Winter 12-20-2021

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Bachelor of Science in Psychology

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December 2018

Submitted in partial fulfillment of requirements for the degree

MASTER OF ARTS OF PSYCHOLOGICAL SCIENCES

at the

CLEVELAND STATE UNIVERSITY

May 2022

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ABSTRACT

Background: About 1 in 4 women and 1 in 10 men have experienced intimate partner violence (IPV; CDC, 2019). Although there have been numerous studies on IPV, our knowledge pertains to IPV in heterosexual couples. Although IPV occurs at similar rates in both opposite and same sex couples, studies suggest that individuals are more likely to evaluate IPV in opposite-sex couples as more severe compared to same-sex couples. Therefore, the purpose of this study was to examine college students' perceptions of IPV in both opposite-sex and same-sex couples. **Procedure:** The study included 144 participants who read eight vignettes, four of depicting psychological abuse and four depicting physical abuse. Vignettes were randomly presented and counterbalanced by perpetrator's gender (male or female) and couple status (same-sex or opposite-sex). Participants answered questions regarding their perceptions of severity and harm in each scenario, as well as items about attitudes towards homosexuality and their own history of IPV.

Result: IPV perceptions of severity and harm did not differ between vignettes with either same-sex or opposite-sex couples, p=0.18. IPV in opposite and same-sex couples involving a male perpetrator did not significantly differ in IPV severity when compared to opposite and same-sex couples involving a female perpetrator, p =0.23. IPV was perceived as more severe with a higher personal history of IPV ($p < 0.01$) and among those who harbored negative views about sexual minorities ($p < 0.01$).

Discussion: Across vignettes, psychological abuse was seen as less severe than physical abuse. When examining the couple × perpetrator interaction, IPV in opposite and same-sex couples involving a male perpetrator did not significantly differ in IPV severity when compared to opposite and same-sex couples involving a female perpetrator. The difference between opposite sex couples was not significantly higher than same-sex couples. Further, in same-sex couples, the difference was not significantly smaller. It is possible that there could be couple and perpetrator effects; however, the effects were too small to be detected by the chosen manipulation.

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CHAPTER I

INTRODUCTION

Intimate partner violence (IPV) has become an epidemic in the United States and worldwide, affecting millions of individuals. IPV is defined as patterns of behavior that involve harm to one person by a current or former partner or spouse (Center of Disease Control (CDC), 2019). IPV can involve physical assault, sexual assault, emotional or psychological mistreatment, threats and intimidation, economic abuse, and violation of individual rights (American Academy of Family Physicians, 2019). In recent years, increased focus has been allocated to IPV, including a focus on the health repercussions of IPV (e.g., mental health disorders, sexually transmitted diseases, physical injuries) and perceptions of IPV severity. Although IPV can occur to any person, women are most affected. According to the CDC (2019), about 1 in 4 females and nearly 1 in 10 males have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime. These individuals also report some form of IPV-related impact. Further, over 43 million women and 38 million men experience psychological aggression by an intimate partner in their lifetime (CDC, 2019).

The most common forms of IPV are physical abuse, psychological abuse, sexual violence, and stalking (Krebs et al., 2011). Often, psychological and physical IPV overlap

with each another, resulting in more detrimental effects on the victims. Experiences with several types of IPV may occur within a single intimate relationship, at different points in time in the same relationship, or with different assailants over the lifespan. In addition, specific incidents of IPV may involve a combination of assaultive acts, psychological aggression, and threats (Krebs et al., 2011). Furthermore, physical and psychological abuse are strongly related with one another, as experiencing psychological abuse relates to the subsequent onset of physical violence (Murphy & O'Leary, 1989). Although many people who use psychological aggression in intimate relationships do not also use physical aggression, the reverse is not true. That is, there are few relationships in which physical abuse occurs without psychological abuse (e.g., Follingstad et al., 1990; Stets, 1990). Given this substantial overlap between physical and psychological abuse, and their high prevalence, this study will focus on these forms of abuse.

1.1 Physical and Psychological Abuse

Physical abuse is defined as the intentional use of force toward another person with the potential to cause death, disability, injury, or harm (Saltzman et al., 2002). Injuries resulting from physical IPV victimization can include bruises, scratches, burns, broken bones, miscarriages, and knife and gunshot wounds (Crowell & Burgess, 1996). Like all forms of IPV, more women than men report higher occurrences of physical abuse. Furthermore, the effects of physical IPV victimization are more prevalent in women than men (Breiding et al., 2011), as female victims of IPV are significantly more likely than men to sustain an injury, receive medical care, be hospitalized, receive counseling, and lose time from work following physical abuse (Tjaden & Thoennes, 2000).

On the other hand, the CDC defines psychological abuse as aggression that includes the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person (CDC, 2020). Behaviors associated with this form of abuse include coercive and controlling behaviors such as derogation, isolation, domination, and patterns of verbal aggression (McHugh et al., 2013; Wiite et al., 2015). Psychological abuse has negative consequences that might be as, or more, damaging than physical abuse (Arias & Pape, 1999; Coker et al., 2002; Herbert, et al.,1991). For example, several researchers have demonstrated a link between psychological abuse, victimization, and mental illness such as depression (Ali et al., 1999; Coker et al., 2005; Orava et al., 1996; Taft et al., 2006). Further, there are several health symptoms implicated in psychological abuse victimization, including chronic neck or back pain, arthritis, headaches, chronic pelvic pain, stomach ulcers, sexually transmitted infections, spastic colon or irritable bowel syndrome, and other gastrointestinal upsets (Coker et al., 2005).

One reason that may explain why women are more likely to experience victimization than men is perceptions of IPV severity. For example, perceptions are reported as more severe when the victim is a woman as compared to a man (Caldwell et al., 2012). These perceptions of severity also expand into perceptions of aggression and judgment. For example, when men are physically aggressive toward a woman, they are more likely to cause serious harm than a physically aggressive woman is to cause harm to a man (Wilson & Smirles, 2020). Furthermore, male perpetrators are viewed as more responsible and judged more harshly for abuse than female perpetrators (Sorenson & Taylor, 2005; Sylaska & Walters, 2014). For example, Sorenson and Taylor (2005) found

that female aggression toward a man was less likely to be considered wrong compared with male aggression toward a woman. These perceptions are possibly influenced by gender roles and how they relate to IPV perceptions.

