-efficacy to leave the violent relationship.

Lenore Walker (1984) proposes that self-blame is a common attribution in battered women that leads to depression. Women typically blame themselves for causing their partner’s violence, which will ultimately result in depression as the abuse continues. Confusing this relationship, in a study of battered women (Andrews & Brewin, 1990), depression was associated with self-blame only in
those women who had left their violent relationship. There was no significant relationship between self-blame and depression for women who were still involved with their abusive partner (Andrews & Brewin, 1990). Perhaps, such findings can be better understood within the framework of the transtheoretical model.

According to the transtheoretical model, each time a woman cycles into the action stage, she learns something that she will use the next time she is in that stage. Rather than viewing each temporary leave-taking as a failure, it can be viewed as another step in the direction of leaving the relationship permanently. Presenting this model to women who are in abusive relationships can help normalize the process for them and reduce the shame they may feel for returning to their partner. As Prochaska (1992) points out, relapse may feel like a failure, creating embarrassment, shame, and guilt. This may ultimately result in the person returning to the precontemplation stage and resisting thought about a behavior change. Further, considering the role of Hopelessness Depression in the stay-leave decision may further reduce embarrassment, shame, and guilt. The hopelessness model offers an non-pejorative explanation to women regarding the difficulty of the stay-leave decision process. It provides a framework for explaining how negative life events result in hopelessness, which results in Hopelessness Depression. The presence of Hopelessness Depression may further impacts their decision-making process, as explained by the Transtheoretical Model.

Typically, after a relapse, an individual will return to the contemplation stage and begin to plan for another action attempt. The implication of the spiral model of change proposed by the transtheoretical model is that an individual does not usually regress all the way to the beginning of the spiral, but rather,
learns from their mistakes and tries a different strategy the next time (DiClemente, et.al., 1991).

This model of behavior change has implications for intervention with abused women. Research by Prochaska and DiClemente (1992) found that the amount of progress clients made after an intervention depended on their pretreatment stage of change. This finding suggests that each client cannot be treated exactly the same and provided with a uniform package of interventions. Instead, the interventions offered should target the specific tasks that are associated with the client's stage of change. Tailoring interventions in this manner may increase the success of the intervention and provide the client with the resources needed to achieve the desired behavior change. Interventions that are designed to help clients progress one stage in a month double the likelihood that action is taken within the near future (Prochaska & DiClemente, 1992).

Self-Efficacy

Self-efficacy has been found to be an important part of a woman's readiness to change in her decision to leave an abusive relationship (Hendricks-Matthews, 1982). Self-efficacy also has implications for the development of interventions targeted towards women leaving abusive relationships (Dutton, 1992). Research by Bandura (1977) has demonstrated that individuals only attempt those behavioral changes that they believe they can manage successfully. They tend to avoid those changes that are believed to be larger than their capacity to cope. According to Bandura (1977), self-efficacy is the most powerful predictor of behavioral change. For women not in physically abusive relationships, their relationship efficacy was protective against depression. However, women in physically abusive relationships do not have this experience (Arias, Lyons, & Street, 1997). In a study of a shelter sample by Campbell,
Sullivan, and Davidson (1995), powerless was found to correlate positively with depression. As women were out of their abusive relationship for longer periods of time, their depression lessened.

Self-efficacy is an important part of the transtheoretical model of behavior change (Prochaska, 1992). Many women return to their abusive partners after leaving them temporarily. Understanding how self-efficacy, as addressed in the transtheoretical model, plays a role in their confidence about leaving permanently can provide information about a woman's likelihood to return to the relationship (Lerner & Kennedy, 2000). It also can provide a direction to tailor interventions based on a woman's readiness for change.

Women who have been out of their violent relationship for more than six months tended to have greater confidence for leaving than women who are currently in their violent relationship. Further, women who had left their violent relationship for less than six months had less confidence than women who had been out of their relationships for over a year. Women who were in their violent relationships or out for less than six months had greater temptation to stay or return than women who had left for over a year (Lerner & Kennedy, 2000).

Self-efficacy has been demonstrated to relate to emotion-focused coping and depression. When a woman's confidence for leaving the relationship was high, she used few emotion-focused coping strategies and was less depressed (Lerner & Kennedy, 2000). This suggests an interaction exists among coping, self-efficacy, and stage of change.

The application of the transtheoretical model, of which self-efficacy is a component, to domestic violence is different from other areas of behavioral change. In other areas in which the model has been applied, the action stage is associated with increased confidence for behavior change. However, in a study
of women leaving abusive relationships, women who took action did not demonstrate greater confidence than women in violent relationships. (Lerner & Kennedy, 2000). The implication of this finding is that women are taking action before they actually experience the self-efficacy to do so. This suggests that the period within six months of leaving the violent relationship may be an extremely precarious time for women. They have taken action to leave their relationship, yet experience temptation to return and have not developed sufficient confidence to stay out of the relationship.

**Stay-Leave Decision**

The decision to stay in or leave a violent relationship is typically not made at one point in time, but rather, develops over time. The Barriers model was proposed by Grigsby and Hartman (1997) to explain factors that influence a woman’s decision to stay in or leave her violent relationship. This model proposes four factors that provide a framework for understanding barriers in women’s decision-making process. The barriers are external environment, family and social role expectations, psychological consequences of relationship violence, and childhood abuse and neglect.

Other important factors that have been shown to influence decision-making are love (Frisch & MacKenzie, 1991), hope, and attachment (Henderson, Bartholomew, and Dutton, 1997).

Research by Kennedy (1996) and Lerner and Kennedy (2000) assessed the value of the Transtheoretical model framework with a sample of battered women who were either currently in or formerly involved in violent relationships. Women in this study were categorized as being currently in the relationship, out less than six months, out six to twelve months, out for one to two years, or out for more than three years. This research found that women had greater confidence
for leaving the relationship when they had been out of the relationship for at least six months. The level of confidence to leave increased for each group, with those out of the relationship more than 3 years the most confident. The opposite was found for temptation to return, with women currently in the relationship experiencing the greatest temptation to return. According to this research, the time six months after leaving a violent relationship may be the most vulnerable time for women. During this time, a woman has low confidence for leaving, high temptation to return, the demand on coping resources is high. Also, trauma symptoms such as sleep disturbance, depression, and dissociation are high.

Purpose and Expectations of the Present Study

The present study hopes to further understanding of women's experience leaving violent relationships, particularly in regard to the role that depression plays in this decision. According to the transtheoretical model, women who are currently in violent relationships will be more likely to be in precontemplation or contemplation. Women who are out of their violent relationship for more than six months are more likely to be in action or maintenance (Lerner & Kennedy, 2000). Further, it is expected that women who are depressed will rate themselves lower on the stages of change while women who are not depressed will be further on the stages of change for stay-leave decisions. It is expected that Hopelessness Depression will be greatest for women who are currently in violent relationships. Because of earlier research identifying the stress associated with leaving, it is proposed that women who have recently left may also experience Hopelessness Depression.

Another aspect of this study is to compare two self-report depression questionnaires in terms of how they describe battered women's experience of depression. The Beck Depression inventory (BDI-II) will be compared to the
Hopelessness Depression Symptoms Questionnaire (HDSQ) in order to test the hypothesis that this measure of Hopelessness Depression taps a different construct than the BDI-II. Metalsky and Joiner (1997) suggests that this questionnaire measures a specific subtype of depression, Hopelessness Depression, that is distinctly different from Beck's cognitive model of depression. It is hypothesized that The Hopelessness Depression Symptom Questionnaire will be a more sensitive measure and better explain battered women's experience of depression.

Women with increased Hopelessness Depression may stay in relationships longer, leave temporarily more times, and be in lower stages on the Transtheoretical model than women who are not experiencing hopelessness.

A summary of hypotheses follows:

1. Participants' stage of change will predict symptoms of Hopelessness Depression. Specifically, lower stage of change (such as precontemplation, contemplation, preparation) scores will predict a higher severity of depressive symptoms.

2. It is anticipated that higher stage of change scores (action, maintenance) will predict a lower severity of symptoms of Hopelessness Depression.

3. In addition to stage of change, several demographic variables will be included in the analyses for exploratory purposes. Severity of violence, whether sexual abuse was experienced in violent relationship, number of previous violent relationships, and history of child sexual abuse will be examined. It is
hypothesized that these variables may predict severity of Hopelessness Depression. More severe violence, sexual abuse in the violent relationship, a higher number of violent relationships, and a history of child sexual abuse is hypothesized to predict increased symptoms of Hopelessness Depression.

4. Differences between Relationship Status groups will also be examined to further explore the first and second hypotheses. It is predicted that there will be significant differences between the five groups in terms of symptoms of Hopelessness Depression, where those in or just out will have higher Hopelessness Depression scores than those out.

5. Social support will moderate the relationship between stage of change (URICA) and depression. Specifically, as severity of Hopelessness Depression increases and perceived social support decreases, stage of change will be lower (precontemplation, contemplation, preparation). As Hopelessness Depression decreases and perceived social support increases, stage of change will be more advanced (action, maintenance). Women who report lower stage of change and increased social support will have lower Hopelessness Depression scores.

6. The Hopelessness Depression Symptom Questionnaire will better predict stage of change for this population than the Beck Depression Inventory. The HDSQ will represent larger variance in the prediction of stage than the BDI-II.
Chapter Two
Method

Participants

The participants in this study were 102 adult victims of domestic violence who are either currently involved in a violent relationship or have experienced violence in a past romantic relationship. Power analyses were conducted using the Sample Power statistical software package, which suggested a range of participants from 61 (most liberal) to 125 (most conservative). Research in this area suggests that 94% of those experiencing abuse by partners are female (Schwartz, 1987). As a result, most of the participants who volunteered for the project were women. This project was limited to women who have either been in or are currently in a violent relationship. Women were recruited from the communities across Western Montana, as well as from the Introductory Psychology Pool.

Women from the community were recruited using advertisements, flyers, and communication with shelters and support organizations for battered women. Flyers and advertisements read: "Relationship distress: Research volunteers needed. We are looking for women to participate in a study investigating relationship distress. We are interested in talking with women from the community who: are currently involved in a violent relationship and do not intend to leave, or are currently involved in a violent relationship and are thinking about leaving, or have left a violent relationship within the past year or more than one year ago. Participants will receive $10 for appreciation of their time. All contact will be strictly confidential." Women who participated in the study, as stated in the advertisement, were reimbursed $10 for their participation. Students who participated from the Introductory Psychology program received up to eight
experimental credits for their participation.

Eligibility of women to participate in this study was assessed during a telephone screening procedure and also confirmed by responses on the Conflicts Tactics Scale (CTS; Straus, 1979). Criteria for inclusion in this research was based upon the experience of four or more moderate incidents of physical violence or one severe incident of severe violence. This approach to screening is similar to those used by other studies in the field (Kemp, Green, Hovanitz, & Rawlings, 1995).

Procedures

Participants in this study were offered a choice of several meeting places in the community. In the Missoula area, options provided included the Clinical Psychology Center at the University of Montana and the YWCA. In other communities in Western Montana, options were provided to meet at mental health centers, community centers, shelters, or other facilities viewed as safe and convenient for participants. The research was conducted by the principal researcher and trained research assistants who are sensitive to the issues facing battered women. Before beginning the research procedure, informed consent was obtained from the participant and she was assured of her monetary reimbursement regardless of a decision to discontinue her research participation.

The first component of data collection involved an individual interview with the participant. The interview was audiotaped for later transcription by trained research assistants. Following the interview, participants completed a packet of questionnaires discussed below. Following completion of the questionnaires, participants were debriefed and offered a list of resources in their community.
Measures

Interview

The interview consisted of 20 items presented in a semi-structured format. Questions addressed the participant’s experience of violence in her relationship, leave-taking behaviors, social supports, and utilization of community resources. At the end of the interview, participants were asked if there is any other information they would like to share with the interviewer. Following this, the interviewer addressed any questions or concerns the participant had, as well as a check-in on how she was feeling.

Demographic Questionnaire

A demographic questionnaire was included in the data collection. This questionnaire addressed background information including age, education, occupation, race, and income. Other information gathered included current and past experiences of violence in romantic relationships, length of these relationships, timing and location of last violent relationship, current contact with abusive partner, fear and distress related to any current contact with abusive partner, support-seeking behaviors during the violent relationship, and information about any children from the relationship.

