University of Massachusetts Boston
ScholarWorks at UMass Boston

Graduate Masters Theses | Doctoral Dissertations and Masters Theses

6-1-2012

How Would You Feel? Stigma and Self-Esteem in Student Responses to Intimate Partner Violence Vignettes

Taylor Lynn Hall
University of Massachusetts Boston, taylor.hall001@umb.edu

Follow this and additional works at: http://scholarworks.umb.edu/masters_theses

Recommended Citation
Hall, Taylor Lynn, "How Would You Feel? Stigma and Self-Esteem in Student Responses to Intimate Partner Violence Vignettes" (2012). *Graduate Masters Theses.* Paper 97.

This Open Access Thesis is brought to you for free and open access by the Doctoral Dissertations and Masters Theses at ScholarWorks at UMass Boston. It has been accepted for inclusion in Graduate Masters Theses by an authorized administrator of ScholarWorks at UMass Boston. For more information, please contact library.uasc@umb.edu.

HOW WOULD YOU FEEL? STIGMA AND SELF-ESTEEM IN STUDENT RESPONSES TO INTIMATE PARTNER VIOLENCE VIGNETTES

A Thesis Presented

by

TAYLOR L. HALL

Submitted to the Office of Graduate Studies,
University of Massachusetts Boston,
in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

June 2012

Applied Sociology Program

© 2012 by Taylor L. Hall
All rights reserved

HOW WOULD YOU FEEL? STIGMA AND SELF-ESTEEM IN STUDENT RESPONSES TO INTIMATE PARTNER VIOLENCE VIGNETTES

A Thesis Presented

by

TAYLOR L. HALL

Approved as to style and content by:

_____
Stephanie Hartwell, PhD, Professor of Sociology
Chairperson of Committee

_____
Melissa Schaefer Morabito, PhD, Assistant Professor of Sociology
Member

_____
Keith Bentele, PhD, Assistant Professor of Sociology
Member

_____
Stephanie Hartwell, Program Director
Applied Sociology Program

_____
Russell Schutt, Chairperson
Applied Sociology Department

ABSTRACT

HOW WOULD YOU FEEL? STIGMA AND SELF-ESTEEM IN STUDENT RESPONSES TO INTIMATE PARTNER VIOLENCE VIGNETTES

June 2012

Taylor L. Hall, B.A., Bridgewater State College
M.A., University of Massachusetts Boston

Directed by Professor Stephanie Hartwell

Intimate Partner Violence (IPV) is a public health issue defined as "a constellation of abusive and controlling behaviors including psychological abuse, isolation, threats, stalking, and physical violence that taken together create a climate of fear and intimidation that maintain one partner in a position of domination and control with the other partner in a position of subordination and compliance" (Family Violence Prevention Fund 2004; Campbell 2002). The current study was carried out at the University of Massachusetts at Boston (UMB), and explores the relationship between being a victim of IPV, self-esteem, and stigma across gender and other characteristics. Approximately 250 male and female undergraduate students responded to a survey examining attitudes about abuse in an intimate partnership after reading an IPV vignette where they are depicted as a victim of IPV. Respondents answered questions about self-esteem and stigma after imagining themselves as an IPV victim. The findings from the study suggest that male respondents report significantly higher levels of self-esteem and lower levels of perceived stigma than the female respondents. The results also suggest that income, race, and setting of upbringing influence respondents' previous knowledge of IPV. This study offers some insight to gender differences in self-esteem and stigma as they relate to all victims of IPV.

TABLE OF CONTENTS

INTRODUCTION AND RATIONALE 1

SECTION Page

1. LITERATURE REVIEW 5
Prevalence and Theory 5
Gender 9
Stigma and Self-Esteem 10

2. METHODOLOGY 14
Setting and Research Design 14
Subjects/Sample 15
Operationalization 17
Instruments 19
Hypothesizes 20

3. FINDINGS 21

4. MULTIPLE REGRESSION ANALYSIS 26

5. DISCUSSION 30

6. REGRESSION ANALYSIS 33

7. LIMITATIONS 36

8. CONCLUSION 38

APPENDIX

A. ROSENBERG'S SELF-ESTEEM SCALE 40

B. THE STIGMA SCALE 41

C. THE SURVEY 42

REFERENCE LIST 46

LIST OF TABLES

Table Page

1. Predictive Factors 6

2. Sample Descriptives 15

3. Sample Characteristics..... 16

4. Independent Samples T-Test (Sex/Self-Esteem Scale) 21

5. Independent Samples T-Test (Sex/Stigma Scale)..... 22

6. Independent Samples T-Test (Race/Self-Esteem & Stigma Scale)..... 23

7. Independent Samples T-Test (Income/Self-Esteem & Stigma Scales) 24

8. Chi-Square (Setting of Upbringing/Affected by IPV)..... 24

9. Correlation (Self-Esteem Scale/Stigma Scale) 25

10. Self-Esteem Regression 26

11. Stigma Regression 28

12. Interaction Effect of Self-Esteem on Male and Female Stigma Scores... 29

INTRODUCTION AND RATIONALE

Intimate Partner Violence (IPV) is defined as "a constellation of abusive and controlling behaviors including psychological abuse, isolation, threats, stalking, and physical violence that taken together create a climate of fear and intimidation that maintain one partner in a position of domination and control with the other partner in a position of subordination and compliance" (Family Violence Prevention Fund 2004). IPV differs from the traditionally held view of "domestic violence," which suggests perpetration primarily by males unto females (Johnson 2010). The term "domestic violence" is subsumed by the term "intimate partner violence" in order to include not only married couples, but nonmarital relationships, dating adolescents, divorced females, and lesbians and gay males (Sorenson & Thomas 2009).

IPV is a public health and social issue for couples, especially for those aged 16-19 (Leaman & Gee 2008). The US Bureau of Justice (USBJ) suggests that although nonfatal IPV has been on the decline since 1993, yet female victims still comprise the majority of IPV victims. The USBJ also found that 22% of nonfatal violent victimizations and 30% of fatal violent victimizations against females were caused by an intimate partner, whereas only 4% of nonfatal violent victimizations and 5% of fatal violent victimizations against men were caused by an intimate partner. The USBJ reports that women and men ages 20-24 are most at risk for being a victim of IPV, and that being married or widowed, versus single, separated, or divorced, lowers one's chance of being a victim of IPV.

Being an American Indian female increases one's chances of being a victim of IPV, which is an effect not seen for white, black, and Hispanic victims according to USBJ. Females with lower annual incomes experience higher annual IPV victimization rates (Catalano USBJ, 2007); the effect of race and income are not seen with male victims. Both males and females living in urban areas reported higher levels of nonfatal IPV, whereas males and females living in rural and suburban areas report less IPV (Catalano USBJ, 2007). About 1 out of every 5 female students (20.2% in 1997 and 18.0% in 1999) reported being a victim of IPV, according to the Massachusetts Youth Risk Behavior Survey (Silverman, Raj, Mucci, & Hathwaway 2001). Leaman and Gee (2008) propose that the prevalence of anxiety and depression during this age could be the cause of increased IPV. Robertson and Murachver (2009) examine the current rise in numbers of female to male perpetrated partner violence, as opposed to the historical concept of male to female perpetrated partner violence. Their examination provides evidence (1) of a higher incidence of female perpetrated intimate partner violence, or (2) that males are beginning to be comfortable reporting their abuse to authorities. Similarly, Melton and Belknap (2003) discovered that males and females reported both perpetrating violence and being victims, yet females were more likely to initiate violence. These broadened findings are particularly problematic, considering the costs for IPV against women alone exceeds an estimated 8.3 billion dollars each year (CDC 2003; Max et al. 2004, as cited in Fang & Corso 2008). The costs of male victims are not included in these estimates.

In addition to the physical consequences of IPV, many IPV victims discuss feeling stigmatized, of being "damaged goods" (Sandelowski, Lambe, & Barroso 2004; Goffman

1963) after repeated victimization, which can either result in a loss of self-esteem and self-worth or becoming resilient (Shih 2004). Goffman (1963) describes stigma as the "negative evaluation of a person as tainted or discredited on the basis of attributes such as mental disorder, ethnicity, drug misuse or physical disability" (as cited in King et al. 2007). Some research details the accounts of stigmatized individuals who understand that "stigmas are social constructions" (Shih 2004: 179) and have overcome both the self and public stigmas associated with being a victim of IPV. In a study exploring IPV and self-esteem, Jezl, Molidor, and Wright (1996) report that about 17% of female subjects reported remaining in physically abusive relationships, and there was a significant difference in the levels of self-esteem for female subjects who had experienced IPV in dating relationships and those who had not, which may explain why abused partners may stay in highly abusive relationships. The purpose of the current study is to understand how males and females view themselves, and how they perceive others view them after being a victim of IPV. This study exclusively looks at the responses and opinions of college students, which, along with the examination between IPV and stigma, is a unique contribution to current literature. Variables previously identified in the literature, such as race, age, setting of upbringing (rural, suburban, urban), and gender, were collected and analyzed in relation to responses to the IPV vignette. Previous research, which has acknowledged IPV to be a "pervasive phenomenon within our wider community" (Robertson & Murachver 2009: 1482), has examined the mixed feelings society has in relation to male victims of female perpetrated intimate violence and female victims of male perpetrated intimate violence (Jezl, Molidor, & Wright 1996). The focus here is on

gendered roles and their differences in terms of normalcy. Research on the matter will help to shed light on different responses for males and females, which could potentially affect treatment methods, policy, and criminal justice actions in the future. In recent efforts, like those undertaken in Boston (Boston Public Health Committee's Domestic Violence Program 2011), seminars have been implemented in the classroom on the prevalence and common occurrence of teen IPV. Public service workers have also attended trainings on how to appropriately deal with victims and perpetrators of IPV with whom they come in contact. A larger body of research on these matters could potentially affect treatment methods or influence policy changes and criminal justice actions in the future (Boston Public Health Committee's Domestic Violence Program 2011).

