THE ROLE OF SELF-COMPASSION AS A BUFFER AGAINST NEGATIVE COGNITIVE APPRAISALS AND COPING STRATEGIES AMONG STALKING VICTIMS

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ABSTRACT

THE ROLE OF SELF-COMPASSION AS A BUFFER AGAINST NEGATIVE COGNITIVE APPRAISALS AND COPING STRATEGIES AMONG STALKING VICTIMS

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The current study sought to understand the mediators and moderators of the relationship between stalking victimization and both trauma-related symptoms and depression. Research has suggested that stalking victimization may contribute to the development of depression (Mechanic, Uhlmansiek, Weaver, & Resick, 2000) and PTSD (Basile, Arias, Desai, & Thompson, 2004). What remains unclear are the mechanisms by which stalking victims might develop symptoms of psychological distress, as well as what factors might provide a buffering effect against negative psychological outcomes for stalking victims. Past research has suggested that numerous variables, such as self-blame, avoidant coping, event-specific attributions, and rumination, contribute to the development and maintenance of trauma-related symptoms and depression. In the current study, these variables were hypothesized to mediate the relationship between stalking victimization and both trauma-related symptoms and depression. Finally, self-compassion was expected to act as a moderator of the relationship between stalking victimization and the proposed mediators (i.e., avoidant coping, rumination, event-specific attributions, and self-blame). Participants were randomly assigned to either a self-compassion or special place condition to examine the effect of condition on a self-compassion measure. Before

the manipulation, participants completed two measures assessing stalking victimization and Time 1 self-compassion. After the manipulation, they completed measures assessing demographics, the proposed mediators, the outcomes, and Time 2 self-compassion. The results failed to support either hypothesis, suggesting that the proposed model was incorrect. However, several limitations of the methodology used in the current study should be considered before drawing any final conclusions about the model.

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CHAPTER 1

INTRODUCTION

Stalking is a power- and control-based crime (Brewster, 2003) by which perpetrators may display a variety of behaviors that cause fear or discomfort in victims. The prevalence of stalking is considerably high in the United States, with 15.2% of women and 5.7% of men reporting being stalked in their lifetime (Breiding, 2015). Moreover, the vast majority of victims, approximately 70%, report knowing their offender (Catalano, 2012). As evidenced by these statistics, stalking is a pervasive problem that can leave victims feeling betrayed, scared, and unsafe.

Because stalking is characterized by eliciting fear from victims, there are clear implications for a victim's psychological well-being. Numerous studies have provided evidence that victims of stalking are more likely to experience negative psychological outcomes. In fact, research suggests that stalking is associated with depression (Mechanic, Uhlmansiek, Weaver, & Resick, 2000), anxiety (Blaauw, Winkel, Arensman, Sheridan, & Freeve, 2002), posttraumatic stress (Basile, Arias, Desai, & Thompson, 2004), and comorbidity of psychological disorders (Kamphuis & Emmelkamp, 2001). Mental health can be negatively impacted long after the abuse has occurred, as evidenced by Fleming, Newton, Fernandez-Botran, Miller, and Burns's (2013) study on post-abuse women. In this study, stalking that included the presence of both fear and threat predicted posttraumatic stress symptoms in post-abuse women (Fleming et al., 2013). The

outcomes associated with stalking highlight the stark reality that victims often face during and after victimization.

There are a number of psychological constructs that might influence the relationship between stalking and both trauma-related symptoms and depression. Event-specific helplessness attributions—the way in which a victim interprets the cause of a negative experience (Ehlers & Clark, 2002)—have demonstrated strong correlations with trauma-related symptoms (Bargai, Ben-Shakhar, & Shalev, 2007; Reiland, Lauterbach, Harrington, & Palmieri, 2014). Research indicates that self-blame, or the process in which an individual attributes a stressful experience to oneself (Janoff-Bulman, 1979), is associated with trauma-related symptoms (Larsen & Fitzgerald, 2011). Next, rumination, which is defined as persistent and intrusive thoughts, has been found to maintain and exacerbate trauma-related symptoms (Elwood, Hahn, Olatunji, & Williams, 2009). Finally, avoidant coping—the tendency to distance one's behaviors and thoughts away from troubling thoughts or behaviors (Krause, Kaltman, Goodman, & Dutton, 2008)—has been associated with trauma-related symptoms beyond the contribution of other factors (Krause et al., 2008). Each of the psychological constructs discussed are related, in some way, to trauma; therefore, these constructs will be examined in their relationship to stalking victimization and subsequent posttraumatic stress and depressive symptoms.

To address the consequences associated with stalking victimization, one might consider the construct of self-compassion (i.e., the ability to extend compassion and understanding towards one's own problems; Neff, 2003b). Research has suggested that self-compassion is associated with a variety of positive outcomes, such as lower levels of depression, perfectionism, and anxiety (Neff, 2003b). Likewise, self-compassion is

suggested to act as a mediator between trauma and trauma-related symptoms (Barlow, Goldsmith Turow, & Gerhart, 2017).

The current study will examine a moderated-mediation model of stalking victimization and both trauma-related symptoms and depression. It is hypothesized that self-blame, event-specific helplessness attributions, avoidant coping, and rumination will mediate the relationship between stalking victimization and trauma-related symptoms and depression, such that stalking victims will be more likely to be high in these constructs, and in turn, will report more severe posttraumatic stress and depressive symptoms. Additionally, it is hypothesized that self-compassion will act as a moderator between stalking victimization and these proposed mediators. That is, stalking victims who are self-compassionate individuals will demonstrate a weaker relationship between stalking and the proposed mediators of rumination, self-blame, and helplessness attributions than those who are less self-compassionate individuals. As a result, they will be less likely to have less severe posttraumatic stress and depressive symptoms.

In the following section, the severity of stalking and its related psychological outcomes will be discussed. Next, potential mechanisms for the relationship between stalking victimization and trauma-related symptoms and depression will be detailed. I will examine self-compassion as a moderator of the relationship between stalking and the hypothesized mediators. Finally, the proposed model will be introduced.

The Stalking Problem

Stalking is a severe issue that is both power-oriented and control-oriented in nature (Brewster, 2003). Specifically, stalking perpetrators seek to control their partners through financial, social, psychological, physical, and sexual means (Brewster, 2003).

Although exact definitions vary by state, stalking generally involves behavior that would cause a reasonable person to feel fear (Catalano, 2012). The Supplemental Victimization Survey (SVS), a measure utilized by the Bureau of Justice Statistics, identifies individuals as victims if their perpetrators have performed at least one of the following stalking behaviors on two separate occasions: (1) making unwanted phone calls; (2) sending unsolicited or unwanted letters or other forms of communication; (3) following or spying on the victim; (4) waiting for the victim outside or inside of a location; (5) showing up at places where the victim was for illegitimate reasons; (6) leaving unwanted items or presents; and (7) sharing information about the victim on the internet, in a public space, or by word of mouth (Catalano, 2012). Stalking is a crime in all 50 states (Catalano, 2012).

Stalking is a prevalent issue. Women are typically more likely to be victims of stalking than men; 15.2% of women have been stalked in their lifetime compared to the 5.7% of men who have similarly been stalked (Breiding, 2015). Additionally, in a 12-month span, 4.2% of women and 2.1% of men reported being victims of stalking (Breiding, 2015). The harmful nature of stalking is highlighted when the relationships between victims and perpetrators are identified. Stalking is overwhelmingly perpetrated by someone the victim knows, such as current or former intimate partners, family members, or acquaintances (Breiding, 2015). In fact, 70% of stalking victims knew their perpetrators in some capacity (Catalano, 2012).

Aside from the seven stalking behaviors identified by the SVS, victims report being subject to other disturbing behaviors. In a study examining the relationship between stalking and psychopathology, researchers found common features of stalking,

such that numerous victims reported being surveilled, physically assaulted, or abducted, along with unwanted approach, damage or theft of property, and harm to pets (Blaauw et al., 2002).

Stalking victims are often subjected to a "pervasive, prolonged, persistent, and intensive stressful experience" (Blaauw et al., 2002, p. 60). The frightening nature of stalking, coupled with the likelihood of knowing the offender, can lead to severe psychological consequences for victims. In one sample, three quarters of stalking victims demonstrated levels of symptomology that would suggest the presence of a psychiatric disorder (Blaauw et al., 2002). In the following section, these outcomes will be reviewed.

Psychological Consequences of Stalking

Depression. Previous research suggests that stalking victimization and depression are positively correlated. In a study that compared psychological outcomes of stalking victims to outcomes of other populations, Blaauw and colleagues (2002) found that stalking victims had higher levels of depression than the general population and general practitioner patients. In fact, victims of stalking had depression levels on par with psychiatric outpatients (Blaauw et al., 2002). Likewise, researchers found evidence that battered women who were relentlessly stalked suffered from more severe depressive symptoms than battered women who were infrequently stalked (Mechanic et al., 2000), indicating that the severity of stalking might contribute to the severity of depression. Finally, in a study examining a random community sample, victims of stalking were more likely to report suicidal ideation (Purcell, Pathé, & Mullen, 2005).

Anxiety. As previously explained, stalking victimization is an ongoing state of stress and fear. These persistent feelings of stress can often lead to anxiety. Alongside

depression, Blaauw and colleagues (2002) measured levels of anxiety in stalking victims; the results indicate that stalking victims had higher levels of anxiety than the general population, general practitioner patients, and psychiatric outpatients. Turmanis and Brown (2006) found that level of stalking positively correlated with and predicted participants' level of anxiety.

Trauma-Related Symptoms. Of particular importance in the current study is the relationship between stalking victimization and trauma-related symptoms. In one sample, researchers found evidence that stalking, alongside other forms of intimate partner violence, is significantly associated with trauma-related symptoms (Basile et al., 2004). Additionally, the literature suggests that fear-and-threat stalking (i.e., stalking that includes being frightened and fearing for one's safety) significantly predicts trauma-related symptoms in post-abuse women; the same results are found even when accounting for other forms of intimate partner violence and life stressors (Fleming et al., 2013). Mechanic and colleagues' findings lend further support of the association between stalking victimization and trauma-related symptoms. The researchers found that women who were relentlessly stalked had more severe PTSD symptoms than women who were infrequently stalked (Mechanic et al., 2000).

It is critical to understand the mechanisms by which stalking may be associated with mental health problems. By identifying these mechanisms, prevention and treatment plans may be developed to help those who have experienced stalking. In the next section, I will discuss the theory behind empirically identified constructs that may serve as such mechanisms.

Potential Mechanisms for the Relationship between Stalking and Trauma

Attributional style. As posited by early researchers, learned helplessness occurs when an individual persistently attempts to escape a stressful situation; after repeated failures, the individual loses motivation to escape comparable situations (Klein, Fencil-Morse, & Seligman, 1976; Seligman & Maier, 1967). Perceived controllability is essential to learned helplessness, in that it is unlikely that learned helplessness will develop when one believes that they have control over a situations outcome. In most stalking cases, the experience is negative and persistent, which may lead to the diminishment of perceived control, and thus, make it likely for learned helplessness to develop (Abramson, Seligman, & Teasdale, 1978).

Although the theory of learned helplessness established groundwork for determining causality of any event, there was a lack of connection between the construct and its relation with mental health and human cognition (Abramson et al., 1978). These limitations prompted the creation of the reformulated learned helplessness model which incorporates the attribution theory (Abramson et al., 1978). When the cause of any event is ambiguous, individuals tend to rely on a habitual way of determining the cause; this is referred to as attributional style (Alloy, Peterson, Abramson, & Seligman, 1984). Typically, attributional style falls in one of three domains: internal versus external, stable versus unstable, or global versus specific (Abramson et al., 1978). According to Abramson and colleagues (1978), internality is the likelihood of an individual attributing the cause of a negative event to an internal trait or an external stimulus. Stability is the degree to which an individual infers that the cause of an event is either permanent or

likely to change (Abramson et al., 1978). Lastly, globality refers to the cause of an event occurring in a broad or narrow range of situations (Abramson et al., 1978).

The bulk of research examining learned helplessness has focused on its relation to depression. Researchers have proposed that depression is a likely outcome when one uses internal, global, and stable attributions (Metalsky, Halberstadt, & Abramson, 1987). In addition, attributional style acted as a mediator in the relationship between traumatic experiences and depression in a sample of earthquake survivors (Greening, Stoppelbein, & Docter, 2002). The researchers did not establish the same findings with trauma-related symptoms. It's important to note, however, that research widely suggests that individuals living with trauma-related symptoms are likely to experience symptoms stemming from anxiety or depression (Elwood et al., 2009). Furthermore, additional research suggests that helplessness attributional style, trauma-related symptoms, and depression are strongly correlated (Bargai et al., 2007). In fact, helplessness attributional style acted as a mediator of the relationship between violence, trauma-related symptoms, and major depressive disorder. These findings lay the groundwork for understanding the etiology of trauma-related symptoms in stalking victims (Elwood et al., 2009).

Event-specific helplessness attributions. The construct of learned helplessness can also apply to one specific event as opposed to all negative events more broadly (Alloy et al., 1984). The generalizability of learned helplessness is determined by two factors. According to the reformulated model of learned helplessness, the transferability of helplessness occurs due to perceived causality of a negative event and the similarity of the negative event to another event (Abramson et al., 1978). In the case of stalking victimization, it is possible that victims feel helplessness only in regards to the stalking

episode. Some studies suggest that event-specific attributions are correlated with trauma-related symptoms more than attributional style, as was found to be the case with Reiland's (2006) study on traumatic events (e.g., rape, serious accidents, abusive relationships, etc.), trauma-related symptoms, and depression. Additionally, Reiland and colleagues (2014) examined attributional style, including trauma-specific attributions, traumatic events (e.g., sexual abuse, serious accidents, being in danger, etc.) and trauma-related symptoms in an undergraduate population. The researchers found that various forms of event-specific attributions (i.e., internal, stable, and global) significantly predicted trauma-related symptoms (Reiland et al., 2014). These studies lend credit to the belief that event-specific attributions may contribute to the development of trauma-related symptoms.