1.2 Gender Roles

Just as psychological and physical abuse differ in the levels of IPV severity perception, perceptions about the role of gender in IPV also vary. One explanation for differences in perceptions regarding male-to-female IPV as being more severe than female-to-male IPV is gender role socialization. The gender role socialization theory suggests that only women can be victims and only men can be perpetrators (Burke & Follingstad, 1999). The basic reasoning behind this theory comes from biological theories that men are naturally more aggressive, dominant, and prone to violence than women. These misconceptions are especially salient when outsiders (such as law enforcement) try to identify the victim (Brown, 2008). Such perceptions could be partially attributed to beliefs of masculinity and femininity. Masculinity is often associated with toughness, power, control, independence, differentiation from womanhood, restricted emotions, physical and sexual competence, assertiveness, and aggressiveness (Canham, 2009). In contrast to masculinity, femininity is often associated with characteristics such as gentleness, patience, kindness, and other nurturing qualities (Kimmel, 2001). When these beliefs of masculinity and femininity are internalized, individuals can more easily picture a woman being abused by a man, someone who is likely physically bigger and has more social power. When such gender expectations are violated, situations of IPV create ambiguity to interpret severity of the IPV and to determine appropriate intervention.

However, gender role socialization may not follow this traditional theory when IPV occurs within same-sex couples.

1.3 IPV within Same-Sex Couples

Although most IPV research has been conducted within heterosexual individuals, some researchers have demonstrated that IPV frequency is comparable among heterosexual and sexual minority groups (i.e., a group whose sexual identity, orientation, or practices differ from the majority sexual orientation, such as lesbian, gay, or bisexual individuals; Math & Seshadri, 2013). In one of the earliest studies to examine the prevalence of same-sex IPV, Kelly and Warshafsky (1987) found a 47% perpetration rate among their sample of gay and lesbian participants. In a more recent study, 48% of lesbian women and 30% of gay men reported being victimized by a same-sex partner (Waldner-Haugrud et al., 1997). However, as of 2015, only 3% of empirical IPV research pertained to the effects of IPV on sexual minorities (i.e., lesbian, gay, bisexual, queer, and other; Edwards et al., 2015). Lack of research within this community could be attributed to numerous proposed reasons. These include beliefs that IPV does not occur within same-sex relationships, reinforcing stigma stereotypes towards sexual minorities (Ristock & Timbang, 2005). Such beliefs contribute to a lack of attention in this area, leading to poor prevention and intervention for sexual minority IPV victims. This is particularly alarming as sexual minority individuals make up 4.5% of the U.S. population (UCLA School of Law Williams Institute, 2019), suggesting a large, understudied population.

Despite limited research on IPV among sexual minorities, some research highlights differences in perceptions of IPV severity in same sex versus heterosexual

couples. Typically, IPV tends to be reported as more severe for heterosexual couples than for same-sex couples (Blosnich & Bossarte, 2009). However, what is relatively unknown is whether there are differences in perceptions of IPV severity among gay men and lesbian women. With the lack of research and reinforced stigma against sexual minorities, same-sex IPV is often overlooked and considered to be a rare phenomenon (Rolle et al., 2018). This opinion of rarity is particularly strong with regard to bisexual and lesbian women, who are often idealized as engaging in peaceful and utopian relationships, far from the violence commonly associated with "typical" male virility (Barnes, 2010; Glass & Hassouneh, 2010). Such opinions likely contribute to the differences in perceptions of IPV severity between same-sex and opposite-sex couples. Such opinions may also contribute to differences in perceptions of IPV severity when comparing gay men and lesbian women.

1.4 Rationale and Hypotheses

Based on limited prior research, the goals of this study were to examine differences in perceptions of IPV severity in same-sex and opposite-sex couples and to examine differences in perceptions of IPV severity between same-sex male couples (i.e., gay men) and same-sex female couples (i.e., lesbian women). To achieve these goals, participant responses to a series of vignettes were examined for discrepancies in perceptions of IPV severity. The vignettes described both physical and psychological IPV abuse within both same-sex and opposite-sex couples. For the study, a total of two hypotheses were tested:

Hypothesis 1: When comparing opposite-sex and same-sex couples, IPV will be perceived as more severe and harmful for opposite-sex couples compared to same-sex couples.

Hypothesis 2: Due to myths and popular opinion that same-sex female relationships are seen as peaceful (Barnes, 2010; Glass & Hassouneh, 2010), we hypothesized that when examining the interaction of couple status by sexual orientation × gender of perpetrator across vignettes, IPV in opposite-sex couples with male perpetrators would be seen as the most severe, followed by opposite-sex couples with a female perpetrators, then same-sex couples with male perpetrators with female perpetrators being evaluated as the least severe. Furthermore, the difference in severity perceptions in IPV in opposite-sex couples would be higher than the difference in same-sex couples with male or female perpetrators.

CHAPTER II

METHODOLOGY

2.1 Procedure

For the study, participants were recruited through SONA system, which was available to all students enrolled in Introduction to Psychology courses and select other psychology classes where research credit is permitted for extra credit. SONA was selected as the participant source as it provides systematic recruitment of a convenience sample and provides participants with equitable rewards. Students who completed the study were given course credit for their participation.

The study implemented a 2×2×2 design utilizing a vignette approach presented in a Qualtrics online survey. Once participants clicked on the link, the consent form appeared. Participants were required to consent prior to participation. The consent form described that participants would read about relationship abuse. The form also reminded participants that participation was voluntary. In the case of discomfort, resources for counseling at both Cleveland State University (CSU) and national services were provided. Information about these services were provided in the consent form.

