An examination of physical and non-physical abuse as correlates of depression and self-esteem in battered women

Patricia Ann Miskofski

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AN EXAMINATION OF PHYSICAL AND NON-PHYSICAL ABUSE AS
CORRELATES OF DEPRESSION AND SELF-ESTEEM
IN BATTERED WOMEN

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Patricia Ann Miskofski
June 2001
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ABSTRACT

Depression and low self-esteem are two of the most common psychological symptomology presenting in female victims of domestic violence. The purpose of this study was to empirically investigate the type of abuse victims experience and its links to their psychological distress. Women ranging in age from 19-63 (n = 30) were recruited from three domestic violence shelters to complete a questionnaire packet. It was hypothesized that women who were victims of non-physical violence were more likely to experience low self-esteem rather than depression. In victims who experienced physical abuse, there would be a greater prevalence of depression compared to low self-esteem. A Pearson product moment was conducted, but failed to significantly support the hypothesis. The data revealed that the women in the sample experienced twice as much non-physical abuse than physical abuse. Physical abuse and non-physical abuse were highly correlated. Depression and low self-esteem were highly correlated. This research indicates that clinical intervention programs utilized by domestic violence shelters and community agencies would benefit from incorporating similar self-report assessments into their treatment
approach. Methodological limitations and suggestions for future research were discussed.
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CHAPTER ONE
INTRODUCTION

Problem Formulation

After centuries of silence, gains are finally being made in understanding the phenomenon of domestic violence. It is only within the past 20 years that violence between intimates has been mentioned in the research literature. Now recognized as a public health and medical concern, the prevalence of domestic violence in American society and the impact it holds for the victims has been acknowledged by medical professionals, clinicians, and researchers alike (Briere & Elliott, 1997). The majority of this research has been published addressing the needs of battered women before, during, and after separation from their perpetrator (Briere & Elliott, 1997; Gelles, 1997). More recent studies however, have focused on the lasting and significant psychological effects of domestic violence. In particular, a number of researchers in the field of domestic violence report finding both low self-esteem and depression problems in battered women. Although anecdotal and clinical accounts have documented the existence of violence in some intimate relationships, estimates of the prevalence are difficult
to obtain mostly because women fear the consequences of disclosure. Still the phenomenon of domestic violence, although based on gross underestimation, has reached epidemic proportions. Every 15 seconds a woman is battered in the United States, and one-third of homicides are domestic violence related (SFTS, 1998). Conservative estimates suggest that at least 2 to 4 million women are assaulted by their male partners or ex-partners each year in the United States alone (Gelles, 1997). Worldwide, estimates suggest that one in three women will have experienced some form of abuse in her lifetime. On average, female victims leave the battering relationship and return approximately seven times before completely severing all ties with their abuser.

Comparatively, victimization effects found in children are devastating. Domestic violence implications have a long-term psychological impact on children. Within the last 5-10 years, witnessing domestic violence has been noted as a children’s mental health concern. Children who witness violence in the home are at risk to continue the violence as adults either as abusers or as victims (Briere & Elliott, 1997). The stress, which these children experience, can manifest itself somatically in headaches, asthma, insomnia, and eating problems (SFTS, 1998). In
some cases of wife abuse, the children are also physically or sexually victimized (Gold, 1997).

Battering is the use of physical, verbal, psychological and/or sexual force intended to control and maintain power over another person (Walker, 1979). The recurring abusive incidents usually escalate in frequency and severity and can result in serious physical harm, disablement or death to the victim. Domestic violence is the single most common source of injury to women. Many of the serious medical and psychological consequences resulting from the battering incident are initially observed by medical professionals. Female victims of partner violence end up in the hospital or health care system seeking medical attention for the abuse (Grigsby & Hartman, 1997; Hamberger & Ambuel, 1997). Frequently, the physical effects of battering are compounded by the emotional consequences. Many battered women who seek medical attention are diagnosed with depression (Cascardi & O’Leary, 1992; Gleason, 1993; Sato & Heiby, 1992). Some women report the physical violence was nothing compared to the psychological and emotional abuse endured.

Such trauma has been shown in the battered women’s research literature to result in a variety of abnormal psychological states for the victim. Consequently, wide
ranges of mental health problems have been documented. A few of the most common manifestations are posttraumatic stress disorder (PTSD), low coping capacity, high psychosexual dysfunction, generalized anxiety disorder, and obsessive compulsive disorder (OCD) (Hamberger & Ambuel, 1997). Psychological symptomology often associated with the aforementioned tend to present as depression, anxiety, low self-esteem, fear, isolation, guilt, and shame (Grigsby & Hartman, 1997; Peled, Eisikovits, Enosh, & Winstok, 2000).

In light of the physical, psychological, and emotional abuse women sustain, it’s no surprise victims experience psychological distress. A number of studies point to depression and low self-esteem as the most common psychological sequel of domestic violence abuse. Cascardi and O’Leary (1992), found repeated physical abuse and chronic emotional stress to have an enduring and profound causal effect on loss of self-esteem and the development of depression. Other research studies on domestic violence have established links between the victims’ depression and low self-esteem (Campbell, 1989; Cascardi & O’Leary, 1992; Sato & Heiby, 1992; Walker, 1984). One study reported depression rates to be four times higher in women who were severely assaulted compared to other women (Straus, 1987).
It appears from these findings that a relationship exists between abuse, frequency, severity and psychological impact.

Gender based violence has been linked to long-term health problems. Health care professionals often times are the first and only line of defense for victims. The percentage of patients that end up in the health care setting seeking medical attention due to partner victimization is equivalent to the number of women who have been victimized in the general population. Ironically, health care professionals rarely inquire about the abuse and further have little knowledge on how to help these women (Hamberger & Ambuel, 1997). "A therapist may be the only one to give the domestic violence victim the number to the local shelter" (Grigsby & Hartman, 1997, p. 490). For many women and children who are abused, domestic violence shelters are the only agency capable, willing, and able to provide assistance.