Forced-choice Stages of Change Questionnaire

The Stages of Change Questionnaire (Fiore, 1993) is a 5-item questionnaire that assesses the participant’s readiness to leave her violent relationship. The statements are representative of the stages of change proposed by the Transtheoretical Model (Prochaska & DiClemente, 1992). The five stages are precontemplation, contemplation, preparation, action, and maintenance. The instructions for this questionnaire ask participants to choose one of five statements that best describes their violent relationship.
University of Rhode Island Change Assessment Scale (URICA) for Battered Women

This questionnaire was originally developed by McConnaughy and colleagues (1983) in order to determine scores on four stage-of-change dimensions: precontemplation, contemplation, action, and maintenance. Fiore (1993) developed a 32-item URICA questionnaire in order to assess the stages of change for women's readiness to leave their violent relationship. For each questionnaire statement, participants are asked to rate how it describes their feelings about their violent relationship on a 5-point Likert scale. In this study, the reliability of this measure was high, with an alpha of .83.

Conflict Tactics Scale

This questionnaire is a 20-item self-report which measures the occurrence of behaviors used to resolve conflict within the past year (Straus, 1979). In this study, the measure was used to assess the extent of violence experienced in the participant's violent relationship as well as ensure that she meets this study's criteria for experience of violence in a romantic relationship. The manner in which this measure was used in this research project is similar to how it was applied in previous research by Kennedy (1996). In this study, the alpha was .88.

Trauma Symptom Checklist (TSC-33)

This instrument is a brief symptom inventory that was developed to assess the long-term effects of child sexual abuse (Briere & Runtz, 1989). However, it has also been used in research on other types of trauma. Participants report how often in the past two months they experience specific symptoms of trauma, ranging from "never" to "very often." There are five main areas that are assessed by this inventory, including dissociation, anxiety, depression, post-sexual abuse trauma, and sleep disturbance.
The internal consistency of this instrument with a sample of battered women was found to be fairly high. The overall alpha was found to be .89, with the average subscale alpha of .71. The specific subscale alphas ranged from .66 to .75. The authors of the instrument (Briere & Runtz, 1989) believe that it is successful in discriminating between abused and non-abused individuals.

Another research application of this instrument with a sample of battered women found coefficient alphas of .92 overall and subscale alphas ranging from .70 to .79 (Lerner & Kennedy, 2000). In this study, the reliability was high, with an alpha of .98.

**Hopelessness Depression Symptom Inventory (HDSQ)**

The HDSQ is a 32-item self-report measure of a sub-type of depression—Hopelessness Depression. Each item consists of four statements that corresponds to a particular component of Hopelessness Depression. The instructions ask respondents to complete the questionnaire based on how they have felt in the past two weeks. Eight subscales form the HDSQ: motivational deficit, interpersonal dependency, psychomotor retardation, anergia, apathy/anhedonia, insomnia, difficulty in concentration/brooding, and suicidality. The specific subscales of the HDSQ are summed to get a subscale score and these scores are summed for the total score. Total scores may range from 0-96 (Nezu, Ronan, Meadows, & McClure, 2000).

The psychometric properties of this scale were developed on research with undergraduate students. There is evidence that this questionnaire is reliable, with high internal consistency of .93 for the full score. Subscale reliability scores range from .70 (motivational deficit) to .86 (anergia, suicidality). The test-retest reliability over several weeks was moderate, with a score of .58. The validity of this measure was supported by a factor analysis that found eight factors which
matched the eight subscales of the HDSQ. A goodness of fit index of .98 was found to further support the validity of the measure. In this study, the alpha was .92, which is consistent with that found by the authors of the questionnaire.

**Beck Depression Inventory, Second Edition (BDI-II)**

The Beck Depression Inventory is a 21-item self-report questionnaire that is used to assess depressive symptomatology during the past two weeks (Beck, Rush, Shaw, & Emery, 1979). It seems to be a valid and reliable measure of depressive symptoms in both psychiatric (.86) and non-psychiatric (.81) populations (Beck, Steer, & Garbin, 1988). In this study, the alpha was .92, which is higher than that found in the original sample.

**Social Support Questionnaire (SSQ-VI)**

This measure is a six-item self report questionnaire that assesses satisfaction with social support. The six-item version used in this research was developed by Sarason, Sarason, Shearin, & Pierce (1987) from the 27-item measure. Each item is composed of two parts: the first indicates the number of individuals in their environment that the participant believes are available for support and the second part is a six-point Likert scale that measures satisfaction with the support. The questionnaire’s internal reliability has been found to be between .90 and .93 (Sarason, et. al., 1987). The alpha in this study was .92, which is consistent with the original sample.
Chapter Three

Results

Demographics

The majority of participants, 85.1% (n=86), described their race as Caucasian. Four percent of participants reported Native American (n=4), 3% reported Hispanic (n=3), 1% reported Asian (n=1), 1% reported African American (n=1), and 5.9% of women described their race as other (n=6). The mean yearly income for participants was between $5,000-$10,000. Ninety percent of participants reported their yearly income was $20,000 or less. The average yearly family income was $20,000-25,000. Yearly family income that was $20,000 or less was reported by 46.2% of participants. Yearly family income of $35,000 or greater was reported by 34.1% of participants. A total of 17.6% of participants reported yearly family income of $50,000 or greater.

A majority of participants, 69.3% (n=70), reported they had completed some college, while 11.9% (n=12) did not complete high school, 7.9% (n=8) achieved a high school education, and 11.9% (n=12) earned a college degree or higher.

The average length of the violent relationship was 5.25 years, with a range from 1 month to 35 years. The average number of previous violent relationships (not including current relationship) was 1, with a range of 0-7. Participants left their violent relationship an average of 4 times, with a range from 0 (for those still in) to 20.

A total of 40.6% (n=41) of women were married to their violent partner,
31.7% (n=32) were living together, and 27.7% (n=28) were dating. Participants reported having an average of 1 child, with a range from 0-8. A percentage of 36.3 participants reported that their children witnessed the violence in their relationship. The average age of participants was 32, with a range of 18-66 years. Participant age was found to be positively correlated to length of relationship \[ r(102) = 0.51 \ (p<0.01) \]. As participant age increased, the length of their violent relationship also increased. Since this is an obvious correlate (time), analyses comparing groups will be examined to determine if significant group differences can be attributed to age.

The descriptive statistics for scales used in this study are presented in Table 2. The norms for the HDSQ report that the mean score is 11.38 (SD=9.67), with a range of 0-58. The mean for this sample (mean=20.36) is higher than the norms. A t-test was performed, which confirmed that the differences between the means is significant \( (t (100)=7.11, \ p=.000) \). See Table 1. The norms for the BDI-II state that the mean is 13. The mean for this sample is consistent with the norms for the measure (mean=13.88).

Table 1
Descriptive Statistics for t-test Comparing HDSQ scores

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>t</th>
<th>df</th>
<th>Significance</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDSQ</td>
<td>101</td>
<td>7.11</td>
<td>100</td>
<td>.000***</td>
<td>8.98</td>
</tr>
</tbody>
</table>

\( ***p<.001 \)
Table 2

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopelessness Depression Symptom Questionnaire</td>
<td>20.36</td>
<td>12.69</td>
<td>1-67</td>
<td>.92</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI-II)</td>
<td>13.88</td>
<td>10.08</td>
<td>0-45</td>
<td>.92</td>
</tr>
<tr>
<td>Social Support Questionnaire (SSQ-VI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of supports</td>
<td>3.89</td>
<td>2.35</td>
<td>0-9</td>
<td>.92</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>4.07</td>
<td>1.15</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>Conflict Tactics Scale (CTS)</td>
<td>38.35</td>
<td>17.21</td>
<td>9-126</td>
<td>.88</td>
</tr>
</tbody>
</table>

**Exploratory Analyses**

Several exploratory analyses were completed prior to testing the main hypotheses. Participants were assigned to relationship status groups, representing their position in the stay-leave decision-making process. Participants were also assigned to stage of change groups using the URICA for battered women (Fiore, 1994). Participants’ use of resources, such as family, community, legal, medical, and religious support, are reported. Participants’ child abuse histories are reported, as well as the role their own children played in their decision to leave a violent relationship.

**Assignment of Participants to Relationship Status Groups**

Relationship status represents women’s position in the stay-leave decision making process. This grouping has been used in previous research examining stage of change in battered women (Lerner & Kennedy, 2000; Kennedy, 1999). These groups are defined by women’s current involvement in a
violent relationship or by calculating the amount of time since they have left their relationship. Women will be classified as either “in” (the relationship), “out < 6 months”, “out 6-12 months”, “out 1-3 years”, “or out >3 years” (see Table 3). The range of time since leaving the violent relationship was calculated using all participants. These relationship status classifications will be used in the Analysis of Variance computations.

Table 3

<table>
<thead>
<tr>
<th>Relationship Status Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>In</td>
</tr>
<tr>
<td>Out &lt; 6 months</td>
</tr>
<tr>
<td>Out 6-12 months</td>
</tr>
<tr>
<td>Out 1-2 years</td>
</tr>
<tr>
<td>Out 2-3 years</td>
</tr>
<tr>
<td>Out &gt;3 years</td>
</tr>
</tbody>
</table>

Assignment of Participants to Stage of Change Groups

Participants were assigned to stage of change groups using the URICA designed for battered women (Fiore, 1994). This measure includes subscales for the stages of change: precontemplation, contemplation, action, and maintenance. The number of women in each stage is reported in Table 4. The URICA is a continuous measure of stage of change. Higher scores indicate
higher stage of change, while lower scores indicate lower stage of change. The descriptive statistics for each group are reported in Table 5.

Table 4
Stage of Change Groups

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>4</td>
</tr>
<tr>
<td>Contemplation</td>
<td>7</td>
</tr>
<tr>
<td>Action</td>
<td>12</td>
</tr>
<tr>
<td>Maintenance</td>
<td>73</td>
</tr>
</tbody>
</table>

Table 5
Descriptive Statistics for Stage of Change Groups

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>14.83</td>
<td>4.69</td>
</tr>
<tr>
<td>Contemplation</td>
<td>14.72</td>
<td>5.74</td>
</tr>
<tr>
<td>Action</td>
<td>23.13</td>
<td>5.86</td>
</tr>
<tr>
<td>Maintenance</td>
<td>18.48</td>
<td>4.16</td>
</tr>
</tbody>
</table>

Use of Resources

The majority of participants, 91.2%, sought some form of support regarding their violent relationship. Family support was sought by 62.7% of participants. Support from friends was sought by 69.6% of participants. Community support was sought by 75.5% of participants. In this study, community support was defined as legal services, battered women’s shelter,
counseling, religious resources, or financial assistance. Counseling was sought by 74.3% of participants to address issues resulting from their violent relationship. Medical treatment was sought by 45.1% of participants.

The two most helpful resources reported were counseling and friends. Counseling was reported most helpful by 22.2% of participants and an additional 22.2% reported that friends were the most helpful resource.

One barrier to accessing resources may be keeping the violence a secret, as 81.4% of women kept the violence a secret from others. Of these women, 49% reported keeping the violence a secret from everyone. When women chose to disclose the violence, 33.3% first disclosed to a female friend, 6.9% disclosed to a male friend, 8.8% disclosed to a sibling, 14.7% disclosed to a parent, 5.9% disclosed to other family, 1% disclosed to a religious leader, 2% disclosed to the police or legal services, 1% disclosed to a battered women’s hotline, 1% disclosed to a co-worker or boss, and 9.8% disclosed to a counselor.

**Participants’ Childhood Abuse Histories**

Information was gathered on history of family violence and specifically for history of child sexual abuse. A history of family violence was reported by 59.8% of participants. Of these, 29 participants reported a history of child sexual abuse, representing 28.4% of the sample.

Two t-tests were performed to compare participants with and without a history of childhood violence and child sexual abuse on hopelessness depression. The first t-test compared participants with and without a history of childhood violence, which includes physical, emotional, and sexual. These two groups did not differ on hopelessness depression ($t (95)=1.36, p=.18$). The second t-test compared participants with and without a history of child sexual abuse and found that the two groups differed significantly on hopelessness depression.
depression \( t (87)=2.48, p=.02 \). Women with a history of child sexual abuse obtained an average of 26.14 on the HDSQ, while women without a history of child sexual abuse obtained an average score of 18.92. See Table 6.