LITERATURE REVIEW

Prevalence and Theory

It is estimated that approximately 8.5 million males and females are physically and sexually assaulted by an intimate partner each year with 2 million injuries and 1,300 deaths annually (Fang & Corso 2008; Cunradi, Caetano, & Schafer 2002). In turn, as the number of perpetrators and victims grow, knowledge of IPV has increased. Estimates may be lower than the actual incidence because victims of dating violence generally keep the violence a secret, withdraw from social activity, and very rarely discuss their victimization with others in fear of loved ones discouraging the relationship or taking legal action (Link, Struening, Rahav, Phelan, & Nuttbrock 1997; Link & Phelan 2006; Jezl, Molidor, & Wright 1996). Reasons for not reporting incidences of intimate partner violence include fear of reprisal of the abuser, feelings of being ashamed or embarrassed about what happened, believing the abuse is too minor to report, the abuse is too personal of an issue to discuss, or fear of being further stigmatized (Melton & Belknap 2003). Henning et al. (2009) found that female suspects of IPV were half as likely to recidivate compared to males in the sample, which could account for the disparity in perpetration numbers. Lack of public acceptance of the concept of the "male victim" may also play a role in these numbers (Robertson & Murachver 2009), for there is still a general belief that males cannot be victims of IPV when in a partnership with a female. The increasing number of IPV victims across the sexes led to "developing public policies and standard

intervention practices for both victims and perpetrators of IPV," which include state grants to start educating youth on the public health issue of IPV in an attempt to increase awareness and decrease prevalence (Gilfus et al. 2010: 246).

A large body of research reveals factors that increase the likelihood of IPV. These predictive factors are depicted in Table 1 below.

Table 1: Predictive Factors

Predictive Factors of IPV	**References**
Living in an economically disadvantaged neighborhood	Gilfus, O'Brien, Trabold, & Fleck-Henderson 2010; Fang & Corso 2008; Leaman & Gee 2008; Fox & Benson 2006; Cunradi, Caetano, & Schaefer 2002.
Being an unmarried female	Leaman & Gee 2008; Fox & Benson 2006.
Having delinquent peer associations	Henning, Martinsson, & Holdford 2009; Fang & Corso 2008.
Antisocial attitudes	Henning et al. 2009; Cunradi et al. 2002.
Alcohol and drug abuse	Henning et al. 2009; Langhinrichsen-Rohling 2009; Cunradi et al. 2002.
Lack of employment	Henning et al. 2009; Cunradi et al. 2002.
Low educational attainment	Henning et al. 2009; Fang & Corso 2008; Cunradi et al. 2002.
Being in a dating relationship	Henning et al. 2009.
Age	Leaman & Gee 2008; Cunradi et al. 2002.
Income	Fox & Benson 2006; Cunradi et al. 2002.
Race/Ethnicity	Gilfus et al. 2010; Leaman & Gee 2008; Cunradi et al. 2002.
Non-religious affiliation	Fang & Corso 2008; Cunradi et al. 2002.
Sexual orientation	Gilfus et al. 2010.
Immigrant status	Gilfus et al. 2010.

Table 1 also supports the findings of existing research surrounding the average members of stigmatized groups as also exhibiting these disadvantaged "life domains" (Link & Phelan 2001: 380) just as IPV victims do. For instance, financial issues from lack of employment, immigrant status, or low educational attainment may create feelings of

stress between partners regardless of social class, and stress may lead to physical aggression between partners (Fox & Benson 2006). Looking at the many factors that can predict or potentially lead to IPV for a couple, it is understandable that recidivism rates are high for IPV offenders, as many of these variables are somewhat fixed or static rather than dynamic and changeable. For example, upward mobility, financially, is difficult to achieve for any population in today's world without an educational background.

The family violence perspective "looks for explanations of violence without regard to gender of perpetrator or victim" (Fox & Benson 2006: 420; Gilfus et al. 2010; Melton & Belknap 2003). The patriarchal control perspective "views men's violent aggression as a tool for maintenance of a gendered hierarchy of control" (Fox & Benson 2006: 420). The social disorganization perspective looks at the link between neighborhood disadvantage and violent crime rates, which can sometimes include IPV (Fang & Corso 2008; Fox & Benson 2006). The feminist perspective maintains that mainly males in the relationship perpetrate intimate partner violence in order to exert power over his female partner (Gilfus et al. 2010; Johnson 2010; Henning et al. 2009; Langhinrichsen-Rohling 2009; Melton & Belknap 2003), and that this patriarchal belief was rooted in Christianity, where women were initially viewed as secondary to men in a power dynamic (Cunradi et al. 2002). The feminist perspective is most often criticized because of the increasing arrest rates of females for domestic assault in recent years (Gilfus et al. 2010). The list of predictive factors of possible perpetration or victimization of IPV makes it difficult to identify the most operative theoretical perspectives in this matter, yet it seems like the relationship between IPV, stigma, and self-esteem is

coinciding with the predictive factors in Table 1. Characteristics such as living in an economically disadvantaged neighborhood, the lack of employment, low educational attainment, and being of a certain race or ethnicity can be stigmatizing and influence self esteem. When stigmas are grouped as predictive factors of IPV (refer back to Table 1), it seems to follow that being a victim of IPV would lead to stigmatization and low self-esteem as well.

The research on stigma is multidisciplinary, across social psychological and sociological works, and the concept of stigma has been linked to an array of conditions, from being diagnosed with AIDS or mental illness to being an unwed mother (Link & Phelan 2001). When viewing stigma through a social-psychological lens, the theory of stigma represents the extent to which a person believes that other people will devalue or discriminate against them based on a certain attribute or trait (Link et al. 1997). The general theory of stigma also suggests that stigma elicits an involuntary response of stressors in the body, whether conscious or unconscious (Major & O'Brien 2005, as cited in Yang et al. 2006). Other approaches to stigma include an anthropological or ethnographic view in which the focus is on lived or social experience, which refers to the experiential flow of the local world, or the person's social network and domain, and lastly the cross-cultural perspective, which views stigma as a "universal phenomenon, a shared existential experience" (Yang, Kleinman, Link, Phelan, Lee, & Good 2006: 1528). The cross-cultural perspective allows us to understand both the stigmatized and the stigmatizers (Yang et al. 2006). This is a great way to look at stigma through a non-gendered view. Link and Phelan (2001) have determined that a multi-faceted approach to

stigma would be most likely to produce fundamental changes in the attitudes and beliefs that attach to power relations in groups of the stigmatized and the stigmatizers.

Gender

Several studies cite IPV as an equally gendered violent act. Many researchers refer to this phenomenon as "gender symmetry," and this means (in terms of IPV) that "roughly the same number of men and women acknowledge that at least once in some specified time period they have engaged in at least one of the violent behaviors listed in whatever survey instrument is used" (Johnson 2010: 213; Melton & Belknap 2003). In addition to this, self-reports claim that psychological abuse is the most common form of IPV (Sorenson & Thomas 2009), and is often initiated by females rather than males in many IPV occurrences (Morse 1995; Whitaker et al. 2007, as cited in Capaldi et al. 2009; Langhinrichsen-Rohling 2009). Research completed by the World Health Organization indicates that "higher rates of female victimization have been found in countries where females' status remains low; whereas, higher rates of male victimization are typically found in countries like the United States where there is a greater gender equality" (Harvey et al. 2007, as cited in Langhinrichsen-Rohling 2009: 180). On the other hand, "male-perpetrated violence is viewed as more serious, more criminal, and more likely to cause harm than female-perpetrated violence" (Robertson & Murachver 2009: 1482-1483), which may help to understand why fewer males come forward after being abused. A male victim of IPV breaks gender role norms, and male victims risk not being taken seriously (Harris & Cook 1994). For example, Robertson & Murachver (2009) found attitudes towards male perpetrated IPV were much more harsh than female perpetrated

IPV, and that "the greater tolerance of female-perpetrated abuse was often associated with the belief that females cannot do as much physical damage as males and that males are more able to 'take' the violence" (Robertson & Murachver 2009: 1492). Males often feel pressure to take on traditional masculine characteristics and do not publically admit being abused.