Literature surrounding event-specific attributions and trauma-related symptoms is scarce; however, research suggests that trauma-related symptoms treatment may benefit from focusing on the cognition regarding the trauma. In her book *Trauma and Recovery* (1992), Herman states that victims should confront and work through their memories of an event instead of avoiding the trauma. By employing this approach, the victim may find respite from their trauma-related symptoms. Although the research is not conclusive, it is possible that the effectiveness of this model is, at least in part, a result of successfully modifying event-specific attributions. The research examining stalking-specific attributions and trauma is considerably more restricted. Because traumatic events may not be fully processed (Halligan, Clark, & Ehlers, 2002), victims who apply stable attributions would view the perpetrator's actions as unchangeable (Reiland et al., 2014), and would be unlikely to change their perceptions of causality. This belief system is

arguably more practical than believing the motivating factor behind a perpetrator's actions will change (i.e., unstable attribution; Greening et al., 2002).

Fais, Lutz-Zois, and Goodnight (2017) examined various mediators and moderators in the association between stalking victimization and depression. Specifically, the authors hypothesized that a helplessness attributional style would emerge as a mediator of the relationship between stalking victimization and depression (Fais et al., 2017). As expected, global attributions were found to act as a mediator in the proposed relationship; neither internal nor stable attributions were found to significantly act as mediators (Fais et al., 2017). Because the symptoms of trauma-related symptoms and depression may overlap (Elwood et al., 2009), these results might provide additional evidence to suggest that event-specific attributions will serve as a mediator of the relationship between stalking victimization and both trauma-related symptoms and depression.

Characterological and behavioral self-blame. Self-blame, attributing the cause of a negative event to oneself (Janoff-Bulman, 1979), can be distinguished as either characterological or behavioral. Characterological self-blame is related to self-esteem; the individual blames their own character as the catalyst for a negative event (Janoff-Bulman, 1979). In a sample of female undergraduate students, Janoff-Bulman (1979) found that depressed participants engaged in more characterological self-blame than participants who did not meet criteria for depression. Similarly, rape survivors who engaged in characterological self-blame blamed themselves for the trauma significantly more than those who engaged in behavioral self-blame (Janoff-Bulman, 1979). If the individual were to blame the negative event on their own behavior, they would be partaking in

behavioral self-blame (Janoff-Bulman, 1979). Because behavioral self-blame involves a sense of control, individuals may feel they are less likely to be revictimized, and thus experience less severe psychological outcomes than those who engage in characterological self-blame.

Due to the negative nature of self-blame, difficulties after trauma may arise. In particular, victims partaking in characterological self-blame may attribute the cause of their trauma to unchangeable personality traits, thus perceiving themselves as a "chronic victim" (Janoff-Bulman, 1979). Characterological self-blame is seen as a maladaptive coping technique (Janoff-Bulman, 1979), which may lead to psychological problems, such as trauma-related symptoms. Although there is a distinction between the two types of self-blame, especially when considering if the styles are adaptive or maladaptive, the bulk of research focuses on the combination of self-blame styles. The results of studies examining the association between self-blame and trauma-related symptoms vary. In a sample of rape victims, Frazier (1990) documented that trauma victims engaged in both characterological and behavioral self-blame. In the same study, self-blame was correlated with the onset of depression; however, the results indicated that there was no link between self-blame and trauma-related symptoms. More recent research challenges this conclusion. Specially, findings by Larsen and Fitzgerald (2011) suggest that self-blame was significantly related to trauma-related symptoms when perceived control over future harassment was controlled. The researchers found that self-blame was associated with lower levels of perceived control over future harassment.

Fais and colleagues (2017) also examined the role of self-blame in the relationship between stalking victimization and depression; the authors predicted that

self-blame would act as a mediator of this relationship. The results, however, did not reveal that characterological self-blame mediated the relationship between stalking victimization and depression (Fais et al., 2017). This non-significant finding may be due to limitations stemming from the measure of stalking. Specific limitations of Fais and colleagues (2017) study will be discussed in-depth in a later section.

Rumination. Rumination, a form of self-focused attention where one excessively and persistently focuses on one's own problems (Butler & Nolen-Hoeksema, 1994), is well-established to exacerbate depression. Recently, researchers have sought to understand the association between rumination and trauma-related symptoms. Theorists suggest that rumination may lead to significant psychological issues, such as trauma-related symptoms, for a number of reasons. Most importantly, the intrusiveness of rumination means that victims are focusing on their trauma persistently. Persistently focusing on trauma may lead to negative feelings, as suggested by Ehlers and Clark (2000) who posited that rumination might trigger hopelessness and nervous tension. For these reasons, it is likely that rumination is related to trauma-related symptoms.

Overwhelmingly, researchers have found significant associations between rumination and trauma-related symptoms. Rumination was found to predict trauma-related symptoms up to six months after a traumatic event (Ehring, Frank, & Ehlers, 2008). Moreover, in a sample of victims of assault, researchers found that victims with PTSD ruminated significantly more than victims without PTSD (Michael, Halligan, Clark, & Ehlers, 2007). Additional research suggests that rumination moderates the association between PTSD and depressive symptoms; that is, greater PTSD predicted greater depressive symptoms in participants who ruminated more (Roley et al., 2015).

Clohessy and Ehlers (1999) conducted a cross-sectional study examining trauma-related symptoms and mental health in ambulance workers. Their findings suggest that rumination was related to trauma-related symptoms severity, such that workers who ruminated frequently had more severe symptomology (Clohessy & Ehlers, 1999). This body of research indicates a significant association between trauma-related symptoms and rumination.

Avoidant coping. Avoidant coping is an individual's proclivity to orient their behaviors (e.g., avoiding situations that cause negative emotions) and thoughts (e.g., denial) away from a stressor (Krause et al., 2008). By definition, avoidant coping implies that an individual dealing with trauma does not focus on or cope with their stressor; oftentimes, this can lead to psychological costs. Roth and Cohen (1986) note that avoidant coping can lead to "emotional numbness", a lack of awareness of the association between their trauma and symptoms, and inaction when stressors are in the individuals control. It's clear that avoidant coping is capable of contributing to negative psychological outcomes. Within this study, the possible association between avoidant coping and trauma-related symptoms will be discussed.

In a longitudinal study examining victims of intimate partner violence, Krause and colleagues (2008) found that avoidant coping was associated with trauma-related symptoms above and beyond multiple covariates known to predict the presence of trauma symptoms (e.g., childhood sexual abuse, severity of violence, revictimization). Furthermore, avoidant coping has been linked to poor psychological adjustment in rape victims (Cohen & Roth, 1987). In the same sample, avoidant coping was negatively correlated with recovery (Cohen & Roth, 1987). Finally, research suggests that avoidant

coping is associated with increased PTSD symptom severity (Boeschen, Koss, Figueredo, & Coan, 2001; Valentiner, Foa, Riggs, & Gershuny, 1996).

It is important to note that not all stalking victims experience these processes; therefore, it is useful to examine possible moderators of the relationship between stalking and these hypothesized mediators of trauma symptoms. Self-compassion may be one such moderator.

Self-Compassion

Born from Buddhist philosophy, self-compassion is a concept used to describe compassion—specifically, kindness, patience, and understanding—directed towards oneself (Neff, 2003b). Self-compassion, similar in nature to mindfulness, is composed of three related aspects: (1) awareness of suffering without over-identification; (2) self-kindness extending towards oneself; and (3) a sense of commonality in the human experience (Neff, 2003a; 2003b). In different ways, each concept is thought to lessen self-judgment, blame, and negative emotions (Neff, 2003b).

Self-compassion and psychological outcomes. As Neff (2003b) notes, self-compassion "transforms negative self-affect into positive self-affect" (p. 225). Due to this transformation, positive psychological outcomes are expected. In particular, it is suggested that self-compassionate individuals may see positive outcomes that are typically associated with high self-esteem, such as feeling kindness towards oneself (Neff, 2003b). Moreover, it is possible that self-compassionate individuals have more positive experiences when compared to individuals low in self-compassion because, due to the non-judgmental nature of self-compassion, their negative experiences (e.g., failure) are not amplified.

Early research on self-compassion has laid the groundwork for understanding the relationships between self-compassion and psychosocial outcomes. Neff (2003b) found that self-compassion was negatively correlated with depression, anxiety, and neurotic perfectionism. In addition, self-compassion was positively correlated with life satisfaction (Neff, 2003b). Using a sample of undergraduate students, Rockliff, Gilbert, McEwan, Lightman, and Glover (2008) recorded participants' cortisol levels during a relaxation imagery exercise (i.e., measuring baseline cortisol levels), compassionate imagery exercise (i.e., imagining they were the recipient of compassionate feelings), and a control imagery exercise (i.e., thinking of their favorite sandwich). The researchers found that, during the self-compassion imagery exercise, participants had lower levels of cortisol than during the relaxation and control imagery exercises (Rockcliff et al., 2008). The study by Rockcliff and colleagues (2008) is particularly noteworthy because self-compassion was experimentally manipulated, thus allowing for speculation about the potential causal role of self-compassion resulted in lower cortisol levels. The authors noted that the compassion imagery had a soothing effect on the hypothalamic-pituitary adrenal axis, an internal system that regulates stress, leading to decreased cortisol levels (Rockcliff et al., 2008). Moreover, researchers asked undergraduate students to describe four events that caused difficulty in their lives within a 20-day period, as well as report on their reactions to the events (Leary, Tate, Adams, Allen, & Hancock, 2007). Participants who had a higher degree of self-compassion were less likely in comparison to participants who had a lower degree of self-compassion to experience isolation as a consequence of their recent problems and more likely to accept responsibility for their part in their problems (Leary et al., 2007).

Furthermore, research has attempted to establish links between self-compassion and trauma-related symptoms and trauma processing. Seligowski, Miron, and Orcutt (2015) suggested that self-compassion was related to overall psychological health, but not PTSD. Self-kindness and mindfulness, however, were associated with decreased PTSD symptoms severity (Valdez & Lilly, 2016). In another study, the results indicate that childhood abuse exposure and PTSD were negatively associated with self-compassion (Barlow et al., 2017). Although the research regarding self-compassion and PTSD is mixed, some results suggest that individuals with lower levels of self-compassion may experience an increase in negative psychological outcomes, such as PTSD (Barlow et al., 2017; Valdez & Lilly, 2016).

Self-compassion as a moderator. The moderating role of self-compassion has been researched in a variety of samples. Samaie and Farahani (2011) used a correlational design to assess the relationship between rumination, self-reflection, stress, and self-compassion in a sample of undergraduate students. Their findings are particularly important for the current study. Specifically, the researchers found a positive association between rumination and stress, indicating that, as individuals ruminate, they may experience increased levels of stress (Samaie & Farahani, 2011). The association between rumination and stress, however, was moderated by self-compassion, such that high levels of self-compassion contributed to a decreased link between rumination and stress (Samaie & Farahani, 2011). These findings align with the conceptual framework surrounding the relationship between self-compassion and rumination. Neff (2003b) posited that self-compassion and rumination would be negatively correlated because self-compassion involves balancing one's emotions instead of repeatedly and excessively

focusing on negative events. These findings also suggest that self-compassion may serve as a buffer against negative cognitive reactions to stress.

That self-compassion may act as a buffer against negative reactions in response to stress is a finding further supported by research. Luo, Qiao, and Che (2018) assessed physiological distress (i.e., heart rate and heart rate variability) and negative affect after a stressful social situation—preparing for and giving a speech to a researcher—in a sample of undergraduate students. Participants high in self-compassion had lower heart rate variability and decreased negative affect than participants low in self-compassion (Luo et al., 2018). These findings suggest that, when faced with a stressful event, self-compassionate individuals may be better able to adapt to the situation by adjusting both their psychological and physiological responses (Luo et al., 2018).

Furthermore, additional research by Hu, Wang, Sun, Arteta-Garcia, and Purol (2018) supports the claim that self-compassion acts as a buffer against negative outcomes associated with stress. In their study, undergraduate participants were asked to record stressful events and sleep outcomes in a sleep diary. According to the results in testing for the significance of the Self-compassion by Daily stressor interaction in the prediction of sleep outcomes, self-compassion acted as a buffer against negative stressors on sleep latency. That is, after experiencing stressful events, self-compassionate individuals did not take a longer time to fall asleep, as was the case with individuals low in self-compassion (Hu et al., 2018). These results suggest that self-compassion plays a meaningful role in attenuating negative outcomes associated with stress.

The Current Study

The current study investigated a moderated-mediation model that examines trauma-related and depressive symptoms among stalking victims (see Figure 1). This study expands upon the moderated-mediation model designed by Fais and colleagues (2017) that examined stalking victimization and depression. The researchers hypothesized that, in the relationship between stalking victimization and depression, attributional style and self-blame would act as mediators while length of stalking, sex, and sex-role identity would act as moderators (Fais et al., 2017). As stated previously, the results indicated that global attributions served as a mediator of the relationship between behavioral harassment and depression; however, self-blame, internal attributions, and stable attributions did not serve as mediators of this relationship (Fais et al., 2017). Moreover, length of harassment, feminine and masculine sex-role identity, and participant gender did not appear to moderate the relationship between stalking and event-specific attributions (i.e., internal/external, global/specific, and stable/unstable helplessness attributions; Fais et al., 2017). It is possible that these results are due to methodological limitations which will be discussed in the following paragraphs.

