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Relationship Self-efficacy Protects against Mental Health Problems among Women in Birectionally Aggressive Intimate Relationships with Men

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Abstract

Research examining predictors or correlates of mental health problems among women who experience or use aggression in intimate relationships typically assesses factors that confer risk. Such research has primarily examined intimate partner violence (IPV) victimization or aggression frequency or severity as central risk factors for mental health problems. In the general population, one factor demonstrating a protective effect on mental health problems is self-efficacy. Research on self-efficacy among women who experience or use aggression in intimate relationships is nearly absent. The purpose of this study is to determine if self-efficacy specific to a woman's ability to manage various relationship problems (i.e., relationship self-efficacy, RSE), plays a protective role against the severity of posttraumatic stress, depression, and anxiety symptoms among 354 community-residing women who are victimized and use aggression (bidirectional IPV). Regression analyses found that RSE uniquely predicted each mental health outcome above and beyond what was accounted for by the frequency of physical, sexual, and psychological victimization and aggression. Further, RSE fully mediated the relationships between psychological victimization and each mental health outcome. If replicated, and in circumstances where it is determined safe to do so, findings suggest RSE as a promising avenue for future research to improve the health and wellbeing of women in bidirectionally aggressive relationships.

Keywords

relationship self-efficacy; intimate partner violence; bidirectional; posttraumatic stress; depression; anxiety

Research examining predictors or correlates of mental health problems among women who experience or use aggression in intimate relationships typically assesses factors that confer risk (e.g., Coker, Davis, et al., 2002; Dutton et al., 2006; Goodman, Smyth, Borges, & Singer, 2009). Research has primarily examined victimization or aggression frequency or severity as central risk factors for mental health problems such as posttraumatic stress, depression, and anxiety (Bonomi et al., 2006; Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005; Golding, 1999; Hedtke et al., 2008), whereas few studies have examined factors such as social support, self-esteem, and locus of control, which may provide protection (Campbell, Sullivan, & Davidson II, 1995; Carlson, McNutt, Choi, & Rose, 2002; Coker, Smith, et al., 2002). One factor demonstrating a protective effect on mental health problems is self-efficacy (Benight & Bandura, 2004; Johansen, Wahl, Eilertsen, & Weisaeth, 2007; Luszczynska, Benight, & Cieslak, 2009; Maciejewski, 2000), defined as a person's sense of control over her environment and the belief that she can master challenging demands (Bandura, 1997). Yet, research on self-efficacy among women who experience or use aggression in intimate relationships is lacking and certainly, no studies have examined this construct among women in relationships where the aggression is bidirectional (i.e., both partners have used aggression against each other).

Given that bidirectional aggression is the most common type of intimate partner violence (IPV) and frequently documented in community populations (see meta-analyses by Archer, 2000, 2002), examining self-efficacy among women in these types of relationships is a sensible approach. It is critical to note that bidirectional aggression does not imply that both partners have the same motives for using aggression (Bair-Merritt et al., 2010; Caldwell, Swan, Allen, Sullivan, & Snow, 2009) nor does it mean that the consequences are equivalent for each partner (Swan, Gambone, Caldwell, Sullivan, & Snow, 2008). Extant literature shows that men's use of aggression against women is more detrimental than women's aggression against men (Caldwell, Swan, & Woodbrown, 2012; Temple, Weston, & Marshall, 2005).

Social Cognitive Theory and Self-Efficacy

According to social cognitive theory, self-efficacy is one of three main constructs via which an individual regulates behavior (Bandura, 1997). These constructs interact with intra-person variables, such as demographics, and extra-person or contextual variables, such as social factors to influence an individual's intimate relations (Lent et al., 2002). Therefore, the application of social cognitive theory to the study of self-efficacy specific to relationships (i.e., relationship self-efficacy; RSE) is a logical next step. To provide a theoretical background for the study of RSE, general self-efficacy is discussed next.

General Self-efficacy

A fair amount of research has examined self-efficacy as a global construct - a trait or generalized sense of personal competence (i.e., general self-efficacy) and a determinant of health-related outcomes of a traumatic event (e.g., Benight & Bandura, 2004; Cutrona & Troutman, 1986) such as IPV. Studies illustrate that general self-efficacy serves a protective role against several mental health outcomes in response to stressful events through both direct and mediating effects (Johansen et al., 2007; Luszczynska et al., 2009; Maciejewski, 2000).