Stigma & Self-Esteem

Goffman (1963) describes stigma as the "negative evaluation of a person as tainted or discredited on the basis of attributes such as mental disorder, ethnicity, drug misuse or physical disability" (as cited in King et al. 2007). In fact, stigma harms self-esteem and self-efficacy (Warner et al. 1989, as cited in Shih 2004), even though there are resources available to the greater public to handle stigma, such as professional therapy and support groups (Miller & Kaiser 2001, as cited in Shih 2004). Although Goffman never mentioned victims of IPV in his original writings, researchers have taken his work and reinterpreted it to apply to many new stigmatized traits in human beings, such as having HIV/AIDS or having mental illness. He describes stigmatized individuals as being "constantly self-conscious and calculating what impression they are making" (Goffman 1963, as cited in King et al. 2007: 248). This is a similar reaction used to describe women growing up in a modern world while still trying to fit into traditional feminine gender roles (Athenstaedt, Heinzle, & Lerchbaumer 2008). Expanding Goffman's work (1963), current researchers have developed the term "self stigma," which can be described as "the reactions of stigmatized individuals towards themselves" (Corrigan et al. 2003; Rusch et al. 2005, as cited in King et al. 2007: 248). Corrigan and

Watson (2002) also created the term "public stigma" that encompasses the "judgments and negative stereotypes that society places on the stigmatized individual" (Shih 2004: 177). Victims of IPV may experience "anticipated stigma," which is "living in fear and the hurtful effects of stigmatization, including social rejection, discrimination, and even violence, in relations with children, partners, relatives, friends, and acquaintances, employers and co-workers, and health care providers" (Sandelowski, Lambe, & Barroso 2004: 124). The stigma scale used in this study incorporates examples of self, public, and anticipated stigma.

Goffman (1963) felt that "stigmas that are perceived to be uncontrollable are judged less severely than stigmas seen as controllable" (Shih 2004: 182). Because being a victim of IPV is seen as controllable, the victims are judged more severely (Plichta 2007). Understanding the link between self-esteem and stigma is important in terms of treatment and outcomes for victims of IPV, but also to understand gender difference in both self-esteem and stigma. When viewing the relationship between stigma and self-esteem, "it is not so much that stigma influences self-esteem, but rather that self-esteem shapes one's perceptions of and responses to the experience of stigma" (Link, Struening, Neese-Todd, Asmussen, & Phelan 1997: 2). In a study by Shih (2004), respondents declared, "overcoming the adversities associated with stigma as an empowering process, as opposed to a depleting process" (175) and that they may even try harder to be well liked in society (178). Although this is a possible avenue of reaction to stigma, respondents' experiences were consistent with the stigma theory in that they reported great difficulty gaining access to "resources such as housing, public accommodations, employment, and

education" (Corrigan et al. 2001; Gibbs 1987, as cited in Shih 2004: 175-176). As suggested by these study results, many times individuals who reject negative public images are more likely to strive to maintain social status and to function at a high level (Warner et al. 1989, as cited in Shih 2004: 181). Goffman (1963) also discussed the ability to overcome stigma suggesting an individual, "may also see the trials he has suffered as a blessing in disguise, especially because of what it is felt that suffering can teach one about life and people" (11). Goffman (1963) suggested using stigma management as well to develop normalization, through "education and advocacy, creation of and participation in supportive communities, and, most importantly, information control" (Sandelowski et al. 2004: 126).

Link (2006/1) identified several components to stigma, which include, labeling human differences, stereotyping, separating "them" from "us," discriminating to the point of loss of status, and the exertion of power over those who have been stigmatized. The inclusion of exerting the role of power in the definition of stigma organically connects to the concept of IPV; in fact, Link and Phelan (2001) believe that "stigma is dependent on power" (376), which when applied to gender, is consistent with a feminist theoretical lens. Similar to Goffman's (1963) research, Link and Phelan (1996) and Link et al. (1997) find that the impact of stigma can strain social interactions and networks, lower quality of life, lower levels of self-esteem, higher levels of stress, and the development of depressive symptoms. Discussed as well is the under-recognized effect of stigma on employment opportunities, housing, and access to medical care, which have only recently been explored in the literature surrounding stigma (Link & Phelan 2001; Link, Struening,

Neese-Todd, Asmussen, & Phelan 1997; Link & Phelan 1996). Link and Phelan (2001) show how "having a status that is devalued in the wider society can lead to very concrete forms of inequality" (371) such as discrimination, which then makes it harder for stigmatized victims with low levels of self-esteem to move forward in their lives. Because victims of both IPV and those who are stigmatized both note feeling as though they are "damaged goods" and exhibit lower levels of self-esteem, it is worth exploring all three factors (IPV, stigma, and self esteem).

METHODOLOGY

Setting and Research Design

Students for this study were recruited at University of Massachusetts Boston (UMB) is a commuter campus with over 150 undergraduate, graduate, and non-degree programs and over 15,000 students, the majority of which are enrolled in undergraduate degree programs. The college campus has a commuter rail train station and MBTA subway station stop located a short distance from campus providing easy access for students from Boston and beyond.

Survey data were collected from the beginning of September through mid October, fall 2011, in 10 undergraduate Sociology and Criminal Justice courses (with anywhere from 25-50 students in attendance per class) at UMB. I obtained approval from professors to enter their classrooms during the data collection phase to administer surveys, which included an oral consent to waive written signatures of participants. This ensured participants' anonymity. Before passing out the survey packets to students, each student received written information on contact information for the UMB Counseling Center and a 24-hour IPV hotline to use if necessary. No names or identifying information were collected on the surveys, therefore, there was nothing linking the students to their survey responses. Because of the nature of the survey, respondents could experience emotional discomfort as a result of participation. However, students were informed on the survey cover page, and verbally, that they could stop completion of the

survey at any time for any reason, without any adverse consequences. Willing undergraduate students in Criminal Justice and Sociology classes (N=250) completed the survey including scales on self-esteem and stigma after reading a vignette depicting IPV. A total of 4 students declined to participate in the survey, returning a blank copy. Although each student in volunteering classrooms received a survey packet, a disclaimer reminding students that they could opt out of the survey at any time, or pass in a blank survey at the end of the survey session was on the cover page of the survey.

The purpose of this survey was to examine the differences of responses by gender; more specifically, if there is a statistically significant gendered difference in the way victims of IPV perceive how society views a male victim from a female victim. Each survey collected background demographic information, followed by the vignette in which the reader is positioned as the victim of intimate partner violence. After reading the vignette, participants completed the Rosenberg's Self-Esteem Scale and an additional scale measuring stigma. Two hundred and fifty (250) students responded to the survey. The survey took approximately 5-10 minutes for students to complete. After the surveys were collected, the numerical and scaled survey information was entered into SPSS for analysis.

Subjects/Sample

The surveyed sample is described below in Table 2.

Table 2: Sample Descriptives

Category	Characteristic	Number	Mean/Mode
SEX	Male	111	Female
	Female	138	
RACE	White	131	White
	Black	25	

	Hispanic	33	
	Asian	35	
	Bi-racial	15	
	Other	5	
AGE	22 and under	175	22 years
	23-30	61	
	31 and over	9	
STUDENT LEVEL	Freshman	35	Junior
	Sophomore	46	
	Junior	88	
	Senior	79	
AREA OF UPBRINGING	Rural	27	Suburban
	Suburban	117	
	Urban	96	
HOUSEHOLD INCOME	$30,000 and less	39	$70,763.95
	$31,000 to $100,000	98	
	$100,000 and above	20	

When comparing the sampled group to the UMB population, percentages reveal the study sample was more racially diverse, younger and included more upper class students (Table 3).

Table 3: Sample Characteristics

Category	Characteristic	Sample %	UMB %	Soc and CJ%
SEX	Male	45%	40%	43%
	Female	55%	60%	57%
RACE	White	53%	61%	47%
	Black	10%	15%	17%
	Hispanic	13%	9%	13%
	Asian	14%	12%	9%
	Biracial	5%	0.6%	3.5%
	Other	3%	1.43%	2%
AGE	22 and under	70%	50%	48%
	23-30	24%	34%	39%
	31 and over	5%	16%	13%
STUDENT	Freshman			

LEVEL		14%	26%	17%
	Sophomore	18%	20%	20%
	Junior	35%	25%	36%
	Senior	31%	23%	29%

In comparing the study sample with Sociology and Criminal Justice major's demographics, descriptive differences emerge with the study sample being younger than the Sociology and Criminal Justice majors. In other areas, the study sample more closely aligns with Sociology and Criminal Justice majors.