Although Fais and colleagues (2017) laid the groundwork of the moderated-mediation model, the current study differs in a number of ways. First, the current study examines the relationship between stalking victimization and trauma-related symptoms in addition to depressive symptoms. By assessing the association between stalking victimization and both depressive and trauma-related symptoms, I am better able to comprehend the scope to which stalking victimization may contribute to mental disorders. That is, I can assess whether the same processes involved with stalking

victimization and depression also apply to stalking victimization and trauma-related symptoms. Next, the current study addresses past limitations by using a better measure of stalking that includes subscales assessing both frequency and intensity of the stalking episode. The new measure allows for a more nuanced look into participants' stalking experiences by examining both the frequency and distressing nature of the stalking events. One distinct difference among the two studies is the inclusion of a manipulation. In this study, participants were randomly assigned to either a self-compassion or special imagery exercise, which entailed listening to an audio recording. The experiment was added to assess the effect of condition on Time 2 self-compassion scores.

Finally, this study examines the moderating role of self-compassion in the relationship between stalking victimization and the proposed mediators of rumination and avoidant coping. Valdez and Lilly (2016) note that, from a theoretical standpoint, negative processing after trauma may manifest as avoidant coping and ruminative thinking. In a study on self-compassion in the face of academic failure, Neff, Hsieh, and Dejitterat (2005) found that self-compassion and avoidant coping were negatively correlated. For these reasons, it is important to assess the relationship between trauma-related symptoms, rumination, and avoidant coping and how this relationship may be affected by self-compassion. Because self-compassion was not assessed in Fais and colleagues (2017) model, its fit into the moderated-mediation model has not been established. It is expected that individuals high in self-compassion will demonstrate a weaker relationship between stalking victimization and the proposed mediators (i.e., self-blame, rumination, avoidant coping, and event-specific helplessness attributions) and thus have decreased trauma-related and depressive symptoms. The three components of self-

compassion—awareness without over-identification, kindness towards self, and a shared experience—provide theoretical support to the hypothesis that individuals high in self-compassion will experience a weakened relationship between stalking victimization and the mediators (Neff, 2003a, 2003b). For example, individuals who are kind to themselves should be less likely to blame themselves for their experienced trauma. Those who possess an awareness without over-identification should not ruminate or participate in avoidant coping. Furthermore, individuals who find meaning from a shared experience should not feel helpless regarding their trauma. If self-compassionate individuals experience a lesser degree of the proposed mediators, they may avoid the negative outcomes related to each construct (e.g., depression or trauma-related symptoms) and experience more positive outcomes associated with self-compassion, such as higher satisfaction with life (Neff, 2003b).

Hypotheses. In the current study, I make the following hypotheses:

Hypothesis 1: The association between stalking victimization and both trauma-related symptoms and depression will be mediated by self-blame, rumination, avoidant coping, and event-specific helplessness attributions.

Hypothesis 2: Self-compassion will moderate the association between stalking victimization and the hypothesized mediators (i.e., self-blame, rumination, avoidant coping, and event-specific helplessness attributions). Specifically, the relationship between the hypothesized mediators and both posttraumatic stress symptoms and depressive symptoms will be weaker for individuals higher in self-compassion when compared to individuals lower in self-compassion.

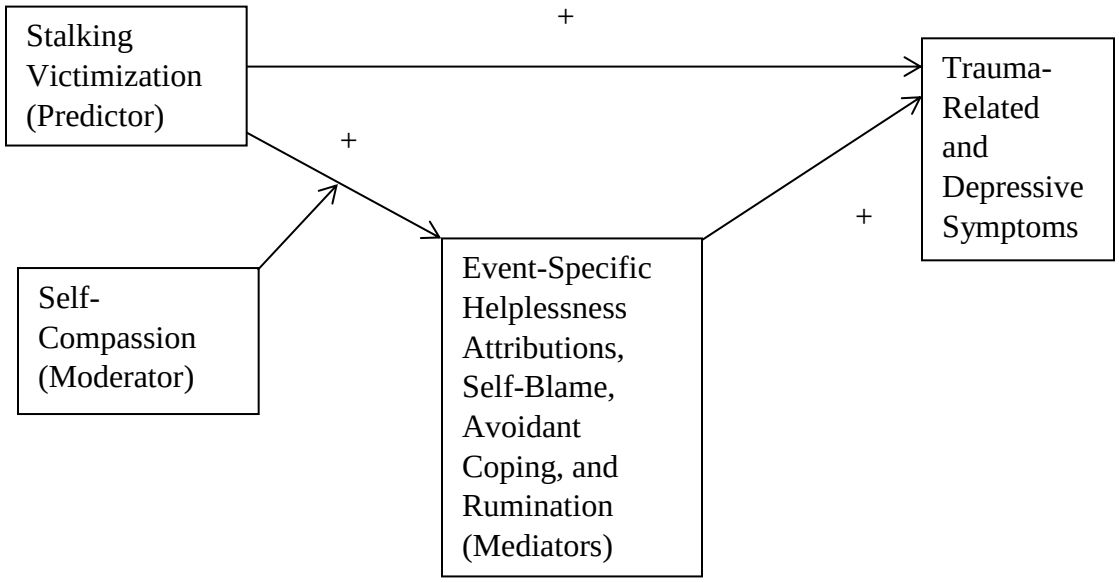

Figure 1. The Proposed Moderated-Mediation Model of Stalking Victimization and both Trauma-Related and Depressive Symptoms.

CHAPTER 2

METHODS

Participants

Ninety-two participants were recruited from introductory and upper-level Psychology courses at a medium-sized private university in exchange for course credit. Students in both introductory and upper-level courses were recruited to increase variability in the length of stalking experienced by participants. The ages of participants ranged from 18 to 23, with the mean age being 19-years-old (n = 36). There were 56 participants who identified as women and 35 participants who identified as men. Finally, 92% of the sample identified as "White" and 8% identified as "Other." On a measure of stalking behavior, 55% of the sample indicated that they had received unwanted attention from another person on more than one occasion, while 45% of the sample had not. Of this 55%, 21 participants were in the self-compassion condition and 20 were in the special place condition. The majority of participants (87%) indicated that these unwanted behaviors caused them significant distress and fear, whereas 13% did not become distressed. The reported genders of perpetrators are as follows: 37% female and 51% male.

Procedure

Prior to data collection, this study was reviewed and approved by the appropriate institutional review board. Both lower and upperclassmen undergraduate students were recruited for this study through an online undergraduate participant pool for students

enrolled in psychology courses. Participants were randomly assigned to either a loving kindness or special place condition. Upon arrival, participants were asked to read and agree to an informed consent form. The researchers informed the participants that they were able to leave at any point during the study. Participants who chose to continue with the study received two measures assessing their stalking experience and level of self-compassion. Next, the participants used the computer and headphones provided by the researcher to listen to an audio recording of a self-compassion (i.e., loving kindness; Appendix I) or relaxation (i.e., a special place; Appendix J) exercise, depending on the assigned condition. After the manipulation, participants completed measures of demographics, PTSD, depression, self-blame, rumination, avoidant coping, event-specific attributions, and a second administration of the same self-compassion administered before the audio-recordings. To reduce order effects, the measures were counterbalanced using a method of random starting order with rotation. For example, some of the questionnaire packets followed the form of ABCD while others followed the form of BCDA, CDAB, and so on.

At the conclusion of the experiment, participants were debriefed on the nature of the study and received contact information for the primary investigator and the Counseling Center. Participants were granted course credit regardless of whether they completed.

Measures

Demographics. A demographic questionnaire assessed participants' age, gender, and race (see Appendix A).

Predictors. The following section includes the measures for the predictor variable.

***Stalking victimization*.** The Stalking and Harassment Behaviour Scale is a measure that assesses both the stalking experience and 42 stalking behaviors (Turmanis & Brown, 2006; see Appendix B). The measure is comprised of two subscales measuring the frequency of harassing behavior (THB; $\alpha = .90$) and the subjective distress scores (SDS; $\alpha = .90$). The current study utilized a modified version of the scale. First, I added four items to assess online stalking behavior (e.g., "How often [they] contacted you through Facebook or other social media") and contact through text or instant messages (e.g., "How often [they] contacted you through text messages"). Next, I changed the scale to include a score of zero. The rationale behind this change is that a score of one might confuse participants who have not experienced stalking behavior. Thus, the modified scale ranges from 0 to 10. Specifically, the THB now asks participants to rate the frequency of stalking behavior (e.g., "How often [they] followed you by car") and ranges from 0 (*no experience*) to 10 (*all the time*). The SDS subscale ranges from 0 (*not at all disturbed/scared*) to 10 (*extremely disturbed/scared*) and asks participants to specify their degree of distress (e.g., "How disturbed/scared [were you when they] followed you by car?"). Scores on these two subscales will each range from zero and 44. In the primary analyses, each subscale was treated as a separate predictor variable.

Turmanis and Brown (2006) tested both the reliability and validity of the Stalking and Harassment Behaviour Scale. Split-half reliability tests revealed coefficients of .84 and .81 for the THB subscale and .86 and .90 for the SDS subscale (Turmanis & Brown, 2006). The authors note that both subscales had alphas over .90 (Turmanis & Brown,

2006). The researchers tested each item on both subscales—THB and SDS—and the level of stalking score (i.e., the product of the frequency and subjective distress scores of harassing behaviors) and found that the items had correlation coefficients ranging from r = .20 to r = .69, indicating that the subscales were moderately correlated (Turmanis & Brown, 2006).

Criterion. In the next section, measures assessing criterion variables will be discussed.

***Posttraumatic Stress Disorder*.** The Posttraumatic Stress Disorder Checklist for the DSM-5 (PCL-5; Blevins, Weathers, Davis, Witte, & Domino, 2015; Appendix C) is a 20-item measure anchored from 0 (*not at all*) to 4 (*extremely*). The measure is composed of the following: 5 items assessing intrusive or dissociative thoughts (e.g., "[In the past month, how much were you bothered by] repeated, disturbing dreams of the stressful experience?"); 2 items assessing avoidance (e.g., [In the past month, how much were you bothered by] avoiding memories, thoughts, or feelings related to the stressful experience?); 7 items assessing negative changes in mood and cognitions (e.g., [In the past month, how much were you bothered by] blaming yourself or someone else for the stressful experience or what happened after it?); and 6 items assessing changes in arousal associated with the event (e.g., [In the past month, how much were you bothered by] trouble falling or staying asleep?). Thus, scores on this measure may fall between zero and 80 based on participant experience, with a score of 33 or above qualifying for a PTSD diagnosis (Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013). The current study utilized the total score for the primary and the four subscales for follow-up analyses.

Previous research has demonstrated the reliability (i.e., test-retest, parallel forms, and internal consistency) and validity of the PCL-5. Blevins and colleagues (2015) found that the PCL-5 had high internal consistency ($\alpha = .95$) and, when compared to the original PCL, had a higher test-retest reliability. Moreover, the PCL-5 has shown to be highly correlated with a myriad of similar measures assessing PTSD, such as the Posttraumatic Diagnostic Scale and the Detailed Assessment of Posttraumatic Stress (Blevins et al., 2015). The researchers also found that the PCL-5 was moderately correlated with theoretically related constructs (e.g., depression; $r = .60$) and weakly correlated with unrelated constructs (e.g., mania; $r = .31$) on the Personality Assessment Inventory (Blevins et al., 2015).

***Depression*.** The Center for Epidemiological Studies-Depression (CES-D) 20-item scale was used to assess depression (Radloff, 1977). The CES-D contains retrospective items that address depressive symptoms (e.g., "I felt hopeful about the future"). The scale includes four responses that indicate how frequently a participant has experienced the statement in the past week question (0 = rarely or none of the time, 1 = some or little of the time, 2 = occasionally or a moderate amount of time, and 3 = most or all of the time). As such, the possible scores range between 0 and 20, with a score of 16 or greater indicating clinical depression. The instructions of the CES-D were modified to specifically address stalking. Instead of asking about any traumatic event, the modified scale now instructs participants to complete the measure only if they endorsed items on question 5 of the SHBS.

The CES-D is a well-validated and reliable measure of depression. Olson, Presniak, and MacGregor (2010) found a significant positive correlation between CES-D

scores and depressed affect. The same researchers found a negative correlation between positive affect and CES-D scores (Olson et al., 2010). Both positive and depressed affect significantly differentiated from low, moderate, and high scores on the Personality Assessment Inventory scale of depression. The CES-D has a high internal consistency across studies, with Radloff (1977) reporting coefficients between .85 and .90. The measure demonstrated moderate test-retest coefficients ranging from .45 and .70 (Radloff, 1977). See Appendix D.

Mediators. In the following section, various mediating variables will be discussed.

***Self-blame*.** The current study utilized O'Neill and Kerig's (2000) 12-item Behavioral and Characterological Self-Blame Scale (BCSB). The scale includes items assessing both behavioral (e.g., "It happened because of something I did") and characterological (e.g., "It happened because of the kind of person I am") self-blame. The scale is anchored at 1 (*strongly disagree*) and 6 (*strongly agree*). Thus, participants can obtain scores between 12 and 72. Fais and colleagues (2017) used a modified version of the BCSB which measured self-blame in stalking victimization. The modification included assessing the amount and type of self-blame that was attributed to participants' stalking victimization. The instructions were modified to explicitly mention harassment and stalking experiences (e.g., "Below is a list of beliefs regarding past harassment and stalking harassments"). Item 8 was modified to reflect the participants stalking experience (e.g., "It happened because I am too passive to confront the stalker").The current study utilized the same modified version of the BCSB, which can be found in Appendix E.