Table 6
Descriptive Statistics for t-test Measuring Differences in Hopelessness Depression for Women with and without a History of Childhood Sexual Abuse

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA</td>
<td>29</td>
<td>26.14</td>
<td>17.95</td>
<td>2.48</td>
<td>.02*</td>
</tr>
<tr>
<td>No CSA</td>
<td>61</td>
<td>18.92</td>
<td>9.56</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*\( p<.05 \)

Role of Children in the Decision to Leave a Violent Relationship

Children's role in the decision to leave a violent relationship was also examined. A significant correlation was found between number of children and length of violent relationship. As the number of children increased, the length of the relationship also increased \( r (87)= .40, p<0.01 \). A follow-up t-test was performed to determine if participants with and without children differed in the length of their relationship. A significant difference was found between participants with and without children \( t (74)=3.19, p=.002 \). Women who have children stayed in the relationship an average of 8.39 years, while women without children stayed an average of 3.66 years. See Table 7. Women who had children stayed in the relationship significantly longer than women who did not have children.
Table 7
T-test Measuring Length of Time in Relationship With and Without Children

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean (in months)</th>
<th>SD</th>
<th>df</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>34</td>
<td>100.65</td>
<td>16.81</td>
<td>74</td>
<td>3.19</td>
<td>.002**</td>
</tr>
<tr>
<td>No Children</td>
<td>42</td>
<td>43.90</td>
<td>8.47</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .01

Testing the Main Hypotheses

Several hypotheses were tested in this study. Stage of change was examined to determine its ability to predict Hopelessness Depression. In addition to stage of change, several demographic variables are included in the analyses for exploratory purposes. Severity of violence and number of previous violent relationships are examined. The role these variables play in the prediction of Hopelessness Depression is examined.

Differences between Relationship Status groups were examined to further explore the first and second hypotheses. Differences in Hopelessness Depression between relationship status groups are examined.

Social support is examined as a moderator of the relationship between stage of change (URICA) and Hopelessness Depression. Specifically, the relationship between stage of change and social support is examined to determine whether, and to what degree, they predict Hopelessness Depression.

Finally, the Hopelessness Depression Symptom Questionnaire and the Beck Depression Inventory are compared to determine which better predicts
One-way ANCOVA Investigating RS Group Differences in Hopelessness Depression (#4)

A one-way Analysis of Covariance was performed in order to test the hypothesis that the relationship status groups differ in terms of Hopelessness Depression with relationship status as the independent variable and the scores of the HDSQ as the dependent variable. Because of the correlation between age and relationship status, age was used as a covariate in the analysis. The ANCOVA did not demonstrate statistical significance for the proposed influence of relationship status on Hopelessness Depression ($F(7, 92)=1.76, p=.11$). The relationship status groups did not differ in levels of Hopelessness Depression. Because the ANCOVA was not significant, follow up analyses were not examined. This information is presented in Tables 9 and 11.

In addition, a second ANCOVA was performed to compare the relationship status groups on the BDI-II. As above, relationship status was the independent variable and age was used as a covariate. In this analysis, BDI-II scores were used as the dependent variable. The relationship status groups did differ statistically on BDI-II scores ($F(7)= 2.34, p=.03$). See Table 8. Follow-up pairwise comparisons revealed that "out <6 months" and "out >3 years" groups significantly differed on the BDI-II (mean difference=16.08, $p=.04$). Women who had recently left their relationship had significantly higher scores (mean=27) than women who had left more than three years ago (mean=11.15). The BDI-II scores for women who had recently left their violent relationship are clinically indicative of depression. The scores for women who have been out for more than 3 years are average and not indicative of depression. See Table 10.
Table 8
Analysis of Covariance for Relationship Status x Beck Depression Inventory-2nd Edition

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F ratio</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>105.61</td>
<td>1</td>
<td>105.61</td>
<td>1.12</td>
<td>.03*</td>
</tr>
<tr>
<td>Rel. Status</td>
<td>1472.87</td>
<td>6</td>
<td>245.48</td>
<td>2.61</td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>1537.55</td>
<td>7</td>
<td>219.65</td>
<td>2.34</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

Table 9
Analysis of Covariance for Relationship Status X Hopelessness Depression Symptom Questionnaire

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F ratio</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>271.71</td>
<td>1</td>
<td>271.71</td>
<td>1.75</td>
<td>.11</td>
</tr>
<tr>
<td>Rel. Status</td>
<td>1741.05</td>
<td>6</td>
<td>290.17</td>
<td>1.87</td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>1912.11</td>
<td>7</td>
<td>273.16</td>
<td>1.76</td>
<td></td>
</tr>
</tbody>
</table>
Table 10
Descriptive Statistics for Relationship Status Groups on the BDI-II

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>In</td>
<td>11</td>
<td>21.71</td>
<td>14.91</td>
</tr>
<tr>
<td>Out &lt;6 months</td>
<td>18</td>
<td>27.00</td>
<td>15.90</td>
</tr>
<tr>
<td>Out 6-12 months</td>
<td>9</td>
<td>14.70</td>
<td>10.56</td>
</tr>
<tr>
<td>Out 1-2 years</td>
<td>17</td>
<td>14.19</td>
<td>9.39</td>
</tr>
<tr>
<td>Out 2-3 years</td>
<td>8</td>
<td>14.00</td>
<td>6.81</td>
</tr>
<tr>
<td>Out &gt;3 years</td>
<td>41</td>
<td>11.14</td>
<td>8.00</td>
</tr>
</tbody>
</table>

Table 11
Descriptive Statistics for Relationship Status Groups on the HDSQ

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>In</td>
<td>11</td>
<td>25.29</td>
<td>12.80</td>
</tr>
<tr>
<td>Out &lt;6 months</td>
<td>18</td>
<td>36.75</td>
<td>21.36</td>
</tr>
<tr>
<td>Out 6-12 months</td>
<td>9</td>
<td>22.60</td>
<td>14.75</td>
</tr>
<tr>
<td>Out 1-2 years</td>
<td>17</td>
<td>19.44</td>
<td>10.96</td>
</tr>
<tr>
<td>Out 2-3 years</td>
<td>8</td>
<td>21.29</td>
<td>7.63</td>
</tr>
<tr>
<td>Out &gt;3 years</td>
<td>41</td>
<td>17.56</td>
<td>10.37</td>
</tr>
</tbody>
</table>
In order to test the hypotheses that stage of change (using URICA scores which, as they increase, represent higher stage of change), severity of violence, and number of previous violent relationships predicts Hopelessness Depression, a multiple regression analysis was performed with these as the independent variables and Hopelessness Depression as the dependent variable.

A main effect was found for the contribution that stage of change, severity of violence, and number of previous violent relationships made to Hopelessness Depression \( (F(3, 87)=4.92, p=.003) \). As predicted, stage of change accounted for the majority of variance in the Hopelessness Depression score \( (t=3.56, p=.001) \). See Table 12.

Table 12

**Standard Multiple Regression using Stage of Change (URICA score), Severity of Violence, and Number Previous Violent Relationships to predict Hopelessness Depression (n=97)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>( t )</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of Change</td>
<td>.37</td>
<td>3.56</td>
<td>.001***</td>
</tr>
<tr>
<td>Severity of Violence</td>
<td>-.07</td>
<td>-.68</td>
<td>.50</td>
</tr>
<tr>
<td># Previous Violent</td>
<td>.02</td>
<td>.19</td>
<td>.85</td>
</tr>
<tr>
<td>Relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** \( R^2 = .15; \Delta R^2 = .15 \text{ (p<.01)} \)

***p<.001
Standard Multiple Regression using Length of Relationship and Social Support to Predict Hopelessness Depression

In order to test the hypotheses that length of relationship and social support predict Hopelessness Depression, a multiple regression analysis was performed with these as the independent variables and Hopelessness Depression as the dependent variable.

A main effect was found for the contribution that length of relationship and social support made to Hopelessness Depression \((F(2, 83) = 7.16, p = .001)\). Social support was found to contribute unique variance to the prediction of hopelessness depression \((t = -3.77, p = .000)\). See Table 13. The correlation between social support and hopelessness depression is negative. As social support increases, hopelessness depression decreases or as social support decreases, hopelessness depression increases.

Table 13
Multiple Regression using Length of Relationship and Social Support to predict Hopelessness Depression \((n=96)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>(t)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Length</td>
<td>.07</td>
<td>.67</td>
<td>.503</td>
</tr>
<tr>
<td>Satisfaction with Social Support</td>
<td>-.38</td>
<td>-3.77</td>
<td>.000***</td>
</tr>
</tbody>
</table>

Note: \(R^2 = .15; \Delta R^2 = .15 (p < .001)\)

***\(p < .001\)
Standard Multiple Regression Predicting Social Support as a Moderator (#5)

The moderating role of social support is tested in this study as suggested by Baron and Kenny (1986). The first step is to enter the independent and moderating variable together to predict the dependent variable. The next step is to enter the interaction between the independent variable and moderator in a second block. In order to calculate the interaction, the product of the independent and moderating variables are computed. Moderation is determined by the significance of the F change score when this interaction term is entered into the regression.

In order to test the hypothesis that social support moderates the relationship between stage of change and depression, a multiple regression analysis was performed using Hopelessness Depression as the dependent variable and stage of change and satisfaction with social support as the independent variables. Stage of change and satisfaction with social support were entered into the regression equation in block 1 and the interaction of the two independent variables (stage of change and satisfaction with social support) were entered into block 2. A main effect was found for the contribution of stage of change and satisfaction with social support to Hopelessness Depression scores (F (2, 98)=16.05, p=.000). In addition, the interaction between stage of change and social support was statistically significant (F (1, 97)=6.89, p=.01). See Table 14. This provides support for the hypothesis that social support moderates the relationship between stage of change and hopelessness depression. Under low levels of social support, as stage of change increases, so does hopelessness depression. Social support plays a moderating role in the relationship between stage of change and depression by strengthening the relationship between stage of change and depression under low levels of social
support. When amount of social support is low, women in lower stages of change report much fewer depressive symptoms while women in higher stages of change report more severe symptoms of depression. Under high levels of social support, stage of change remains about the same, regardless of severity of depression. Figure 1 illustrates the moderating effect.

Table 14

Multiple Regression Analyses for the Moderating Effects of Social Support on the Relationship between Stage of Change and Hopelessness Depression (n=101)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of Change</td>
<td>.90</td>
<td>3.54</td>
<td>.001***</td>
</tr>
<tr>
<td>Satisfaction with Social Support</td>
<td>.62</td>
<td>1.62</td>
<td>.11</td>
</tr>
<tr>
<td>Stage of Change X Satisfaction with Social Support</td>
<td>-1.04</td>
<td>-2.62</td>
<td>.01**</td>
</tr>
</tbody>
</table>

Note: $R^2 = .25$; $\Delta R^2 = .25 (p<.001)$

**p<.01
***p< .001
Figure 1
Social Support as a Moderator Between Stage of Change and Hopelessness Depression

![Graph showing the relationship between Social Support and Stage of Change with Hopelessness Depression](image)

Standard Multiple Regression Predicting Stage of Change (#6)

A correlation was performed with the BDI-II and HDSQ, resulting in a significant correlation between the two measures ($r(101) = .84$, $p < .01$). As these two measures are highly correlated, it is likely that they share a large portion of the variance in the following analyses.

In order to test the hypothesis that the HDSQ will predict stage of change (measured by URICA) above and beyond the BDI-II, a multiple regression was
performed with the HDSQ and the BDI-II as the independent variables and stage of change as the dependent variable. As the BDI-II is the measure used more commonly in clinical practice, it was entered into the regression equation first, followed by the HDSQ. The two variables combined significantly predict stage of change ($F = 8.13$, $p = .001$), although they did not contribute a lot of variance ($R^2 = .13$). See Table 15. However, neither variable demonstrated a unique contribution to stage of change. Partial correlations were examined to determine the amount of variance each accounted for when the other variable’s influence was removed. The BDI-II ($r_p = .13$) and the HDSQ ($r_p = .10$) both contributed similar variance to the prediction of stage of change, although the BDI-II did account for slightly more variance. Beta weights were also examined to compare the two measures on a standardized score. The BDI-II ($\beta = .22$) and the HDSQ ($\beta = .18$) demonstrated similar beta weights, with the BDI-II accounting for slightly more variance when the effect of the HDSQ was controlled. See Table 15. While both measures of depression together predict stage of change, neither makes a unique contribution to the prediction of stage of change. The HDSQ does not make a contribution to predicting stage of change above and beyond the BDI-II. The BDI-II, which is used more commonly in clinical practice, contributes slightly more variance to the prediction of stage of change.
Table 15

Multiple Regression using HDSQ and BDI-II to Predict Stage of Change (n=101)

<table>
<thead>
<tr>
<th></th>
<th>Variable</th>
<th>Beta</th>
<th>t</th>
<th>Partial Correlations</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>BDI-II</td>
<td>.22</td>
<td>1.25</td>
<td>.13</td>
<td>.21</td>
</tr>
<tr>
<td>Step 2</td>
<td>HDSQ</td>
<td>.18</td>
<td>1.02</td>
<td>.10</td>
<td>.31</td>
</tr>
</tbody>
</table>

Note: $R^2 = .15; \Delta R^2 = .15$ ($p<.001$)
Chapter Four
Discussion

This study was designed to investigate the role of depression in a woman's decision to leave a violent relationship. Specifically, this study examines the role of hopelessness depression, a proposed subtype of depression, in the stay-leave process. The Transtheoretical Model of behavior change guided participants' placement in the stay-leave process. This model proposes that change is a dynamic process in which a person goes through various stages of readiness before making a behavioral change.