Operationalization

This research project employs a vignette that describes a story of IPV with the respondent as the victim. This technique is used because vignettes are useful in exploring potentially sensitive topics that participants might otherwise find difficult to discuss (Neale 1999, as cited in Barter & Renold 2000). Vignette methodologies, "can help to avoid potential harm to participants from their co-operation in social research" (Hughes & Huby 2001). Robertson and Anderson (1993) agree, suggesting, "vignettes have been used to study judgment formation on sensitive topics, such as race relations, crime, and attitudes towards ethic, religious, or gender groups" (627). Although Robertson and Anderson's 1993 study dealt with business ethics, they found that the use of vignettes and a scale on ethics allowed the subjects' to be more honest and less socially desirable. Sorenson and Thomas (2009) used vignette methodology in a study on IPV and same-sex relationships, and the vignette in this study is closely modeled after their vignette. Because the vignette positions the reader in relation to an imagined partner, this vignette methodology works well across gender and sexual orientation, whereas other studies

conducted on IPV use assessment tools "developed and tested for use with only one gender- typically for women who are battered or for men who batter- and with heterosexual samples" (Gilfus et al. 2010: 256). Vignettes are a way to discuss sensitive topics while still enabling a high level of control over the research process (Barter & Renold 2000; Robertson & Anderson 1993).

One of the independent variables in this study is reported or identified gender, not sex in order to let the respondent's reply based on gender roles. The respondent's identifying gender is answered either male or female. Also, household income is an independent variable. Low overall household income will be identified as less than $30,000 per year per household. A $30,000 cutoff for low-income households was designated based on the 2011 Federal Poverty Guidelines; low-income at the federal level for a family of four is set at $28,813, and because Massachusetts minimum wage is higher than the federal minimum wage, the low-income cutoff was rounded up to $30,000 for a family of four. Reported race/ethnicity and reported area raised in (rural, suburban, or urban) also serve as independent variables.

The dependent variables in this study are reported levels of self-esteem and social stigma. Self-esteem is measured by responses to Rosenberg's (1965) Self-Esteem Scale, with scores from 0-30. This scale is shown to have high test-retest reliability and concurrent validity, and is suitable to pair with the stigma scale to explore the relationship between perceived stigma and self-esteem. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem (See Appendix A).

Social stigma is measured by responses to the questions taken from the Stigma Scale developed by a group of psychiatrists in 2007 after being tested several times for validity and reliability (King, Dinos, Shaw, Watson, Stevens, Passetti, Weich, & Serfaty 2007). Originally consisting of 28 questions broken down into three subscales, this research project uses a combination to measure experienced stigma, which is originally derived from the work of Goffman (1963); they are: (1) discrimination, (2) disclosure, and (3) potential positive aspects of stigma. The responses are measured using a Likert scale from strongly agree (for a score of 5) through strongly disagree (for a score of 1), receiving a number of points from each answer to create a combined score. King et al. (2007) "chose a five-point Likert scale as a straightforward, widely used response style that avoided more difficult formats such as visual analogue scales and yet accurately reflected participants' experiences" (249). This scale is also unique because it includes both *felt* and *enacted* examples of stigma. *Felt* stigma is "internalized negative views that lead to behaviors to hide it" and *enacted* stigma is "episodes of discrimination against people for their perceived status" (King et al. 2007: 253). Scores range from 0-75 (see Appendix B).

Instruments

The surveys combine the above scales (see also Appendix A and B) and are given survey ID numbers for data entry by individual respondent/case. The four components of the survey are (see survey attachment, Appendix C):

1. Demographic questions: participant's gender, age, area of residence, and academic major.

2. IPV Vignette: depicts the respondent as a victim of intimate partner violence.

3. Rosenberg Self-Esteem Survey: Scoring on the items (see previous section) is from 0 to 3; from strongly disagree, to strongly agree. This survey has 10 questions and will be used to measure how respondents feel after being placed as a victim of IPV in the survey's vignette.

4. The Stigma Scale: This research project uses a combination of (1) discrimination, (2) disclosure, and (3) potential positive aspects of stigma from the scale with responses ranging from strongly agree (score of 5) through strongly disagree (score of 1), each receiving a number of points from each answer combined to create a score.

Hypotheses

The following six study hypotheses emerged from findings in previous literature surrounding IPV:

H1: Males will report higher responses on the self-esteem scale than females after the IPV vignette reading.

H2: Females will have higher reported levels of perceived social stigma after the IPV vignette reading.

H3: Subjects reporting minority racial status will have lower responses on the self-esteem scale and higher levels of perceived social stigma after the IPV vignette reading.

H4: Subjects reporting lower household incomes will have lower levels of self-esteem and high levels of reported perceived social stigma after the IPV vignette reading.

H5: Setting of upbringing will be related to whether or not respondents have themselves been affected by IPV or if someone they know has been affected by IPV.

H6: High scores of the self-esteem scale will correlate to low scores on the stigma scale.

FINDINGS

H1: Males will report higher responses on the self-esteem scale than females after the IPV vignette reading.

An independent samples T-test was performed to show the mean scores of male and female respondents on the self-esteem scale, which is scored from 0-30. Scores below 15 are considered low self-esteem, with scores between 15-25 considered average. Table 4 shows that the mean score of 111 male respondents is 21.65 and the mean score from 138 female respondents is 18.51 with a standard deviation of 5.33 and 7.00, respectively. Results from the T-test show a highly significant difference between mean scores of males and females on the self-esteem scale at the 0.001 level.

Table 4: Independent Samples T-Test (Sex/Self-Esteem Scale)

		f	Sig.	T	Df	Sig. (2-tailed)	Mean difference	Std. Error	Lower (95%)	Upper (95%)
Rosenberg's Self-Esteem Scale	Equal Variances Assumed	9.75	.002	3.90	247	.000	3.14140	.8948	1.556	4.726
	Equal Variances Not Assumed			4.02	246	**.000**	3.14140	.7817	1.602	4.681
N=249										

H2: Females will have higher reported levels of perceived social stigma after the IPV vignette reading.

An independent samples T-test was performed to show the mean scores of male and female respondents on the stigma scale. The stigma scale scores can range from 15-75, with higher scores representing a higher level of perceived social stigma. Table 5 shows that the mean score of 110 male respondents is 43.82 and the mean score from 138 female respondents is 47.14 with a standard deviation of 10.99 and 8.81, respectively. Results from the T-test show a highly significant difference between mean scores of males and females on the stigma scale at the 0.01 level.

Table 5: Independent Samples T-Test (Sex/Stigma Scale)

		F	Sig.	T	Df	Sig. (2-tailed)	Mean difference	Std. Error	Lower (95%)	Upper (95%)
Stigma Scale	Equal Variances Assumed	2.208	.139	-2.65	246	**.008**	-3.326	1.253	-5.795	-.857
	Equal Variance Not Assumed			-2.59	207	0.10	-3.326	1.284	-5.858	-.795
N=248										

H3: <u>Subjects reporting minority racial status will have lower responses on the self-esteem scale and higher levels of perceived social stigma after the IPV vignette reading.</u>

Race was recoded to define two groups: white and non-white. An independent samples T-test was performed to show the mean scores of white and non-white respondents on the self-esteem scale and the stigma scale. Table 6 shows that the mean score on the self-esteem scale of 131 white respondents is 18.56 and the mean score from 116 non-white

respondents is 21.49 with a standard deviation of 6.57 and 6.06, respectively. Results from the T-test show a highly significant difference between mean scores of whites and non-whites on the self-esteem scale at the 0.001 level. Table 6 also shows that the mean score on the stigma scale of 131 white respondents is 46.07 and the mean score for 115 non-white respondents is 45.30 with a standard deviation of 9.68 and 10.24, respectively.

Table 6: Independent Samples T-Test (Race/Self-Esteem & Stigma Scales)

		f	Sig.	T	df	Sig. (2-tailed)	Mean Difference	Std. Error	Lower (95%)	Upper (95%)
Rosenberg's Self-Esteem Scale	Equal Variances Assumed	.191	.662	3.63	245	**.000**	-2.934	.8077	4.525	1.343
N=247										
Stigma Scale	Equal Variances Assumed	.318	.573	.629	244	.530	.799	1.270	1.713	3.312
N=246										

H4: <u>Subjects reporting lower household incomes will have lower levels of self-esteem and higher levels of reported perceived social stigma after the IPV vignette reading.</u>

Reported household income was recoded to two categories: low income ($30,000 or less per household per year) and middle-wealthy income ($31,000 and above per household per year). An independent samples T-test was performed to show the mean scores of low-income and middle-wealthy income respondents on the self-esteem scale and the stigma scale. Table 7 shows that the mean score on the self-esteem scale of 39 low-income respondents is 20.51 and the mean score from 108 middle-wealthy class respondents is 19.36 with a standard deviation of 5.70 and 6.30, respectively. Table 7 also shows that the mean score of 39 low-income respondents on the stigma scale is 47.82 and the mean

score from 107 middle-wealthy class respondents in 46.48, with a standard deviation of 8.29 and 9.87, respectively. Neither of these tests proved significant, though low-income respondents scored higher on the self-esteem scale than middle-wealthy level respondents.

Table 7: Independent Samples T-Test (Income/Self-Esteem & Stigma Scales)

		F	Sig.	T	df	Sig. (2-tailed)	Mean difference	Std. Error	Lower (95%)	Upper (95%)
Rosenberg's Self-Esteem Scale	Equal Variances Assumed	.843	.360	1.008	145	.315	1.151	1.142	1.107	3.410
N=147										
Stigma Scale	Equal Variance Assumed	.1088	.743	.758	144	.450	1.343	1.773	2.161	4.848
N=146										

H5: Setting of upbringing will be related to whether or not respondents have themselves been affected by IPV or if someone they know has been affected by IPV.