In a sample of battered women, the authors reported internal consistency alphas of .71 and .78 for behavioral and characterological self-blame, respectively (O'Neill & Kerig, 2000). Characterological self-blame is related to depression, as found by Janoff-Bulman (1979) and Plaufcan, Wamboldt, and Holm (2012).

***Rumination*.** The Ruminative Response Scale (RRS; Treynor, Gonzalez, & Nolen-Hoeksema, 2003) includes 22 items that measure the frequency of ruminative thoughts. Each item is rated on a scale ranging from 1 (*almost never*) to 4 (*almost always*). The RRS is composed of two subscales that assess brooding (e.g., "I think 'why do I always react this way?'") and reflection (e.g., "Analyze recent events to try to determine why you are depressed"). The sum of the subscales can be used as an overall measure of rumination. Individual scores will range from 22 to 88 depending on how each participant endorses the frequency of their ruminative thoughts. The current study used the overall measure of rumination in the primary analyses.

Treynor and colleagues (2003) assessed RRS in a community sample of adults (n = 1,328) and reported psychometric data for both subscales. Both the reflection (α = .72) and brooding (α = .79) subscales had adequate internal consistency coefficients. Test-retest stability was adequate, as well, with coefficients of .60 for the reflection subscale and .62 for the brooding subscale. In a sample of undergraduates, Roelofs, Muris, Huibers, Peeters, and Arntz (2006) found that the measure of rumination was associated with measures of depression, neuroticism, and trait anxiety. See Appendix F.

***Avoidant coping*.** Finest, Steine, Haugli, Steen, and Laerum's (2002) Brief Approach/Avoidance Coping Questionnaire (BACQ) was used to measure coping style. The 12-item scale consists of five response options, ranging from 1 (*disagree completely*)

to 5 (*agree completely*). The scale is composed of six items assessing approach coping (i.e., “I say so if I am angry or sad.”), three items assessing resignation and withdrawal (i.e., “I find it difficult to do something new.”) and three items assessing diversion (i.e., “I try to forget my problems.”). The items assessing resignation and withdrawal and diversion create the avoidant coping subscale. Therefore, scores on each subscale can fall between six and 30. The current study used scores of both the approach and avoidance subscales in the analyses.

When measuring internal consistency, Finest et al. (2002) found a satisfactory alpha of the overall BACQ ($\alpha = .68$) and the two separate factors ($\alpha = .59$ and .55). The measure’s validity was tested, as well. Each of the three indexes (i.e., approach, diversion, and resignation and withdrawal) were significantly correlated with corresponding subscales on the COPE (Finest et al., 2002). See Appendix G.

***Event-specific attributions*.** In order to assess event-specific attributions, the current study utilized a modified version of the measure used by Fais et al. (2017). Fais and colleagues (2017) used an item from the Obsessive Relational Intrusion scale (ORI; Cupach & Spitzberg, 1998) that assessed the presence of behavioral harassment. If participants endorsed the ORI item, they were asked to answer questions regarding the causality of their specified event. Specifically, participants used three 7-point Likert scales to rate the internality vs. externality, stability vs. instability, and globality vs. specificity of the event. The researchers followed the format of the Attributional Style Questionnaire (ASQ; Abramson et al., 1978) due to its demonstrated reliability; across subscales, the ASQ had alphas of .70 or higher. Instead of using the item from the ORI, the current study modified the Fais et al. (2017) scale by using question 5 from the SHBS

which asks participants to rate the frequency of and distress caused by stalking behavior (Turmanis & Brown, 2006). See Appendix H for the modified measure.

Moderator. The measure assessing self-compassion will be detailed within this section.

***Self-compassion*.** The Self-Compassion Scale (Neff, 2003b) measures an individual's level of self-compassion. The 26-item measure is on a scale of 1 (*almost never*) to 5 (*almost always*), with total scores ranging between 26 and 130. Further, the measure is broken down into six subscales assessing self-kindness (i.e., "I try to be loving towards myself when I'm feeling emotional pain"), self-judgment (i.e., "I'm disapproving and judgmental about my own flaws and inadequacies"), common humanity (i.e., "When things are going badly for me, I see the difficulties as part of life that everyone goes through"), isolation (i.e., "When I'm feeling down, I tend to feel like most other people are probably happier than I am"), mindfulness (i.e., "When something upsets me I try to keep my emotions in balance"), and over-identification (i.e., "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). The total score for this measure was used in the primary analyses.

With respect to the psychometric properties of this measure, Neff (2003b) had participants respond to the Self-Compassion Scale are two separate time points with approximately three weeks in between each administration. Test-retest reliability coefficients were found for each of the six subscales and the grand mean and ranged from $r = .80$ to $r = .93$. Likewise, when assessing internal consistency, Neff (2003b) found correlation coefficients ranging from $r = .75$ to $r = .81$. The results also indicated that the Self-Compassion Scale had good construct validity, as well. The Self-Compassion Scale

was positively correlated with theoretically similar measures (i.e., Rosenberg Self-Esteem Scale, Berger's Self-Acceptance Scale, Self-Determination Scale, and the Basic Psychological Needs Scale) and negatively correlated with theoretically different measures (i.e., Rumination Responses Scale and White Bear Thought Suppression Inventory). See Appendix I.

Materials

Scripts. The current study used two audio scripts that guided participants through either a self-compassion or special place exercise. Both scripts were recorded by the same, female graduate student. The self-compassion script utilized in this study was developed by Germer and Neff (2014) and is seven minutes and two seconds long. The script, entitled Loving-Kindness for a Loved One, instructs participants to direct compassionate love and kindness toward a cherished friend before redirecting the compassion towards themselves. The script was modified to include present-tense language (e.g., "Bring to mind" instead of "Bringing to mind"). The special place script, developed by Lutz-Zois (n.d.), is six minutes and 17 seconds long. This script guided participants through a visualization exercise designed to reduce anxiety and increase relaxation. Both scripts can be found in Appendices I and K, respectively.

CHAPTER 3

RESULTS

Preliminary Analyses

All descriptive statistics for continuous variables can be found in Table 1. An independent t-test found that there were no significant group differences in trauma-related symptoms between men (M = 23.13, SD = 20.77) and women (M = 13.07, SD = 13.98), $t(40) = -1.87$, $p = .0683$. Similar results were found when assessing depressive symptoms; men (M = 38.02, SD = 12.43) did not significantly differ from women (M = 36.72, SD = 9.87) on a measure of depression, $t(89) = -0.56$, $p = .5803$. When compared to participants who identified as "White" (M = 16.25, SD = 17.13), those who identified as "Other" (M = 25.00, SD = 22.63) did not have significant group differences in trauma-related symptoms, $t(40) = -0.70$, $p = .4888$. Depressive symptoms also did not differ between participants who identified as "White" (M = 36.71, SD = 10.76) and participants who identified as "Other" (M = 41.82, SD = 12.10), $t(90) = -1.20$, $p = .2342$. One-way ANOVAs were conducted to compare trauma-related and depressive symptoms across age groups. The results did not reveal a significant difference in scores on a trauma-related scale as a function of age, $F(5) = 1.16$, $p = .3498$. Similarly, there were no age differences in depressive symptoms, $F(5) = 1.30$, $p = .2716$. Therefore, none of these demographic variables will be controlled for in the primary study analyses.

As a manipulation check, I also conducted a t-test with condition (i.e., self-compassion or special place) as the grouping variable and residualized change scores between the first and second administration of the self-report self-compassion measure (i.e., before versus after the manipulation) as the criterion variable. This analysis revealed that the self-compassion (M = -0.11, SD = 0.94) and special place (M = 0.11, SD = 1.04) conditions did not differ in change in self-reported levels of self-compassion from Time 1 to Time 2, $t(90) = -1.06$, $p = .2908$. This suggests that the experimental manipulation was not effective in inducing self-compassion. Likewise, I also conducted t-tests with condition as the grouping variable and both outcomes as the criterion variables. There were not differences in the self-compassion (M = 16.00, SD = 16.55) or special place (M = 17.12, SD = 17.91) conditions in trauma-related symptoms, $t(40) = -0.21$, $p = .8386$. In the second analysis assessing depressive symptoms, similar nonsignificant results were found, $t(90) = 0.32$, $p = .7478$. Participants in the self-compassion condition had a mean score of 37.48 (SD = 11.42) compared to the mean score of 36.74 (SD = 10.48) in the special place exercise. Therefore, condition will not be tested as a moderator variable in the primary analyses. Rather, only Time 1 self-reported self-compassion will be tested as a moderator in the primary analyses.

Table 1

Descriptive Statistics of the Study Variables

Measure	*M*	*SD*	Range	α
THB	32.44	34.36	0-10	.91
SDS	26.70	39.97	0-10	.93
SCS1	76.12	15.41	1-5	.90
SCS2	76.68	16.82	1-5	.92
PCL	16.67	17.18	0-4	.95
Category B	3.43	4.82		.93
Category C	2.29	2.31		.78
Category D	5.62	6.34		.90
Category E	5.33	5.79		.87
CES-D	37.10	10.88	1-4	.92
BCSB	26.04	9.18	1-7	.72
RRS	47.09	13.85	1-4	.93
ASQ			1-7	
Internal	4.14	1.85		
Global	2.25	1.34		
Stable	3.28	1.58		
BACQ			1-5	
Approach	22.21	3.70		.65
Avoidant	16.93	3.43		.51

Note. THB = The Harassing Behavior; SDS = Subjective Distress Score; SCS1 = Self-Compassion Scale (first administration); SCS2 = Self-Compassion Scale (second administration); PCL = Posttraumatic Stress Disorder Checklist; CES-D = Center for Epidemiological Studies-Depression; BCSB = Behavioral and Characterological Self-Blame Scale; RRS = Ruminative Response Scale; ASQ = Attributional Style Questionnaire; BACQ = Brief Approach/Avoidance Coping Questionnaire.

Primary Analyses

Data Analytic Strategy. Using a bootstrapping moderated-mediation model (Model 7; Preachers & Hayes, 2004), four analyses were conducted in version 3.30 of SPSS-macro PROCESS (Hayes, 2017). All four analyses produced 5,000 bootstrapped samples with confidence intervals set at 95%.

In two analyses, depression was used as the criterion variable. Specifically, one of these analysis used stalking frequency as the predictor, while the other analysis used stalking distress as the predictor. The other two analyses followed the same form described above, but instead used trauma-related symptoms as the criterion variable. All four models used the scores on the first administration of the self-compassion scale as the moderator between stalking victimization (i.e., frequency or distress) and the proposed mediators (i.e., self-blame, avoidant coping, rumination, and event-specific attributions). In each analysis, the predictor and criterion variables not included were controlled. For example, in the first analysis between stalking frequency and depressive symptoms, stalking distress and trauma-related symptoms were controlled. To reduce the likelihood of encountering problems with multicollinearity (Cohen, Cohen, Aiken, & West, 2003), stalking victimization and self-compassion were mean centered.

Hypotheses 1 and 2. The first hypothesis stated that self-blame, avoidant coping, rumination, and event-specific attributions would mediate the relationship between stalking victimization and both trauma-related symptoms and depression. Self-compassion, as stated by Hypothesis 2, was predicted to moderate the relationship between stalking victimization and the proposed mediators (i.e., self-blame, avoidant

coping, rumination, and event-specific attributions). As previously mentioned, four analyses were tested, with a breakdown of each analysis described below. A summary of the direct effects for each analyses of the predictors and proposed mediator on the criterion variable (i.e., depression or trauma-related symptoms, depending on the analysis in question) can be found in Tables 2, 3, 4, and 5, respectively.

Analysis 1. In the first equation, stalking frequency was used as the predictor variable and depressive symptoms was used as the criterion variable. Stalking distress and trauma-related symptoms were controlled. The results failed to reveal evidence of moderated-mediation for any of the proposed study mediators. Specifically, moderated-mediation was not found for the hypothesized mediators of self-blame (95% CI = -0.0055, 0.0017), rumination (95% CI = -0.0043, 0.0032), approach coping (95% CI = -0.0023, 0.0019), avoidant coping (95% CI = -0.0912, 0.0614), internal attributions (95% CI = -0.0038, 0.0020), global attributions (95% CI = -0.0017, 0.0028), or stable attributions (95% CI = -0.0036, 0.0027).

Similar results were found when assessing non-conditional mediation of the relationship between stalking frequency and depressive symptoms. That is, the results failed to find evidence that self-blame (95% CI = -0.0829, 0.0679), rumination (95% CI = -0.1192, 0.0498), approach coping (95% CI = -0.0613, 0.0683), avoidant coping (95% CI = -0.0019, 0.0029), internal attributions (95% CI = -0.0553, 0.0464), global attributions (95% CI = -0.0716, 0.0495), or stable attributions (95% CI = -0.1368, 0.1112) mediated the relationship between stalking frequency and depressive symptoms when self-compassion at Time 1 was not treated as a moderator variable.

Analysis 2. In the second equation, stalking distress was used as the predictor variable and depressive symptoms was used as the criterion variable. Stalking frequency and trauma-related symptoms were controlled. The results failed to reveal evidence of moderated-mediation for any of the proposed study mediators. Specifically, moderated-mediation was not found for the hypothesized mediators of self-blame (95% CI = -0.0045, 0.0019), rumination (95% CI = -0.0040, 0.0029), approach coping (95% CI = -0.0021, 0.0032), avoidant coping (95% CI = -0.0017, 0.0025), internal attributions (95% CI = -0.0016, 0.0020), global attributions (95% CI = -0.0011, 0.0021), and stable attributions (95% CI = -0.0036, 0.0031) did not act as moderated-mediators.