After consenting, the participants read eight vignettes followed by a series of questions regarding their perceptions about the conflict (see Appendix A for vignettes and Appendix B for the follow-up questions). Four vignettes described a scenario of

physical abuse, and four described a scenario of psychological abuse. The vignettes were completely counterbalanced by the gender of the perpetrator (woman, man), type of abuse (physical, psychological), and the status of the couple (same-sex and opposite-sex). The vignettes were presented in a randomized order for each participant. Participants also completed two additional measures [i.e., Community Composite Abuse Scale (CAS_R-SF) and Attitudes Towards Homosexuality (ATHS)] to see if attitudes towards sexual minorities and prior experiences with IPV influenced perceptions of IPV severity. Participants also completed a standard demographic questionnaire that recorded age, current school classification (freshman, sophomore, junior, senior, other), racial identity, sex at birth, gender identity, and sexual orientation. After the questionnaire, participants were debriefed and reminded of the resources provided in the consent form. Prior to data collection, this study was approved by CSU Institutional Review Board (IRB).

2.2 Participants

Participants consisted of CSU students who were 18 years or older. A total of 175 students participated. During data cleaning, 17 participants were eliminated from the study, as their completion times fell below the cutoff duration (5 minutes). An additional 9 survey responses were removed, as these were pilot tests for the study. The 5-minute cutoff was determined by trial testing before the study, which indicated that the study should take a minimum of 5 minutes to complete. Therefore, data was omitted for those participants whose completion times were below 5 minutes. Six additional participants were removed, as their completion time was over two hours to complete the study. The decision to omit those who took over 2 hours was based on a review of the distribution of completion times. Most participants' completion times were under 2 hours, 96.6%;

participants who took more than 2 hours were outliers. To arrive at this decision, the mean and standard deviation of completion time were calculated (M = 2.8 hours, SD = 18.6 hours). After data cleaning, the final number of participants was 143 participants. The mean completion time after data cleaning was 12.7 minutes.

2.3 Demographic Data Frequencies

Demographics information (Appendix E) on sexual orientation, gender identity, racial identity, school year classification, and sex assigned at birth is presented below. For gender, there were 64.6% female participants, 32.6% male participants, 0.7% transgender participants, and 1.4% gender nonvariant/non-conforming participants. The demographic information for racial identity was: 59.7% Caucasian or European American participants, 22.2% Black or African American participants, 6.9% Middle Eastern or Northern African participants, 6.3% Asian participants, 4.2% Hispanic, Latino or Spanish Origin participants, and 0.7% American Indian or Alaskan Native participants. The data for school classification was 55.6% Freshman, 23.6% Sophomores, 10.4% Juniors, 7.6% Seniors, and 2.8% other. For sexual orientation: 85.4% heterosexual or straight, 8.3% gay or lesbian, 2.8% bisexual, 1.4% fluid, 0.7% pansexual, 0.7% queer, and 0.7% demisexual. For sex assigned at birth, the data reported 65.3% female participants, 33.3% male participants, and 1.4% unidentified.

2.4 Vignettes

Participants were provided with eight vignettes that described either physical IPV or psychological IPV. Each vignette differed on couple status (same-sex and opposite-sex) and gender of the perpetrator (man, woman) but were otherwise identical in storyline across both physical IPV and psychological IPV.

To create the vignettes, former studies utilizing vignettes were examined (e.g., Hammock et al., 2016) in conjunction with a literature review. First, a thorough literature search of various forms of abuse was conducted to identify common forms of physical and psychological IPV abuse. For the psychological abuse vignettes, the use of gaslighting (a form of psychological manipulation in which the individual secretly causes the person to doubt their memory, perception, or judgment) was used. Further, gaslighting is a good representation of psychological abuse with uncertain effects. Other forms of psychological abuse were considered (e.g., verbal abuse, economic abuse) but were not selected, as the level of intensity would not match the behaviors chosen for the physical abuse vignette. Grabbing and pulling behaviors were used for the physical IPV vignettes. These behaviors were selected as they are salient yet still uncertain or ambiguous to outside observers. The usage of a more subtle form of physical abuse was selected to make the vignette seem more realistic and less obvious and, thus, less likely to sway participants' judgments. Through pilot testing and feedback from lab members, the levels of severity between the forms of physical and psychological IPV were determined to be of moderate severity for each form of abuse. The decision to use moderate abuse was to allow for equivalence in severity but represent different forms.

A draft of the vignettes was created initially with the vignettes utilizing verbal abuse, economic abuse, and more severe forms of physical abuse (i.e., punching, throwing things) and were sent out to members of the CSU Healthy Relationships (HEART) lab to read and review for clarity, appropriateness, and readability. Corrections to the vignettes were made based on the lab members' feedback, specifically regarding the form of abuse used, as well as the names used in the vignettes.

Prior to starting the study, vignettes were pilot tested with initials in place of names; however, this method was reported as confusing by pilot participants. Therefore, feminine and masculine versions of the names were used. Names were chosen for easy translation between feminine and masculine names (e.g., Oliver and Olivia). To differentiate between opposite and same sex couples, the titles of "boyfriend" and girlfriend" were used, as well as gender-based names (i.e., Olivia & Oliver, Vance & Valencia) and gender-based pronouns (i.e., he/him/his and she/her/hers).

Three follow up questions were created to assess for severity. These follow up questions intended to show face and construct validity and were created to assess the level of severity of the IPV present in the vignettes (see Appendix B). The first two questions—"How severe is this form of dating abuse or domestic violence?" and "How much harm do you think this causes the victim?"—were rated on a 5-point Likert scale from *no abuse/no harm* to *severe abuse/severe harm.* The last question—"Does this relationship need intervention?"—was rated on a 3-point scale including, *yes*, *no*, and *maybe/not sure*. This third item was not included in the final analyses.

2.5 Measures

2.5.1 Covariates

To further assess if severity of IPV perceptions differed on extraneous variables, two additional measures were included. The first measure is a scale of attitudes toward homosexuality to account for individual beliefs and attitudes regarding same-sex couples. The second captures prior experiences with IPV, as these experiences may differentially impact one's beliefs about IPV severity.