A chi-square was used to determine the relationship between setting of upbringing and previously being affected by intimate partner violence. Table 8 shows that 234 participants responded to this set of questions, and that 82 had themselves been affected or someone they have known been affected by IPV, and 152 had not been affected by IPV. There is no statistical significance in the relationship between these two variables.

Table 8: Chi-Square (Setting of Upbringing/Affected by IPV)

	Value	Df	Asymp. Sig. (2-tailed)
Pearson Chi-Square	.237	2	.888
Likelihood Ratio	.236	2	.889

Linear-by-Linear Association	.144	1	.704
N=234			

H6: <u>High scores of the self-esteem scale will correlate to low scores on the stigma scale.</u>

A correlation was used to determine the relationship between scores on the self-esteem scale and scores on the stigma scale. Table 9 shows that the Pearson's R correlation coefficient is -0.217, which shows significance at the 0.01 level with negative, weak to medium correlation strength. This shows that as scores on the self-esteem scale increase, scores on the stigma scale decrease, as predicted.

Table 9: Correlation (Self-Esteem Scale/Stigma Scale)

		Rosenberg's Self-Esteem Scale	Stigma Scale
Rosenberg's Self-Esteem Scale	Pearson Correlation	1	**-0.217****
	Sig. (2-tailed)		.001
	N	250	249
Stigma Scale	Pearson Correlation	**-0.217****	1
	Sig. (2-tailed)	.001	
	N	249	249

MULTIPLE REGRESSION ANALYSIS

Multiple regression analyses were run for both the self-esteem scale and the stigma scale. In Table 10, we see that the variables for sex (male) and race (white) are highly significant at the 0.01 level when explaining the scores on the self-esteem scale. Low-income ($30,000 annual household income or less) and setting of upbringing (urban) are not significant in the regression, yet the R^2 value of 0.147 suggests these factors only explain 14.7% of the variation of the scores in the self-esteem scale. When using the raw score for income instead of the low-income dummy variable, the finding is less significant than when using the dummy variable for income, as seen in Table 10. Also not shown an interaction effect between raw income and race. This interaction effect was not significant, but it did raise the R^2 value from 14.7% to 14.9%.

Table 10. Self-Esteem Regression

	Model 1
Race Non-White	0.000***
Income Raw Income	0.85
Area Urban Setting	0.270
Male	.004***
Constant	.000***

Number of Observations	147

^p < .1 * $p < .05$ ** $p < .01$ *** $p < .001$

A multiple regression analysis was also run for the stigma scale. In Table 11, Model 1, we see that all the variables, besides being a male, that were hypothesized to predicted high scores on the stigma scale are not significant. The R^2 value of 0.064 suggests these factors only explain 6.4% of the variation of the scores in the stigma scale. Once the Self-Esteem Scale score is added to the regression model, we see how our significant scores change. The Self-Esteem Scale score is inserted in this regression because there is a theory that self-esteem may mediate or impact levels of stigma (Warner et al. 1989), so applying that thought to this situation is crucial. In Table 11 Model 2, the R^2 value has now increased from 6.4% to 9.9%, and although being a male is now less significant, both being male and scores on the Self-Esteem Scale are significant in this regression model. Because being a male and the scores on the self-esteem scale are significant in this model, an interaction effect between male and scores on the self-esteem scale is added to the stigma regression model in Table 11, Model 3. An interaction effect is added to the model to examine whether the relationship between self-esteem and stigma is different for men and women. The R^2 value has now increased from 9.9% to 14.2%, and now being a male with high self-esteem is significant in this regression model, showing that this combination of traits is a positively predictive factor of low scores on the perceived stigma scale.

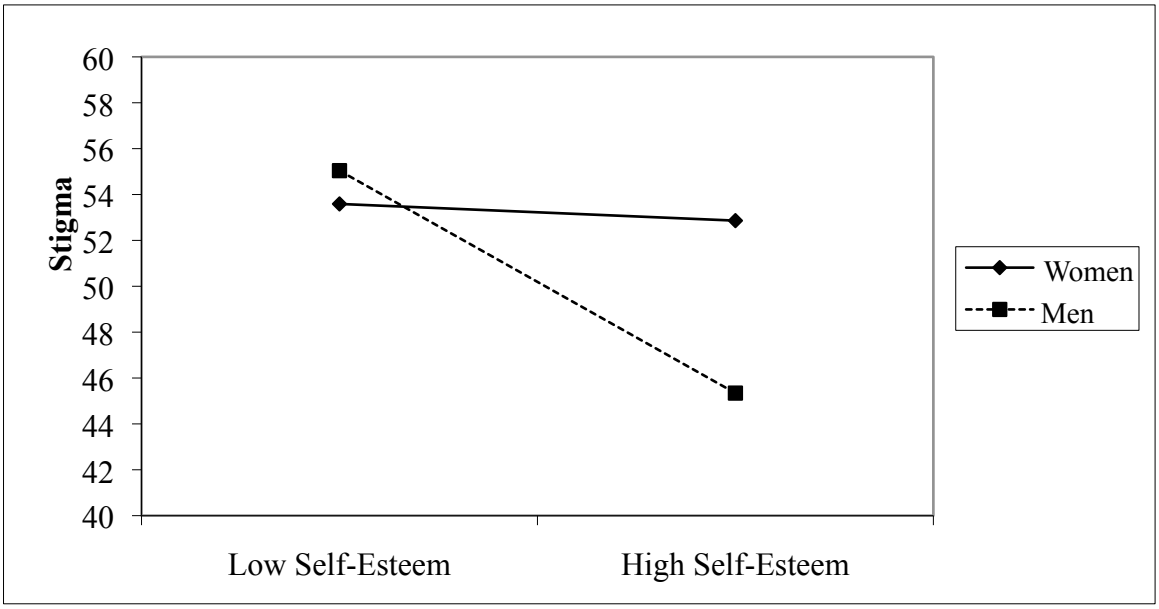
Table 11. Stigma Regression

	Model 1	Model 2	Model 3
Race Non-White	0.422	0.880	0.737
Income Raw Income	0.763	0.617	0.666
Area Urban Setting	0.212	0.310	0.336
Male	.012**	.057**	0.052^
Self-Esteem		.022**	0.732
Male*Self-Esteem			0.009**
Constant	.000***	.000***	.000***
Number of Observations	146	146	146

^p < .1 * $p < .05$ ** $p < .01$ *** $p < .001$

In Table 12, the interaction effect of self-esteem onto gender is demonstrated in terms of scores on the stigma scale. This graph plots the mean scores of both men and women on the stigma scale, and then shows the effect of self-esteem on these scores. Table 12 shows that the impact of self-esteem on stigma is much stronger for men than women. This interaction effect shows that regardless of reported high or low self-esteem, females, on average, perceive much more social stigma than males. For males, the effect of self-esteem on how they perceive social stigma is much more drastic, as seen in Table 12.

Table 12: Interaction Effect of Self-Esteem on Male and Female Stigma Scores



DISCUSSION

H1: Males will report higher responses on the self-esteem scale than females after the IPV vignette reading.

Males generally score higher than females on self-esteem scales to begin with, and this is found to be true at any age, with the disparity between reported levels of self-esteem growing as age progresses (Block & Robbins 1993). This finding goes against the "gender symmetry" theory that supports the gendered behaviors in IPV. Educational attainment increases one's levels of self-esteem (Baumeister, Campbell, Krueger, & Vohs 2003), and since males score higher on self-esteem scales regardless of the context (even in the context of a victim of IPV), then it seems sensible that males would score higher on the self-esteem scale than females. Also, because a male victim of IPV breaks the gender role norms, and male victims are not likely to be taken seriously (Harris & Cook 1994), the males in this study may have underreported their negative self feelings in the scale based on this gender norm, rather than being truthful as the females may have been.

H2: Females will have higher reported levels of perceived social stigma after the IPV vignette reading.

Similar to hypothesis one, it is often noted that females generally report lower levels of self-esteem than males, even before being put in the situation as a victim of IPV (Block & Robbins 1993). Females also have reported feeling more stigmatized in society than males, reporting higher levels of stigma consciousness at all times than males

(Brown & Pinel 2003). It is possible that the reading of the vignette highlights gender differences in the perception of stigma, where men and women have stable differences in this study. As noted prior, for women it is less of a violation of gender norms to identify as a victim of IPV, yet males are brought up learning to remain stoic to any possible emotional disruption in their lives (Good, Dell, & Mintz 1989). Becoming a victim of IPV might provide an instance where men can exhibit an attitude of imperviousness, given that women are not expected by society to act in this way, the results of this analysis are not surprising.

H3: Subjects reporting minority racial status will have lower responses on the self-esteem scale and higher levels of perceived social stigma after the IPV vignette reading.