Fortunately, resources available to battered women have grown in recent years and are more readily accessible than in years past. Domestic violence shelters are available to women in cities all across the country (Walker, 1999). Commonly, shelters provide desperately needed community outreach, legal assistance, 24 hour
crisis hotlines, emergency food, and clothing to victims and their children (SFTSN, 1998). Shelter programs dedicated to helping these women provide important services such as individual counseling, women’s support groups, parenting support groups, and children’s groups. Paramount to the intervention process is empowering women through counseling, training, and education to create a life that is violence free. Hence, there is a growing need for clinicians working in domestic violence shelters who administer intervention to this fragile population to be able to diagnose depression, low self-esteem, and any other mental health disorders experienced by victims of domestic abuse.

Clearly, domestic violence can never be eradicated from our society as it is woven into its very fabric (Peled, et al., 2000). In the absence of any clear-cut resolution to the problem, the profession is forced to administer a reactive approach via a comprehensive intervention program designed to accommodate the growing demands of this population. After the bruises have healed, human service workers are left with the arduous task of administering treatment toward stabilizing victim’s mental health. In accordance, intervention must incorporate an empowerment-based focus and educational aspects intended
to facilitate victims taking back control of their lives, making decisions on their own (Peled, et al.), and increasing their self-esteem. Therefore, it is critical that clinical intervention programs are aware of and sensitive to the fact that both non-physical and physical abuse are likely to manifest in different disorders and to govern treatment plans accordingly.

The statistics on women who are victims of domestic violence are staggering. National statistics indicate that as many as 50% of all women in America experience violence in their intimate relationships (SFTS, 1998). Perhaps even more troublesome is the underreporting. Although it is impossible to assist individuals who deny or hide the problem and choose not to seek help, it is the ethical and professional responsibility of helpers to adequately assist the select few who are strong enough to break the cycle of violence. For many women who finally decide to leave the battering relationship, the only safe haven is a domestic violence shelter.

Problem Focus

There is now a groundswell of interest in the problem of domestic violence, of concern for studying it, and finding ways to cope with its impact on victims. In light
of the existing literature and research committed to helping victims, it is imperative that professionals be knowledgeable of presenting symptomology that coincides with domestic violence. Moreover, it is paramount that proper assessment and intervention programs are implemented within the shelters that are providing services to these women who enter with poor mental health. An examination of non-physical and physical abuse as correlates to low self-esteem and depression respectively, has the potential of providing an increased understanding in guiding effective clinical intervention programs in domestic violence shelters and other community agencies.

The purpose of this research study is to investigate empirically the type of abuse female victims of domestic violence experience and its link to their psychological distress. The study seeks to determine whether a dichotomy exists between the type of abuse inflicted and subsequent presenting psychological symptomology. First, it is hypothesized that victims of non-physical abuse will be more likely to suffer from low self-esteem than from depression. Second, in victims of physical abuse there will be a greater prevalence of depression than low self-esteem.
CHAPTER TWO
REVIEW OF THE LITERATURE

The social problem of domestic violence has been aimed at public awareness within the past two decades paralleling the evolution of the women's movement (Walker, 1979; Briere & Elliott, 1997; Peled et al., 2000). With victims seeking assistance in relation to abuse from a variety of community and agency settings, hospitals, family service agencies, public welfare agencies, and mental health settings (Davis, 1987), wife abuse is a social problem that can no longer be a private matter, but belongs in the social domain (Hamlin II, 1995). The process of giving social recognition and visibility to the phenomenon was inevitable.

Exact figures documenting the rate of domestic violence are difficult to ascertain. Part of the problem lies in the severe underreporting of intrafamily assaults. Estimates on the extent of domestic violence within the general population vary, but there is a growing consensus among researchers in the field that nearly 2 to 4 million women are abused yearly (Gelles, 1997). Sullivan and Bybee (1999) approximated that between 21% to 34% of all women
in the United States will be victims of intimate violence in their lifetime.

Domestic violence implications have a long-term psychological impact on children. Within the last 5-10 years, witnessing domestic violence has been noted as a children's mental health concern. Children who witness violence in the home are at risk to continue the violence as adults either as abusers or as victims (Briere & Elliott, 1997). The stress, which these children experience, can manifest itself somatically in headaches, asthma, insomnia, and eating problems (SFTS, 1998). In some cases of wife abuse, the children are also physically or sexually victimized (Gold, 1997).

Further, it is experienced more frequently by dating couples than married couples (Hamberger & Ambuel, 1997). Research by Williams (1992) found that partner abuse can be multicultural and exists on all socioeconomic levels.

To some extent, victims of spousal abuse will likely suffer emotionally, physically, psychologically (Williams, 1992), and spiritually (Walker, 1979). Existing research substantiated two of the most common presenting psychological consequences in battered women as depression and low self-esteem. Several studies indicated that women who were battered by their intimate partners experienced
moderate to high levels of depression (Cascardi & O'Leary, 1992; Follingstad, Brennen, Hause, Polek, & Rutledge, 1991; Gleason, 1993; Sato & Heiby, 1992). Some studies have established a link between depression and low self-esteem (Campbell, 1989; Cascardi & O'Leary, 1992; Sato & Heiby, 1992; Walker, 1984).

The literature on battered women describes and identifies the various characteristic traits resulting from the abuse, specifically depression and low self-esteem. However, efforts to establish the personality characteristics of women that predispose them to become victims have largely failed (Tutty, Bidgood, & Rothery, 1993). Campbell and Belknap (1997) espoused that rather than the abuse being seen as a consequence of the depression, it is usually conceptualized as the woman's reaction to it. Follingstad, Rutledge, Berg, Hause, and Polek (1990), found the frequency of the abuse served as a reinforcement to maintain the low self-esteem. While focusing on characteristics of the victim as predictors of victimization may no longer be appropriate (Tutty et al., 1993) the current study attempts to establish the possible relationship between type of abuse experienced and presenting psychological symptomology. These data are
beneficial to clinical intervention programs when administering and developing treatment for battered women.

Depression and Physical Abuse

Depression has consistently been found to be more prevalent in women compared to men. It can be life threatening to a woman in a dangerous situation because it impairs her ability to assess the circumstances accurately (Sato & Heiby, 1992). Existing research has found that as abuse escalates, so does the depression.