2.4.2 Attitudes Towards Homosexuality Scale

The Attitudes Towards Homosexuality Scale (ATHS) is a 16-item questionnaire used to assess participants' attitudes towards homosexuality (Anderson et al., 2018). Participants responded to each item on a Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). A high score represents more accepting attitudes toward homosexuality. Example items include "I prefer not to go to gay bars or nightclubs (reverse coded)" and "I would be happy if my children had a gay or lesbian teacher." Anderson and colleagues (2018) conducted several tests of the scale's psychometric properties. These analyses showed strong temporal (test-retest) stability, $r(60) = .96$, $p < .001$, solid internal consistency, as evidenced by strong Cronbach's alpha coefficients for the main sample ($\alpha = .97$), and for the sample recruited for re-test reliability (time 1: $\alpha = .96$, time 2: $\alpha = .97$), and a composite reliability of 0.97. Convergent validity for the ATHS was demonstrated by a high concurrent validity coefficient compared to the original English Attitudes Towards Homosexuality Scale, $r(235) = -.94$, $p < .001$, suggesting that the ATHS is indeed a measure of anti-gay attitudes. The Cronbach's alpha in the current study for the ATHS was $\alpha = .90$. The ATHS can be found in Appendix C.

2.4.3 Community Composite Abuse Scale

The Community Composite Abuse Scale (CAS_R-SF) is a questionnaire used to assess participants' past experiences with IPV (Gilboe et al., 2016). The scale originally consisted of 30 items; however, this study used a shortened version of 15 items, known as the CAS_R-SF. Examples of items are "Partner forced me to take part in unwanted sexual activity" and "Partner told me I wasn't good enough." The scale includes a total of 6

response options for each item: *never, only once, several times, once a month, once a week,* and *daily.* The reliability and validity of the shortened scale was comparable to the standard 30-item CAS, with reported internal consistency of the CAS_R-SF at 0.942. The concurrent validity compared to the 30-item CAS was reported to be similar and of suitable use (Gilboe et al., 2016). The Cronbach's alpha for the CAS_R-SF in the current study was $\alpha = .90$.The CAS_R-SF can be found in the Appendix D.

2.4.4 Analytic Plan and Power Analysis

Because there are eight repeated measures (i.e., 8 vignettes) in the study, the experiment utilized random coefficient modeling for all hypotheses. The random coefficient model is used for clustered data or repeated measures. Because the vignettes have clustering, random coefficient modeling was determined to be the most efficient analysis to run. With random coefficient modeling, two variances are examined: the Level 1 variance, which is the variance within subjects, and Level 2 variance, which is the variance between subjects. The study examined Level 1 effects: type of abuse (physical, psychological), gender of perpetrator (male, female), and couple status (same-sex, opposite-sex). These variables accounted for Level 1 variance because each participant saw the same vignettes and randomization took place to ensure participants read the vignettes in different orders . The Level 2 variables are the CAS_R-SF and ATHS scale scores, as between subject comparisons. In the study, the dependent variable is the severity/harm variable. For Hypothesis 1, the Level 1 variables, along with the covariates, were included in the model. For Hypothesis 2, the Level 1 predictors and covariates were retained, and an interaction between couple and perpetrator was added into the model.

The first step in testing random coefficient modeling is to calculate a null model to determine if there was clustering in the data. The reason for this was to determine if the random coefficient model should utilize a single level method approach or a multilevel approach. To determine if there was clustering, the intraclass correlation coefficient (ICC) was calculated. The ICC is the expected correlation between any two randomly chosen individuals with the same vignettes and is computed as the proportion of variation in the Level 1 outcome explained by the condition (Heck et al., 2014). Calculating the ICC allows for evaluation of non-independence in the outcome at Level 1. The general cutoff for the ICC is 0.05. An ICC below 0.05 would mean that there is a trivial level of clustering in the data and that a single level approach should be used. If the ICC is larger than 0.05, there is a significant amount of clustering suggesting a multilevel approach should be used. To determine the sample size, a rule of thumb of 100 participants was used based on a textbook chapter on sample sizes for random coefficient modeling (Hahs-Vaughn, 2017).

CHAPTER III

RESULTS

3.1 Data Cleaning and Descriptive Statistics

For the experiment, the data were exported and converted into a long dataset, which is the necessary format for random coefficient modeling analysis. A long dataset results in scores of each participant for each vignette in a separate row with variables including type, couple status, and gender of perpetrator. Type of abuse, couple status, and gender of perpetrator were coded as 0 and 1 (type of abuse, 1=*psychological,* 0 = *physical,* couple status, 1 = *same-sex,* 0 = *opposite-sex,* and perpetrator, 0 = *female* and 1 = *male*).

Before converting, the dataset was inspected and cleaned for any errors. During the exporting of data, a duplication in one vignette (same-sex female psychological abuse) was identified. To mitigate the issue, trial runs were conducted to determine which vignette was duplicated, since the vignettes were randomly presented to participants. A bivariate correlation was conducted to determine if severity scores for the two identical vignettes were strongly correlated. Bivariate correlations were conducted for the items "Does this relationship need intervention?" and "How much harm do you think this causes the victim?" for the identical vignettes. The analysis found that there was a strong

correlation, $r(143) = 0.85$, $p < .001$ and $r(143) = 0.83$, $p < .001$. Therefore, the first vignette in the dataset was retained for all subsequent analyses.

The severity and harm items of the vignettes were examined for overlap in similarity between the two items, as both items may be measuring similar constructs. To examine, a random coefficient model analysis was conducted to examine for similarity between the items. First, a null model was conducted using the severity item as the dependent variable. In the next step, the harm item was added as a predictor variable, and another random coefficient model was conducted. Then, the effect size was calculated using the initial residual from the null model and the latter random coefficient model. The percent change of Level 1 variance was calculated to be 60.1%, indicating that 60.1% of the variance of severity was accounted for by the harm variable. To resolve this issue, the two items were combined into a single item labeled "severity/harm." Below, the descriptive statistics along with the intercorrelation for the predictor variables amongst the dependent variables are presented in Table 1.