Relationship Self-Efficacy (RSE)

In contrast to literature on general self-efficacy, a large body of research examines self-efficacy specific to a context (e.g., Clark & Dodge, 1999; Raghavan, Swan, Snow, & Mazure, 2005). Context-specific self-efficacy – namely RSE – warrants examination among

women who experience and use aggression. RSE is defined as the extent to which a woman is confident in her ability to manage day-to-day relationship issues with her partner such as expressing emotional needs, accepting support, or dealing with disagreements openly (Lopez & Lent, 1991; Vanzetti, Notarius, & NeeSmith, 1992). RSE operationalized in this way is not about the IPV, but about managing and navigating the relationship in which it occurs.

The few studies that have examined RSE and IPV have primarily explored the role of RSE in the decision to stay in or leave the relationship (Lerner & Kennedy, 2000; Raghavan et al., 2005). One notable exception is a study by Arias and colleagues (1997) which examined RSE specific to IPV – that is, the extent to which women believed they could resolve the IPV. Findings showed that victimized women who reported greater IPV-specific RSE, relative to those who reported less, experienced more depressive symptoms; this finding is contrary to previous findings that general self-efficacy is a protective factor for mental health symptoms such as depression and posttraumatic stress (Johansen et al., 2007; Luszczynska et al., 2009; Maciejewski, 2000). Given that RSE was specific to IPV in Arias' study, perhaps women experienced more depression because they felt confident in their ability to deal with the IPV but in practice, were unable to do so. The current study operationalizes RSE as inclusive of general relationship challenges. RSE may function as a protective factor because, like other factors such as coping, resource utilization, and social support (Coker, Smith, et al., 2002; Meadows, Kaslow, Thompson, & Jurkovic, 2005), it may contribute to one's sense of control and confidence, lower levels of distress and subsequently reduce the severity of mental health problems (e.g., Thompson et al., 2000).

Purpose

The purpose of this study is to determine if RSE plays a protective role against posttraumatic stress, depression, and anxiety symptom severity among women in bidirectionally aggressive relationships. We hypothesize that: (a) greater levels of RSE will be associated with lower severity of posttraumatic stress, depression, and anxiety symptoms; and (b) RSE will mediate the effects of IPV victimization (and possibly aggression) on the severity of posttraumatic stress, depression, and anxiety symptoms such that the effect of victimization on the outcomes of interest operate through RSE.

Methods

Participants

Recruitment flyers advertising a *Women's Relationship Study* were posted in urban-area primary care clinics and emergency departments, local businesses such as grocery stores, laundromats and shops, and selected state offices such as the Department of Employment. Eligibility was determined via a phone-screen based on the following inclusion criteria: (a) female 18 to 64 years of age; (b) current involvement in a heterosexual intimate relationship of at least six months duration; (c) a woman's commission of at least one act of physical aggression against her male partner within the previous six months; (d) residency in the greater urban area; and (e) household income of less than \$50,000 (determined a priori to methodologically control for the differential access to and utilization of resources associated with income, which in turn, could affect study outcomes). This study focused specifically on women in relationships with men; the dynamics of IPV in same-sex-relationships are unique and therefore, the theories on which this study is based may not apply (Johnson & Ferraro, 2000).

A total of 412 women participated in the larger study on women's use of aggression. The current study focused on the subsample of women ($n = 369$) who experienced physical

victimization and used physical aggression; 354 of these women had complete data on core variables and composed the final sample. The average age of participants was 36.65 years ($SD = 9.01$). The majority (72%) had an annual household income of less than \$20,000. Sixty nine percent had a high school education or less. Sixty-five percent were unemployed and the majority (62%) lived with their partners. Forty-one percent had been in their relationships one to five years, 22% for five to ten years and 23% for ten to twenty years. Regarding race/ethnicity, 36% were African American, 37% were Latina, and 27% were White.

Sampling Procedures

Items from the Conflict Tactics Scales-2 (CTS-2; Straus, Hamby, & Warren, 2003) were used to screen for women's use of physical aggression; so as not to reveal this as the central inclusion criterion, both victimization and aggression items from the negotiation, psychological aggression, and physical assault scales were included.

Measures

The protocol was developed in English and Spanish. Spanish versions of the measures for RSE, sexual and psychological IPV, and posttraumatic stress severity were not available at the time of the study. These measures were translated by a bilingual, bicultural member of the research team and back-translated by a bilingual, bicultural consultant according to standard procedures (Brislin, 1970). With the exception of the Relationship Self-efficacy Questionnaire, all measures have been used in previous research with women experiencing IPV. With the exception of measures assessing physical, sexual, and psychological IPV, no other study measures were developed specifically for use with or have been validated with women experiencing IPV.