In this study, the behavior change of interest is the decision to leave a violent relationship. Participants were selected for this study if they reported experiencing severe physical violence in a current or past romantic relationship. The present study examines the role that hopelessness depression plays in the stay-leave decision-making process. Specifically, stage of change, severity of violence, number of previous violent relationships, length of relationship, and social support were found to predict hopelessness depression scores. Also, the role of social support as a moderator of the relationship between stage of change and hopelessness depression was investigated. Social support was found to moderate the relationship between stage of change and depression. Higher stage of change is related to higher levels of hopelessness depression. When social support is low, this relationship is particularly strong. When social support is high, the relationship weakens.

The present study sought to contribute to the understanding of factors that
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contribute to women’s decision to remain in a violent relationship. Knowledge about the role depression plays in the decision-making process is hoped to provide helping professionals the means to better assist women during this time. Furthermore, improved awareness of how to address the psychological needs of battered women as part of the leave-taking process may enhance women’s capacity and self-efficacy to leave their violent relationship or seek safety.

Barriers to Leaving a Violent Relationship

Participants in this study left their violent relationships an average of 4 times. This is consistent with findings of research with this population (Lerner & Kennedy, 2000; Kennedy, 1999). There are several reasons why women may remain in violent relationships. As in other studies, women reported significantly less yearly income than total family income with their abusive partner. Financial concerns may be a powerful motivator to remain in a violent relationship. Women may perceive the need to remain in the relationship to maintain financial stability.

Children also play a role in a woman’s decision to leave her violent relationship. Women with children were more likely to stay in their relationship than women without children. The more children a woman had, the longer she remained in her relationship. Women who had children remained in their relationship an average of 5 years longer than women without children. Women express several reasons why they may stay longer. Many report feeling committed to remaining in the relationship for the sake of their children. They express wanting their children to grow up with a father. When describing this reason to stay, women made statements to the effect that their partner was a bad
husband, but a good father. Given the new evidence regarding the harmful consequences their children suffer when exposed to domestic violence, it is clear that not all women are aware of and weigh the exposure to violence and the loss related to the absence of the father in their decision-making.

Women may also remain in their relationship for financial reasons. They may not have the financial resources to leave their partner and support their children. They may remain with their abuser to provide financial stability to the family. Another reason women may remain in relationships longer is religious beliefs. They may believe in keeping the family together, despite the abuse.

Resources Utilized

The majority of participants accessed some form of resource as a result of their violent relationship. Community support and counseling were the most commonly accessed resources, followed by support from family and friends. Medical treatment was sought by about half of the participants. Most of the resources accessed were related to women's emotional support following violence. Many more women sought assistance for this reason than for physical injury. There are several possible explanations for this. In the interview, some women reported hesitance to seek medical attention. Their abuser prevented help seeking or the women chose not to seek treatment out of embarrassment. Other reasons women reported not seeking treatment included fear of retribution from their abuser, fear he may get into trouble (and subsequently get angry and harm her), and shame or guilt about disclosing abuse. Women have also commented that the emotional aspects of the abuse were far more damaging to
them than the physical. This may explain why many women sought more assistance related to emotional support. Consistent with this, women reported that counseling and friends were the most helpful resource they accessed. Accessing support that assists with the emotional sequelae may be most essential to managing the challenges of the stay-leave decision-making. As indicated in the analyses, women who sought increased support had lower hopelessness depression scores. Leave-taking is a vulnerable time for women and social support plays an important role in reducing the vulnerability to depression. It is interesting to note that although many women report seeking support following their violent relationship, overall depression scores are high. This study measured satisfaction with social support, which previous research has found to be the most meaningful measure of social support. It may be that, although women sought community resources, they did not perceive them as all that supportive. This highlights the importance of developing interventions that target women’s individual needs as they prepare to leave their relationship. Improving satisfaction with social support is a key to reducing the occurrence of depression and improving women’s capacity and self-efficacy to seek and maintain safety from their abusive partner. One possibility is to develop a mentoring program in which women who have left successfully are paired with women who are contemplating leaving their relationship or have recently left. Building positive relationships with other women is likely to increase satisfaction with social support. Many battered women’s services offer support groups, which appear to be a useful intervention to improve social support. As will be discussed
below, social support was found to play a moderating role in the relationship between stage of change and depression.

**History of Family Violence**

A majority of participants reported a history of family violence (59.8%). This supports previous research findings that identify experiencing violence in childhood as a risk factor for adult involvement in a violent relationship (Hotaling & Sugarman, 1986; McMurran, 1999). Almost a third of women in this study reported that their childhood abuse included sexual abuse (28.4%). This finding supports previous research that has linked a history of child sexual abuse to adult violent relationships (Dutton, 1998; Oriel & Fleming, 1998).

These findings suggest some contribution of the intergenerational transmission of violence. Children who grow up in violent homes appear more likely to become victims of violence. Thus, understanding childhood abuse issues is likely to be an important step in addressing the experience of domestic violence. Many women also reported that their children witnessed the violence in the home, which places their children at risk for experiencing violence as an adult based on recent research findings (Whitfield, Anda, Dube, & Felitti, 2003).

Given that 40 percent of participants do not have a history of family violence, other factors contribute to involvement in a violent relationship. Since women of all backgrounds become involved in violent relationships, it is important to seek to understand the dynamics of relationships and how history may increase one's risk. In this way, women who experienced child sexual abuse reported significantly higher hopelessness depression scores than women who
had not experienced abuse. Thus, the experience of child sexual abuse places women at risk for developing hopelessness depression. The current study has found that the presence of hopelessness depression is related to women's decision-making process to leave or stay in a violent relationship. An understanding of the role abuse history plays in the development of hopelessness depression may allow helping professionals to assist women to optimize their chances of successfully seeking and maintaining safety.

The family appears to be an important factor in shaping beliefs and attitudes towards violence and as an influence on a woman's risk to become a victim of domestic violence. This study offers further evidence that the negative impact of experiencing violence as a child places children at risk for becoming adult victims of violence.

**Relationship Status and Hopelessness Depression**

The hypothesis that relationship status groups would differ on Hopelessness Depression was not supported. The groups were not significantly different from each other. The amount of time that a woman has been out of her relationship does not impact her level of hopelessness depression. Women have similar levels of hopelessness depression, regardless of how long they have been out of their relationship. Even though there was not a statistically significant difference between the HDSQ scores for relationship status groups, it is notable that the scores for all groups are clinically indicative of hopelessness depression. This suggests that women experience hopelessness depression at all stages of the decision-making process. This implies that symptoms of hopelessness
depression should be evaluated in all battered women, regardless of the length of time out of relationship. Women experience difficulty with seeking and maintaining safety from their abuser at various points in the decision-making process. It is possible that hopelessness depression plays a role in the decision to return to a violent relationship. A better understanding of the role of hopelessness depression may assist helping professionals improve women’s capacity and self-efficacy to seek and maintain safety from their violent relationship.

An additional analysis was performed comparing relationship status groups on levels of depression as measured by the BDI-II. The two groups that differed significantly were women who were out of their relationship less than six months and women who had been out for more than three years. The women who had recently left their violent relationship reported clinically significant levels of depression, while the women who had left over 3 years ago did not report clinical levels of depression. Examining the means for the other groups reveals that all groups, with the exception of those out more than 3 years, have clinically meaningful depression scores. This suggests that depression, as measured by the BDI-II, is a chronic mental health issue for battered women, especially early in the stay-leave process. Not until three years or more do the average scores reflect non-clinical scores.

The fact that the HDSQ is sensitive to depression in women who have left for more than 3 years, while the BDI-II is not, provides evidence that the HDSQ is a valuable clinical instrument with this population. Perhaps the HDSQ, as its
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authors propose, is a more sensitive measure of the hopelessness component of depression than the BDI-II. If this is the case, then use of the HDSQ, in addition to the BDI-II, will provide more clinically relevant information.

Since women report highest levels of depression (as measured by both HDSQ and BDI-II) immediately following leave-taking, this finding has implications for practitioners and other helping professionals. Women report the highest depression scores at the time when most vulnerable to harm and when most challenged to change. Research has found that women leave multiple times before leaving the relationship permanently. Perhaps depression plays a role in their vulnerability to return to the relationship.

There is a strong relationship between social support and depression. A high quality of satisfaction with social support serves as a protective factor against depression. When women first leave their violent relationship, they lose an important component of their social network—their partner. Although violent, women still report missing their partner and the love of the romantic attachment. For some women, their violent relationship may be their only means of support. Isolation has been found to be a common power tactic used by batterers. This isolation may no longer be evident three years out.

It is interesting to note that there is a significant difference in relationship status groups only for the BDI-II, the measure of depression most commonly used in clinical practice. Women's levels of hopelessness depression did not differ significantly across relationship status groups. However, their level of hopelessness depression across time/status groups is, overall, higher than that
of their level of depression measured by the BDI-II. This suggests that both measures of depression are meaningful, though they may operate differently. As well as discussed below, HDSQ plays an important role in relationship to stage of change.

This finding that depression is a significant mental health issue in battered women is not surprising considering the relationship between social support and depression. Low levels of satisfaction with social support result in greater symptoms of depression. Leaving a violent relationship is a vulnerable time for women. They have lost a primary source of support and may not have other relationships on which to depend. Isolation is a common power tactic used by batterers, at great cost to the victim. Perhaps the experience of depression contributes to women’s vulnerability to return to her abuser.

**Predicting Hopelessness Depression**

Stage of change, severity of violence in relationship, and number of previous violent relationships contributes to the prediction of greater levels of Hopelessness Depression. In addition, stage of change contributed its own unique variance to the prediction of Hopelessness Depression. Furthermore, length of relationship and lack of social support were found to significantly predict hopelessness depression. In addition, lack of social support contributed its own unique variance to the prediction of hopelessness depression.

The finding that stage of change makes its own unique contribution to Hopelessness Depression has important implications for how women’s leave-taking decision is addressed. A higher stage of change predicts a higher
hopelessness depression score that means that women who are more ready to change report more depression. In this questionnaire, however, maintenance questions hold many relapse or return questions. They focus on concerns of experiencing slips, insecurity about the ability to sustain change, and ongoing struggles with the problem. This may explain why women are so vulnerable to returning to their violent relationships. Even though they may be preparing or initiating a change, they are also feeling hopeless about the future and more likely to make internal, stable, and global attributions. In other words, they are likely to blame themselves for their problems rather than recognizing the environmental contributions. They may criticize themselves for relapses in which they return to their partner. Helping women understand the role that depression plays in the decision-making process and treating the depressive symptoms may improve their capacity and self-efficacy to seek and maintain safety from their abusive partner.

The stage of change model states that the most effective interventions are targeted at the specific stage of change. For example, taking an action-oriented strategy with women in contemplation would not be effective. Women in contemplation need more support, exploration of options, an discussion of barriers. When women have made their decision to leave, then action-oriented strategies to prepare for leave-taking are beneficial. For example, assistance with finding housing, obtaining legal assistance, and arranging a leave-taking plan are useful at this time. When depression remains an issue, then each of these stages may present greater challenges for those helping as well as the women facing
The occurrence of hopelessness depression in advanced stages of change presents a challenge to battered women. They are preparing to make or initiating a very difficult behavior change, yet are in a psychologically vulnerable state. They are likely to experience decreased motivation, sleep problems, hopelessness, lack of interest in activities, and lack of energy. Hopelessness, clearly, can be additionally challenging. Yet, at the same time, they are attempting to leave their violent relationship. Without the proper support and psychological intervention, they are likely to be at increased risk to return to their violent relationship or be unable to keep themselves from harm.

Since depression is likely to occur in all relationship status groups, hopelessness depression should be evaluated for each woman who seeks assistance, regardless of relationship status. Identifying women who are experiencing hopelessness depression and offering treatment-focused interventions may increase women’s capacity and self-efficacy to initiate and maintain a decision to leave the relationship.