This combined dependent variable was also assessed for normality. This normality distribution check was conducted, and the data was interpreted using a Shapiro-Wilk test. The test was statistically significant for the severity/harm dependent variable, indicating that it was not normally distributed. Due to the sample size being robust, it was decided that it would not be an issue to continue even though there was non-normality. The mean statistics of severity/harm are displayed in Table 1. The means of the severity/harm variables were used to examine the differences in the mean scores of severity/harm for each of the eight vignettes. Overall, there seemed to be a floor effect (scores < 2 on the 5-point Likert scale) for all the psychological abuse configurations.

The highest mean score of severity was for Physical Abuse/Same-Sex/Female perpetrator ($M = 2.22$, $SD = 0.95$).

Table 1

Mean Scores of Severity/Harm for the Eight Vignettes

Severity/Harm	Mean	SD
Physical Abuse Vignettes		
Opposite-Sex/Male perpetrator	2.15	0.97
Opposite-Sex/Female perpetrator	2.05	0.98
Same-Sex/Male perpetrator	2.03	0.93
Same-Sex/Female perpetrator	2.22	0.95
Psychological Abuse Vignettes		
Opposite-Sex/Male perpetrator	1.72	1.01
Opposite-Sex/Female perpetrator	1.73	0.99
Same-Sex/Male perpetrator	1.78	1.04
Same-Sex/Female perpetrator	1.75	1.10

Table 2

Descriptive Statistics and Correlations for Study Variables

Variable	Mean	Standard Deviation	1	2	3	4	5
1. Severity/Harm	1.93	1.01	—				
2. Couple Status	0.50	0.50	0.02	—			
3. Type of Abuse	0.50	0.50	-0.18**	0.00	—		
4. Gender of Perpetrator	0.50	0.50	0.07	0.00	0.00	—	
5. ATHS	5.45	1.03	0.20**	0.00	0.00	-0.00	—
6. CAS_R-SF	0.24	0.48	0.17**	0.00	-0.00	-0.00	-0.06

Note. *$p < .05$, **$p < .001$; ATHS = Attitudes towards Homosexuality; CAS_R-SF = Community Composite Abuse

3.2 Hypothesis 1

Hypothesis 1 stated that when comparing opposite-sex and same-sex couples, IPV will be perceived as more severe/harmful when the couple involved is an opposite-sex couple. First, a null model was calculated to determine the need for a random coefficient model using either a multilevel or single level approach. An intraclass correlation coefficient was calculated (ICC= 0.59, $p < .001$), which suggested a significant amount of clustering in the data. This rationalized the need to run a random coefficient model using a multilevel approach.

For the next step, the Level 1 fixed effect predictors from the vignettes, Type (Physical versus Psychological), Couple Status (Same-sex or Opposite-sex couple) & Perpetrator Sex (Male versus Female) were added. The covariates, ATHS and CAS_R-SF were also added to see if the variables had a covarying effect on the Level 1 predictors. The following equation represents this model:

After adding the Level 1 predictors and covariates, another random coefficient modeling analysis was conducted (see Table 3). The percentage change of Level 1 variance was 18.97, indicating that 18.97% of the residual variance in the IPV perceptions was explained by the Level 1 predictors of couple status, perpetrator gender, and type of IPV. Results revealed that IPV perceptions of severity and harm did not differ amongst vignettes depicting either same-sex or opposite-sex couples, $b = 0.03$, $SE = 0.04$, $p = .18$. The results for type of abuse showed that in the physical abuse vignettes (coded as 0), the IPV perception of severity/harm was higher when compared to vignettes that depicted psychological abuse (coded as 1), $b = -0.28$, $SE.= 0.09$, $p = .02$. Lastly, the results for gender of the perpetrator found that the gender of the perpetrator did not influence IPV perceptions in the vignettes, $b = 0.03$, $SE.= 0.02$, $p = .24$.

Regarding covariates, results showed that IPV was perceived as more severe across vignettes with a higher personal history of IPV experiences (i.e., higher scores on the CAS_R-SF), ($b = 0.39$, $SE = 0.15$, $p < .01$). Lastly, those who had accepting attitudes about homosexuality (higher scores on the ATHS) also had a higher perception of severity/harm across the vignettes ($b = 0.26$, $SE = 0.15$, $p < .01$). The change in Level 2 variance for the combined covariates was 0.14.

Table 3

Random Coefficient Modeling Fixed Effects for Hypothesis 1

	Coefficient	*t*	*SE*	*p*
Intercept (*approximate df* = 112.05)	0.532	1.28	1.78	.20
Couple Status	0.031	1.34	0.04	.184
Type of Abuse	-0.28	-3.14	0.04	.002**
Gender of Perpetrator	0.026	1.18	0.04	.238
ATHS mean	0.261	3.55	0.07	< .001***
CAS_R-SF mean	0.395	2.49	0.15	.014*

Note. *$p < .05$, **$p < .01$, ***$p < .001$; Couples status was coded 0 for opposite-sex, 1 for same-sex; Type of Abuse was coded 0 for physical, 1 for psychological; Gender was coded 0 for female, 1 for male. ATHS = Attitudes towards Homosexuality; CAS_R-SF = Community Composite Abuse Scale

3.3 Hypothesis 2

Hypothesis 2 stated that when examining the couple × perpetrator interaction, IPV in opposite-sex couples with male perpetrators would be seen as the most severe, followed by opposite-sex couples with a female perpetrators, then same-sex couples with male perpetrators with female perpetrators being evaluated as the least severe. For the next hypothesis testing, an interaction between couple and perpetrator for all vignettes was added. The Level 1 variance change was calculated, indicating that 19.01% of the Level 1 variance was explained by type of vignette, couple status, gender of the perpetrator, and the couple × perpetrator interaction. The interaction term alone accounted for 0.27% of the variance. However, the couple × perpetrator interaction was not significant (see Table 4); ($b = 0.09$, $SE = 0.08$, $p = .23$).