Relationship Self-Efficacy—The RSE Questionnaire (Lopez & Lent, 1991) is a 35-item measure used to assess respondents confidence in their ability to manage aspects of their relationships with their intimate partners. Participants were asked “Within your present relationship, how confident are you in your ability to do each of the following?” Using a 9-point Likert-type scale from 1 (*I'm not at all confident*) to 9 (*I'm completely confident*), respondents indicated confidence in their skills to: express their needs for separateness and assertively maintain clear interpersonal boundaries (e.g., Deal with important disagreements openly and directly); provide and receive care and support from their partner (e.g., Share equally with your partner in planning activities together); and appropriately regulate negative feelings of frustration, anger, or disappointment in relation to their partner (e.g., Show respect to your partner when you disagree with his opinions). Ten items were omitted as they may have been experienced as victim-blaming (e.g., Accept your partner's desire to do things his own way). Items were summed to create a total score ($\alpha = .92$).

Posttraumatic Stress—The Posttraumatic Diagnostic Scale (PDS; Foa, 1995) is a 49-item self-report measure used to assess posttraumatic stress based on the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM; American Psychiatric Association, 1994). Participants reported whether incidents of IPV were consistent with criterion A, namely that they believed there was imminent risk to themselves or someone else and that they felt helpless or terrified. The frequency of symptoms experienced in the past 6 months were rated on a 4-point scale (0 = *not at all or only one time*) to (3 = *five or more times a week/ almost always*). To the extent possible, symptom ratings were in relation to IPV with the current partner. A total symptom severity score was created by summing the 17 symptom severity items ($\alpha = .91$).

Depression—The Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977) was used to assess depressive symptoms within the past six months. The response scale ranges from 0 (*experienced symptoms 0 days in the last six months*) to 3 (experienced symptoms 5-7 days in the last six months). All 20 items were summed to create the total score with higher scores indicating more symptoms of depression ($\alpha = .92$).

Anxiety—The 20-item State-Anxiety (S-Anxiety) subscale of the State-Trait Anxiety Inventory (STAI; Spielberger & Sycleman, 1994) was used to assess anxiety. Participants rated the intensity of their anxiety as an emotional state on a 4-point scale: from 1 (*not at all*) to 4 (*very much so*). Items were summed to create a total score ($\alpha = .93$).

Physical IPV—Physical IPV victimization and aggression was measured by the 78-item CTS-2 (Straus et al., 2003). A referent time period of six months was used to assess the occurrence of victimization and use of aggression. Response options were recoded (Straus et al., 2003) [i.e., 3 - 5 times (recoded to 4), 6 - 10 times (recoded to 8), 10 or more times (conservatively recoded to 11)]. The physical IPV score was a sum of the 12 CTS-2 physical assault items (victimization $\alpha = .91$; aggression $\alpha = .87$).

Sexual IPV—Sexual IPV victimization was measured by the 10-item Sexual Experiences Survey (SES; Koss, Gidycz, & Wisniewski, 1987). The same 10-items were used to assess sexual IPV aggression (20 items total were administered). The original SES response options are *yes/no*. To gain greater knowledge about the frequency of experiences, the response options and scoring system from the CTS-2 were used. A referent time period of six months was used to assess victimization and aggression. Each sexual IPV score was a sum of the 10 item scales (victimization $\alpha = .91$; aggression $\alpha = .83$).

Psychological IPV—Psychological IPV victimization and aggression was measured by the Psychological Maltreatment of Women – Short version (PMWI-S; Tolman, 1999) and the CTS-2 emotional verbal scale (Straus et al., 2003) and one item developed for this study. Both the PMWI and CTS-emotional verbal scale were included because they each measure different dimensions of psychological IPV (e.g., the PMWI assesses dominance and isolation whereas the CTS-2 does not). In order to obtain the most comprehensive assessment of psychological IPV, we used the PMWI-S in its entirety and items from the CTS emotional-verbal abuse scale that did not overlap with the PMWI-S. We added the item, “has your partner followed you out of the house to check on what you were doing?” a stalking tactic experienced of by victims of IPV (Basile, Arias, Desai, & Thompson, 2004; Basile & Hall, 2011) which was not included in the two aforementioned measures. A referent time period of six months was used to assess the occurrence of victimization and use of aggression. The psychological IPV score was a sum of 21 non-overlapping items. Response options ranged from 1 (*never*) to 5 (*very frequently*) (victimization $\alpha = .82$; aggression $\alpha = .66$).