This finding is interesting because other studies have shown white respondents to report higher levels of self-esteem all around (Kenny & McEachern 2009), yet this study demonstrates alternate results that support more recent literature examining race and self-esteem (Bachman, O'Malley, Freedman-Doan, Trzesniewski, & Donnellan 2011). Although the results from the T-test show no significant difference in the mean scores between whites and non-whites on the stigma scale, it is still interesting to note that whites, on average, reported higher levels of perceived stigma than non-whites, which is different than what previous studies have noted before (Link & Phelan 2001). For both of these findings, it shows that college students may be a distinct population with clear opinions. Table 1 shows that low educational attainment is a positively predictive factor of IPV, and this is also true of having lower reported levels of self-esteem and higher reported levels of stigma (Link & Phelan 2001). Since educational attainment produces

self-esteem (Baumeister et al. 2003) and class and race are correlated with self-esteem (Twenge & Crocker 2002), it is unsurprising that the responses of educated minorities in this study would shows higher levels of self-esteem and lower levels of perceived stigma.

H4: Subjects reporting lower household incomes will have lower levels of self-esteem and high levels of reported perceived social stigma after the IPV vignette reading.

Although results from a T-test show no significant differences between those reporting low-income and those reporting middle-wealthy class income and their scores on the self-esteem and stigma scales, it is interesting to note that low-income respondents did score higher, on average, on the self-esteem scale than middle-wealthy income level respondents. Again, this unexpected finding could solely be because this data is taken from a college-educated population, and college educated people, regardless of reported income, report higher levels of self-esteem (Baumeister et al. 2003) and will be less stigmatized against in society than those without an education (Henning et al. 2009; Fang & Corso 2008; Cunradi et al. 2002).

H5: Setting of upbringing will be related to whether or not respondents have themselves been affected by IPV or if someone they know has been affected by IPV.

Research has shown that the culture of violence in the United States is pocketed in low-income areas (Wilson, Woods, Emerson, & Donenberg 2012), so it is possible that setting of upbringing (rural, suburban, urban) is not related to previously being affected by IPV because it has almost been normalized. Then again, there is also evidence of IPV occurring in all areas, with specific evidence of a newly discovered prevalence of IPV in rural areas of the United States (Breiding, Ziembroski, & Black 2009). Although initial

research singled out living in an economically disadvantaged neighborhood as a positively predictive factor of being affected by IPV (Gilfus, O'Brien, Trabold, & Fleck-Henderson 2010; Fang & Corso 2008; Leaman & Gee 2008; Fox & Benson 2006; Cunradi, Caetano, & Schaefer 2002), this does not specify population in this area. Therefore, IPV is a phenomenon that may impact the entire social continuum, regardless of classification as a rural, suburban, or urban area.

H6: High scores of the self-esteem scale will correlate to low scores on the stigma scale.

Previous research has revealed that in viewing the relationship between stigma and self-esteem, "it is not so much that stigma influences self-esteem, but rather that self-esteem shapes one's perceptions of and responses to the experience of stigma" (Link, Struening, Neese-Todd, Asmussen, & Phelan 1997: 2). Therefore, if a person has low self-esteem, he or she is more likely to be more critical of themselves and the views of society unto themselves in terms of stigmatization. This theory is true for those with high self-esteem as well. Gender is the main finding in the differences in both of these scales, in both the T-tests and the multiple regressions. The impact of IPV on self-esteem and stigma is different for both males and females. There is some variation and a greater range of men's scores than women's scores, leading to the significant difference in mean scores for males and females on the self-esteem scale.

Regression Analysis

The findings in the self-esteem multiple regressions suggest that being a non-white male is predictive of scoring high scores on the self-esteem scale after being a victim of IPV. This is supported in the literature of both Bachman et al. (2011) and Block

and Robbins (1993). When adding raw income into the multiple regression, the significance of being non-white increases and the significance of being a male decreases, yet the finding is still significant. This regression model shows that there are racial differences in self-esteem, and T-tests suggest that race is significant, though when gender is in the model, race is not affected. This finding supports previous literature and the concept that being non-white and having an education increases ones chances of having a higher income (Kimbro, Bzostek, Goldman, & Rodriguez 2008), which is because these are the responses of a college educated sample, and because of the plethora of opportunities, instead of disadvantage, more available to educated persons over non-educated persons, regardless of race (i.e. access to education, access to transportation, access to healthcare). When looking at the stigma multiple regressions, yet again being a male is predictive of having a lower reported value of perceived social stigma after being a victim of IPV. This is supportive of previous literature indicating the prevalence of the idea that men are not worthy victims if their perpetrator is a female that male victims should not be taken seriously (Robertson & Murachver 2009). Males internalize this belief and therefore remain confident in the face of potential social stigma (Harris & Cook 1994). Once adding the self-esteem scale as a variable into the stigma multiple regression, we now see that both being a male and higher levels of self-esteem are predictive of having lower reported levels of perceived social stigma after being a victim of IPV, although being a male is now less significant. Men with high self-esteem generally experience a lower sense of perceived social stigma (Baumeister et al. 2003), but self-esteem levels are much more predictive of lower scores on the perceived social

stigma regression than gender. This finding is confirmed when the interaction effect between gender and self-esteem emerges as highly significant in the stigma regression model. Therefore, a large component of the gender effect in these regressions is due to self-esteem, as seen in the interaction effect in Table 12. From these results, it seems as though race is less connected to stigma in this study than in previous studies (Gilfus et al. 2010; Leaman & Gee 2008; Cunradi et al. 2002).

LIMITATIONS

Sample size and selection bias is a limitation in this study, where a convenience sample of 250 students in Criminal Justice and Sociology classes were surveyed out of approximately 15,000 students on campus; because the characteristics of the students completing the survey are a close match to the undergraduate Sociology and Criminal Justice student population demographics, this study's responses are generalizable to that demographic Therefore, the attitudes demonstrated in the results of the survey are attributed to only to the respondents at in Sociology and Criminal Justice majors at UMB. Another limitation of the study is the use of vignette methodology, which is not widely used in research methods, because like any research tool, "they (vignettes) can never mirror completely the reality and dynamism of people's lives" (Faia 1980; Parkinson & Manstead 1993; Kinicki et al. 1993, as cited in Hughes & Huby 2001; Robertson & Anderson 1993), yet this seemed to be the best way to truly put the respondents in the position of a victim of IPV and to capture levels of reported self-esteem and stigma after this incident. Additionally, the respondents may have provided socially desirable responses as opposed to being truthful about previous experiences with IPV.

In retrospect, there are aspects of the survey instrumentation that would change if this study were replicated in a different setting. For example, the demographic background questionnaire asks for respondents to report their annual household income. This leaves room for error in the fact that while the intention of the question was to report

the total income for each person living in the respondent's household, regardless of the living situation (singularly, with family, with roommate, with mate, etc.), this information was not specified in the questionnaire. Students were confused on whether or not they should report their individual annual income, their family's annual income, or their current living situation's annual household income. This discrepancy left many of the responses to this question blank. Additionally, the question asking if respondents have heard of the term IPV before could have caused confusion as well. Because the term IPV has been widely implemented only recently, many of the student respondents may know about this phenomenon and regard it as domestic violence, and not intimate partner violence, which is the term used in this study. Finally, it is possible that the classroom style administration could have resulted in socially desirable responses. Online administration could perhaps decrease this limitation while increasing others such as selection and sample yield. If replicated, these issues of implementation and instrumentation need consideration.

CONCLUSION

Although many studies have explored the connections between IPV, self-esteem, and stigma, no study has examined the perceptions of stigma on victims of IPV. In this way, this study is a contribution to the current body of literature. The findings in this study are distinctive as well. We see that while some of the results in this research do support the findings of previous literature, some do not. When viewing the prevalence of students who themselves or someone they know had been affected by IPV, the numbers were surprisingly lower than studies completed with high school age daters (Fang & Corso 2008; Jezl, Molidor, & Wright 1996). This could be the case because "people with greater resources of knowledge, money, power, prestige, and social connections are generally better able to avoid risks and to adopt protective strategies" (Link & Phelan 1996: 529), like avoiding the discomfort associated with this study's focus of personal issues surrounding IPV, stigma, and self-esteem. While males scoring significantly higher than females on the self-esteem scale supports the literature, minority students scoring higher than white students on the self-esteem and lower scores on the stigma scales is a counterintuitive finding based on the literature. Additionally, low-income students reporting higher levels on the self-esteem scale is different than what is presented in all the reviewed literature, but it is supported by some studies. Self-esteem is an important mechanism in the gender findings, which is visually displayed in the interaction effect in Table 12. Because this study was conducted on an urban college

campus in Boston, the demographics of the student population are racially and financially diverse; this means that the factors that are associated with being a victim IPV - low levels of self-esteem and higher values of perceived stigma - become less distinctive (refer to Table 1 and 2). This campus could be considered extremely diverse. In fact, UMB was listed as the number two campus in New England with the highest percentage of minority students at 38.7% (The Integrated Postsecondary Education Data System, 2003). These results could be part of the culture at UMB and in particular around Sociology and Criminal Justice undergrad students; the responses could be a product of normative behavior for college students, where lower rates of IPV and being affected by IPV could be predicted because it is an educated college sample. Although these findings are not generalizable to the larger society, they are generalizable to and representative of the UMB undergraduate Sociology and Criminal Justice student population.