One of the pioneering studies measuring depression in battered women was performed by Walker (1984). Using the Center for Epidemiologic Studies—Depression Scale (CES-D) to measure depression in battered women, results revealed that battered women who left the battering relationship were more depressed than women who remained with their battering partner. Moreover, the depression persisted long after the battering circumstances ceased. Apparently, the actual loss of the relationship and its concomitant stressors seem to cause the depression to increase before it dissipates.

Campbell and Belknap (1997) examined the correlates and predictors of depression in 164 battered women. According to the Beck’s Depression Inventory, 28% of the
participants were moderately to severely depressed and 11% were severely depressed. Their findings suggested that physical abuse was an important part of the etiology of the sample's depression.

In 1993, Gleason found one of the primary responses in women who were battered in an ongoing intimate relationship to be depression. The sample included 62 battered women, 30 still living at home with or without their abuser and 32 women living in a domestic violence shelter. Some 63% of the women staying in the shelter and a staggering 81% of the women residing in personal residences were diagnosed with major depression. Gleason’s findings of depression, anxiety, PTSD, and OCD reflected the major components of Walker’s (1984) battered woman syndrome.

In another study linking physical abuse to depression, Follingstad et al. (1991) found physical violence was the only form of abuse that was a significant predictor of depression using a multiple regression analysis. Of 234 women recruited from a domestic violence shelter and other shelters, 77% reported experiencing depression. Contrary to Walker’s (1984) research, emotional stability returned to pre-relationship levels after the abuse ended.
Straus (1987) conducted a national epidemiological study of 6,002 families. Based on research statistics, it was estimated that 34 out of every 1,000 women were victims of violent acts (kicking, choking, use of a weapon) that posed serious risk or injury. Results indicated severely assaulted women had significantly higher rates of psychological disorders compared to other women and four times the rate of feeling depressed.

In a more recent study, Campbell, Sullivan, and Davidson II (1995) examined depressive symptoms in 146 women who used domestic violence shelters. Using a longitudinal design to examine changes in depression level over time, the CES-D was administered at 3 stages: upon intake, after 10 weeks, and again at 6 months. This group of researchers found a gradual decrease in depression levels. Upon entry, 83% of the women were mildly depressed. Only 58% were depressed 10 weeks later and in the following 6 months, 58% still measured mildly depressed.

Sato and Heiby (1992) analyzed depression levels in 136 Hawaiian women from various battered women’s groups and shelters. Participants reported physical victimization by a spouse or significant other within the past year. Data collected from a multi-scale questionnaire was used
to explore the concomitants of depressive symptoms reported by the women. Depression and depressive symptoms were a significant problem for 50% of the participants. Unlike Follingstad et al.'s (1991) research findings, abuse was not a significant predictor of depression. Through a simultaneous multiple regression analysis, negative self-reinforcement was found to be the strongest predictor of depression.

Self-Esteem and Emotional Abuse

Although physical forms of abuse and their impact on female victims have been extensively researched, psychological forms of abuse can be equally devastating. Emotional abuse can have long term debilitating effects on a woman's self-esteem and coping capacity (Ferraro, 1979). Battered women usually have low self-esteem, which may affect their interpretation of reality (Shamai, 2000) and compromise their safety. Follingstad et al. (1990) found that 99% of the battered women in their study had experienced some form of psychological abuse at least once. In comparing battered and non-battered women experiencing problems in their intimate relationships, Campbell (1989) found both to have significantly lower than normal levels of self-esteem. These findings
suggested that regardless of physical abuse, when there are serious problems in the relationship, the woman's sense of self is impacted.

In her early works, Walker (1979) identified three types of emotional abuse: jealousy, verbal harassment/criticism, and social isolation due to restriction. These were the three most frequently occurring types. However, five years later, Walker's (1984) sample of battered women described psychological degradation, fear, and humiliation as constituting the most painful abuse they experienced.

To place the psychological devastation of battering relationships into perspective, Walker (1979) makes the comparison between learned helplessness and depression in female victims of domestic violence. According to this study, the depressive state leaves the victim overwhelmed with hopelessness. She feels as if she lacks control for her own future. "Whatever confidence she once had in her own capabilities deserts her and she suffers from a massive ebbing away of her self esteem" (Walker, 1979, p.174). It should be noted however, that many women fight the depression to the very end. Unfortunately, for many victims desperate enough, suicide seems the only alternative.
Viewing wife abuse from a sociocultural perspective, self-esteem is attributed to the socialization process. According to this theory, social forces are in place that keep wives from leaving their abusive husbands. Women are socialized to believe their self-esteem is tied into their roles as wives and mothers, which creates psychological and economic dependence on their husband. An example of the traditionalist perspective toward sex role stereotypes is demonstrated in the sample used by Walker (1979).

Low self-esteem was at the top of a list characterizing the battered women interviewed by Walker (1979) for her book *The Battered Woman*. Walker writes, "because of their lowered sense of self esteem, these women typically underestimated their abilities to do anything... doubted their competence and underplayed any successes they had. They were in constant doubt about their abilities as housekeepers, cooks, or lovers" (Walker, 1979, p.32). Constant criticism by the abuser further exacerbates the issue of low self-esteem while "...adversely affecting their judgment... making her feel even more of a failure" (Walker, 1979 p. 32).

Follingstad et al., (1990) interviewed 234 battered women assessing the relationship of physical abuse to emotional abuse. Two hundred twenty nine women reported
having experienced at least one incident of emotional abuse. Emotional abuse was classified in 6 types: threats of abuse, ridicule, jealousy, threats to change marriage, restriction, and damage to property. Ridicule was experienced more than any other type (N = 211) and 85% claimed it has the most negative impact. Almost 46% rated ridicule as the worst type of emotional abuse to experience. Some women, 72% (N = 159), felt that the emotional abuse had a more severe impact on them than enduring the physical abuse. Accordingly, ridicule was the most destructive form of emotional abuse as it attacks the women’s sense of self-esteem, makes them believe they are not worthwhile, and destroys their ability to feel good about themselves. Moreover, as the emotional abuse increased overtime the negative effects increased and the women began to believe what the men said or the women felt the men were justified in their abusive comments.