Depression, particularly Hopelessness Depression, includes symptoms of lack of motivation, lack of hope for the future, and lack of energy. This makes it extremely difficult to take a course of action when faced with a problem. Women who are feeling more depressed are less likely to consider leaving their violent relationship. This fits with the finding that women who had been out of their relationship for over 3 years were less depressed than those who had been out shorter amounts of time. Women who are experiencing depression appear to
have more difficulty seeking and maintaining safety from their violent relationship.

At first glance, it seems confusing that women are more hopelessly depressed in a higher stage of change and report less depressive symptoms when they have been out of their relationship for more than 3 years. However, according to the transtheoretical model, a person is considered in action 6 months into the behavior change. Following 6 months, they proceed into maintenance. Therefore, the participants who self-identified in the maintenance and action stages (the higher stages of change) are likely to represent a range of time out of the relationship from 6 months to over 3 years. It is likely that the higher rates of depression in the higher stage of change are contributed by women who have been out of their relationship for less than 3 years. As discussed above, many of the maintenance questions on the URICA represent relapse.

The severity of violence, along with number of previous violent relationships, longer length of relationship, and lack of social support, contributed to the prediction of Hopelessness Depression. This finding fits with the theory of learned helplessness, in which women become increasing helpless and hopeless when faced with severe, chronic, levels of violence. When evaluating women's stage in the process of leave-taking, the severity of violence is important to consider. This research suggests that even women who endorse a higher stage of change may have experienced severe levels of violence and a higher number of previous violent relationships. They would be more likely to become depressed and have increased difficulty mustering the resources to leave their violent
Number of previous violent relationships contributed to the prediction of Hopelessness Depression, along with stage of change and severity of violence. A higher number of previous violent relationships was related to higher levels of Hopelessness Depression. Women who have been in more than one violent relationship are more likely to have more exposure to violence and more of an opportunity to develop learned helplessness and subsequent hopelessness. There is also more opportunity to learn that their behaviors do not have an effect on the outcome of violence. Perhaps there is a cumulative effect of multiple violent relationships in which levels of hopelessness increase with each subsequent violent relationship. Women may become disheartened and come to believe that violence is an accepted part of relationships. This sense of having no control over the nature of their relationship may lead to hopelessness, placing them at risk for developing Hopelessness Depression.

Social support was also found to uniquely predict hopelessness depression. As social support increased, depression decreased and as social support decreased, depression increased. As discussed below, social support was found to moderate the relationship between stage of change and hopelessness depression. Research on stress implicates social support as an important component of the stress and coping response. Having access to social support resources may have a protective effect and increase coping responses in a stressful situation, including domestic violence (Walker, 1983). The current study provides additional evidence about the role social support plays as a
These factors taken together significantly predict Hopelessness Depression. The decision to leave a violent relationship is a difficult one. There are many complex factors that play a role. Stage of change, severity of violence, number of previous violent relationships, length of relationship, and social support all play a role in contribution to Hopelessness Depression. When evaluating depression in battered women, all of these factors should be considered. The more severe the violence, the longer the relationship, the more previous violent relationships, the less social support, and lower stage of change all put a woman at risk for increased symptoms of depression. Understanding more about women's stage of change and the role it plays in the development of depression will assist in developing more effective interventions for battered women.

**Social Support as a Moderator between Stage of Change and Hopelessness Depression**

Baron & Kenny (1986) define a moderator as a variable that alters the direction or strength of a relationship between an independent and dependent variable. This study was interested in examining the role of social support as a moderator of the relationship between stage of change and hopelessness depression.

The role of social support in depression has been discussed extensively in research that has found higher social support to relate to less depressive symptoms. (Kendler, et.al., 1993; Parker, et.al., 1992). Research also suggests
that amount of social support actually serves as a protective factor against the occurrence of violence in relationships (Straus, Gelles, & Steinmetz, 1980; National Research Council Institute of Medicine, 1998).

This study hypothesizes that social support will moderate the relationship between stage of change and depression. As levels of social support change, so will symptoms of depression. In fact, the hypothesis was supported that social support does have a moderating effect on the relationship between stage of change and depression. Social support plays an important role in a woman’s decision to leave a violent relationship. The presence of high satisfaction with social support lowers a woman’s risk to develop Hopelessness Depression.

Research has demonstrated that satisfaction with social support is more critical to examine than quantity of social support when considering the role of social support (Ellis, 1992; Mitchell & Hodson, 1986; Lazarus, 1981). This makes intuitive sense in that one’s satisfaction with social support is more important to well being than quantity of support available. One can have many supports, but not feel that they are helpful. Alternatively, a few supports may be deemed highly useful. For this reason, the current study used measures of satisfaction with social support.

In the above model, stage of change, along with several other key variables, predicts Hopelessness Depression. In this model, stage of change and satisfaction with social support were found to significantly predict Hopelessness Depression. In addition, support was found for the hypothesis that social support moderates the relationship between stage of change and hopelessness.
depression. It is interesting to note that higher stage of change is related to higher levels of hopelessness depression. When social support is low, this relationship is particularly strong. When social support is high, the relationship weakens.

One way in which to frame these findings is to consider how women’s need for support changes as a result of stage of change. Brown (1986) proposes that social support consists of social interactions that create stable meanings for the individual that result in an improved adjustment to life transitions and changes. When women leave violent relationships, they are losing a possible source of support—their spouse. Although suffering abuse from their partner, women may find them to be a source of social support. The loss of this important relationship may increase, rather than alleviate, women’s symptoms of depression. She needs alternative sources of social support more in the time after leaving the relationship than when involved in the relationship. Women with higher levels of satisfaction with social support report fewer symptoms of depression than women with lower levels of satisfaction with social support. The implications of this finding are that women need ongoing supportive services after they leave their relationship. Although the initial crisis is over, many treatment needs remain.

This research has also found that women in higher stages of change have higher ratings of depression. Scores on both depression measures are clinically meaningful across relationship status groups. Social support plays a moderating role in the relationship between stage of change and depression by
strengthening the relationship between stage of change and depression under low levels of social support. When amount of social support is low, women in lower stages of change report much fewer depressive symptoms while women in higher stages of change report more severe symptoms of depression. Under high levels of social support, stage of change remains about the same, regardless of severity of depression. When amount of social support is low, women's depression increases when they are more likely to have left the relationship (because they are in a higher stage of change). This is consistent with research that has found that lack of social support increases depression. When women do not have social support networks in place and leave their partner, who may be their only source of support, they are more vulnerable to experiencing severe symptoms of depression. When social support is high, the relationship between stage of change and depression weakens. This emphasizes the importance of evaluating both depressive symptoms and amount of social support when treating battered women. Building strong social support networks for battered women increases their capacity and self-efficacy to seek and maintain safety from their violent relationship.

Comparisons between the HDSQ and BDI-II

As was expected, the BDI-II and the HDSQ are significantly correlated. As a result of this high correlation, it is likely that they share a large amount of variance in the statistical model. The results comparing the two depression measures found that the combination of both did significantly predict stage of change. However, when examined independently, neither significantly predicted
stage of change.

The finding that both the HDSQ and BDI-II measures of depression predict stage of change is valuable, despite the fact that neither measure makes a unique contribution. Women reported clinically meaningful scores on both measures across length of time out of the relationship. On the HDSQ, women reported clinically meaningful scores across all groups and on the BDI-II, women reported clinically meaningful scores in all groups except those out more than 3 years. Clearly, each of these measures provides useful information regarding depression in battered women. The HDSQ may provide more clinically meaningful information for women out of their relationship more than 3 years. Perhaps the HDSQ is capturing the hopelessness component at this time in women's decision-making process that the BDI-II misses. The fact that both measures together significantly predict stage of change suggest an advantage to using both in clinical practice.

Interventions targeted towards battered women may not consider the role that experienced depression plays in a woman's decision to leave her relationship and maintain or seek safety. The awareness that depression is an important factor to address when treating battered women is in itself a contribution. A surprising finding is that depression seems to increase along with stage of change. Women who are in maintenance have clinically meaningful depression scores on both the HDSQ and BDI-II. The exception in that women out of their relationship for more than 3 years do not report clinically meaningful depression on the BDI-II, though they do on the HDSQ. It appears that
depression plays a role in all stages of women’s decision-making process. Perhaps hopelessness depression plays a larger role in a woman’s decision to return to her relationship than it does during her decision to leave. Since many maintenance questions on the URICA target relapse potential, it is possible that the women experiencing hopelessness depression are also vulnerable to relapse. Hopelessness depression scores may provide useful information regarding a women’s relapse potential. Since depression appears to play a significant role in all stages of the decision-making process and may place women at risk to return to their violent relationship, assessing and properly treating hopelessness depression may increase the capacity and self-efficacy to seek and maintain safety from the abuser.

One reason that neither measure made an independent contribution to stage of change may be that they are highly correlated with each other. Clearly, both the HDSQ and BDI-II predict stage of change together, but this research was not able to determine whether Hopelessness Depression makes a significant unique contribution to stage of change because of the multicollinearity issue. When one or more predictor variables are highly correlated, this results in less stable partial regression coefficients, greater standard errors and confidence intervals, which reduce the likelihood of finding statistical significance. This has been described as the “catch-22” of multiple regression (Grimm & Yarnold, 1995). An advantage of using multiple regression is that it can statistically control for the effects of individual predictor variables. The most reasonable predictor variables to use, based on theoretical considerations, tend to be correlated.
According to Grimm & Yarnold (1995), eliminating predictor variables because they are correlated is not a useful solution because removing key variables from the regression equation also creates statistical difficulties and reduces the utility of the statistical method. They suggest that when multicollinearity is an issue, the results of the statistical analysis should be interpreted conservatively.

In this case, the BDI-II accounts for slightly more variance than the HDSQ. Neither measure accounts for a large portion of the variance ($r^2 = .13$), regardless of whether the effects are considered together or alone. Although depression is a key piece of the prediction of stage of change, there are likely other variables involved. Further research is needed to evaluate the best way to assess the components of Hopelessness Depression that are unique to the construct. Given the considerable overlap between the two measures, this will be a challenging task.

**Clinical Implications**

Domestic violence is an issue that has been gaining increased attention in the literature. There are many consequences of domestic violence for women, including physical, emotional, and financial losses. There are resources established to assist women once they have left their relationship, but little is known about the process a woman goes through when considering leaving. This research examines issues related to the decision-making process and how depression affects a woman’s decision to leave or stay in a violent relationship. Understanding more about a woman’s decision-making process will assist in developing more effective interventions. This theory proposes that targeting
interventions to a woman’s stage of change will increase the likelihood that she
will be successful in the leave-taking process. This also includes framing her
leave-taking process as a dynamic process of decision-making rather than more
pejorative or judgmental traditional views. The Transtheoretical Model allows for
lapses as an inherent part of the change process. This information will be helpful
to providers of services to battered women who often become frustrated when
women return to their abusers, often more than once, and may assist family and
the women themselves in better understanding the challenges of change.

Since the hopelessness model of depression is derived from the Learned
Helplessness model of depression (Seligman, 1975), it applies very easily to
battered women. Lenore Walker (1984) first applied the concept of learned
helplessness to battered women. The application of hopelessness depression to
the experience of battered women extends this research in a new and very
promising direction. A better understanding of how depression, particularly
Hopelessness Depression, affects a woman’s decision to leave a violent
relationship has important implications for treatment of women who are in or
have left violent relationships. The current study found that hopelessness
depression is a critical mental health issue for battered women. Women reported
clinically meaningful depression scores, even when they had been out of their
relationship for more than 3 years. Clearly, depression is not a temporary
reaction to the violent relationship or leave-taking. This study suggests it is a
chronic mental health issue for battered women that needs to be addressed at all
points in the decision-making process.
Several variables were found to significantly increase hopelessness depression scores. Women with a history of child sexual abuse, who experienced a higher severity of violence, had one or more previous violent relationships, remained in the relationship longer, and reported a lack of social support reported higher depression scores. This is very valuable information for the helping professionals who work with battered women because it provides a framework to guide the assessment and treatment of hopelessness depression in this population. This provides some information regarding what exactly women may be hopeless about. Additional insight is gained from women's own statements regarding their relationships. They report feeling hopeless about ever finding happiness, "I don't believe in things turning out, getting past the worst", "when I was little I remember thinking, well, you just grow up and you get married, and you get beaten". They also report feeling hopeless about obtaining help from others, "it seems as though people who weren't in a situation like that really aren't that interested". Finally, the reported hopelessness about their ability to leave their relationship, "since it didn't work out that time, it never crossed my mind to leave him, until much, much later."