Similar results were found when assessing non-conditional mediation of the relationship between stalking distress and depressive symptoms. The results found that self-blame (95% CI = -0.0259, 0.0830), rumination (95% CI = -0.0665, 0.0696), approach coping (95% CI = -0.0565, 0.0483), avoidant coping (95% CI = -0.0216, 0.0613), internal attributions (95% CI = -0.0364, 0.0396), global attributions (95% CI = -0.0216, 0.0229), and stable attributions (95% CI = -0.0558, 0.0521) did not mediate the relationship between stalking distress and depressive symptoms when self-compassion at Time 1 was not treated as a moderator variable.

Analysis 3. In the third equation, stalking frequency was used as the predictor variable and trauma-related symptoms was used as the criterion variable. Stalking distress and depressive symptoms were controlled. The results failed to reveal evidence of moderated-mediation for any of the proposed study mediators. Specifically, moderated-mediation was not found for the hypothesized mediators of self-blame (95% CI = -0.0033, 0.0077), rumination (95% CI = -0.0031, 0.0041), approach coping (95% CI = -

0.0053, 0.0062), avoidant coping (95% CI = 0.0053, 0.0060), internal attributions (95% CI = -0.0036, 0.0067), global attributions (95% CI = -0.0028, 0.0109), and stable attributions (95% CI = -0.0082, 0.0034).

I also looked for evidence for non-conditional mediation. According to the results, neither self-blame (95% CI = -0.1100, 0.1391), rumination (95% CI = -0.0822, 0.1565), approach coping (95% CI = -0.1948, 0.0727), avoidant coping (95% CI = -0.1515, 0.1474), internal attributions (95% CI = -0.0834, 0.1116), global attributions (95% CI = -0.2319, 0.0428), nor stable attributions (95% CI = -0.3107, 0.1302) mediated the relationship between stalking frequency and trauma-related symptoms when self-compassion at Time 1 was not treated as a moderator variable.

Analysis 4. In the fourth equation, stalking distress was used as the predictor variable and trauma-related symptoms was used as the criterion variable. Stalking frequency and depressive symptoms were controlled. The results failed to reveal evidence of moderated-mediation for any of the proposed study mediators. Specifically, moderated-mediation was not found for the hypothesized mediators of self-blame (95% CI = -0.0021, 0.0078), rumination (95% CI = -0.0030, 0.0046), approach coping (95% CI = -0.0081, 0.0039), avoidant coping (95% CI = -0.0052, 0.0055), internal attributions (95% CI = -0.0034, 0.0032), global attributions (95% CI = -0.0016, 0.0072), and stable attributions (95% CI = -0.0094, 0.0031) did not act as moderated-mediators.

Similar results were found when assessing non-conditional mediation of the relationship between stalking distress and trauma-related symptoms. Specifically, self-blame (95% CI = -0.1556, 0.0422), rumination (95% CI = -0.1074, 0.0779), approach coping (95% CI = -0.0587, 0.1632), avoidant coping (95% CI = -0.1391, 0.0519), internal

attributions (95% CI = -0.0772, 0.0637), global attributions (95% CI = -0.0621, 0.0966), and stable attributions (95% CI = -0.0502, 0.1617) did not mediate the relationship between stalking distress and trauma-related symptoms when self-compassion at Time 1 was not treated as a moderator variable.

Table 2

Simple Direct Effects of Stalking Frequency or the Hypothesized Mediators and Depressive Symptoms

					95% CI	
Category	*b*	*SE*	*t*	*p*	*LL*	*UL*
THB	0.03	0.07	0.50	.6767	-0.1109	0.1805
BCSB	0.33	0.19	1.79	.0900	-0.0573	0.7244
RRS	0.22	0.14	1.57	.1325	-0.0718	0.5050
ASQ						
Internal	-0.42	0.90	-0.46	.6502	-2.3099	1.4763
Global	0.67	1.28	0.53	.6044	-2.0000	3.3454
Stable	-0.27	1.16	-0.23	.8171	-2.6965	2.1533
BACQ						
Approach	-0.03	0.51	-0.06	.9537	-1.1063	1.0458
Avoidant	0.33	0.49	0.66	.5171	-0.7057	1.3559

Note. THB = The Harassing Behavior; BCSB = Behavioral and Characterological Self-Blame Scale; RRS = Ruminative Response Scale; ASQ = Attributional Style Questionnaire; BACQ = Brief Approach/Avoidance Coping Questionnaire.

Table 3

Simple Direct Effects of Stalking Distress or the Hypothesized Mediators and Depressive Symptoms

					95% CI	
Category	*b*	*SE*	*t*	*p*	*LL*	*UL*
SDS	-0.02	0.04	-0.39	.7009	-0.1004	0.0689
BCSB	0.33	0.19	1.79	.0900	-0.0573	0.7244
RRS	0.22	0.14	1.57	.1325	-0.0718	0.5050
ASQ						
Internal	-0.42	0.90	-0.46	.6502	-2.3099	1.4763
Global	0.67	1.28	0.53	.6044	-2.000	3.3454
Stable	-0.27	1.16	-0.23	.8171	-2.6965	2.1533
BACQ						
Approach	-0.03	0.51	-0.06	.9537	-1.1063	1.0458
Avoidant	0.33	0.49	0.66	.5171	-0.7057	1.3559

Note. SDS = Subjective Distress Score; BCSB = Behavioral and Characterological Self-Blame Scale; RRS = Ruminative Response Scale; ASQ = Attributional Style Questionnaire; BACQ = Brief Approach/Avoidance Coping Questionnaire.

Table 4

Simple Direct Effects of Stalking Frequency or the Hypothesized Mediators and Trauma-Related Symptoms

					95% CI	
Category	*b*	*SE*	*t*	*p*	*LL*	*UL*
THB	0.26	0.13	1.93	.8839	-0.0220	0.5421
BCSB	-0.50	0.41	-1.22	.2385	-1.3532	0.3581
RRS	-0.20	0.30	-0.64	.5288	-0.8334	0.4423
ASQ						
Internal	0.56	1.91	0.29	.7720	-3.4335	4.5555
Global	3.35	2.59	1.29	.2120	-2.0793	8.7778
Stable	2.09	2.39	0.88	.3921	-2.9122	7.1020
BACQ						
Approach	-0.89	1.06	-0.83	.4146	-3.1088	1.3371
Avoidant	-0.29	1.05	-0.28	.7837	-2.4792	1.8970

Note. THB = The Harassing Behavior; BCSB = Behavioral and Characterological Self-Blame Scale; RRS = Ruminative Response Scale; ASQ = Attributional Style Questionnaire; BACQ = Brief Approach/Avoidance Coping Questionnaire.

Table 5

Simple Direct Effects of Stalking Distress or the Hypothesized Mediators and Trauma-Related Symptoms

					95% CI	
Category	*b*	*SE*	*t*	*p*	*LL*	*UL*
SDS	-0.06	0.08	-0.71	.4871	-0.2361	0.1167
BCSB	-0.50	0.41	-1.22	.2385	-1.3532	0.3581
RRS	-0.20	0.30	-0.64	.5288	-0.8334	0.4423
ASQ						
Internal	0.56	1.91	0.29	.7720	-3.4335	4.5555
Global	3.35	1.29	1.29	.2120	-2.0793	8.7778
Stable	2.09	0.88	0.88	.3921	-2.9122	7.1020
BACQ						
Approach	-0.89	1.06	-0.83	.4146	-3.1088	1.3371
Avoidant	-0.30	1.05	-0.28	.7837	-2.4792	1.8970

Note. SDS = Subjective Distress Score; BCSB = Behavioral and Characterological Self-Blame Scale; RRS = Ruminative Response Scale; ASQ = Attributional Style Questionnaire; BACQ = Brief Approach/Avoidance Coping Questionnaire.

Follow-Up Analyses

In the follow-up analyses, I used the same analytic format to test only the moderating effect (Model 1; Hayes, 2017) of Time 1 self-compassion scores in the relationships between predictor variables (i.e., stalking frequency and stalking distress) and criterion variables (i.e., depressive and trauma-related symptoms). In the first analysis, the predictor variable was stalking frequency and the criterion variable was depressive symptoms. The results failed to find evidence of a moderating effect of Time 1 self-compassion scores, $b = 0.00$, $p = .9974$, 95% CI [-0.0041, 0.0041]. The second analysis examined the relationship between stalking distress and depressive symptoms. Similarly, self-compassion did not have a significant moderating effect, $b = 0.00$, $p = .6593$, 95% CI [-0.0028, 0.0043]. Next, the third analysis used stalking frequency as the predictor and trauma-related symptoms as the criterion, and found that self-compassion did not act as a moderator in this relationship, $b = 0.00$, $p = .4313$, 95% CI [-0.0060, 0.0138]. The last analysis examined the relationship between stalking distress and trauma-related symptoms. The results indicated that self-compassion was not a moderator of this relationship, either, $b = 0.00$, $p = .8060$, 95% CI [-0.0103, 0.0081].

CHAPTER 4

DISCUSSION

The purpose of this study was to investigate psychosocial buffers and mechanisms involved in the negative sequelae of stalking victimization. Specifically, I examined the possible mediating effects of rumination, event-specific attributions, self-blame, and avoidant coping, as well as the moderating effect of self-compassion on the relationship between stalking and both depressive and trauma-related symptoms. Within a sample of undergraduate students, the analyses revealed that the hypothesized mediators did not significantly explain the relationship between stalking victimization and both trauma-related and depressive symptoms. Furthermore, self-compassion did not moderate the relationship between stalking victimization and the hypothesized mediators. In the remainder of this section, I will discuss the implications of these findings. In addition, I will identify limitations that might have impacted the results and propose suggestions for future studies.

It is well-established that the hypothesized mediators of self-blame, rumination, avoidant coping, and event-specific attributions are positively related to trauma-related and depressive symptoms. Research has also shown that self-compassion can act as an effective buffer against negative psychological outcomes of trauma (Neff, 2003b). In fact, researchers have found that self-compassion, when experimentally manipulated, resulted in lower cortisol levels, even when compared to other relaxing manipulations (Rockcliff et al., 2008). The current study, however, failed to find support for either hypothesis. As noted in an earlier section, one hope for this study was that investigating the roles of

various psychosocial constructs might inform interventions for survivors of interpersonal trauma. For example, had the results found evidence to support the expectation that self-compassion would lead to a decrease in the proposed mediators of self-blame, rumination, avoidant coping, and event-specific attributions, interventions could have been designed to implement cost-effective self-compassion exercises. Taken at face value, the lack of findings for either hypothesis might suggest to researchers that neither self-compassion nor the proposed mediators are meaningful agents in the study of interpersonal violence and related sequelae. That is, these results could lead one to believe that self-compassion has no significant effect on self-blame, rumination, avoidant coping, or event-specific attributions, meaning that this relationship could be overlooked in future research.

Similarly, the results suggest that the hypothesized mediators do not act as explanatory mechanisms of the relationship between stalking victimization and negative psychological outcomes such as trauma-related and depressive symptoms. Research on various forms of interpersonal trauma overwhelmingly disagrees with the results of this study. Researchers found that the relationship between childhood sexual abuse and current psychological distress was mediated by both feelings of stigma and self-blame (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996). Rumination has been found to mediate the relationship between childhood trauma and later depression/anxiety (Kim, Jin, Jung, Hahn, & Lee, 2017). Additionally, avoidant coping mediated the relationship between sexual abuse and severity of trauma symptoms in a sample of adolescents (Bal, Van Oost, de Bourdeaudhuji, & Crombez, 2003). The results of these studies may differ

from the current study in that, while they were conducted with victims of interpersonal trauma, none of them looked at stalking victimization. This difference could be meaningful because, as will be discussed further, individuals might not consider themselves stalked if they have only experienced common behaviors (e.g., being contacted over social media). Other forms of interpersonal trauma, however, might be more "cut and dry" in terms of what behaviors are considered inappropriate or criminal.

In their study on mediators and moderations of the relationship between stalking and psychological distress, Fais and colleagues (2017) found that global attributions mediated the association between stalking and depressive symptoms. As the current study was based on the study by Fais and colleagues (2017) and used many of the same measures, it is unclear why the current study failed to replicate their results. The current study differed from the study by Fais and colleagues (2017) in a number of ways, including using a different measure of stalking and the inclusion of trauma-related symptoms as an outcome and self-compassion as a moderator. It could be that the inclusion of a different measure of stalking behavior might have impacted the results. In their study, Fais and colleagues (2017) used a scale that instructed participants to rate the frequency of four factors measuring pursuit, violation, threat, and hyper-intimacy, whereas the current study used a measure that had two subscales assessing frequency and distress. The results of the current study might have been impacted by the scale being less nuanced in assessing stalking behaviors. Perhaps the most important difference between the two studies is the inclusion of an experiment, by which participants either received a self-compassion or special place imagery manipulation. It is possible that both conditions affected the outcome variables equally. Participants in both the self-compassion and

special place conditions received active manipulation; that is, the two conditions induced relaxation. It could be that both conditions were equally effective at inducing self-compassion.