Although one would think that, with treatment, victims could overcome the negative outcomes of stigma as it related to IPV and self-esteem, a study by Link and colleagues (1997) found that "stigma continues to complicate the lives of the stigmatized even as treatment improves their symptoms and functioning" (177). More analysis and research on issues surrounding significant gender differences in stigma and self-esteem in terms of their relationship to victimology and IPV is necessary to complete this study and understand the necessary policy and treatment initiatives and social implications of this phenomenon from both a sociological and criminal justice perspective.

APPENDIX A

ROSENBERG'S SELF-ESTEEM SCALE

ROSENBERG'S SELF-ESTEEM SCALE
Please do your best to respond to the following statements in terms of how you, being the victim of IPV, would respond after the situation portrayed in the story above.

I feel that I am a person of worth, at least on an equal plane with others.
Strongly Agree Agree Disagree Strongly Disagree

I feel that I have a number of good qualities.
Strongly Agree Agree Disagree Strongly Disagree

All in all, I am inclined to feel that I am a failure.
Strongly Agree Agree Disagree Strongly Disagree

I am able to do things as well as most other people.
Strongly Agree Agree Disagree Strongly Disagree

I feel I do not have much to be proud of.
Strongly Agree Agree Disagree Strongly Disagree

I take a positive attitude toward myself.
Strongly Agree Agree Disagree Strongly Disagree

On the whole, I am satisfied with myself.
Strongly Agree Agree Disagree Strongly Disagree

I wish I could have more respect for myself.
Strongly Agree Agree Disagree Strongly Disagree

I certainly feel useless at times.
Strongly Agree Agree Disagree Strongly Disagree

At times I think I am no good at all.
Strongly Agree Agree Disagree Strongly Disagree

APPENDIX B

THE STIGMA SCALE

THE STIGMA SCALE

After reading the vignette where you are a victim of IPV, please do your best to answer in terms of how you think being a victim of IPV would effect how a person is viewed and treated in society.

Victims of IPV are excluded from social gatherings.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are disconnected from their family.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are abandoned by their significant others.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are further threatened by violence because of their victim status.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are isolated in their households.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are further physically assaulted.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are gossiped about.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are teased, insulted, or sworn at.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have lost respect and/or standing in the community.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are denied religious rites and/or services.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have lost their jobs.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have lost their housing.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are given poorer quality health services.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have been denied a promotion.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are viewed differently in the community.
Strongly Agree Agree Neutral Disagree Strongly Disagree

APPENDIX C

THE SURVEY

University of Massachusetts Boston
Department of Applied Sociology
100 Morrissey Boulevard
Boston, MA. 02125-3393

How Would You Feel? An Examination of Student Responses to IPV Vignettes and Measures of Self-Esteem and Stigma

You are asked to take part in a research project on student responses to Intimate Partner Violence, Self-Esteem, and Stigma. The researcher, Taylor Hall, is a Graduate Student and Principal Investigator from the Department of Applied Sociology. Feel free to ask questions. If you have further questions after the completion of the survey, she will be available to discuss them by telephone (508-246-0606). This study involves research, which is developed through a group of short surveys. If you have questions about this, you may contact Dr. Stephanie Hartwell, Graduate Director of Applied Sociology, Wheatley 4th floor, 017. Her phone number is (617) 287-6271.

Participation in this study will take 10-15 minutes of your time. If you decide to participate in this study, you will be asked to complete a short survey that includes personal information. No information will include personal identifiers. The primary risk associated with this study is the emergence of negative feelings or distress in completing the research materials. This study is voluntary and you can refuse or stop participation at any time. It involves putting yourself in the position of a victim of Intimate Partner Violence (IPV). If participation causes duress or you wish to discuss concerns with a counselor, you are encouraged to contact the Umass Boston Counseling Center in the Quinn Administration Building, 2nd Floor. The phone number there is (617) 287-5690. Also, the National Domestic Violence helpline can be reached 24 hours a day at 1−800−799−SAFE(7233).

This study is designed to be anonymous. That is, the information collected will not include information that specifically identifies you such as your name or telephone number. After you return the research materials, there will be no way of linking your identity to the data collected. Again, the decision whether or not to take part in this research study is voluntary. If you do decide to take part in this study, you may terminate participation at any time without consequence. In fact, you may take the survey and hand back a blank copy during survey collection.

You have the right to ask questions about this research at any time during the study. If you have any questions or concerns about your rights as a research participant, please contact a representative of the Institutional Review Board (IRB), at the University of Massachusetts, Boston, which oversees research involving human participants. The Institutional Review Board may be reached at IRB, Quinn Administration Building-2-080, University of Massachusetts Boston, 100 Morrissey Boulevard, Boston, MA 02125-3393. You can also contact the Board by telephone or e-mail at (617) 287-5370 or at human.subjects@umb.edu.

Background Demographic Questionnaire

What is your sex/gender?
Male
Female

What is your sexual orientation/sexual identity?
Straight
Lesbian
Gay
Bisexual
Transgender
Queer

What is your race/ethnicity? (Circle all that apply to you)
White
African American/Black
Hispanic/Latino
Native American
Asian
Cape Verdean
Other, please describe:_____

What is your major (or planned major if undeclared)? _____

What is your age? _____

What year of study are you in?
Freshman
Sophomore
Junior
Senior

Did you grow up in a rural, suburban, or urban area?
Rural
Suburban
Urban

What is your average annual household income? _____

Were you familiar with the term IPV before? YES NO

Have you or someone you know been affected by IPV? YES NO

IPV VIGNETTE

The scenario begins with a concerned neighbor calling the police after hearing screaming and glass breaking coming from the house next door, which is your house. When the police arrive at the scene, they find several pieces of furniture overturned and you, the victim, nursing wounds on your knee and hand. The police question the perpetrator, your partner, who informed them that you both are “soul mates” and had been arguing because you had been unfaithful to your partner.

Your partner claims that, out of frustration, dishes were thrown on the floor after you repeatedly denied being unfaithful; one of the dishes accidentally hit your knee. Your partner maintains that you then became verbally and physically violent. Your partner pushed you away, and you fell on a piece of the broken dishes. Your partner showed police officers the alleged injuries sustained during the altercation.

The police then question you, the victim, and you explain that the perpetrator, your partner, became verbally abusive when you came in late from work after having coffee with some friends. You stated that your partner was extremely jealous and that they were always accusing you of being unfaithful. You also mention that your partner called you worthless and threatened to kick you out of the house that you both share. When you tried to calm your partner down, dishes were thrown on the floor. One of the dishes hit your leg. You said that your partner then prevented you from leaving the room and pushed you onto the broken pieces of dishes. You implied that this was not the first time a situation like this had happened.

ROSENBERG'S SELF-ESTEEM SCALE

Please do your best to respond to the following statements in terms of how you, being the victim of IPV, would respond after the situation portrayed in the story above.

I feel that I am a person of worth, at least on an equal plane with others.

Strongly Agree Agree Disagree Strongly Disagree

I feel that I have a number of good qualities.

Strongly Agree Agree Disagree Strongly Disagree

All in all, I am inclined to feel that I am a failure.

Strongly Agree Agree Disagree Strongly Disagree

I am able to do things as well as most other people.

Strongly Agree Agree Disagree Strongly Disagree

I feel I do not have much to be proud of.

Strongly Agree Agree Disagree Strongly Disagree

I take a positive attitude toward myself.

Strongly Agree Agree Disagree Strongly Disagree

On the whole, I am satisfied with myself.

Strongly Agree Agree Disagree Strongly Disagree

I wish I could have more respect for myself.

Strongly Agree Agree Disagree Strongly Disagree

I certainly feel useless at times.

Strongly Agree Agree Disagree Strongly Disagree

At times I think I am no good at all.

Strongly Agree Agree Disagree Strongly Disagree

THE STIGMA SCALE

After reading the vignette where you are a victim of IPV, please do your best to answer in terms of how you think being a victim of IPV would effect how a person is viewed and treated in society.

Victims of IPV are excluded from social gatherings.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are disconnected from their family.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are abandoned by their significant others.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are further threatened by violence because of their victim status.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are isolated in their households.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are further physically assaulted.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are gossiped about.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are teased, insulted, or sworn at.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have lost respect and/or standing in the community.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are denied religious rites and/or services.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have lost their jobs.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have lost their housing.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are given poorer quality health services.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV have been denied a promotion.
Strongly Agree Agree Neutral Disagree Strongly Disagree

Victims of IPV are viewed differently in the community.
Strongly Agree Agree Neutral Disagree Strongly Disagree

REFERENCE LIST

Athenstaedt, Ursula, Cornelia Heinzle, and Gudrun Lerchbaumer. 2008. "Gender Subgroup Self-Categorization and Gender Role Self-Concept." *Sex Roles.* 58(3-4): 266-278.

Bachman, Jerald G., Patrick M. O'Malley, Peter Freedman-Doan, Kali H. Trzesniewski, and M. Brent Donnellan. 2011. "Adolescent Self-Esteem: Difference by Race/Ethnicity, Gender, and Age." *Self and Identity.* 10(4): 445-473.