Understandably, much of the focus of treatment with battered women involves encouragement to seek and maintain safety from the abuser. Helping professionals are concerned for her welfare and actively strive to support her attempts to leave and remain out of the violent relationship. It becomes extremely frustrating for helping professionals, however, when women choose to return to the abuser. It is helpful for providers, and less pathologizing for battered women,
to view the return as a relapse that sets the stage for another, likely more successful, attempt at leaving. This also may lessen the hopelessness experienced by battered women, their families, friends, and helping professionals.

The current study has provided evidence that hopelessness depression is an important factor in battered women’s decision-making process. The experience of hopelessness depression likely places battered women at risk for relapse by reducing her motivation and hope for the future. When working with a battered woman, the intake process should include assessment of hopelessness depression and stage of change. Women who report clinically meaningful depression should be provided with appropriate referrals for psychotherapy and to evaluate the need for medication. Addressing depression early in treatment may improve women’s hope and capacity and self-efficacy to seek and maintain safety.

In addition, treatment guidelines need to be developed to specifically address battered women’s needs at all stages of the decision-making process. If the intake assessment identifies women as being in contemplation, treatment should include recognition of stage-based challenges to change. For example, the current research has found that women with children tend to stay in the violent relationship longer because they do not want to deprive their children of a father figure. Providing psychoeducation regarding the effects that witnessing violence has on children may counter this challenge and increase the likelihood of movement from contemplation to preparation. Although it is tempting,
interventions that address action-oriented activities such as making preparations to leave the relationship should be avoided until a higher stage of change is reached.

This approach to the assessment and treatment of battered women is unlike the usual interventions used in most clinical practice and may encounter some opposition because the prevailing treatment values identify leaving the relationship as the most critical goal. While this may be an important outcome, the current research suggests that women’s capacity and self-efficacy to initiate and maintain leave-taking may be greatly enhanced by efforts to address hopelessness depression and target interventions toward women’s readiness to change.

An interesting finding is that this study found support for the hypothesis that stage of change significantly predicts hopelessness depression. Although levels of hopelessness depression did not differ for relationship status groups, stage of change does differentiate and is able to predict hopelessness depression. This raises interesting questions regarding depression in battered women. It also provides additional support for the use of stage of change when developing interventions for battered women.

Hopelessness Depression scores do not significantly differ across relationship status groups, although BDI-II scores do differ. For hopelessness depression scores, women report clinically meaningful scores even when they have been out of their relationship for more than 3 years. Women experience depression for many years after the violent relationship. Depression affects the
decision to leave a violent relationship and also lingers on long past the end of the relationship. Depression needs to be a significant consideration in the treatment of battered women, both during the battering and long afterward.

This study hoped to provide support for the HDSQ as a more effective tool than the BDI-II for measuring depression in this population. Support was not found for this hypothesis. However, this study did find that both measures of depression significantly predict stage of change and had meaningful relationships with other aspects of decision-making and treatment planning. The study found some support for the use of the HDSQ as an adjunct to the more commonly used BDI-II. Used together, they provide valuable information about depression in battered women.

Limitations

One limitation of this study is the homogeneity of participants. Due to the fact that the research was conducted in a rural area in Montana, participants were primarily Caucasian women of a low to middle class background. A greater diversity of participants may provide additional insights into the full range of experience of domestic violence.

The majority of participants had left their violent relationship and been out for at least 1 year. A limitation of this study, as in other similar studies (Lerner & Kennedy, 2000; Kennedy, 1999; Kennedy, 1996), is that there are a limited number of participants who are currently in their relationship. In order to more completely understand the full extent that stage of change and Hopelessness Depression play in a woman's decision to leave a violent relationship, a more
evenly distributed range is desirable.

Another limitation of this study is the difficulty of measuring the small differences in variance between the BDI-II and the HDSQ. The two measures are highly correlated and share a lot of variance. Because of this, it is difficult to determine the unique contribution that each makes to predicting stage of change. It is possible that, because the effect size being examined is small, that this study does not have sufficient power to detect small differences. When initial power analyses were performed, they indicated that, with the current sample size, the study has a power of .85 to detect effect sizes of at least .20. The effect size in this comparison is likely smaller than .20. Increasing the sample size would improve the power to detect small effect sizes and the likelihood of finding small differences that do exist.

Future Research

The findings of this study have provided new information on the role of Hopelessness Depression in a woman’s decision-making in a violent relationship. It has extended the knowledge available regarding the decision-making process and important influencing factors. Little to no research has been conducted investigating the actual application of learned helplessness theory to domestic violence. Learned helplessness in the form of hopelessness depression appears to play a distinctive role in women’s experience.

Social support plays an important role in the development of depression. Research has demonstrated that couples that report high levels of social support engage in less violence than couples with little social support. An interesting area
for further research is the relationship between amount of satisfaction with social support of the couple and levels of violence in those with violent relationships. Does increased social support buffer against violence?

Further examination of how the BDI-II and the HDSQ differ in their measurement of depression in this population would be useful. Because they share so much variance, their unique contributions to stage of change are difficult to determine. A larger sample size and perhaps a measure that more distinctly measures hopelessness could address these issues.

Women who are currently in their violent relationship have been hesitant to come forward to participate in these studies. To more completely understand women’s decision-making prior to leaving a violent relationship, more women from this group would provide more robust conclusions.
References


47(9), 1102-1114.


Hopelessness Depression

(Eds.), The Dark Side of Families: Current Family Violence Research, Beverly Hills: Sage.


Appendices: Consent forms, interview, and questionnaires
Consent for Participation-Psychology 100 Students

1. The purpose of this project is to investigate the experience of women in violent relationships.

2. You will be asked to respond to a series of questionnaires and an interview regarding your relationship. It typically takes approximately 2 to 3 hours to complete the interview and questionnaires. If you consent, the interviews will be audiotaped to aid in future transcription of the interview by the researcher or trained research assistants. The questionnaires, interview, and audiotape will be reviewed by the researchers and trained research assistants. The questionnaires and interviews will be used to better understand women’s experiences in violent relationships.

3. All information gathered for research purposes will be kept confidential. Confidentiality will be maintained throughout this process by assigning a code number to your records. Only the researchers and trained research assistants will have access to the questionnaires, interviews, audiotapes, and consent forms.

4. We expect to have collected and analyzed all data by December 2002. If you wish, you may receive the results of the overall project upon its completion by calling the Psychology Department at the University of Montana in Missoula at 243-4521 or by writing Heather Paluso, M.A. at the following address:
   Department of Psychology
   University of Montana
   Missoula, MT 59812

5. This project aims to better understand the decision-making process around staying in or leaving violent relationships. You may not directly benefit from participation, but your involvement may help in the development of assistance programs for women in such relationships.

6. Your involvement in this project is entirely voluntary. You may withdraw at any time without loss of research credits.

7. If you have any questions about this project, you can speak with Christine Fiore, Ph.D. or Heather Paluso, M.A. at 243-4521. You may also contact us by mail at the address listed above in point 4. Upon completion of the interview and questionnaires, a list of area resources will be provided to you.

8. No potential risks and discomforts are expected. However, you may feel some discomfort after talking about the violence you have experienced and after completing the measures. If you experience any discomfort, you may talk with the research assistant who interviewed you or contact Dr. Fiore or Heather Paluso, M.A., using the phone number and address provided above in point 4. In addition, you will be given a list of referrals within the community. Although this research does not entail any physical contact and risk of physical injury is considered minimal, the University of Montana extends to each research participant the following liability information:
"In the event that a participant is injured during the course of this research, he or she should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, the participant may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of the Administration under the authority of the M.C.A., Title 2, Chapter 9. In the event of a claim for such personal injury, further documentation may be obtained from University Legal Counsel."

I UNDERSTAND EACH OF THE ABOVE ITEMS AND AGREE TO PARTICIPATE IN THIS PROJECT.

__________________________________________  ____________
Signature of Participant  Date

I ________________________________ consent to have this interview audiotaped.

__________________________________________  ____________
Signature of Participant  Date
Consent for Participation-Community Participants

1. The purpose of this project is to investigate the experience of women in violent relationships.

2. You will be asked to respond to a series of questionnaires and an interview regarding your relationship. It typically takes approximately 2 to 3 hours to complete the interview and questionnaires. If you consent, the interviews will be audiotaped to aid in future transcription of the interview by the researcher or trained research assistants. The questionnaires, interview, and audiotape will be reviewed by the researchers and trained research assistants. The questionnaires and interviews will be used to better understand women's experiences in violent relationships.

3. All information gathered for research purposes will be kept confidential. Confidentiality will be maintained throughout this process by assigning a code number to your records. Only the researchers and trained research assistants will have access to the questionnaires, interviews, audiotapes, and consent forms.

4. We expect to have collected and analyzed all data by December 2002. If you wish, you may receive the results of the overall project upon its completion by calling the Psychology Department at the University of Montana in Missoula at 243-4521 or by writing Heather Paluso, M.A. at the following address:
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6. Your involvement in this project is entirely voluntary. You may withdraw at any time without loss of the $10 monetary reimbursement.

7. If you have any questions about this project, you can speak with Christine Fiore, Ph.D. or Heather Paluso, M.A. at 243-4521. You may also contact us by mail at the address listed above in point 4. Upon completion of the interview and questionnaires, a list of area resources will be provided to you.

8. No potential risks and discomforts are expected. However, you may feel some discomfort after talking about the violence you have experienced and after completing the measures. If you experience any discomfort, you may talk with the research assistant who interviewed you or contact Dr. Fiore or Heather Paluso, M.A., using the phone
number and address provided above in point 4. In addition, you will be given a list of referrals within the community.

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I UNDERSTAND EACH OF THE ABOVE ITEMS AND AGREE TO PARTICIPATE IN THIS PROJECT.

__________________________________________  __________________________
Signature of Participant                      Date

I ________________________________ consent to have this interview audiotaped.

__________________________________________  __________________________
Signature of Participant                      Date
Interview

Interviewer ____________ Location ________________ ID# ________

We are studying women’s experience of violent relationships and your responses, needs, and beliefs. We understand that talking about the relationship you are in may be difficult for you. Feel free to take your time and to present information as best as you are able. Also know that you can take a break, ask questions, or let us know any particular needs and/or feelings you may experience while being interviewed.

1. Please tell me about the (violent) relationship you (are/were) in:

   a. When did the violence begin? (Time)

   b. (Have you/did you) ever (left/leave)? Y N (If so, go to 2; if not, go to 3).

      b1. Temporarily or permanently? (Circle).

         _____# of times (if temp) _____# of times (if perm)

2. a. If you ever left your partner, where did you go?

       Friend       Relative       Shelter Motel/hotel       Other   N/A

   b. If you left more than one time, what would you describe as the reason(s) for returning?

       Love       Fear       Financial       Children       Family

       Religion   Personal beliefs   Friend       Peer pressure       Other

       N/A

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c. If you left permanently, what would you describe as the reason(s) you left for good?

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d. If you left temporarily, what would you describe as the reason(s) you left?

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e. Was there a turning point for you in your decision...a specific situation or realization that might have occurred? Y N

What?

f. (Have you/did you) ever (threatened/threaten) to leave?

Never Once Sometimes Often

g. **If the woman has children, ask:

What role do you think your children played in your decision?

3. a. ***Only ask this question if it appears that they are still in the violent relationship.

What would you describe as your reason(s) for staying in the relationship?

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4. (Is there/was there) anything that (would change/would have changed) your mind about staying/leaving? Y N

If so, what?
5. Was there any violence in your family when you were growing up?   Y   N
   Did the violence include sexual abuse?   Y   N
   Of whom/by whom?

   Any violence outside your family?   Y   N
   Did the violence include sexual abuse?   Y   N
   Of whom/by whom?

6. Do you have anyone that you (seek/sought) support from or talk to about the relationship?
   Y   N
   Who?
   Family     Friend     Therapist     Religious leader
   Shelter staff     Support group     Other

7. (Has your/was your) family been supportive?   Y   N
   What have they done?

8. Have your friends been supportive?   Y   N
   What have they done?

9. Have you sought any community support specifically in regard to your relationship?
   Y   N
   What? (Legal, Battered Women’s Shelter, Counseling, Religious, Financial, etc.)
   Where?
   From whom?

10. If you sought counseling, was it helpful?   Y   N
    Why or why not?
    (If not already clear, ask): How was it helpful?
11. Which of the supports have been the most helpful for you?
(Legal, Battered Women’s Shelter, Counseling, Religious, Financial, Friends, Family)

Why?

12. (Is/was) there anything or anyone that interfered with you accessing community
resources?  Y  N
Who or what?