There are limitations of this study that might explain the surprising findings. One major limitation of the study is the sample. Ideally, the sample would have consisted solely of participants who had experienced stalking victimization. The participants of this study, however, did not have to endorse stalking victimization to participate. On its own, the overall sample was small (n = 92), meaning that the number of participants who had endorsed stalking was even smaller (n = 50). Moreover, there was only a small number of participants who noted a high frequency of stalking behaviors and distress experienced as a result of the stalking behaviors. It is possible that the present sample did not provide enough statistical power or variance of stalking experiences to provide accurate results. Along the same lines, the sample was relatively young, as well as racially and economically narrow. The demographics of this sample are an important consideration, as stalking prevalence varies based on factors such as age, socioeconomic status, and race. In one national survey, the findings indicated that stalking victimization is highest among individuals aged 18 to 24 (Catalano, 2012). The mean age of the present sample is 19-years-old, which falls at the low end of this range. It's possible that, by being a younger sample, participants have not been as exposed to stalking victimization. Catalano (2012) also reported that low SES individuals experienced higher levels of stalking victimization when compared to high SES individuals. Although the current study did not include an item assessing SES, it can be reasonably assumed that the sample is economically advantaged, as the participants were recruited from a private university.

Differences in stalking as a function of race are not as conclusive, but there is some data to suggest that those who identify as multiracial or American Indian / Alaska Native have higher prevalence rates of both stalking and harassment when compared to other races (Baum, Catalano, Rand, & Rose, 2009).

There are other notable limitations that exist within this study. First, the instructions for completion of the measures might have resulted in inaccurate data. The directions on some of the measures were modified to instruct participants to complete the measures *only* if they had experienced stalking. This may have been confusing to participants because they might not classify their experiences as stalking, despite endorsing items on the stalking measure. This was further compounded by the nature of a few of the items on the stalking measure. For example, some of the items asked participants if they had received unwanted contact over social media. Because social media use is fairly common, it's likely that participants did not consider this as a behavior indicative of stalking. Second, participants did not have a long enough exposure to the self-compassion exercise, as they only listened for approximately seven minutes over the course of one experimental session. This level of exposure may not have been sufficient to result in meaningful changes in self-compassion. Previous studies that have manipulated self-compassion have utilized exercises lasting approximately 30 minutes (Arimitsu & Hofmann, 2017). Further, Petrocchi, Ottaviani, and Couyoumdjian (2016) instructed participants to listen to a self-compassion exercise on three separate occasions. A third limitation is the study design. The current study utilized cross-sectional data, which is not optimal for mediation analyses. In their paper on bias in mediation analyses, Maxwell and Cole (2007) argue that a longitudinal design is more appropriate when

testing mediation, as mediation analyses imply causation. Cross-sectional designs, such as the one utilized by the current study, only provide a snapshot of a participant's life. It might be argued that cross-sectional designs only provide correlational information. Finally, the descriptive statistics of the outcome measures (i.e., mean) might have had an impact on the study. Participants in this study had similar mean scores on the PCL-5 when compared to college students recruited in another study (Blevins et al., 2015)—16.67 and 15.42, respectively. However, in a study assessing stressors and depressive symptoms in college students, Acharya, Jin, and Collins (2018) wrote that the mean score on the CES-D was 16.24, which is lower than the current study's mean of 37.10. Therefore, specific methodological changes can be made to enhance the validity of future empirical investigations of these research questions.

Before it is ascertained that the hypotheses have no merit, the same study should be completed in a sample of stalking victims who are racially and economically diverse. Likewise, the sample could be improved by recruiting a diverse range of ages. If this is not possible, researchers should focus on recruiting a higher number of participants to bolster statistical power. Next, the modified directions should be clarified to reduce confusion. That is, the directions on the measures of hypothesized mediators and psychological outcomes (i.e., trauma-related and depressive symptoms) should instruct participants to complete the items if they endorsed any item on the stalking measure. Participants should also have more exposure to their assigned condition (i.e., self-compassion or special place). The study could have participants listen to either of the recordings for an extended period of time to assess the long-term effect of condition.

Finally, the study would benefit from using a longitudinal design to better support any causal relationships between variables.

If these improvements can be made and significant findings are found, there are additional questions that could further inform treatment. One such avenue is assessing individual differences and any possible effects they may have on the likelihood of engaging in certain behaviors (i.e., the hypothesized mediators). For example, it could be beneficial to include items measuring utilization of therapeutic services, personality traits, etc., to see if they influence the hypothesized mediators and symptoms of psychological distress. For example, researchers have found that engagement in mindfulness-based cognitive therapy was helpful in reducing intrusive thoughts (i.e., rumination) in a sample of chronically depressed patients (Cladder-Micus, Becker, Spijker, Speckens, & Vrijsen, 2019). Individual differences, such as attachment, might also be related to the hypothesized mediators. In one sample of young adults, preoccupied and dismissing individuals were more likely to employ avoidance strategies than securely attached individuals (Ognibene & Collins, 1998). Another potential question to address is how a self-compassionate approach compares to other exercises in a sample of stalking victims. Although the current study compared a self-compassion and a special place exercise, it would enhance the rationale of using self-compassion techniques if it had been compared to a number of therapeutic approaches, such as techniques used in CBT and DBT (e.g., distress tolerance, journaling, etc.). Finally, researchers might be interested in assessing appreciable differences in what participants consider stalking behaviors. Research along this line could clarify the perception of some behaviors being indicative of stalking (e.g., threatening harm to the victim) while others might be regarded as commonplace or

harmless (e.g., making contact through social media). This is especially important because it is possible that some individuals do not currently consider themselves to be victims of stalking, even though they have experienced behaviors that are classified as stalking.

In conclusion, the current study did not find evidence to support the hypotheses that (1) rumination, self-blame, avoidant coping, and event-specific attributions would mediate the relationship between stalking victimization and both trauma-related and depressive symptoms; and (2) self-compassion moderated the relationship between stalking victimization and the proposed mediators. Despite the non-significant findings, researchers should continue to explore this topic, especially once the limitations of the study are addressed. Existing literature suggests that these psychosocial constructs play an important role in understanding the impact of trauma, and thus they should continue to be studied to improve upon treatment.

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APPENDIX A

Demographic Sheet

Please complete the demographic information below. If you wish to refrain from completing the demographic information or providing information that may identify you, please move on to the remainder of the questionnaire packet.

1. Age (circle): 18 19 20 21 22+

2. Gender (circle): Woman Man Other

3. Race (check one):

__White
__Other

APPENDIX B

SHBS

For each question (unless specified), please circle only one answer.

1. Have you ever had a personal relationship (romantic or friendly), which has ended, where either you ended it or you were the predominant one in ending it?

(a) Yes

(b) No

2. For whatever reasons have you ever had someone (known or unknown) give you unwanted attention MORE THAN ONCE either by letters, notes left for you, e-mails, phone calls, faxes, following you, attempts to approach you, driving by your home, sending you gifts, or finding information about you?

(a) Yes

(b) No

3. Was this repeated unwanted attention conducted in a manner, which made you feel disturbed, intimidated, distressed or scared, to the point where it seriously disrupted your life and caused you to fear for your OR your family's/partner's/friend's health?

(a)Yes

(b) No

If you answered no to all three questions 1, 2, and 3, then please skip question 4 and record all zeros (0's) in each question in question 5 and continue on to the next questionnaire.

If you answered yes to question 3, then please answer the rest of the questionnaire in reference to this one person. If you answered no to question 3 but yes to question 2, then please answer the rest of the questionnaire in reference to this one person. If you answered no to question 2 and 3 but yes to question 1, then please answer the rest of the questionnaire in reference to this one person.

4. Was or is this person

(a) Male?

(b) Female?

(c) Unknown?

5. Could you please circle any behaviors that this person has performed and write down next to each behavior how often it occurred in the first space provided on a scale of 0–10 where 0 is *no experience*, 5 is *regularly*, and 10 is *all the time*. Then, in the next column, on a scale of 0–10 where 0 is *not at all disturbed/scared* and 10 is *extremely disturbed*, please write down how disturbing and scary such behaviors were for you.

Has this person?	**How often it occurred (0-10)**	**How disturbed/scared (0-10)**
Telephoned you at work?		
Telephoned you at home?		
Made hang-up calls?		
Tapped your phone?		
Left messages on your machine?		
E-mailed you?		
Written you letters?		
Left you notes?		
Written graffiti about you?		
Faxed you?		
Followed you on foot?		
Followed you by car?		
Driven by your home?		
Approached you in public?		
Come to your home?		
Knocked on door and fled?		
Come to your work/university?		
Spied on you?		
Sent flowers?		
Ordered something for you?		
Broken into your home?		
Stolen something of yours?		
Left things on your property?		
Injured or killed your pets?		
Damaged property of your new partner?		
Damaged your property?		
Stolen/read your post?		
Tried to discredit you?		
Violated restraining order?		
Attempted to break into car?		
Went through your garbage?		
Threatened to cause self-harm?		

Threatened you?		
Threatened your friends?		
Threatened your family?		
Threatened your partner?		
Verbally abused you?		
Physically harmed you?		
Sexually abused you?		
Harmed your new partner?		
Boasted of the information they'd gained about you?		
Threatened suicide?		
Contacted you through Facebook or other social media?		
Located you through information on Facebook or other social media?		
Contacted you through text messages?		
Contacted you through instant messages?		
Other (please specify)		

6. Were or are this person's behaviors persistent and unwanted?

(a) Yes

(b) No

If yes, then what was the length of time before you felt that this person's attention to you was unwanted?

(a) Straight away

(b) A few hours

(c) A few days

(d) A few weeks

(e) A few months

(f) A few years

7. Are these behaviors still continuing?

(a) Yes

(b) No

(c) Unsure

8. How many years of age were you when you noticed these behaviors occurring?
_____

9. How long did or have this person's behavior towards you last/ed for?

(a) Less than 1 month

(b) 1-3 months

(c) 4-12 months

(d) 1-3 years

(e) More than 3 years (please specify) _____

10. Has anyone else ever behaved like this towards you prior to this person's behavior?

(a) Yes

(b) No

11. How helpless and vulnerable do/did you feel to this person's behaviors and their threats?

a) Not at all	b) A little	c) Moderately	d) Very	E) Extremely

APPENDIX C

PCL-5

If you have NOT experienced stalking, please skip this measure and move on to the next.

Instructions: Question 5 on the SHBS asked you to rate a number of statements regarding the frequency of and amount of distress experienced by a stalking episode. If you responded to any of the questions (e.g. "Has this person followed you by car?") with a score greater than zero (0), answer the following questions. Read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by the stalking episode in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
Repeated, disturbing, and unwanted memories of the stressful experience? **B**	0	1	2	3	4
Repeated, disturbing dreams of the stressful experience? **B**	0	1	2	3	4
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving) it? **B**	0	1	2	3	4
Feeling very upset when something reminded you of the stressful experience? **B**	0	1	2	3	4
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? **B**	0	1	2	3	4
Avoiding memories, thoughts, or feelings related to the stressful experience? **C**	0	1	2	3	4
Avoiding external reminders of the stressful experience (for example, people, places,	0	1	2	3	4

conversations, activities, objects, or situations)? **C**					
Trouble remembering important parts of the stressful experience? **D**	0	1	2	3	4
Having strong negative beliefs about yourself, other people or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? **D**	0	1	2	3	4
Blaming yourself or someone else for the stressful experience or what happened after it? **D**	0	1	2	3	4
Having strong negative feelings such as fear, horror, anger, guilt, or shame? **D**	0	1	2	3	4
Loss of interest in activities that you used to enjoy? **D**	0	1	2	3	4
Feeling distant or cut off from other people? **D**	0	1	2	3	4
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? **D**	0	1	2	3	4
Irritable behavior, angry outburst, or acting aggressively? **E**	0	1	2	3	4
Taking too many risks or doing things that could cause you harm? **E**	0	1	2	3	4
Being “superalert” or watchful or on guard? **E**	0	1	2	3	4
Feeling jumpy or easily startled? **E**	0	1	2	3	4
Having difficulty concentrating? **E**	0	1	2	3	4
Trouble falling or staying asleep? **E**	0	1	2	3	4

Note: B = Cluster B diagnostic criteria; C = Cluster C diagnostic criteria; D = Cluster D diagnostic criteria; E = Cluster E diagnostic criteria.

APPENDIX D

CES-D

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate value to the right of the statement to indicate how you have felt over the past **week.**

	During the Past Week			
	Rarely or none of the time (less than 1 day)	**Some or a little of the time (1-2 days)**	**Occasionally or a moderate amount of time (3-4 days)**	**Most or all of the time (5-7 days)**
1. I was bothered by things that usually don't bother me.	1	2	3	4
2. I did not feel like eating; my appetite was poor.	1	2	3	4
3. I felt that I could not shake off the blues even with help from my family.	1	2	3	4
4. I felt that I was just as good as other people.*	1	2	3	4
5. I had trouble keeping my mind on what I was doing.	1	2	3	4
6. I felt depressed.	1	2	3	4
7. I felt that everything I	1	2	3	4

did was an effort				
	Rarely or none of the time (less than 1 day)	**Some or a little of the time (1-2 days)**	**Occasionally or a moderate amount of time (3-4 days)**	**Most or all of the time (5-7 days)**
8. I felt hopeful about the future.*	1	2	3	4
9. I thought my life had been a failure.	1	2	3	4
10. I felt fearful.	1	2	3	4
11. My sleep was restless.	1	2	3	4
12. I was happy.*	1	2	3	4
13. I talked less than usual.	1	2	3	4
14. I felt lonely.	1	2	3	4
15. People were unfriendly.	1	2	3	4
16. I enjoyed life.*	1	2	3	4
17. I had crying spells.	1	2	3	4
18. I felt sad.	1	2	3	4
19. I felt that people disliked me.	1	2	3	4
20. I could not get going.	1	2	3	4

Note: * indicates reverse scored items

APPENDIX E

BCSB (Modified #8)

Below is a list of beliefs regarding past harassment and stalking experiences. Please read each item, and then indicate your level of agreement with each of the statements with respect to your most intense stalking-related experience.

NOTE: If you have never experienced unwanted pursuit by another individual, please skip this measure and move on to the next.