Cascardi and O’Leary (1992) assessed the incidence and severity of depression, low self-esteem, and self blame in 33 women who were involved in a battering relationship during the study. Seventy percent of the women reported moderate to severe depression. Depressive symptomology and low self-esteem were highly correlated with the frequency and severity of physical aggression.
Battering had the greatest negative influence on self-esteem. They found that as the number, form, and subsequent consequences of physically aggressive acts increased, the depressive symptoms increased while self-esteem decreased.

Domestic Violence Shelters and Intervention

Wife abuse has been endemic for centuries. A review of the literature demonstrates societies' inadequate attempts at remedying domestic violence. Alternative institutions such as battered womens shelters were created by radical feminists in the 1960's and 1970's (Reinelt, 1995). By the 1980's, there was a rapid increase of shelters all over the country that played a crucial role in both sustaining and building the battered women's movement. Many womens' shelters endorse women leaving the battering relationship and rebuilding their lives without the interference of batterers. However, once the crisis is over, victims need to adjust to life as single women outside of the battering relationship without slipping into a serious depression.

In addition to their pivotal role with women who enter domestic violence shelters, shelters are developing outreach programs. Today, outreach services are becoming a
necessary component for domestic violence shelters to continue the provision of services to this fragile population while in the community. Shelter From The Storm (1998) reported assisting over 1,200 battered women and children not in need of shelter, and took over 3,000 calls on their 24-hour crisis hotline.

Sullivan and Bybee (1999) designed and evaluated a community based advocacy program for abused women. Two hundred seventy eight battered women were assigned to post-shelter random and control groups. Participants received 10 weeks of paraprofessional advocate outreach services. As a result of the outreach, data verified participants experienced a decrease in depressive symptoms, less abuse, less physical abuse, higher social support, and increased quality of life.

McNamara, Ertl, Marsh, and Walker (1997), evaluated short term responses from 81 women receiving treatment in a domestic violence shelter. The results revealed that after just three sessions of case management or counseling, clients reported a noticeable decrease in abuse, increased life satisfaction, and an increase in their perceived coping ability. Interestingly, the clients who received counseling, as opposed to case management showed a greater overall improvement.
Perspectives on abuse are slowly changing. Davis (1987) reported that changes in social workers' perceptions and solutions for wife abuse were initiated once it was realized how large and diverse a group of women were affected by domestic violence. Davis (1987) reviewed 33 major journal articles on the topic. The results showed that social workers primarily focused on therapeutic strategies to modify the behavior of individuals and couples. Concomitantly, there was a decrease in attention given to improving the service delivery system, policy development, and program development toward eradication of the domestic violence problem.

Human service workers quite often can become overwhelmed by the extent and complexity of a problem as grave as domestic violence. Yet, they must remain sensitive and responsive to the needs of individuals victimized by domestic violence. Delivery of proper intervention is imperative. Toward this end, Miller and Veltkamp (1997) summarize clinical algorithms and identify critical pathways that might be relevant to the delivery of quality intervention programs. On the other hand, Grigsby and Hartman (1997) suggest using a simpler integrative model of intervention that incorporates case
management and psychotherapy. Their model focused the therapeutic intervention on primary environmental barriers (i.e. family, socialization, role expectations, childhood neglect) and away from psychological factors.

Conversely, one article purposed a constructivist model of empowerment for women who choose to stay in the battering relationship (Peled et al., 2000). According to Peled et al., "...when the decision to stay is deligitimized, battered women's freedom to choose is denied and they become disempowered" (p. 19). This model acknowledges the needs and rights of battered women by empowering them to make choices on their own. Furthermore, Peled et al. suggested empowering women by promoting and operationalizing each of the identified ecological components: sociocultural, institutional, organizational, interpersonal levels, and finally individual level. However, when women make this decision to stay, it must coincide with a major shift in perception toward responsibility for the violence and decide if the risk to benefit ratio is in their favor.

Female victims of domestic violence manifest a vast and extensive range of mental health problems, major depression, PTSD, anxiety disorders, and OCD (Hamberger and Ambuel, 1997). In fact, depression is one of the most
frequently studied aspects in women abused by a spouse (Russell & Uhlemann, 1994). Two affective constructs, depression and low self-esteem are the most commonly found symptoms resulting from incidents of domestic violence.

The statistics on women victimized by domestic violence are staggering. Frequently, the only alternative for many women who want to escape the battering relationship is a domestic violence shelter. While in the shelter, it is imperative victims receive the necessary services to facilitate the recovery process. Agencies providing services to this delicate population are ethically and professionally responsible for being educated on presenting symptomology and it’s identification. Following assessment, considerable attention needs to focus on the victims’ mental health needs and services.
In light of the existing literature and research conducted in the area of domestic violence, several recurrent symptoms continue to surface as a result of both physical and non-physical abuse. Two of the most prevalent psychological symptoms requiring intervention tend to be depression and low self-esteem. Therefore, it is the intention of this study to empirically examine the type of abuse female victims of domestic violence experience and its link to their psychological distress. Specifically, it is hypothesized that victims of non-physical abuse will be more likely to experience low self-esteem than depression. Victims of physical abuse will have a greater prevalence of depression than low self-esteem.

Despite the methodological limitations, a post-positivist paradigm was employed to conduct the research. Conducting research with this model will not yield a cause and effect relationship. The small sample size and inability to control for extraneous variables limits the generalizability of the data. It is still important, and even necessary, to initiate the process of
analysis at some point. Utilizing this approach, the researcher gained the opportunity to speculate as to possible associations between the variables measured.

Sampling

Women 18 years of age and older were requested to participate in the study. Volunteers were recruited from three domestic violence shelters. The agencies were located in San Bernardino County and Kern County, California. All participants were advised prior to participation of confidentiality, anonymity, and the option to terminate participation at any time during the survey process. Participation in the study was non-compensatory.

Convenience sampling was utilized for sample selection, primarily due to time constraints and lack of participant availability. In regards to utilizing this sampling approach, it was assumed that the sample under study would truly reflect the larger population. However, the researcher acknowledges the limitations contingent upon this type of sample selection. By using a small number of participants, the study introduces the possibility of the sample only marginally representing the larger population. It should be noted that all
participants were clients receiving assistance from domestic violence shelters; hence they shared many similar characteristics and attributes.