Table 4

Random Coefficient Modeling Fixed effects for couple×perpetrator variable for Hypothesis 2

	Coefficient	*t*	*SE*	*p*
Intercept (*approximate df* = 118.32)	0.98	2.52	0.39	.01*
Couple Status	-0.01	-0.26	0.04	.798
Type of Abuse	-0.27	-6.74	0.04	<.001***
Gender of Perpetrator	-0.02	-0.41	0.06	.683
ATHSmean	0.26	3.38	0.07	< .001***
CCASmean	0.38	2.63	0.15	.010*
Couple×Perpetrator	0.09	1.19	0.08	.234

Note. * $p < .05$, ** $p < .01$, ***$p < .001$; Couples status was coded 0 for opposite-sex, 1 for same-sex; Type of Abuse was coded 0 for physical, 1 for psychological; Perpetrator was coded 0 for male, 1 for female. ATHS = Attitudes towards Homosexuality; CCAS = Community Composite Abuse Scale

CHAPTER IV

DISCUSSION

The present study served to analyze if there was a difference in the perceptions of severity when examining IPV within opposite-sex couples compared to same-sex couples. Furthermore, the study also sought to examine if there was a difference in perceptions of IPV severity when comparing same-sex male couples to same-sex female couples. Prior research indicates that, typically, IPV tends to be reported as more severe for heterosexual couples than for same-sex couples (Blosnich & Bossarte, 2009). Conversely, there is limited research on IPV severity perceptions in same-sex male and same-sex female couples.

The analysis of the first hypothesis found that the severity perceptions of IPV in opposite and same-sex couples did not significantly differ from one another, thus not supporting the hypothesis. However, replication of the study may be needed. Although the study utilized vignettes, which allowed for manipulation of variables and randomization, a larger concern regarding vignettes relates particularly to construct validity. Construct validity was a concern because it is not certain if these vignettes realistically portray intimate partner violence among young adults. When creating the vignettes, steps were taken to ensure that the vignettes were as realistic as possible by examining previous examples (Hammock et al., 2014) and conducting pilot testing.

Counterbalancing of the vignettes by type of abuse, couple status, and gender of perpetrator, as well as randomization of the vignettes was used to reduce threats to internal validity such as attrition and repeat testing. Debate continues as to whether vignettes capture social reality and true opinions of reality (Erfanian et al., 2020), which contributes to the limitation of vignettes. However, there are ways to effectively utilize vignettes, including ensuring improving on internal validity. Future research could improve on the validity of these vignettes through other methods, including having IPV experts evaluate the representation of the vignettes' abuse type (Erfanian et al., 2019).

When examining type of abuse, the analysis found that IPV severity perception was higher for the vignettes that depicted physical abuse compared to the ones that depicted psychological abuse. This was even true after we intentionally measured forms of physical and psychological abuse that were both of moderate severity. The result is not surprising considering that prior research routinely indicates that perceptions of physical aggression are more negative than perceptions of psychological aggression (Basow et al. 2007; Hammock et al., 2015). This finding is likely because the negative impact of physical abuse tends to be more salient compared to psychological abuse (Basow et al., 2007). Despite such findings, psychological abuse is more prevalent than physical abuse, and the damage can exceed the harmful effects of physical abuse (Stark, 2006). Such research implies that psychological abuse is just as serious and requires just as much attention as physical abuse.

The analysis also examined the effects of the related constructs, namely attitudes toward homosexuality and history of intimate partner violence. Results found that IPV was perceived as more severe with a greater self-endorsed history of experiencing IPV.

Interestingly, the literature varies on whether a perceiver's own experiences with abuse (whether physical or psychological) impacts one's judgement on other situations. Basow et al. (2007) found that more experience with physical or relational aggression as a victim or perpetrator was related to judging aggression as more acceptable. However, DeHart et al. (2010) found that participant characteristics had little impact on judgments of the abusiveness of psychologically aggressive behaviors. Additional research is recommended to better understand the relationship between IPV experiences of the perceiver and their judgement of IPV severity.

The analysis found that participants who had accepting views about sexual minorities also had a higher perception of severity/harm for all vignettes. The findings are somewhat consistent with the present literature stating that negative attitudes towards homosexuality are consistent with less severe perceptions of IPV within same-sex couples (Rolle et al., 2018). The finding is interesting as the literature does not examine homophobia and perceptions of IPV in opposite-sex couples. A possible reason for the results could be that the participants' demographics overrode the positive views about sexual minorities being related to higher perceptions of IPV severity. Most of the participants in the study were female. Studies show that female participants typically rate IPV as more severe and less acceptable than male participants (Bastow et al., 2007; Dardis et al., 2015; Hamby & Jackson, 2010; Hutchinson, 2012; Little & Terrance, 2010). As such, additional research with varied participant demographics (namely gender) should be considered.

When examining the couple × perpetrator interaction, there was no significant difference in IPV perceptions of IPV severity between opposite-sex couples with male perpetrators, opposite-sex couples with a female perpetrators, same-sex couples with male

perpetrators and female perpetrators, nor was the difference between opposite sex couples (male and female) significantly higher than same-sex couples (male/female), thus not supporting Hypothesis 2.The literature for IPV severity perceptions among same-sex male and female couples is lacking, thus creating limitations in knowledge of how this kind of research works for same-sex couples. Prior research indicates that the general perception of IPV within same-sex couples is often less severe and overlooked as trivial or even nonexistent (Rolle et al., 2018). However, this study's findings did not support this trend. The results showed effects for type of abuse (physical and psychological) but did not show any effects for couple status (same-sex or opposite-sex) or for gender of perpetrator (male or female). One possibility could be that there was couple and perpetrator effects; however, the effects were too small to be detected by the chosen manipulation.