Research Design—Eligible participants met with a female interviewer who administered a 2-hour computer-assisted interview. All interviewers were trained extensively in the conduct of research with women in bidirectionally aggressive relationships. The interviewer and participant sat side-by-side in front of a computer that contained the protocol questions so that they could simultaneously view the screen. The interviewer read the questions aloud, the participant responded verbally, and the interviewer selected her response option on the computer. This method was selected to reduce barriers associated with low levels of literacy and to assist with comprehension difficulties. Forty-nine percent of Latina participants elected to have the protocol administered in Spanish. At the conclusion of the interview,

participants were debriefed, remunerated \$50, and provided with a list of relevant community resources.

Results

Data Analysis

Multiple linear regression was used to test the central question of whether greater levels of RSE are associated with lower severity of posttraumatic stress, depression, and anxiety symptoms after controlling for the effects of physical, sexual and psychological IPV and race/ethnicity. We also examined the possibility that RSE mediated the effects of the physical, sexual, and psychological victimization and aggression variables on posttraumatic stress, depression, and anxiety.

To test the first hypothesis, we first estimated models predicting posttraumatic stress, depression and anxiety symptom severity from race/ethnicity; physical, sexual, and psychological victimization and aggression; and RSE. Two dummy codes were created for race/ethnicity (African American and White), with Latinas serving as the reference group. A block entry approach was used; race/ethnicity, physical, sexual, and psychological victimization and aggression were entered in block 1 and RSE was entered in block 2. If RSE was a unique predictor of the outcomes, results would provide support for the first hypothesis. Entering RSE in the second block allowed us to examine the change in the effects of the victimization and aggression predictors on the dependent variables of interest. As per Baron and Kenny (1986), demonstrating that these effects were reduced in size when RSE was entered into the model would be consistent with our second hypothesis regarding the mediating role of RSE. Significant effects of physical, sexual, and psychological victimization and aggression variables in predicting the mediator (RSE) were necessary to demonstrate mediation. Thus, a similar model was estimated using RSE as the dependent variable predicted from race/ethnicity, physical, sexual, and psychological victimization and aggression. MPLUS software (Muthen & Muthen, 2008) was used to calculate significance tests (using bootstrap standard errors: see Shrout & Bolger, 2002) of the indirect (mediated) effects.

Descriptive Statistics and Correlations

Correlations and descriptive statistics for study variables are shown in Table 1. RSE was negatively associated with the frequency of physical, sexual, and psychological victimization and the severity of posttraumatic stress, depression, and anxiety symptoms.

Unique Effects of RSE on Symptom Severity

Results of regression models predicting the severity of posttraumatic stress, depression, and anxiety symptoms are shown in Table 2. African Americans had lower levels of posttraumatic stress and anxiety symptom severity compared to Latinas. Whites also had lower levels of anxiety compared to Latinas. For the core predictors of interest, psychological and sexual victimization were uniquely and positively related to the severity of posttraumatic stress, depression, and anxiety symptoms. In contrast, physical victimization did not demonstrate any significant unique effects. Among the aggression variables, only sexual aggression demonstrated a unique positive effect in predicting the severity of posttraumatic stress. RSE, which was entered in step 2, was a unique negative predictor of the severity of posttraumatic stress, depression and anxiety symptoms, supporting our first hypothesis.

Mediation Results

Inclusion of RSE into the model reduced the size of the coefficients for most of the significant predictors in step 1, however sexual and psychological victimization and sexual aggression in the posttraumatic stress model and sexual victimization in the depression model remained significant – a pattern consistent with partial mediation (see Baron & Kenny, 1986). In contrast, the unique effects for sexual and psychological victimization in the anxiety model and psychological victimization in the depression model were no longer significant with RSE present, a pattern indicative of full mediation.

Results for the model predicting RSE are shown in Table 3. Sexual and psychological victimization were unique predictors; lower levels of victimization were associated with higher levels of RSE. Neither physical victimization nor any of the aggression variables were uniquely associated with RSE at $p < .05$. There was no race/ethnicity effect. Follow up significance tests indicated that the only indirect effects significant at $p < .05$ (two-tailed) were for psychological victimization through RSE on the severity of posttraumatic stress ($Z = 2.7$), depression ($Z = 3.04$), and anxiety symptoms ($Z = 3.4$). Thus, our hypothesis regarding the mediating role of RSE was supported only for psychological victimization.