Thirty-one questionnaires were completed, and a total of 30 were analyzed. A compilation of demographics yielded the following information. The age of women in the sample ranged from 19-63 with a mean of 30.61 (SD = 8.88). Forty percent of the women described themselves as Caucasian, 26.7% Black/African American, 30% Hispanic/Latina, and the remaining 3.3% selected other to describe their ethnic background. Only 3 women, 10%, were employed. One woman was a dental assistant, one was a manager/supervisor, and one woman was a receptionist. Twenty percent of the women reported an education level of eighth grade or less with the remaining participants reporting the following: 30% some high school, 33.3% high school diploma, and 16.7% some college, but no degree. All of the women had children, 26.7% had only one child, 20% had two children, 30% had three children, 10% had four children, 3.3% had 5 children and 10% had six children. The children ranged in age from 5 months to 43 years. An overwhelming majority of the women, 63%, reported an estimated total household income under $15,000, 10% $15,000-$24,999, 6.7%
$25,000-$34,999, and 20% chose not to answer the question as it was optional.

Not surprisingly, some 83.3% of the women reported having previously left their abuser, 16.7% had not. Of the 83.3%, over half, 56.7% left between 1-4 times, another 16.6% left between 5-10 times, and 3.3% left between 11-15 times. The primary reason reported for returning to their abuser was financial security or money in 27.6% of the women. In 10.3%, the abuser threaten to take her children, 3.4% had her abuser threaten her life, 20.7% were hopeful he would change, and 10.3% of the women returned because they were lonely and felt they still loved him. Ten percent were undecided as to whether or not they would return to their abuser, and 90% reported no. Thirty percent of the women had been a client of the shelter for 1 week, 30% 2 weeks, 10% 4 weeks, 3.3% 6 weeks, and 20% 7 or more. Eighty percent of the women described the relationship with their abuser as containing both physical and non-physical abuse, 13.3% claimed non-physical abuse only and 6.7% reported physical abuse only.

Data Collection and Instruments

Participants were requested to complete a questionnaire packet that assessed their current level of
depression, self-esteem, and severity of abuse experienced in the dyadic relationship (see Appendix A). The packet consisted of a demographic questionnaire, letter of consent, four instruments (each assessing one variable), and a debriefing statement. The following scales were used in the assessment: Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1979); Center For Epidemiological Studies-Depressed Mood Scale (CES-D) (Radloff, 1977); Partner Abuse Scale: Non Physical (PASNP) (Attala, Hudson, & McSweeney, 1994; Attala, Oetker, & McSweeney, 1995) and the Partner Abuse Scale: Physical (PASPH) (Attala, Hudson, & McSweeney, 1994; Attala, Oetker, & McSweeney, 1995).

The widely used Self-Esteem Scale (Rosenberg, 1979) has a reliability of .92, with an alpha coefficient of .89, indicating good internal consistency. The large amount of research performed with this instrument demonstrates concurrent, predictive, and construct validity (Corcoran & Fischer, 1987). The Likert scale consists of 10 items designed to measure participant’s self worth. High self-esteem, as reflected in the scale items, expressed feelings that one is good enough and respects herself. Low self-esteem on the other hand, implied self-dissatisfaction and self-rejection. Low
self-esteem responses are "disagree" or "strongly disagree" on items 1, 3, 4, 7, & 10 and "strongly agree" or "agree" on items 2, 5, 6, 8, and 9.

One of the greatest strengths of the RSE is the amount of research conducted, and the wide range of populations who have completed the questionnaire. Originally, the scale was normed on approximately 5,000 high school students with diverse ethnic backgrounds. Subsequent research involved instrument administration to a number of populations, including adults employed in a variety of occupations, professions, ethnic backgrounds (Corcoran & Fischer, 1987) and victims of domestic violence (Cascardi & O'Leary, 1992; Russell & Hulson, 1992; Tuel & Russell, 1998).

The CES-D (Radloff, 1977) was designed to measure depressive symptomology in the general public with an emphasis on the affective component--depressed mood. The Likert scale has an alpha coefficient of .85 for the general population. This measure exhibits good internal consistency and fair stability with test retest correlations ranging from .51 to .67 (Corcoran & Fischer, 1987). This measure has excellent concurrent validity as it has been shown to correlate significantly with a number of other depression scales.
The CES-D consists of 20 items, designed to measure the participant’s depressive mood. Of the 20 items, four were reversed in order to avoid participant bias: 4, 8, 12, and 16. To score the instrument, the 4 items were reversed and all 20 items were totaled for a sum. Higher scores were indicative of greater depression levels.

The CES-D has been used in extensive research, hence having developed broad applicability. Originally, it was developed for use with the general population. However, it has been found useful in both psychiatric and clinical settings. Questionnaire respondents included male and female Caucasians and African Americans from various education levels. Referring to the aforementioned, it was reported that subgroup reliability and validity was confirmed in each study (Corcoran & Fischer, 1987). Domestic violence research utilizing the measure includes studies by Walker (1984) and Campbell, Sullivan, & Davidson (1995). Moreover, this particularly useful measure can be easily administered, scored, and was reported to be participant friendly by past respondents.

The PASPH (Attala, Hudson, & McSweeney, 1994; Attala, Oetker, & McSweeney, 1995) measured the degree or magnitude of the victim's perceived physical abuse. It was developed for heterosexual couples who are dating, live
together, married or unmarried. There is good internal consistency, and the scale achieved an alpha coefficient of .97. In an investigation of content, construct, and factorial validity, the PASPH nearly always achieved a validity coefficient of .60 or greater.

The PASNP (Attala, Hudson, & McSweeney, 1994; Attala, Oetker, & McSweeney, 1995) is completed by the abuse victim and is designed to measure the severity of perceived non-physical abuse from a spouse or partner. Similar to the PASPH, the PASNP also was designed for heterosexual couples who are dating, live together, married or unmarried. It consistently receives an alpha coefficient of .98 and a validity coefficient of .60 or greater.

Both the PASPH and the PASNP are Likert-type scales consisting of 25 questions each. Two scores are computed for each respondent: a PASPH score that represents the severity of physical abuse, and a PASNP score that represents the severity of non-physical abuse. Scores on both scales ranges from 25-175 with a low score indicating an absence of the problem and a high score indicating the presence of a more severe problem.
Procedure

Women who were screened for eligibility and accepted as clients into the shelters were recruited to participate in the study. Clients were invited by agency personnel to attend a recruitment meeting. Recruitment meetings were conducted in the domestic violence shelters. During the two months of data collection, meetings were held as frequently as once per week in some shelters and only twice in others. Frequency was subject to new client availability.