4.1 Limitations

The present study posed numerous limitations that could be addressed in future research. Although the use of vignettes allowed for manipulation and randomization, as stated above, there is still the possible problem of construct validity. Other research tools may be more equipped to effectively capture realistic aspects related to IPV severity. An alternative to vignettes would be to use a narrated video approach. The video could feature actors executing various IPV acts with follow up questions after the video presentation. Since the participant would be viewing the act, this may improve instrument validity and result in presenting a more realistic narrative of IPV. This method may then address the potential issue of whether the research effectively captures reality. Furthermore, the use of the names in the vignettes may have created some bias. Although

the vignettes were pilot tested to detect if the names were biased, as well as the realistic nature of the IPV, there is still a possibility of bias, as some participants may be partial to certain names than others due to prior experiences or stereotypes (Conway & Bethune, 2015). Another way to handle this issue could have been to replace the use of names with initials to decrease any potential biases; however, the lack of readability of the vignettes may suffer, as was noted during pilot testing.

Another limitation refers to the non-normality of the IPV perceptions construct. A normality distribution check indicated that the data were not normally distributed. Future research should include conducting a nonlinear transformation to combat the issue of the normality violation. Further, a closer examination focused on the mean scores of severity/harm indicated that for the psychological abuse vignettes, the severity/harm scores averaged below 2 on a 5-point Likert scale, whereas the physical abuse vignettes scores averaged above 2 for the severity/harm scores. This may indicate a floor effect for psychological abuse. These floor effects could potentially explain the limited variance across couple status and gender of the perpetrator.

For the present study, random coefficient modeling was used due to the repeated measures of the vignettes (i.e., nesting in the data). However, there are limited ways to conduct a power analysis to determine the baseline needs for an adequate sample size. An alternative analytic approach would have been a repeated measures ANCOVA, for which G*Power could be used to determine the sample size. While a random coefficient modeling multilevel approach is appropriate for the nested data and the repeated measures design of the vignettes, a repeated measures ANCOVA could also effectively handle those issues and allow for a proper power analysis to calculate a sample size.

The study also neglected the use of participant demographics (i.e., race, gender identity, school classification, and sexual orientation) as Level 2 predictors. Given the research that suggests that demographic information can correlate with differences in IPV perceptions, results from the study could have been attributed to specific participant demographics rather than one's attitudes towards sexual minorities. Due to this possibility, including participant demographics as predictors along with the predicted covariates could provide more of an explanation about the results. Finally, for the hypotheses, there was a lack of prior research that has focused on the comparison of IPV severity and harmful perceptions between same-sex and opposite-sex couples. This lack of research made hypotheses difficult to justify, especially regarding the second hypothesis within same-sex couples. Despite these limitations, the study's findings were able to produce practical and theoretical implications that may prove to be fruitful in future research.

4.2 Future Directions for Research and Intervention

Additional research is needed to focus on same-sex and opposite-sex couples and IPV perceptions. Further research can help broaden our understanding of IPV perceptions as well as differences in those perceptions when pertaining to sexual minorities. New methods of observing differences in IPV perceptions should be considered. The findings for the first hypothesis did not report any effects for the Level 1 predictors: couple status and gender of the perpetrator. It is possible that there were effects for these predictors, but that the effects were not large enough to detect. In conjunction with examining the Level 1 predictors, a future direction could be to also examine reaction time on each item in the data collection to test for implicit reactions. Observing reaction times on the

vignette items could show patterns of certain results being in reaction times instead of through couple status. It is possible that slower reaction times when responding to vignettes of same-sex couples may support findings that perceptions of IPV are higher in opposite-sex couples than same-sex couples. In conjunction with these findings of the first hypothesis, it would also be helpful to examine participant demographics as additional covariates. Observing participant demographics in relation to IPV severity may provide a further explanation to the results and support previous literature on differences in IPV severity perception.

The findings of the analysis for the second hypothesis found that there was no difference in IPV severity when examining the couple × perpetrator interaction: there was no significant difference in IPV perceptions of severity between opposite-sex couples with male perpetrators, opposite-sex couples with a female perpetrators, same-sex couples with male perpetrators and female perpetrators, thus not supporting Hypothesis 2.The research comparing same-sex male and same-sex female couples and IPV severity perceptions is lacking; thus, it would be beneficial to do more research in this area.

The dearth of research examining IPV among sexual minorities may be a contributing factor in the lack of treatment options available for sexual minority victims of IPV. For example, Brown and Groscup (2009) found that the majority of IPV advocacy programs historically failed to adequately respond to abuse within lesbian, bisexual, and gay groups. Furthermore, because of the lack of cultural competency and culturally informed support, the services that are provided to sexual minorities can be traumatizing and may cause a victimized individual to return to a perpetrating partner (Ard & Makadon, 2011). Research in sexual minority IPV can be useful in uncovering unique patterns and trends that we may not see in opposite-sex IPV. The research in

return cannot only help in promoting training programs for clinicians and social service providers but can also be used to help establish IPV treatment programs that are more tailored to sexual minority IPV victims. Therefore, by examining differences in perceptions of IPV among same-sex couples versus opposite-sex couples, we can begin to provide important information to change treatment barriers for same-sex couples experiencing IPV.

Additional research focusing on IPV in same-sex couples is needed for improving and expanding upon treatment services for sexual minorities who are IPV victims. Often, sexual minorities who are IPV victims have found that treatment services have been unhelpful. The present literature has found that although many services including emergency departments, shelters, agencies, and clinics had IPV advocacy programs, most of these programs historically failed in responding adequately to abuse in same-sex relationships (Goodman et al., 2015). The present study sought to explore this issue in hopes of adding to the literature that could be used to improve the services provided for sexual minority IPV victims. The study did not find any differences in perceptions of same-sex and opposite-sex couples, nor did the study find any significant differences in IPV severity perceptions in same-sex male and same-sex female couples. Despite the limitations mentioned earlier, additional research may benefit from using a vignette approach. Such vignette questions should not only focus on the perception but also gauge the individual's belief of urgency in intervening. By looking at concepts such as intervention and perceptions, the research can help provide more findings that could be used in adjusting services provided as well as helping to create services tailored to same-

sex IPV victims. Such research that has focused on IPV in same-sex couples has led to creation of lesbian, gay, and bisexual tailored treatments (Rolle et al., 2018).