13. Are there any sources of support that you would not turn to again?  Y  N
Why?

14. Have you ever felt the need to keep the violence secret from others?  Y  N
Who?

Why?

15. Who did you first disclose your abuse to?

How long after the start of the violence?

If not immediate, what kept you from telling anyone?

16. What (do you/did you) do to keep yourself safe or protect yourself?

17. **If they have not told you specifically about the nature of the physical violence
(pushed, slapped, hit, kicked), ask NOW:
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Would you feel comfortable telling me exactly what was the nature of the physical violence you (experience/experienced)?

Have you ever needed medical attention due to this violence?  Y   N

18. (Do you/did you) have a limit to what behavior you would tolerate in your relationship?  Y   N  
(If yes:) What?

Was your limit expressed to your partner?  Y   N  
(If yes:) When?  With what consequences?

19. (Are/were) either you or your partner involved with drugs and/or alcohol?  Y   N  
(If yes:) Who?

What role do you believe they (play/played)?

20. (Are/were) either you or your partner experiencing any particular stress?  Y   N  
(If yes:) What?

21. **If you are unsure if she has children, ask now. If she does ask:
   During pregnancy, was there any change in the level of violence?  Y   N

   How?

22. (Are/were) there specific reasons that the violence would occur?  Y   N  
Could you give me examples?

23. What are your feelings for your partner at the present time?
24. **If they have left their relationship, ask the following questions:
   a. Do you still have contact with your partner? Y N
   b. How much?
   c. What is it like for you?
   d. (If they have children, add:) Do your children (does your child) still have contact with your partner? Y N
   e. How much?
   f. What is that like for them? How do they feel about it?
   g. What is that like for you?

25. What do you believe would be most helpful for you in regard to this/that relationship at this time?

26. What influence do you believe this/that relationship has had on you?

27. a. Have you ever experienced a sense of shame related to this (violent) relationship? Y N
   (**If yes, continue. If no, go on to #27f.)
   b. To what would you credit these feelings of shame? (if she seems confused, say “what do you think was the cause of these feelings of shame?”)
   c. What role, if any, has shame played in your experience?
      1. In leaving the relationship?
2. In seeking help from others?

3. In talking to others?

d. What (could have helped/could help) to decrease your feelings of shame?

e. Are you currently experiencing feelings of shame? Y N
(If no, go on to #27e(2)).

(1) What level on a scale from 1 to 10 (1 = no shame and 10 = complete shame)?

(2) What level of shame did you experience during the relationship on a scale from 1 to 10?

(3) (Skip this if answered no to 27e) Why do you think you are experiencing shame right now?

f. What is your definition of shame?

28. a. Have you ever experienced guilt related to this (violent relationship)? Y N
(If yes, continue. If no, go on to #28f.)

b. To what would you credit these feelings of guilt? (if she seems confused, say “what do you think was the cause of these feelings of shame?”)

c. What role, if any, has guilt played in your experience?

1. In leaving the relationship?

2. In seeking help from others?

3. In talking to others?
d. What (could have helped/could help) to decrease your feelings of guilt?

e. Are you currently experiencing feelings of guilt? Y N
   (If no, go on to #28e(2)).
      (1) What level on a scale from 1 to 10 (1=no guilt and 10=complete guilt)?
      (2) What level of guilt did you experience during the relationship on a scale from 1 to 10?
      (3) (Skip this if answered no to 28e) Why do you think you are experiencing guilt right now?

f. What is your definition of guilt?

g. In your opinion, do shame and guilt differ? Y N
   If yes, how do they differ?

29. We have completed the interview.
   Do you have anything that you would like to add that I did not ask about?

30. If we were to do a follow up study on the effects of DV on children, would you be willing to participate? Y N

   In your opinion, what would be the best way to recruit women and their children for that study?
31. Do you have any questions? Concerns? Y    N
If yes, what questions/concerns do you have?

How are you feeling right now?
Demographic Questionnaire

We would like some general background information about you and your partner who has been violent. If the violence occurred in a past relationship, please provide information about that partner and your relationship.

1. a. In the past, have you ever been married, lived as a couple, or dated someone who has shoved, slapped, hit, or kicked you, or physically hurt or threatened you in some other way? Please refer to the most recent past violent relationship you have been in. (Check one)
   - No, not in the past (If no, talk to interviewer)
   - Yes, was married but now separated
   - Yes, was married but now divorced
   - Yes, was living as a couple
   - Yes, dating

   b. If yes, how long were you in this relationship?
   - Years
   - Less than a year?
   - Months
   - Not applicable

   c. If yes, did you ever leave your partner who had been violent?
   - Yes
   - No
   How many times did you leave your violent partner?

   d. How long ago did this relationship end? (Check one)
   - Less than 1 month ago
   - 1 to 2 years ago
   - 6 months to 1 year ago
   - Over 3 years ago

   If over 3 years ago, how many years ago did the relationship end?
   - Years

   e. Have you been in other violent relationships in the past?
   - Yes
   - No
   If “yes”, how many?

For the remainder of the questions, please refer to your most recent past violent relationship.

2. How long ago did the last violent incident occur? (Please fill in one blank with a number)
   - Days ago
   - Months ago
   - Years ago

3. Where were you living at the time of the violence? (Check one)
   - In a town/city
   - Out in the country
   - Both

4. a. Do you still have contact with your partner who has been violent?
   - Yes
   - No

   If you answered “no” to this question, please skip 4b-f and go on to #5.

   b. If yes, how often do you still have contact? (Check one)
   - Daily
   - 4 to 5 days per week
   - 2 to 3 days per week
   - Once a week
   - Once a month
   - Once every couple of months
   - Once every 6 months (more on next page)
   - Once a year
   - Once every 2 years
   - Less often: Please specify ____________

   c. If yes, how would you rate your level of stress surrounding these meetings?

   
   1  2  3  4  5
   Not stressful Somewhat stressful Moderately stressful Very stressful Extremely stressful

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d. If yes, how would you rate your level of fear surrounding these meetings?

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<th>3</th>
<th>4</th>
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<tr>
<td>Not fearful</td>
<td>Somewhat fearful</td>
<td>Moderately fearful</td>
<td>Very fearful</td>
<td>Extremely fearful</td>
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e. Is violence still involved?  
______ Yes  
______ No

f. For what reasons do you still have contact with your partner who has been violent?

__________________________

5. Your age now?  
__________________________

6. a. Your gender? (Circle one)  
______ M  
______ F

b. The gender of your partner who has been violent? (Circle one)  
______ M  
______ F

7. Your education completed? (Check one)  
______ Eighth grade or less  
______ Some high school/GED  
______ High school graduate  
______ Some college/vocational school  
______ College graduate  
______ Some graduate school  
______ Graduate degree

Your partner’s education? (Check one)
______ Eighth grade or less  
______ Some high school/GED  
______ High school graduate  
______ Some college/vocational school  
______ College graduate  
______ Some graduate school  
______ Graduate degree

8. Are you currently employed? (Check one)  
______ Yes, full-time  
______ Yes, part-time  
______ Homemaker  
______ No, unemployed  
______ Student only  
______ Student and employed

Was your partner employed? (Check one)
______ Yes, full-time  
______ Yes, part-time  
______ Homemaker  
______ No, unemployed  
______ Student only  
______ Student and employed

9. Were you employed at the time that the violence took place? (Check one)
______ Yes, full-time  
______ Yes, part-time  
______ Homemaker  
______ No, unemployed  
______ Student only  
______ Student and employed

If you were employed, what was your occupation (at the time of the violence)?

__________________________

10. If he was employed, what was the occupation of your partner while you were together?

What is his occupation currently?  
__________________________

11. How many children did you have at the time of this relationship? ________

If any, what are their ages/genders? / / / / / / / / / / / / / / /

How many children were born out of this relationship? ________

How many lived at home during the violence? ________

How many children do you have now? ________
If any, what are their ages/genders? __ __ __ __ __ __ __ __

If you do not have any children, please skip to #15.

13. If you do have children, how many are still living with you at home? __________
   If any, what are their ages/genders? __ __ __ __ __ __ __ __

14. a. If you had children at the time of the violent relationship, did they see the violence between you and your partner?
   ______Yes ______No

   b. If yes, what do you think were the effects of seeing the violence for your children?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

   c. If yes, have your children received any services related to the exposure to the violence?
   ______None ______Support groups
   ______Shelter activities ______Therapy/counseling
   ______Foster care/group home placement ______School counseling
   ______Other: Please specify __________________________________________________________________________

   d. If yes, have you talked to your children about the violence?
   ______Yes ______No   What did you tell them about the violence?
   (Space on next page to answer this question)
   __________________________________________________________________________
   __________________________________________________________________________

   e. Do your children still have contact with your partner who has been violent?
   ______Yes ______No

   If yes, how often do they have contact? (Check one)
   ______Daily ______Once every couple of months
   ______4 to 5 days per week ______Once every 6 months
   ______2 to 3 days per week ______Once a year
   ______Once a week ______Once every 2 years
   ______Once a month ______Less often: Please specify __________
15. What was your own annual income before taxes during the violent relationship you were in? (Check one)
   _______None
   _______$5,000 or less If you do not know your annual income, how much did you make per hour? __________________________
   _______$5,001 to $10,000
   _______$10,001 to $15,000
   _______$15,001 to $20,000
   _______$20,001 to $25,000
   _______$25,001 to $30,000
   _______$30,001 to $35,000
   _______$35,001 to $40,000
   _______$40,001 to $45,000
   _______$45,001 to $50,000
   _______More than $50,000

16. What was your annual family annual income before taxes during the violent relationship you were in? (Check one)
   _______None
   _______$5,000 or less
   _______$5,001 to $10,000
   _______$10,001 to $15,000
   _______$15,001 to $20,000
   _______$20,001 to $25,000
   _______$25,001 to $30,000
   _______$30,001 to $35,000
   _______$35,001 to $40,000
   _______$40,001 to $45,000
   _______$45,001 to $50,000
   _______More than $50,000

17. Who was the primary breadwinner during the violent relationship? (Check one)
   _______You
   _______Your violent partner
   _______Other

18. Your race? (Check one)
   _______White
   _______Hispanic
   _______American Indian
   _______African-American
   _______Asian
   _______Other (If more than one, please list)

19. The race of your partner who has been violent? (Check one)
   _______White
   _______Hispanic
   _______American Indian
   _______African-American
   _______Asian
   _______Other (If more than one, please list)
20. a. To what degree did you access each of these resources? Circle the number that best applies.

1 = Not at all  
2 = Very little  
3 = Somewhat  
4 = Often  
5 = Very much

<table>
<thead>
<tr>
<th>Resource</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td>Police?</td>
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<td>Counseling/therapy?</td>
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<td>Shelter (BWS)?</td>
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<td>Support groups?</td>
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<tr>
<td>Neighbor?</td>
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</table>

b. How helpful were each of these resources? Circle N/A if you did not seek services from this resource. Circle the number that best applies.

1 = Not helpful  
2 = Somewhat helpful  
3 = Helpful  
4 = Very helpful  
5 = Extremely helpful

<table>
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<tr>
<th>Resource</th>
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<td>Support groups?</td>
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<td>Church?</td>
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<td>N/A</td>
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<tr>
<td>Support Type</td>
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<tr>
<td>Medical?</td>
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<td>N/A</td>
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<td>Crisis helpline?</td>
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<td>N/A</td>
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<tr>
<td>Neighbor?</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

c. If you did not access some or all of these supports, please tell us any helpful information about why you did not.

- 

- 

-
Stages 2

Please read each item below carefully. Answer each item as it best describes how you FEEL about your relationship RIGHT NOW. Please indicate the extent to which you agree or disagree with each statement. In each case, remember to think about how you feel RIGHT NOW, not how you have felt in the past or how you would like to feel. There are five possible responses. Please CIRCLE the answer that represents how much you agree or disagree with the statement for describing you right now.

1= strongly disagree/does not apply
2= disagree
3= undecided
4= agree
5= strongly agree

1. As far as I'm concerned, leaving my relationship is not an option. 1 2 3 4 5
2. I think about leaving, but haven't made any moves yet. 1 2 3 4 5
3. I am doing something to prepare to leave my relationship. 1 2 3 4 5
4. I think it might be good for me to leave. 1 2 3 4 5
5. I am not the one who should leave. It doesn't make sense for me. 1 2 3 4 5
6. Since I've left, I have concerns about returning. 1 2 3 4 5
7. I am relieved to have left my relationship. 1 2 3 4 5
8. I have been thinking about what I need to do to be able to leave my relationship. 1 2 3 4 5
9. I have been successful at leaving my relationship and don't believe I will return. 1 2 3 4 5
10. At times I struggle with the thought of returning but I have stayed out this time. 1 2 3 4 5
11. Leaving my relationship is not realistic at this time. 1 2 3 4 5

NEXT PAGE
12. I guess I could leave, but I don’t believe I can follow through with it.