During the meeting, the researcher introduced the study, explained the purpose, and requested volunteers to participate in the questionnaire process. Non-participating shelter clients were requested to exit the meeting. The remaining clients were given verbal instructions to be followed during the completion of the questionnaire packet. Of the 31 women requested to participate in the research process all 31 willingly participated.

The researcher requested there be no discussion of the questionnaire packet content, no sharing of answers, and to refrain from conversing during the procedure. If participants had questions, they were directed to the researcher. Each participant was then issued one
questionnaire packet, a pen, and envelope. The questionnaire packet was completed during this time. On average, questionnaires took between 10-30 minutes to complete. Upon completion, the packet was placed into unmarked envelopes by the participant, sealed by the participant, and returned to the researcher. The researcher was present during the entire participant recruitment meeting to ensure privacy, confidentiality, and anonymity.

Protection of Human Subjects

The participants' names were not requested or recorded; as participants can not be identified, their anonymity and confidentiality was assured. Each questionnaire included one unmarked envelope. The completed questionnaire was placed in the unmarked envelope by the participant and given to the researcher. There was no deception used in the study.

The cover letter constitutes the informed consent statement. It included identification of the researcher, an explanation of the nature and purpose of the study, anticipated completion time, a statement confirming anonymity and confidentiality, indicated that participation in the study was completely voluntary, and
that participants could withdraw at any time from the survey. The cover letter and debriefing statement explained the goals of the investigation and responded to issues relating to the informed consent. Additionally, both letters provide a contact person for any questions regarding the study.
CHAPTER FOUR

RESULTS

Data Analysis

A univariate analysis was carried out. The central tendencies (mean and mode) and the dispersion of data (standard deviation) were analyzed (see Appendix B). Frequency distributions were conducted examining the variables physical abuse (PASPH), non-physical abuse (PASNP), self-esteem (RSE), and depression (CES-D). The mean score for the PASPH was 2.70, SD = 1.19, with a mode of 2.68. For the PASNP, the mean score was 5.05, SD = 1.46, with a mode of 5.00. According to the analysis, women reported experiencing almost twice as much non-physical abuse (X = 5.50) in their relationships compared to physical abuse (X = 2.70).

The RSE had a mean score of 2.36, SD = .53, with 2.20 for the mode. Because descriptive statistics for the RSE are not available, comparisons of the RSE results cannot be made with other normative data. However, the possible RSE scores range from 10-40, 10 reflecting higher self-esteem and 40 being lower self-esteem. In the current sample, the mean total score was 23.6, indicating low to average levels of global self-esteem.
The mean score for the CES-D was 2.51, $\overline{SD} = .76$, with a mode of 1.45. The mean total score for the sample was 50.13. Scores ranging from 0-15.5 signify no depression, 16-20.5 mild depression, and scores 31 or above are indicative of severe depression (Radloff, 1977). Only 3.3% of the women were mildly depressed leaving 96.7% of the sample to fall somewhere towards the severe depression end of the continuum.

The test of correlation, a Pearson product moment, investigated the strength of relationship between the four variables (see Appendix C). It was anticipated that the results would reveal an association between non-physical abuse and low self-esteem. Also, an association was anticipated to exist between physical abuse and depression. Both correlations were non-significant and failed to support either assumption. These non-significant findings were probably due to small sample size. However, the data revealed a small positive correlation ($r = .303$, non significant) between the PASNP and RSE. Women who reported themselves as being recipients of non-physical abuse tended to have lower self-esteem. Additionally, there was a small positive correlation ($r = .206$, non significant) between the PASPH and CES-D. Therefore, women...
who rated themselves as being physically abused tended to report greater levels of depression.

Further correlational analysis was carried out between the PASPH and the PASNP. The data revealed a high medium correlation, \((r = .448, p < .05)\) two tailed, indicating women who reported being physically abused were likely to experience psychological and emotional abused in their relationships also. There was a large positive correlation \((r = .613, p < .01)\) between the RSE and CES-D. This points to the fact that there is a high probability that women who are in abusive relationships and become depressed will concurrently experience low self-esteem.
CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS

A large body of research has demonstrated depression and low self-esteem, as two of the most common presenting psychological symptomology found in female victims of domestic violence. This research study was designed to empirically investigate types of abuse, physical and non-physical, and their link to self-esteem and depression issues with female victims of domestic violence. The results of this investigation have important implications for domestic violence shelters and community agencies in the delivery of effective clinical intervention programs.

There was no statistical support for either hypothesis, probably due in part to the small sample size. However, physical and non-physical abuse was highly correlated, confirming pervious studies (Campbell, 1989; Follingstad et al., 1990). The disorders, depression and low self-esteem were highly correlated. These results are consistent with previous research (Campbell, 1989; Cascardi & O'Leary, 1992; Sato & Heiby, 1992; Walker, 1984). Although the results failed to prove a significant association between physical abuse and depression or non-physical abuse and self-esteem as anticipated, it
clearly showed that the disorders experienced by the respondents occurred simultaneously. If this is true for the majority of victims who experience domestic violence abuse and seek support from shelters, as it was demonstrated with this sample, then domestic violence shelters need to implement a concurrent treatment intervention addressing low self-esteem and depression regardless of degree, magnitude, or type of abuse experienced.

Walker (1984) wrote about the need to clarify the nature of victims' disorders, so that domestic violence shelters and community agencies serving this population could develop programs that are more effective in treatment. It seems evident from this research that the prevalence of disorders exhibited by victims is widespread and complicated. Hence, the argument could be made that focusing a clinical assessment on identifying the victims origin of symptomology is unnecessary, given both physical and non-physical abuse are so strongly correlated. If the victim is physically abused, it can be inferred that psychological and emotional abuse is occurring simultaneously.