Use the following scale to indicate your opinion:

1= Strongly Disagree
2 = Mostly Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Mostly Agree
6 = Strongly Agree
7 = Never experienced harassment

It happened because of something I did. **B**	1	2	3	4	5	6	7
It happened because of the kind of person I am. **C**	1	2	3	4	5	6	7
It happened because I am unattractive. **C**	1	2	3	4	5	6	7
It I had done things differently, it wouldn't have happened. **B**	1	2	3	4	5	6	7
It has nothing to do with the kind of person I am.* **B**	1	2	3	4	5	6	7
It wasn't caused by anything I did.* **C**	1	2	3	4	5	6	7
It happened to me because of who I am. **C**	1	2	3	4	5	6	7
It happened because I am too passive to confront the stalker. **C**	1	2	3	4	5	6	7
If I were a different person, it wouldn't have happened. **B**	1	2	3	4	5	6	7

Note: * indicates reverse score items. B = behavioral self-blame; C = characterological self-blame.

APPENDIX F

RRS

People think and do many different things when they feel depressed. Please read each of the items below and indicate whether you almost never, sometimes, often, or almost always think or do each one when you feel down, sad, or depressed. Please indicate what you generally do, not what you think you should do.

1 = almost never
2 = sometimes
3 = often
4 = almost always

_____1. Think about how alone you feel. **D**
_____2. Think "I won't be able to do my job if I don't snap out of this." **D**
_____3. Think about your feelings of fatigue and achiness. **D**
_____4. Think about how hard it is to concentrate. **D**
_____5. Think "What am I doing to deserve this?" **B**
_____6. Think about how passive and unmotivated you feel. **D**
_____7. Analyze recent events to try to understand why you are depressed. **R**
_____8. Think about how you don't seem to feel anything anymore. **D**
_____9. Think "Why can't I get going?" **D**
_____10. Think "Why do I always react this way?" **B**
_____11. Go away by yourself and think about why you feel this way. **R**
_____12. Write down what you are thinking about and analyze it. **R**
_____13. Think about a recent situation, wishing it had gone better. **B**
_____14. Think "I won't be able to concentrate if I keep feeling this way." **D**
_____15. Think "Why do I have problems other people don't have?" **B**
_____16. Think "Why can't I handle things better?" **B**
_____17. Think about how sad you feel. **D**
_____18. Think about all your shortcomings, failings, faults, mistakes. **D**
_____19. Think about how you don't feel up to doing anything. **D**
_____20. Analyze your personality to try to understand why you are depressed. **R**
_____21. Go someplace along to think about your feelings. **R**
_____22. Think about how angry you are with yourself. **D**

Note: D = depression; R = reflection; B = brooding

APPENDIX G

BACQ

The questions on this page deal with how you usually act in relation to problems and disease. For each item, place a tick in the box that fits best with what you think about yourself just now. The questions are written in 'I' form, and you place your tick depending on how much you agree/disagree. The purpose of the questions is to make you think about whether or not you are satisfied with the way you react to problems and illness.

Response categories:

Agree completely	5
Tend to agree	4
Yes and no	3
Tend to disagree	2
Disagree completely	1

	Agree completely (5)	**Tend to agree (4)**	**Yes and no (3)**	**Tend to disagree (2)**	**Disagree completely (1)**
I say so if I am angry or sad. **A**					
I like to talk with a few chosen people when things get too much for me. **A**					
I make an active effort to find a solution to my problems. **A**					
Physical exercise is important to me. **A**					
I think something positive could come out of my complaints/problems. **A**					
I firmly believe that my problems will decrease (and my situation improve). **A**					
I try to forget my problems. **D**					
I put my problems behind me by concentrating on something else. **D**					

I bury myself in work to keep my problems at a distance. **D**					
I often find it difficult to do something new. **RW**					
I am well on the way towards feeling I have given up. **RW**					
I withdraw from other people when things get difficult. **RW**					

Note: A = approach coping, D = diversion, and RW = resignation and withdrawal

APPENDIX H

Modified ASQ

If you have NOT experienced stalking, please skip this measure and move on to the next.

Question 5 on the SHBS asked you to rate a number of statements regarding the frequency of and amount of distress experienced by a stalking episode. If you responded to any of the questions (e.g. "Has this person followed you by car?") with a score greater than zero (0), answer the following questions.

A) On the line below, write down the **one** major cause of this stalking episode.

CAUSE_____

B) Think about the **cause** that you wrote down. Is it something about you or something about other people the causes this situation?

Totally caused by other people or circumstances	1 2 3 4 5 6 7	Totally caused by me

C) Think about the **cause** you wrote down. Is it something that leads to negative outcomes in **other** areas of your life or **just** in this situation?

This cause leads to negative outcomes **just** in this situation	1 2 3 4 5 6 7	This cause leads to negative outcomes in **all** areas of my life

D) Think about the **cause** you wrote down. Will the case of this current situation be present in similar situations in the future?

This cause will never be present in similar situations	1 2 3 4 5 6 7	This cause will always be present in similar situations

APPENDIX I

SCS

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never Almost always

1 2 3 4 5

_____ 1*. I'm disapproving and judgmental about my own flaws and inadequacies. **SJ**

_____ 2*. When I'm feeling down I tend to obsess and fixate on everything that's wrong. **OI**

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through. **CH**

_____ 4*. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. **I**

_____ 5. I try to be loving towards myself when I'm feeling emotional pain. **SK**

_____ 6*. When I fail at something important to me I become consumed by feelings of inadequacy. **OI**

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. **CH**

_____ 8*. When times are really difficult, I tend to be tough on myself. **SJ**

_____ 9. When something upsets me I try to keep my emotions in balance. **M**

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. **CH**

_____ 11*. I'm intolerant and impatient towards those aspects of my personality I don't like. **SJ**

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need. **SK**

_____ 13*. When I'm feeling down, I tend to feel like most other people are probably happier than I am. **I**

_____ 14. When something painful happens I try to take a balanced view of the situation. **M**

_____ 15. I try to see my failings as part of the human condition. **CH**

_____ 16*. When I see aspects of myself that I don't like, I get down on myself. **SJ**

_____ 17. When I fail at something important to me I try to keep things in perspective. **M**

_____ 18*. When I'm really struggling, I tend to feel like other people must be having an easier time of it. **I**

_____ 19. I'm kind to myself when I'm experiencing suffering. **SK**

_____ 20*. When something upsets me I get carried away with my feelings. **OI**

_____ 21*. I can be a bit cold-hearted towards myself when I'm experiencing suffering. **SJ**

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness. **M**

____ _ 23. I'm tolerant of my own flaws and inadequacies. **SK**

_____ 24*. When something painful happens I tend to blow the incident out of proportion. **OI**

_____ 25*. When I fail at something that's important to me, I tend to feel alone in my failure. **I**

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like. **SK**

Note: SK = self-kindness; SJ = self-judgment; CH = common humanity; I = isolation; M = mindfulness; OI = over-identified. * indicates reverse scored items

APPENDIX J

Loving-Kindness for a Loved One

Allow yourself to settle into a comfortable position. If you like, put a hand over your heart or another location that is soothing as a reminder to bring not only awareness, but loving awareness, to our experience and to ourselves.

Bring to mind a person or other living being who naturally makes you smile. This could be a child, your grandmother, your cat or dog—whomever naturally brings happiness to your heart. Let yourself feel what it's like to be in that being's presence. Allow yourself to enjoy the good company. Create a vivid image of this being in your mind's eye. (Pause)

Now, recognize how this being wishes to be happy and free from suffering, just like you and every other living being. Repeat softly and gently, feeling the importance of your words:

May you be happy.
May you be peaceful.
May you be healthy.
May you live with ease.
(Repeat twice, slowly, pause)

When you notice that your mind has wandered, return to the words and the image of the loved one you have in mind. Savor any warm feelings that may arise. Take your time.

Now, add yourself to your circle of good will. Create an image of yourself in the presence of your loved one, visualizing you both together.

May we be happy.
May we be peaceful.
May we be healthy.
May we live with ease.
(Repeat twice, slowly, pause)

Now, let go of the image of the other, and let the full focus of your attention rest directly on yourself. Put your hand over your heart and feel the warmth and gentle pressure of your hand. Visualize your whole body in your mind's eye, noticing any stress or uneasiness that may be lingering within you, and offer yourself the phrases.

May I be happy.
May I be peaceful.
May I be healthy.
May I live with ease.
(Repeat twice, slowly, pause)

Finally, take a few breaths and just rest quietly in your own body, accepting whatever your experience is, exactly as it is. You may be feeling good will and compassion or you may not, it doesn't matter. We are simply setting our intention to open our hearts and seeing what happens. (pause).

Gently ring the bell.

APPENDIX K

A Special Place

Let's begin your journey to your special place. Close your eyes and begin to breathe, slowly and deeply.I want you to imagine that you are in the middle of a forest. It is summer, but it is nice and cool because of all of the shade. Soft rays of sun trickle through the leaves of the trees above. You are feeling incredibly calm and at peace as you walk along the path through the forest. It is almost like you are in a different time or dimension; far, far from the pressures and concerns of your normal life. You hear the trickling of a stream just ahead of you. As you approach, you pause to bend over and run your hand through the cool, clean water. The stream runs over some rocks causing a thin spray of water to tickle your face. This sensation fills you with pleasure and delight.

You straighten up and proceed back on your path. The light ahead slowly becomes brighter, signaling to you that a clearing lies ahead. As you reach the clearing, you see a meadow of beautiful green grass and bright flowers. You decide to take off your shoes so that you can feel the pliant blades of warm grass between your toes. You feel light and carefree as you move across the meadow.

You now approach a series of caves. You enter the dark, cool cave, and begin to move through a series of doors. Each door you pass through takes you closer and closer to the door of your special place. Open and move through these doors. 10-9-8 you are becoming more and more relaxed 7-6-5 you are letting go of all tension in your body 4-3-2-1.

You have now reached the door to your special place. Before you open it, take a moment to imagine what your special place looks like. Now open the door and go into your special place. Make yourself very comfortable. Spend several moments quietly observing all of the sensations of your special place. Absorb all of the sights, sounds, smells, and touch of this glorious place. Enjoy the feel of tranquility and safety that you draw from this place.

You are now going to leave your special place, but always remember, you can return here whenever you want. This is your own personal sanctuary. Your own paradise. Begin now to go back through the doors. 1-2-3-4-5-6-7-8-9-10. Walk through the meadow and return through the forest by the same path you took before. As you exit the forest, you see your house in the clearing. You approach your house feeling relaxed and refreshed.

APPENDIX L

Informed Consent to Participate in a Research Project

Project Title:	Stressful Events and Mental Health
Investigator(s):	Alicia M. Selvey and Dr. Catherine Zois, PhD (faculty sponsor)
Description of Study:	This study examines factors that may affect the relationship between stalking victimization and both trauma-related symptoms and depression. You will be asked to complete eight questionnaires. One questionnaire will ask about demographic information while the remaining seven questionnaires will ask about several aspects of the study, including symptoms of PTSD and depression, potential stalking and harassment experiences, negative attributes (i.e., self-blame, rumination, avoidant coping, and event-specific attributes), and self-compassion. You will also listen to an audiotape lasting approximately seven minutes that most people find relaxing.
Adverse Effects and Risks:	This study will ask you to recall experiences resembling stalking (e.g. "How disturbed or scared [were you when they] telephoned you at work"). Should any such psychological distress occur (e.g. anxiety, sadness, or anger) or if you no longer wish to participate in the study, you are able to stop at any time without penalty. You are not required to report a reason for discontinuing your participation. If you experience psychological distress and wish to discuss it, you may inform the graduate student in charge of the session. If you should choose to do this, please note that the graduate student is required to report situations involving any type of assault or harassment to the university's Title IX coordinator should she become privy to such information. The graduate student will assist you in getting in touch with Dr. Zois for further assistance. The graduate student may also assist you in contacting the University of Dayton Counseling Center at 937-229-3141. This resource may be helpful to participants who feel the need to process their distress in a safe and confidential environment. The university counseling center is free to University of Dayton undergraduates.
Duration of Study:	The study will take approximately 45-60 minutes to complete.

Confidentiality of Data:	Your name will be kept separate from the data. You will not be asked to place your name on any of the questionnaires and your responses will be identified with a random research code. The sign in sheet with your name and the data will be kept in a locked filing cabinet separate from the rest of the data provided. Only the investigators named above will have access to the locked filing cabinet. Your name will not be revealed in any document resulting from this study. After completion of the study, the researchers will have no way of contacting you. Please know that if you should choose to contact Dr. Zois or the chair of the Research Review and Ethics Committee (RREC), whose contact information is listed below, they are required as employees of the University of Dayton to report any and all harassment and/or dating/domestic violence, etc. to the university's Title IX coordinator. We do not mention this fact to discourage you from contacting either of us, but simply to help you make an informed decision. Having said this, UD employees who work at the UD Counseling Center, as clergy, and/or as doctors in the UD Health Center are confidential and as such, are not required to report such information.
Contact Person:	Participants may contact Dr. Catherine Zois by phone at 937-229-2164 or by email at czios1@udayton.edu. If you have questions about your rights as a research participant you may also contact the chair of the Research Review and Ethics Committee, at rrec@udayton.edu or (937) 229-2713 or in SJ 329.
Consent to Participate:	I have voluntarily decided to participate in this study. If I had questions about this study, I have contacted the investigator named above and he or she has adequately answered any and all questions I have about this study, the procedures involved, and my participation. I understand that I may voluntarily terminate my participation in this study at any time and still receive full credit. In addition, I certify that I am 18 (eighteen) years of age or older. By checking the box below, I consent to participate in this study. If I do not want to participate, I can return the questionnaire packet to the researcher. ☐ I have read the informed consent and I consent to participate in this study.