Discussion

To our knowledge, this study is the first to examine RSE as a protective factor among women in bidirectionally aggressive relationships. Findings highlight the importance of factors beyond demographics and IPV victimization as predictors of mental health problems and the potential counseling utility of RSE. As suggested by social cognitive theory, RSE uniquely predicted each mental health outcome above and beyond what was accounted for by each type of IPV. If replicated, these findings could play an integral role in reducing the negative sequelae of IPV, at least among women in bidirectionally aggressive relationships.

Results demonstrate differential relationships of IPV by type to RSE and the severity of posttraumatic stress, depression and anxiety symptoms. Greater frequency of psychological and sexual victimization (but not physical victimization or any type of aggression) was associated with lower levels of RSE. Greater frequency of psychological victimization was related to greater severity of posttraumatic stress, depression and anxiety symptoms - but those relationships were all mediated through RSE. These findings suggest that the relationship between psychological victimization and greater symptom severity is accounted for by RSE. It seems that, in the face of being isolated, dominated, called names and belittled, women's sense of competence or confidence in managing relationship struggles protects them against mental health problems. In fact, several studies have suggested that constructs similar to RSE (e.g., general self-efficacy) may be a source of resiliency for women involved in aggressive intimate relationships (Thompson, Kaslow, Short, & Wyckoff, 2002). If replicated, these findings provide strong support for the importance of examining and targeting women's experiences of psychological victimization and its relationship with RSE in counseling interventions and psycho-educational programming. Women who perceive themselves as ineffective at handling challenges in their current relationships may feel less capable of ending their relationships (for emotional, economic, and/or safety reasons, among others) or may be convinced that they are unable to form healthier romantic connections. For such women, to the extent to which it is safe, effective counseling interventions could target RSE directly or indirectly so that women are empowered to make choices about the status of their relationship. In addition, interventions may assist women in understanding the potentially detrimental effects of victimization on their RSE.

Many of these bidirectionally aggressive relationships were of long duration (e.g., 55% were in their relationship for five years or longer). If women are not interested in ending these relationships (or if it is not possible to end them for safety or other reasons), targeting RSE by working with women to determine what they can control and improve upon in the relationship may be a way to decrease mental health problems and/or improve well-being. If future research indicates that RSE is a beneficial component of intervention, logical next steps are the development of new or modification of existing interventions to enhance women's RSE. Suggestions to target RSE in intervention warrant a strong note of caution. The positive effects of RSE on psychological well-being shown in this study were found for women in bidirectionally aggressive relationships, not women who were solely victims of violence. It is critical that future research determines for which women it is safe to enhance RSE before interventions are tested so that women are not put at risk for further victimization.

Limitations

Findings should be considered in the context of the following limitations. Data were cross-sectional and therefore, causality cannot be determined. It is plausible that relationships among variables are in the direction opposite of what we hypothesized/tested. For example, it is possible that RSE contributes to women's victimization or that mental health symptoms contribute to RSE. More likely, an interactive process among these exists. Further, it would be useful for prospective studies to examine the extent to which IPV contributes to changes in RSE. Results suggested that effects of IPV victimization on mental health outcomes were mediated through RSE, such that RSE protected against the negative effects of victimization – however significance tests showed that only the effects of psychological IPV were fully mediated. It is possible that with a larger sample and more power, the mediating effects for all types of IPV would be supported. Last, though there is a broad range of IPV severity in this sample, it is likely that the most severely abused women are not represented given that participation required enough freedom and autonomy to participate in a phone screen and a two-hour interview.

Implications for Intervention and Conclusions—If replicated, findings of this novel study have implications for how clinicians, victim advocates, and domestic violence service providers conceptualize a woman's ability to manage relationship challenges, at least for women in bidirectionally aggressive relationships. Findings highlight the negative roles of physical, sexual, and psychological victimization frequency and RSE in relation to mental health. This study provides further evidence that women's use of aggression plays a relatively small role in their experiences of mental health problems.