Shelters need to implement a concomitant program that aids in assessment and diagnostic confirmation of multiple
dysfunctions or problems. To achieve this, utilizing self-report assessment measures, similar to the ones employed in this study, would facilitate that endeavor. They would also serve as an aid in the evaluation of client change defined as growth or decomposition.

Self-report assessment scales are simple, but powerful devices that are capable of revealing both minor and serious symptoms victims are experiencing. While victims may seek psychological help, they rarely disclose presenting symptomology. Oftentimes, victims lack the ability to articulate how they are feeling due to trauma or fear resulting from the abuse or the abuser (Hamberger & Ambuel, 1997). Data review indicates that, eighty percent of the women described the relationship with their abuser as containing both physical and non-physical abuse. Some 13.3% claimed non-physical abuse only and 6.7% reported physical abuse only. Comparing this data with the PASNP and PASPH measures, women reported suffering non-physical abuse twice as much. Employing measures that would facilitate a diagnostic benchmark and establish a criterion against which to judge the effectiveness of treatment is essential. Measurements periodically throughout the intervention can be re-administered to
monitor and evaluate the severity of the problem and further evaluate the effectiveness of intervention.

In addition to the aforementioned, these findings underscore the need for agencies serving battered women to carefully consider how battering and subsequent mental health disorders resulting from the abuse affect her life and her children. Violence in the family often results in severe consequences for children.

Attention given to the long-term effects on children who witness domestic violence is a relatively new phenomenon. Children witnessing the abuse are themselves exposed to a form of emotional maltreatment. There is the possibility that abused women will be so caught up in their own survival that the children’s needs become neglected. Moreover, there is increasing evidence that children who witness physical violence in the home become abusive themselves (Briere & Elliott, 1997).

When interpreting this data, some caution must be taken. One of the methodological limitations impacting this study was the small sample size. Another limitation was the use of a conveniences sample. All participants were recruited exclusively from domestic violence shelters. Both of which limit the generalizability of the results.
The possibility exists that the associations made regarding symptomology and type of abuse may not be a common pattern exhibited in abused women who do not use domestic violence shelters. Repeated replication with larger and more diverse groups of abused women is needed before substantiative conclusions can be drawn. Specifically, it is recommended that replication of this research project be conducted in a community where women who are victimized by domestic violence may participate.

Despite the high incidence of domestic violence, information about the effectiveness of clinical intervention programs is limited. The ubiquity of violence against women demands this urgent response. A conceded effort in the area of research dissemination on clinical practice, program development, implementation, and outcome is much needed. The challenge remains paramount in the fight against this epidemic.
APPENDIX A

QUESTIONNAIRE PACKET
LETTER OF CONSENT

Dear Participant:

Thank you for agreeing to participate in this research project. The purpose of this study is to examine self-esteem and depression in female victims of domestic violence. The study is being conducted by Patricia Ann Miskofski, MSW Student Researcher, CSUSB, under the supervision of Lawrence Vasquez, L.C.S.W. with guidance from Rosemary McCaslin, Professor of Social Work. This project has been approved by the Institutional Review Board, California State University San Bernardino.

Please respond to each of the items on the attached questionnaire in a manner that reflects accurately and honestly how you feel. The questionnaire should take approximately 20-25 minutes of your time. You are not asked to provide your name. Your responses will be anonymous. All data will be examined and reported in group form only. Please keep in mind that your participation in this study is completely voluntary and that you may choose to withdraw at any time without penalty. Whether or not you choose to participate, it will in no way affect the services you receive from this shelter. When you have completed the questionnaire, place it into the attached envelope, seal it, and return it to the researcher.

Results of this research study will be available in the John M. Pfau Library on the CSUSB campus in September 2001. If you have any questions regarding the nature of this study, please feel free to contact Dr. Rosemary McCaslin at (909) 880-5507.

Sincerely,

Patricia Miskofski,
MSW Student Researcher, CSUSB

Please Check: I have read the above description, understand the study's nature and purpose, and agree to participate. I also acknowledge that I am at least 18 years of age.

Date: ______________
PARTNER ABUSE SCALE: Physical (PASPH)

This questionnaire is designed to measure the physical abuse you have experienced in your relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number besides each one as follows:

<table>
<thead>
<tr>
<th>1 = None of the time</th>
<th>2 = Very rarely</th>
<th>3 = A little of the time</th>
<th>4 = Some of the time</th>
<th>5 = A good part of the time</th>
<th>6 = Most of the time</th>
<th>7 = All of the time</th>
</tr>
</thead>
</table>

1. ____ My partner physically forces me to have sex.  
2. ____ My partner pushes and shoves me around violently.  
3. ____ My partner hits and punches my arms and body.  
4. ____ My partner threatens me with a weapon.  
5. ____ My partner beats me so hard I must seek medical help.  
6. ____ My partner slaps me around my face and head.  
7. ____ My partner beats me when he/she drinks.  
8. ____ My partner makes me afraid for my life.  
9. ____ My partner physically throws me around the room.  
10. ____ My partner hits and punches my face and head.  
11. ____ My partner beats me in the face so badly, I am ashamed to be seen in public.  
12. ____ My partner acts like he/she would like to kill me.  
13. ____ My partner threatens to cut or stab me with a knife or other sharp object.  
14. ____ My partner tries to choke or strangle me.  
15. ____ My partner knocks me down and then kicks or stomps me.  
16. ____ My partner twists my fingers, arms, or legs.  
17. ____ My partner throws dangerous objects at me.  
18. ____ My partner bites or scratches me so badly that I bleed or have bruises.  
19. ____ My partner violently pinches or twists my skin.  
20. ____ My partner badly hurts me while we are having sex.  
21. ____ My partner injures my breasts or genitals.  
22. ____ My partner tries to suffocate me with pillows, towels, or other objects.  
23. ____ My partner pokes or jabs me with pointed objects.  
24. ____ My partner has broken one or more of my bones.  
25. ____ My partner kicks my face and head.
Using the scale below, indicate the number which best describes how often you felt or behaved this way—DURING THE PAST WEEK.