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APPENDIX A
Vignettes

Vignette 1

- Vance has been in a relationship with his boyfriend, Oliver for a while. Recently, Vance has been making charges on Oliver's card without his permission. When Oliver confronts him about it, Vance tells him that he told Aspen about it and that he told him it was fine.

- Valencia has been in a relationship with her boyfriend, Oliver for a while. Recently, Oliver has been making charges on Valencia's card without her permission. When Valencia confronts him about it, Oliver tells her that he told Valencia about it and that she told him it was fine.

- Valencia has been in a relationship with her girlfriend, Olivia for a while. Recently, Olivia has been making charges on Valencia's card without his permission. When Valencia confronts her about it, Olivia tells her that she told Valencia about it and that she told her it was fine.

- Vance has been in a relationship with his girlfriend, Olivia for a while. Recently, Olivia has been making charges on Vance's card without his permission. When Vance confronts her about it, Olivia tells him that she told Vance about it and that he told her it was fine.

Vignette 2

- Vance and his boyfriend, Oliver go to mall one day. While in the mall, Vance gets mad at Oliver for buying a shirt without consulting him. The two argue, embarrassed and angry, Vance grabs Oliver by his arm and pulls him out of the store.

- Valencia and her boyfriend, Oliver go to mall one day. While in the mall, Valencia gets mad at Oliver for buying a shirt without consulting him. The two argue, embarrassed and angry, Valencia grabs Oliver by his arm and pulls him out of the store.

- Vance and his girlfriend, Olivia go to mall one day. While in the mall, Vance gets mad at Olivia for buying a shirt without consulting him. The two argue, embarrassed and angry, Vance grabs Olivia by her arm and pulls her out of the store.

- Valencia and her girlfriend, Olivia go to mall one day. While in the mall, Valencia gets mad at Olivia for buying a shirt without consulting him. The two argue, embarrassed and angry, Valencia grabs Olivia by her arm and pulls her out of the store.

APPENDIX B

Vignette Follow up questions

Follow up questions on severity

1. **How severe is this form of dating abuse or domestic violence?**
2. **How much harm do you think this causes the victim?**

No abuse	Minor to little abuse	Some abuse	Significant abuse	Severe abuse
No harm	Minor or little harm	Some harm	Significant harm	Severe harm

3. **Does this relationship need intervention**

Yes No Maybe/Not sure

APPENDIX C

Attitudes Toward Homosexuality Scale

Indicate the extent of your agreement or disagreement with the following statements about gay men and lesbian women (1=strongly disagree,7= strongly agree).
*R: items to be reverse coded
1. I prefer not to go to gay bars or nightclubs. (R)

2. Homosexuality is a natural expression of affection and sexuality.

3. Gay couples should have the same tax benefits (for example, joint income taxation) as straight couples.

4. Gay people disgust me. (R)

5. Homosexuality is incompatible with starting a family. (R)

6. I feel empathy for gay people.

7. I would be embarrassed if a gay person made sexual advances toward me. (R)

8. Gay couples (with or without adopted children) represent an enrichment to the traditional family model.

9. Gay couples should have the right to a residence permit if the partner is a foreigner.

10. I am embarrassed by gay people. (R)

11. I would be happy if my children had a gay or lesbian teacher.

12. Gay couples should have the right to marry.

13. Homosexuality goes against human nature. (R)

14. Gay couples should have the right to adopt children.

15. I am in solidarity with gay people.

16. It would not bother me at all if my child was gay or lesbian.

(R) These items are negatively worded and should be reverse scored before average scores are aggregated.

APPENDIX D

Community Composite Abuse Scale

Choose one of 6 response options for each item that reflected frequency of the experience: 'never', 'only once', 'several times', 'once a month', 'once a week'; and 'daily'.

My partner has:

1. Blamed me for causing their violent behavior
2. Shook, pushed, grabbed or threw me
3. Tried to convince my family, children, or friends that I am crazy or tried to turn them against me
4. Used or threatened to use a knife or gun or other weapon to harm me
5. Made me perform sex acts that I did not want to perform
6. Followed me or hung around outside my home or work
7. Threatened to harm or kill me or someone close to me
8. Choked me
9. Forced or tried to force me to have sex
10. Harassed me by phone, text, email or using social media
11. Told me I was crazy, stupid, or not good enough
12. Hit me with a fist or object, kicked or bit me
13. Kept me from seeing or talking to my family or friends
14. Confined or locked me in a room or other space
15. Kept me from having access to a job, money, or financial resources

APPENDIX E

Demographic Information

How old are you?

a. 18-21
b. 22-25
c. 26-29
d. Other, please specify

What is your classification

a. Freshmen
b. Sophomore
c. Junior
d. Senior

What is your racial/ethnic identity? :

a. American Indian or Alaska Native—For example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community
b. Asian—For example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese
c. Black or African American—For example, Jamaican, Haitian, Nigerian, Ethiopian, Somalian
d. Hispanic, Latino or Spanish Origin—For example, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Columbian
e. Middle Eastern or North African—For example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian
f. Native Hawaiian or Other Pacific Islander—For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese
g. White—For example, German, Irish, English, Italian, Polish, French
h. Other, please specify: _____
i. I prefer not to answer.

What is your gender identity? :

a. Male
b. Female
c. Transgender
d. Gender variant/non-conforming
e. Not listed, please specify:
f. I prefer not to answer

What is your sexual orientation? :

a. Heterosexual or straight
b. Gay or lesbian
c. Bisexual
d. Fluid
e. Pansexual
f. Queer
g. Demisexual
h. Questioning
i. Asexual
j. Other, please specify:
k. I prefer not to answer.