Results reveal that RSE may play a protective role against mental health problems and therefore, (a) may be a target of intervention to reduce the negative mental health sequelae that is highly prevalent in this population and (b) is worthy of future research. In situations where it is safe to do so, counseling interventions could help women who do not want to end their relationships by building on their strengths and ability to openly and confidently communicate with their partners. Similarly, when it is determined safe, interventions that work with partners together could aim to improve each partners' abilities to manage day-to-day relationship problems (McCollum & Stith, 2008). As emerging literature suggests (Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Sullivan, Cavanaugh, Buckner, & Edmondson, 2009), psychological victimization plays more of a central role in women's mental health than previously thought – a finding that has implications for women's own treatment as well as the treatment of their male partners. Taken together, findings of this study suggest RSE as a promising avenue for targeted interventions and future research to improve the health and wellbeing of women in bidirectionally aggressive relationships.

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Table 1

Correlations and descriptive statistics for study variables

	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9
1. Relationship Self Efficacy	147.41	41.35									
2. PTSD	18.93	10.80	-.41								
3. Depression	23.58	10.68	-.36	.67							
4. Anxiety	39.07	13.30	-.34	.45	.53						
5. Physical Victimization	20.54	23.73	-.35	.43	.24	.13					
6. Sexual Victimization	8.51	15.85	-.32	.37	.30	.17	.49				
7. Psychological Victimization	84.39	45.21	-.45	.49	.32	.21	.61	.46			
8. Physical Aggression	19.02	19.98	-.11	.27	.12	-.02	.58	.26	.32		
9. Sexual Aggression	2.72	7.05	-.05	.16	.07	-.03	.15	.17	.06	.28	
10. Psychological Aggression	70.25	32.88	-.17	.30	.18	.09	.36	.20	.52	.59	.22

Note. Correlations larger than .105 are significant at the .05 alpha level (two-tailed).

Table 2

Results of regressions with victimization, aggression, and RSE predicting posttraumatic stress, depression, and anxiety symptom severity

Block		PTSD			Depression			Anxiety		
		b	SE	p	b	SE	p	b	SE	p
1	African American	-.244	1.24	.05	-.01	1.35	.99	-.8.02	1.70	<.001
	White	-.143	1.26	.26	2.10	1.37	.13	-.5.60	1.72	.00
	Physical victimization	.06	.03	.07	.01	.04	.79	.04	.05	.40
	Sexual victimization	.10	.04	.01	.14	.04	.00	.10	.05	.04
	Psychological victimization	.08	.02	<.001	.05	.02	.01	.05	.02	.04
	Physical aggression	.02	.04	.66	-.01	.04	.73	-.09	.05	.07
	Sexual aggression	.18	.08	.02	.04	.08	.64	.08	.11	.44
	Psychological aggression	.00	.02	.87	.02	.02	.45	.01	.03	.69
2	African American	-.2.04	1.22	.09	.45	1.32	.74	-.7.37	1.65	<.001
	White	-.1.55	1.23	.21	1.97	1.33	.14	-.5.78	1.66	.00
	Physical victimization	.05	.03	.15	-.01	.04	.88	.02	.04	.70
	Sexual victimization	.08	.04	.03	.11	.04	.01	.07	.05	.14
	Psychological victimization	.06	.02	<.001	.03	.02	.16	.02	.02	.44
	Physical aggression	.03	.04	.51	-.00	.04	.91	-.08	.05	.11
	Sexual aggression	.16	.08	.04	.02	.08	.81	.06	.10	.59
	Psychological aggression	.01	.02	.74	.02	.02	.34	.02	.03	.55
	RSE	-.06	.01	<.001	-.06	.01	<.001	-.09	.02	<.001

Note. For PTSD block 1 model $R^2 = .30, p < .001$, block 2 model $R^2 = .33, p < .001$; for Depression block 1 model $R^2 = .14, p < .001$; for Anxiety block 1 model $R^2 = .13, p < .001$, block 2 model $R^2 = .19, p < .001$. ΔR^2 =change in model R^2 for entering variable last.

Table 3

Regression results predicting relationship self-efficacy

<i>Predictor</i>	<i>b</i>	<i>SE</i>	<i>p</i>	Δr^2
African American	7.20	4.93	.15	.01
White	-2.06	5.00	.68	.00
Physical victimization	-.23	.13	.07	.01
Sexual victimization	-.34	.15	.02	.01
Psychological victimization	-.33	.07	<.001	.06
Physical aggression	.15	.15	.31	.00
Sexual aggression	-.30	.31	.34	.00
Psychological aggression	.06	.09	.48	.00

Note. Model $R^2 = .28$, $p < .001$, Δr^2 =change in model R^2 for entering variable last.