1 = Rarely or none of the time (less than 1 day)
2 = Some or a little of the time (1-2 days)
3 = Occasionally or a moderate amount of time (3-4 days)
4 = Most or all of the time (5-7 days)

DURING THE PAST WEEK:

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

This questionnaire is designed to measure the non-physical abuse you have experienced in your relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number besides each one as follows:

- 1 = None of the time
- 2 = Very rarely
- 3 = A little of the time
- 4 = Some of the time
- 5 = A good part of the time
- 6 = Most of the time
- 7 = All of the time

1. ____ My partner belittles me.
2. ____ My partner demands obedience to his/her whims.
3. ____ My partner becomes surly and angry if I say he/she is drinking too much.
4. ____ My partner demands that I perform sex acts that I do not enjoy or like.
5. ____ My partner becomes very upset if my work is not done when he/she thinks it should be.
6. ____ My partner does not want me to have any male friends.
7. ____ My partner tells me I am ugly and unattractive.
8. ____ My partner tells me I couldn’t manage or take care of myself without him/her.
9. ____ My partner acts like I am his/her personal servant.
10. ____ My partner insults or shames me in front of others.
11. ____ My partner becomes very angry if I disagree with his/her point of view.
12. ____ My partner is stingy in giving me money.
13. ____ My partner belittles me intellectually.
14. ____ My partner demands that I stay home.
15. ____ My partner feels that I should not work or go to school.
16. ____ My partner does not want me to socialize with my female friends.
17. ____ My partner demands sex whether I want it or not.
18. ____ My partner screams and yells at me.
19. ____ My partner shouts and screams at me when he/she drinks.
20. ____ My partner orders me around.
21. ____ My partner has no respect for me.
22. ____ My partner acts like a bully towards me.
23. ____ My partner frightens me.
24. ____ My partner treats me like a dunce.
25. ____ My partner is surly and rude to me.
Please record the appropriate answer per item, depending on whether you strongly agree, agree, disagree, or strongly disagree with it.

1 = Strongly Agree
2 = Agree
3 = Disagree
4 = Strongly Disagree

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I'm a person of worth, at least on an equal plane others with.
8. I wish I could have more respect for myself.
9. All in all, I am inclined to feel that I am a failure.
10. I take a positive attitude toward myself.
DEMOGRAPHICS

Please respond as accurately as possible and answer all questions on the following page. Thank you for your cooperation.

1. Age: ___

2. Ethnic Background (check which best describes you):
   ___ Asian
   ___ Black/African American
   ___ American Indian
   ___ Caucasian
   ___ Hispanic/Latina
   ___ Other (please specify): ____________________________

3. a. Are you employed? Yes ___ or No ___
   b. If employed, how many hours per week do you work? ____________
   c. If employed, please indicate your job title _______________________

4. a. Please check the HIGHEST level of education you have completed.
   ___ Eighth Grade or Less
   ___ Some High School
   ___ High School Diploma
   ___ Some College-No Degree
   ___ A.A. Degree
   ___ B.A./B.S. Degree
   ___ Masters Degree
   ___ Doctorate Degree

5. a. If you have children, how many ___?
   b. If applicable, please indicate the age and gender of your children:
      Age Gender Age Gender Age Gender
      1. ___ ___ 3. ___ ___ 5. ___ ___
      2. ___ ___ 4. ___ ___ 6. ___ ___

6. Please estimate total yearly HOUSEHOLD INCOME (optional):
   ___ Under $15,000
   ___ $15,000-$24,999
   ___ $25,000-$34,999
   ___ $35,000-$44,999
   ___ $45,000-$54,999
   ___ $55,000-$64,999
   ___ $65,000-$74,999
   ___ Over $75,000

7. a. Have you ever left your abuser before? Yes ___ or No ___
   b. If yes, how many times? ______
   c. Please explain the primary reason for returning to him.
   d. Do you think you will go back this time? Yes ___ or No ___
   e. Why or Why Not? ________________________
   f. For how long have you been a client of this shelter? __________

8. Examples of Physical Abuse are: hitting, kicking, choking, shoving, burning, slapping, spanking. Examples of Non-physical Abuse are: yelling, bullying, withholding money or sex, swearing, interrupting your sleep or eating, threatens you or threatens to leave the relationship. What type of abuse most accurately describes the relationship you have with your abuser?
   a. Physical Abuse ___
   b. Non-physical Abuse ___
   c. Both Physical & Non-physical Abuse ___
DEBRIEFING STATEMENT

Dear Participant,

Thank you again for participating in this research project. As indicated, the purpose of this study was to assess self-esteem and depression in female victims of domestic violence. Specifically, the study was designed to investigate the type of abuse (physical and non-physical) victims of domestic violence experience and its link to self-esteem and depression. Please remember we did not request your name, your responses are anonymous and confidential, and will be used only to determine how groups of women responded.

Please do not reveal the nature of the study to other potential participants or clients because it may bias the results. If, after completing this questionnaire, you have any personal concerns or feelings that you would like to discuss with a counselor, please feel free to consult with a counselor at the shelter. If you have any questions regarding the nature of the study, please contact Dr. Rosemary McCaslin, Professor of Social Work, California State University San Bernardino at (909) 880-5507.
APPENDIX B

CENTRAL TENDENCIES
<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASPH</td>
<td>2.70</td>
<td>1.19</td>
<td>2.68</td>
</tr>
<tr>
<td>PASNP</td>
<td>5.05</td>
<td>1.46</td>
<td>5.00</td>
</tr>
<tr>
<td>RSE</td>
<td>2.36</td>
<td>0.53</td>
<td>2.20</td>
</tr>
<tr>
<td>CES-D</td>
<td>2.51</td>
<td>0.76</td>
<td>1.45</td>
</tr>
</tbody>
</table>
APPENDIX C

RESULTS OF CORRELATION ANALYSIS
### Results of Correlation Analysis

<table>
<thead>
<tr>
<th>Variables</th>
<th>Statistic</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASNP &amp; RSE</td>
<td></td>
<td>( r = .303^{***} )</td>
</tr>
<tr>
<td>PASPH &amp; CES-D</td>
<td></td>
<td>( r = .206^{***} )</td>
</tr>
<tr>
<td>PASPH &amp; PASNP</td>
<td></td>
<td>( r = .448^{*} )</td>
</tr>
<tr>
<td>RSE &amp; CES-D</td>
<td></td>
<td>( r = .613^{**} )</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).
***Non-significant.
REFERENCES