13. I am really working hard to stay out of this relationship.

14. I need to leave and I really am thinking seriously about how to do it.

15. I have left my relationship and don't feel I will return.

16. I have not been able to stay away from my partner as I had hoped, but I am working hard to end the relationship.

17. Even though it has been hard for me to leave, I am continuing to stay out of my relationship.

18. I thought once I left I would be done with my relationship, but I sometimes still find myself struggling with my decision.

19. I wish I had more ideas about how I could leave.

20. I have started to consider leaving, but I would like help.

21. Maybe others will be able to help me with leaving.

22. I may need support right now so that I can stay out of my relationship.

23. I may be a part of the problem in my relationship, but I don't think that I am.
1 = strongly disagree/does not apply
2 = disagree
3 = undecided
4 = agree
5 = strongly agree

24. I hope that someone will be able to provide me with good advice about how to leave. 1 2 3 4 5
25. Anyone can talk about leaving. I have actually done it. 1 2 3 4 5
26. All the talk about leaving is unnecessary. I am not considering it. 1 2 3 4 5
27. I am working to stay out of violent relationships. 1 2 3 4 5
28. It is frustrating, but I feel I might be in another violent relationship. 1 2 3 4 5
29. I worry about my relationship, but others worry about theirs too. I prefer not to think about it. 1 2 3 4 5
30. I am actively staying out of my relationship. 1 2 3 4 5
31. After having done everything to leave my relationship, every now and then it comes back to haunt me. 1 2 3 4 5
32. I'd rather learn how to cope with my partner than to leave my relationship. 1 2 3 4 5

THANK YOU.
SSQ-VI

Instructions:

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list directly onto the questionnaire all the people you know, excluding yourself, whom you can count on for support in the manner described. List the persons' initials and their relationship to you (e.g., parent, sibling, friend, teacher, etc.). Do not list more than one person next to each of the letter beneath the question.

Next, on your bubble sheet, record the total number of persons using the following scale:

**HOW MANY:**

A = no one
B = one person
C = two people
D = three people
E = four people
F = five people
G = six people
H = seven people
I = eight people
J = nine people

For the second part, indicate how satisfied you are with the overall support you have using the following scale:

**HOW SATISFIED:**

A = very dissatisfied
B = fairly dissatisfied
C = a little dissatisfied
D = a little satisfied
E = fairly satisfied
F = very satisfied

NOTE: If you had no support for a question, bubble in "A" for "no one" but still rate your level of satisfaction. Please answer all the questions as best you can.

1. Who can you really count on to be dependable when you need help?

   A) NO ONE
   B)
   C)
   D)
   E)
   F)
   G)
   H)
   I)
   J)
2. How satisfied?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>

3. Who can you really count on to help you feel more relaxed when you are under pressure or tense?

A) NO ONE

B) F)

C) G)

D)

4. How satisfied?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>

5. Who accepts you totally, including both your worst and best points?

A) NO ONE

B) F)

C) G)

D)

6. How satisfied?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>

7. Who can you really count on to care about you, regardless of what is happening to you?

A) NO ONE

B) F)

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8. How satisfied?

Very Dissatisfied  A  B  C  D  E  F  Very Satisfied

9. Who can you really count on to help you feel better when you are feeling generally down-in-the-dumps?

A) NO ONE  E)  H)  
B)  F)  I)  
C)  G)  J)  
D)  

10. How satisfied?

Very Dissatisfied  A  B  C  D  E  F  Very Satisfied

11. Whom can you count on to console you when you are very upset?

A) NO ONE  E)  H)  
B)  F)  I)  
C)  G)  J)  
D)  

12. How satisfied?

Very Dissatisfied  A  B  C  D  E  F  Very Satisfied
HDSQ

Instructions:

On this questionnaire are groups of statements. Please read all of the statements in a given group. Then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number of the statement you have chosen. If several statements in the group seem to apply equally well, circle the highest number that applies for that group. Be sure that you do not choose more than one statement for any group. BE SURE TO READ ALL OF THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1.
0 = I have not stopped trying to get what I want.
1 = I have stopped trying to get what I want in some situations.
2 = I have stopped trying to get what I want in most situations.
3 = I have stopped trying to get what I want in all situations.

2.
0 = I am not passive when it comes to getting what I want these days.
1 = In some situations I am passive when it comes to getting what I want these days.
2 = In most situations I am passive when it comes to getting what I want these days.
3 = In all situations I am passive when it comes to getting what I want these days.

3.
0 = I have not given up trying to accomplish what’s important to me.
1 = I have given up trying to accomplish some things that are important to me.
2 = I have given up trying to accomplish most things that are important to me.
3 = I have given up trying to accomplish all things that are important to me.

4.
0 = My motivation to get things done is as good as usual.
1 = In some situations, my motivation to get things done is lower than usual.
2 = In most situations, my motivation to get things done is lower than usual.
3 = In all situations, my motivation to get things done is lower than usual.
5.

0 = I need little or no support from other people.
1 = I need some support from other people.
2 = I need a lot of support from other people.
3 = I need total support from other people.

6.

0 = I don’t rely on other people to do things for me.
1 = Sometimes I rely on other people to do things for me.
2 = Most of the time I rely on other people to do things for me.
3 = All of the time I rely on other people to do things for me.

7.

0 = These days I am not overly dependent on other people.
1 = Sometimes these days I am overly dependent on other people.
2 = Most of the time these days I am overly dependent on other people.
3 = These days I am always overly dependent on other people.

8.

0 = I am not a burden to other people.
1 = I am a burden to other people sometimes.
2 = I am a burden to other people most of the time.
3 = I am a burden to other people all of the time.

9.

0 = I am not doing things in “slow motion” these days.
1 = Sometimes I do things in “slow motion” these days.
2 = Most of the time things in “slow motion” these days.
3 = I always do things in “slow motion” these days.

10.

0 = I do not walk around like a zombie these days.
1 = Sometimes I walk around like a zombie these days.
2 = Most of the time I walk around like a zombie these days.
3 = I always walk around like a zombie these days.
11.

0 = My speech is not slowed down.
1 = My speech is somewhat slowed down.
2 = My speech is very slowed down.
3 = My speech is extremely slowed down.

12.

0 = My thoughts are not slowed down.
1 = My thoughts are somewhat slowed down.
2 = My thoughts are very slowed down.
3 = My thoughts are extremely slowed down.

13.

0 = My energy is not lower than usual.
1 = My energy is somewhat lower than usual.
2 = My energy is much lower than usual.
3 = My energy is extremely lower than usual.

14.

0 = I can get things done as well as usual.
1 = In some situations I can’t get things done as well as usual.
2 = In most situations I can’t get things done as well as usual.
3 = In all situations I can’t get things done as well as usual.

15.

0 = I have as much energy as usual.
1 = In some situations I have less energy than usual.
2 = In most situations I have less energy than usual.
3 = In all situations I have less energy than usual.

16.

0 = I do not get tired out more easily than usual.
1 = In some situations I get tired out more easily than usual.
2 = In most situations I get tired out more easily than usual.
3 = In all situations I get tired out more easily than usual.
17.

0 = I enjoy things as much as usual.
1 = In some situations I don’t enjoy things as much as usual.
2 = In most situations I don’t enjoy things as much as usual.
3 = In all situations I don’t enjoy things as much as usual.

18.

0 = When doing things I normally enjoy (e.g., work; being with people) I have as much fun as usual.
1 = When doing things I normally enjoy (e.g., work; being with people) I have somewhat less fun than usual.
2 = When doing things I normally enjoy (e.g., work; being with people) I have much less fun than usual.
3 = When doing things I normally enjoy (e.g., work; being with people) I don’t have fun at all anymore.

19.

0 = When it comes to the things in life that count, I am as interested as usual.
1 = When it comes to the things in life that count, I am somewhat interested than usual.
2 = When it comes to the things in life that count, I am much less interested than usual.
3 = When it comes to the things in life that count, I don’t have any interest anymore.

20.

0 = I enjoy sex as much as usual.
1 = I enjoy sex somewhat less than usual.
2 = I enjoy sex much less than usual.
3 = I don’t enjoy sex at all anymore.

21.

0 = I do not have trouble falling asleep.
1 = It takes me somewhat longer to fall asleep than usual (i.e., up to one hour longer).
2 = It takes me much longer to fall asleep than usual (i.e., up to two hours longer).
3 = It takes me substantially longer to fall asleep than usual (i.e., more than two hours longer).
22.

0 = I do not have trouble sleeping through the night.
1 = Sometimes I have trouble sleeping through the night.
2 = Most of the time I have trouble sleeping through the night.
3 = I always have trouble sleeping through the night.

23.

0 = I do not wake up early in the morning and have trouble falling back to sleep.
1 = Sometimes I wake up early in the morning and have trouble falling back to sleep.
2 = Most of the time I wake up early in the morning and have trouble falling back to sleep.
3 = I always wake up early in the morning and have trouble falling back to sleep.

24.

0 = I can fall asleep as well as usual.
1 = Sometimes I have trouble falling asleep.
2 = Most of the time I have trouble falling asleep.
3 = I always have trouble falling asleep.

25.

0 = My concentration is as good as usual.
1 = My concentration is somewhat less focused than usual.
2 = My concentration is much less focused than usual.
3 = I can hardly concentrate anymore.

26.

0 = I can concentrate as well as usual.
1 = In some situations I can not concentrate as well as usual.
2 = In most situations I can not concentrate as well as usual.
3 = In all situations I can not concentrate as well as usual.

27.

0 = I do not brood about unpleasant events these days.
1 = Sometimes I brood about unpleasant events these days.
2 = Most of the time I brood about unpleasant events these days.
3 = I always I brood about unpleasant events these days.
28.

0 = I am not distracted by unpleasant thoughts.
1 = In some situations I am distracted by unpleasant thoughts.
2 = In most situations I am distracted by unpleasant thoughts.
3 = In all situations I am distracted by unpleasant thoughts.

29.

0 = I do not have thoughts of killing myself.
1 = Sometimes I have thoughts of killing myself.
2 = Most of the time I have thoughts of killing myself.
3 = I always have thoughts of killing myself.

30.

0 = I am not having thoughts about suicide.
1 = I am having thoughts about suicide but have not formulated any plans.
2 = I am having thoughts about suicide and am considering possible ways of doing it.
3 = I am having thoughts about suicide and have formulated a definite plan.

31.

0 = I am not having thoughts about suicide.
1 = I am having thoughts about suicide but have these thoughts completely under my control.
2 = I am having thoughts about suicide but have these thoughts somewhat under my control.
3 = I am having thoughts about suicide and have little or no control over these thoughts.

32.

0 = I am not having impulses to kill myself.
1 = In some situations I have impulses to kill myself.
2 = In most situations I have impulses to kill myself.
3 = In all situations I have impulses to kill myself.
Conflict Scale-B

No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reasons. They also use different ways of trying to settle their differences. Please read the list below of some things that you and your spouse/partner might have done when you argue.

Please circle how often you or your partner did the following during any one year of your relationship. Circle "Ever?" if it did not happen during that year but happened at any time prior to or after the year you are describing.

1. Discussed the issue calmly.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

2. Got information to back up (your/his/her) side of things.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

3. Brought in or tried to bring in someone to help settle things.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

4. Argued heatedly, but short of yelling.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

5. Insulted, yelled, or swore at each other.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

6. Sulked and/or refused to talk about it.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

7. Stomped out of the room or house (or yard).
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

8. Cried.
   - YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   - PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?
9. Did or said something to spite the other one.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

10. Threatened to hit or throw something at the other one.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

11. Threw or smashed or hit or kicked something.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

12. Threw something at the other one.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

13. Pushed, grabbed, or shoved the other one.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

14. Slapped the other one.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

15. Kicked, bit, or hit with a fist.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

16. Hit or tried to hit with something.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

17. Beat up the other one.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

18. Threatened with a knife or gun.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

19. Used a knife or gun.
    YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
    PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?
20. Forced the other one to perform sexually against his or her will.
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

21. Other: ________________________________________
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

22. Other: ________________________________________
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

23. Other: ________________________________________
   YOU: Never 1 2 3-5 6-10 11-20 20+ Ever?
   PARTNER: Never 1 2 3-5 6-10 11-20 20+ Ever?

Thank you.