Barter, Christine and Emma Renold. 2000. "'I wanna tell you a story': exploring the application of vignettes in qualitative research with children and young people." *International Journal of Social Research Methodology.* 3(4): 307-323.

Baumeister, Roy F., Jennifer D. Campbell, Joachim I. Krueger, and Kathleen D. Vohs. 2003. "Does High Self-Esteem Cause Better Performance, Interpersonal Success, Happiness, or Healthier Lifestyles?" *Psychological Science in the Public Interest.* 4(1): 1-44.

Block, Jack and Richard W. Robbins. 1993. "A Longitudinal Study of Consistency and Change in Self-Esteem from Early Adolescence to Early Adulthood." *Child Development.* 64(3): 909-923.

Breiding, Matthew J., Jessica S. Ziembroski, and Michele C. Black. 2009. "Prevalance of Rural Intimate Partner Violence in 16 US States, 2005." *The Journal of Rural Health.* 25(3): 240-246.

Brown, Michael J. and Jennifer Groscup. 2008. "Perceptions of Same-Sex Domestic Violence Among Crisis Center Staff." *Journal of Family Violence.* 24:87-93.

Brown, Ryan P. and Elizabeth C. Pinel. 2003. "Stigma on my mind: Individual differences in the experience of stereotype threat." *Journal of Experimental Social Psychology.* 39(6): 626-633.

Campbell, Jacquelyn C. 2002. "Health Consequences of Intimate Partner Violence." *The Lancet.* 359(9314): 1331-1336.

Capaldi, Deborah M., Joann Wu Shortt, Hyoun K. Kim, Jane Wilson, Lynn Crosby, and Shivan Tucci. 2009. "Official Incidents of Domestic Violence: Types, Injury, and Associations with Nonofficial Couple Aggression." *Violence and Victims.* 24(4): 502-517.

Catalano, Shannan. 2007. "Intimate Partner Violence in the United States." United States Bureau of Justice Statistics.

Cunradi, Carol B., Raul Caetano, and John Schafer. 2002. "Religious Affiliation, Denominational Homogamy, and Intimate Partner Violence among US Couples." *Journal for the Scientific Study of Religion.* 41(1): 139-151.

"Domestic Violence Program." (2009). Boston Public Health Commission. (http://www.bphc.org/programs/cafh/violenceprevention/domesticviolenceandsexualassault/Pages/Home.aspx).

Falk, Gerhard. 2001. Stigma: How We Treat Outsiders. Prometheus Books: New York City.

Fang, Xiangming and Phaedra S. Corso. 2008. "Gender Differences in the Connections Between Violence Experienced as a Child and Perpetration of Intimate Partner Violence in Young Adulthood." *Journal of Family Violence.* 23: 303-313.

Federal Poverty Guidelines. 2011. (http://www.masslegalhelp.org/housing/poverty-guidelines).

Fox, Greer Litton and Michael L. Benson. 2006. "Household and Neighborhood Contexts of Intimate Partner Violence." *Public Health Reports.* 121: 419-426.

Gilfus, Mary E., Patricia O'Brien, Nicole Trabold, and Ann Fleck-Henderson. 2010. "Gender and Intimate Partner Violence: Evaluating the Evidence." *Journal of Social Work Education.* 46(2): 245-257.

Goffman, Erving. 1963, 1986. Stigma: Notes on the Management of Spoiled Identity. Simon & Schuster Inc.: New York.

Good, Glen E., Don M. Dell, and Laurie B. Mintz. 1989. "Male role and gender role conflict: Relations to help seeking in men." *Journal of Counseling Psychology.* 36(3): 295-300.

Harris, Richard Jackson, and Cynthia A. Cook. 1994. "Attributions to Spouse Abuse: It Matters Who the Batterers and Victims Are." *Sex Roles.* 30(7-8): 553-565.

Henning, Kris, Rochelle Martinsson, and Robert Holdford. 2009. "Gender Differences in Risk Factors for Intimate Partner Violence Recidivism." *Journal of Aggression, Maltreatment, and Trauma.* 18: 623-645.

Hughes, Rhidian, and Meg Huby. 2001. "The application of vignettes in social and nursing research." *Journal of Advanced Nursing.* 37(4): 382-386.

Jezl, David R., Christian E. Molidor, and Tracy L. Wright. 1996. "Physical, Sexual, and Psychological Abuse in High School Dating Relationships: Prevalence Rates and Self-Esteem Issues." *Child and Adolescent Social Work Journal.* 13(1): 69-86.

Johnson, Michael P. 2009. "Langhinrichsen-Rolling's Confirmation of the Feminist Analysis of Intimate Partner Violence: Comment on 'Controversies Involving Gender and Intimate Partner Violence in the United States.'" *Sex Roles* 62: 212-219.

Kenny, Maureen C. and Adriana McEachern. 2009. "Children's Self-Concept: A Multicultural Comparison." *Professional School Counseling.* 12(3): 207-212.

Kimbro, Rachel Tolbert, Sharon Bzostek, Noreen Goldman, and German Rodriguez. 2008. "Race, Ethnicity, And The Education Gradient In Health." *Health Affairs.* 27(2): 361-372.

King, Michael, Sokratis Dinos, Jenifer Shaw, Robert Watson, Scott Stevens, Filippo Passetti, Scott Weich, and Marc Serfaty. 2007. "The Stigma Scale: Development of a Standardized Measure of the Stigma of Mental Illness." *British Journal of Psychiatry.* 190: 248-254.

Langhinrichsen-Rohling, Jennifer. 2009. "Controversies Involving Gender and Intimate Partner Violence in the United States." *Sex Roles* 62: 179-193.

Leaman, Suzanne C. and Christina B. Gee. 2008. "Intimate Partner Violence Among Adolescent and Young Adult Mothers." *Journal of Family Violence.* 23: 519-528.

Link, Bruce G. and Jo C. Phelan. 2006. "Stigma and its Public Health Implications." *The Lancet.* 367: 528-529.

Link, Bruce G., Elmer L. Struening, Sheree Neese-Todd, Sara Asmussen, and Jo C. Phelan. 2006. "Stigma as a Barrier to Recovery: The Consequences of Stigma for the Self-Esteem of People with Mental Illness." *Psych Services.*

Link, Bruce G., Elmer L. Struening, Michael Rahav, Jo C. Phelan, and Larry Nuttbrock. 1997. "On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse." *Journal of Health and Social Behavior.* 38(2): 177-190.

Link, Bruce G. and Jo C. Phelan. 2001. "Conceptualizing Stigma." *Annual Review of Sociology.* 27: 363-385.

Melton, Heather C. and Joanne Belknap. 2003. "He Hits, She Hits: Assessing Gender Differences and Similarities in Officially Reported Intimate Partner Violence." *Criminal Justice and Behavior.* 30(3): 328-348.

Plichta, Stacey Beth. 2007. "Interactions Between Victims of Intimate Partner Violence Against Women and the Health Care System: Policy and Practice Implications." *Trauma, Violence, Abuse.* 8(2): 226-239.

Robertson, Diana C. and Erin Anderson. 1993. "Control Systems and Task Environment Effects on Ethical Judgment: An Exploratory Study of Industrial Salespeople." *Organization Science.* 4(4): 617-644.

Robertson, Kirsten and Tamar Murachver. 2009. "Attitudes and Attributions Associated With Female and Male Partner Violence." *Journal of Applied Social Psychology.* 39(7): 1481-1512.

Sandelowski, Margarete, Camille Lambe, and Julie Barroso. 2004. "Stigma in HIV-Positive Women." *Journal of Nursing Scholarship.* 36(2): 122-128.

Shih, Margaret. 2004. "Positive Stigma: Examining Resilience and Empowerment in Overcoming Stigma." *Annals of the American Academy of Political and Social Science.* 591: 175-185.

Silverman, Jay G., Anita Raj, Lorelei A. Mucci, and Jeanne E. Hathaway. 2001. "Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality." The Journal of the American Medical Association. 286(5): 572-579.

Sorenson, Susan B. and Kristie A. Thomas. 2009. "Views of Intimate Partner Violence in Same- and Opposite- Sex Relationships." *Journal of Marriage and Family.* 71: 337-352.

Twenge, J. M. and Jennifer Crocker. 2002. "Race and self-esteem: Meta-analyses comparing Whites, Blacks, Hispanics, Asians, and American Indians and comment on Gray-Little and Hafdahl (2000)." *Psychological Bulletin.* 128(3): 371-408.

Wilson, Helen W., Briana A. Woods, Erin Emerson, and Geri R. Donenberg. 2012. "Patterns of Violence Exposure and Sexual Risk in Low-Income, Urban African American Girls." *Psychology of Violence.*

Yang, Lawrence Hsin, Arthur Kleinman, Bruce G. Link, Jo C. Phelan, Sing Lee, and Byron Good. 2007. "Culture and Stigma: Adding Moral Experience to Stigma Theory." *Social Science and Medicine.* 64: 1524-1535.