The University of Dayton supports researchers' academic freedom to study topics of their choice. The topic and/or content of each study are those of the principal investigator(s) and do not necessarily represent the mission or positions of the University of Dayton.

APPENDIX M

Debriefing Form

Information about the Stressful Events and Mental Health study

Objective:

The goal of this study was to examine potential factors that may lead a person who has experienced stalking to develop trauma-related symptoms) or depression. Should the data from this study be significant, it could be useful in identifying why some people who have experienced stalking developed trauma-related symptoms or depression and others do not.

Hypothesis:

We hypothesize that stalking will be related to both trauma-related symptoms and depression, and that the strength of that relationship will be affected by the way in which people avoid the negative events, the way in which people think about their stalking experience specifically, the degree to which people ruminate on the negative event, and the degree to which people have the tendency to blame themselves for said events. We further hypothesize that the relationship between stalking victimization and these variables will be weaker for individuals high in self-compassion. Self-compassion is a construct understood as having kindness, patience, and understanding for oneself (Neff, 2003).

Your Contribution:

The answers you have provided in this questionnaire may help researchers learn more about the relationship between stalking and both trauma-related symptoms and depression. Your input may also help researchers find out more about negative attributes and their possible connection to stalking. Specifically, your answers may inform researchers of variables that affect the relationship between stalking and both trauma-related symptoms and depression. Additionally, your responses may help researchers better understand how levels of self-compassion can influence negative cognitions (i.e., self-blame, rumination, avoidant coping, and event-specific attributes) in stalking situations.

Benefits:

This study may provide information about what factors may lead to trauma-related symptoms and depression development among stalking victims, versus what factors may serve as a buffer against the possible negative, psychological effects of stalking. Ultimately, such information might be useful in helping clinicians most effectively treat stalking victims.

Assurance of Privacy:

We are studying stalking and its effects on mental health and are not evaluating you personally in any way. Your responses will be kept completely confidential.

Researchers will identify your responses by a participant number in the data set with other participant numbers. Your name will not be revealed in any document resulting from this study. As your name is not associated with your responses, there is no way for the researchers to contact you if any of your responses on the questionnaires indicate any potential psychological problems for which you could benefit from counseling; however, the researchers highly encourage you to follow up with the Counseling Center upon feeling any distress associated with your participation in this study (see Counseling Center information below).

Please note:

- We ask you to kindly refrain from discussing this study with others in order to help us avoid biasing future participants.
- If you have any questions please do not hesitate to contact any of the individuals listed on this page.
- For further information about this area of stalking research, you may consult the references cited on this page.

Contact Information:

Students may contact Dr. Catherine Zois at 937-229-2164 or czois1@udayton.edu if you have questions or problems after the study. If you have questions about your rights as a research participant you may also contact the chair of the Research Review and Ethics Committee at rrec@udayton.edu, or (937) 229-2713, or in SJ 329. Please know that if you should choose to contact Dr. Zois and/or the chair of the Research Review and Ethics Committee (RREC), as employees of the University of Dayton they are required to report any and all harassment and/or dating violence, etc. to the university's Title IX coordinator. We do not mention this fact to discourage you from contacting either of us, but simply to help you make an informed decision. Having said this, UD employees who work at the UD Counseling Center, as clergy, and/or as doctors in the UD Health Center are confidential resources and as such, are not required to report such information. You may also wish to contact the University of Dayton Counseling Center at 937-229-3141. Individuals who feel distressed by unwanted attention or harassment may benefit from receiving counseling. Please note, the Counseling Center is free for all University of Dayton undergraduates. If you believe you may currently be in a dangerous situation, it is strongly encouraged that you immediately contact law enforcement and/or inform a counselor for your safety and protection.

Thank you for your participation. I will update your research credit on the online system or inform your faculty member of your participation.

Disclaimer:

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Reference:

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2,* 223-250. doi: 10.1080/15298860390209035

APPENDIX N

Take-Home Debriefing Form

Information about the Stressful Events and Mental Health study

Thank you for your participation in this study. The answers you have provided in this questionnaire may help researchers better understand what factors negatively affect mental health. This, in turn, may help clinicians provide treatment for mental health concerns.

Assurance of Privacy:

We are assessing negative events and mental health and are not evaluating you personally in any way. Your responses will be kept completely confidential and your responses will only be identified by a participant number in the data set with other participant numbers. Your name will not be revealed in any document resulting from this study.

Please note:

- We ask you to kindly refrain from discussing this study with others in order to help us avoid biasing future participants.
- If you have any questions please do not hesitate to contact any of the individuals listed on this page.

Contact Information:

Students may contact Dr. Catherine Zois at 937-229-2164 or czois1@udayton.edu if you have questions or problems after the study. If you have questions about your rights as a research participant you may also contact the chair of the Research Review and Ethics Committee at rrec@udayton.edu, or (937) 229-2713, or in SJ 329. You may also wish to contact that University of Dayton Counseling Center at 937-229-3141 if you feel the need to process the effects of the study in a safe and confidential place. Please note, the Counseling Center is free for all University of Dayton undergraduates. If you believe you may currently be in a dangerous situation, it is strongly encouraged that you immediately contact law enforcement and/or inform a counselor for your safety and protection.

Thank you for your participation. I will update your research credit on the online system or inform your faculty member of your participation.

Disclaimer:

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VITA

Alicia M. Selvey
CURRIVULUM VITAE

3495 CR 233
Fremont, OH 45420

(419) 765-0345
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EDUCATION

August 2019	M.A. Clinical Psychology University of Dayton Dayton, OH GPA: 3.95/4.00
December 2016	B.A. Psychology Bowling Green State University Bowling Green, OH GPA: 3.95/4.00

MASTER'S THESIS

The Role of Self-Compassion as a Buffer against Negative Cognitive Appraisal and Coping Strategies among Stalking Victims

Advisor: Dr. Catherine Lutz-Zois

Committee: Dr. Erin O'Mara Kunz & Dr. Lee Dixon

Description: The study aims to (1) examine the mediating roles of self-blame, rumination, avoidant coping, and event-specific attributions in the relationship between stalking victimization and both trauma-related and depressive symptoms, and (2) assess the moderating role of self-compassion in the relationship between stalking victimization and the hypothesized mediators.

MANUSCRIPTS

Lutz-Zois, C., **Selvey, A**., Anderson, K., & Smidt, A. (2019). *The role of mistrust in sexual abuse revictimization: A serial mediation analysis*. Manuscript in preparation.

Selvey, A., Barry, A., Budde, E., Allbaugh, L., & Kaslow, N. (2019). *Childhood maltreatment, revictimization, and stay/leave decision making*. Manuscript in preparation.

POSTERS AND PRESENTATIONS

* denotes being a co-advisor

National

Lutz-Zois, C., Smidt, A., Anderson, K., & **Selvey, A**. (2019, August). *The role of mistrust in sexual abuse revictimization: A serial mediation analysis*. Poster presented at the 127th annual American Psychological Association Convention, Chicago, Illinois.

Hunt, C. A., **Selvey, A**., Gibbins, K., & Reeb, R. N. (2018, August). *Service-learning students in participatory community action research in local homeless shelters.* Poster presented at the 126th annual American Psychological Association Convention, San Francisco, California.

Regional

Selvey, A., Barry, A., Budde, E., Allbaugh, L., & Kaslow, N. (2019, November). *Childhood maltreatment, revictimization, and stay/leave decision making.* Poster presented at the 35th annual International Society for Traumatic Stress Studies, Boston, Massachusetts.

Barry, A., Reeb, R. N., Gibbins, K., **Selvey, A**., & Hunt, C. (2019, June*). Participatory community action research in homeless shelters: Civic-related outcomes for service-learning research assistants*. Poster presented at the 17th biennial meeting of the Society of Community Research and Action, Chicago, Illinois.

Gibbins, K., Barry, A., **Selvey, A**., Hunt, C., Reeb, R. N., Elvers, G., Londo, A., & Mills-Walsniak, S. (2019, June). *Participatory community action research in homeless shelters: Outcomes for shelter residents and service-learning research assistants*. Presentation at the 17th biennial meeting of the Society of Community Research and Action, Chicago, Illinois.

Reeb, R. N., **Selvey, A**., Gibbins, K., Barry, A., Hunt, C., Zicka, J., & Julian, K. (2019, June). *Fostering the citizen psychologist: Service-learning pedagogy emphasizing self-efficacy, psychopolitical validity, and systems-oriented thinking.* Workshop at the 17th biennial meeting of the Society of Community Research and Action, Chicago, Illinois.

Gibbins, K., Reeb, R. N., Londo, A., & Mills-Walsniak, S., **Selvey, A**., Zicka, J., Andrews, R., & Elvers, G. (2019, April). *Therapeutic benefits of urban farming for homeless shelter residents.* Poster presented at the 91st annual Midwestern Psychological Association, Chicago, Illinois.

Zicka, J., Reeb, R. N., Gibbins, K., Barry, A., & **Selvey, A**. (2019, April). *Efficacy of teaching American Sign Language in homeless shelters.* Poser presented at the 91st annual Midwestern Psychological Association, Chicago, Illinois.

Benoit, M. F., Mattei, G., **Selvey, A**., & Stein, C. H. (2017, June). *The role of social networks in helping adults cope with the loss of a sibling*. Poster presented at the 16th biennial meeting of the Society for Community Research and Action, Ottawa, Ontario, Canada.

Local

Gibbins, K., **Selvey, A**., Barry, A., & Reeb, R. N. (2019, April). *Participatory community action research in homeless shelters: New findings and future plans.* Presentation at the Stander Symposium, Dayton, Ohio.

Silone, G., Karpuszka, V., Lawson, S., Vazquez, C., Nash, M., **Selvey, A***., & Davis, S. (2019, April). *Sleeping on "it"* does *work: Memory for pictures becomes stronger the day after learning, even with an interruption in the learning task.* Poster presented at the Stander Symposium, Dayton, Ohio.

Silone, G., Karpuszka, V., Lawson, S., Vazquez, C., **Selvey, A***., & Davis, S. (2019, April). *Sleep on it! Sleep consolidation produces strong delayed memory retrieval much like immediate retrieval.* Poster presented at the Butler University Undergraduate Research Conference, Indianapolis, Indiana.

Zhoa, Y., Jatczak, T., Flowers, A., Yeager, R., Blakemore, T., Propes, H., Clark, C., **Selvey, A***., & Davis, S. (2019, April). *Over-confident or calibrated: Are preferences for paintings and memory strength affected when paintings have a context?* Poster presented at the Stander Symposium, Dayton, Ohio.

Gibbins, K., **Selvey, A**., Zicka, J., & Reeb, R. N. (2018, November). *Behavioral Activation research project in homeless shelters.* Presentation at the Roesch Social Sciences Symposium, Dayton, Ohio.

Gibbins, K., **Selvey, A**., Wetter, S., Hartman, C., & Hunt, C. (2018, April). *Participatory community action research in homeless shelters: Applications of behavioral activation and service-learning pedagogy*. Presentation at the Stander Symposium, Dayton, Ohio.

Selvey, A., Krueger, E., Luis, A., Panella, E., Salih, H., & Vargas, G. (2018, April). *The mediating role of idealization in the association between couples' geographical separation and infidelity*. Poster presented at the Stander Symposium, Dayton, Ohio.

Selvey, A., Reeb, R. N., & Hunt, C. (2018, April). *Urban gardening initiative for the enhancement of wellness and environmental attitudes of service-learning research*

assistants: Participatory community action research project within local homeless shelters. Poster presented at the Stander Symposium, Dayton, Ohio.

Selvey, A., & Gibbins, K. (2017, November). *Participatory community action research in homeless shelters: Plans for expanding the research project*. Poster presented at the Roesch Social Sciences Symposium, Dayton, Ohio.

Wetter, S., Hartman, C., **Selvey, A**., & Gibbins, K. (2017, November*). Behavioral Activation research project in homeless shelters: Project overview and findings.* Presentation at the Roesch Social Sciences Symposium, Dayton, Ohio.

Selvey, A., & Pratt, M. (2016, May). *Mapping neighborhood activity using ArcMap*. Poster presented at the Undergraduate Research Symposium, Bowling Green, Ohio.

RESEARCH EXPERIENCE

University of Dayton

Resilience and Recovery Lab **2018 – 2019**

Graduate Research Assistant

Advisor: Dr. Lucy Allbaugh

Role: My primary role was to aid in the development, implementation, and maintenance of a longitudinal study assessing outcomes associated with childhood maltreatment. Specific duties included conducting reviews of the literature, writing up the Research Review and Ethics Committee proposal, and mentoring and training undergraduate research assistants. Additionally, I assisted in a collaborative project between McLean Hospital and University of Dayton that examined epigenetics in trauma survivors.

Memory, Aesthetics, Attention, & Perception Lab **2017 – 2019**

Graduate Research Assistant

Advisor: Dr. Susan Davis

Role: I was responsible for overseeing undergraduate research assistants involved in three projects examining (1) attitudes about the aesthetic pleasingness of paintings that vary by descriptive or elaborative titles; (2) deception detection utilizing eye-tracking software; and (3) the effect of sleep consolidation on memory. Specifically, I assisted the undergraduates by troubleshooting and revising IRB proposals, conference abstracts, and posters. My additional duties included grading course assignments and developing workshops for classes.

Dixon Lab **2017 – 2018**

Graduate Research Assistant

Advisor: Dr. Lee Dixon

Role: My primary focus was to collect, input, and analyze data regarding the mediating role of idealization on the relationship between maintenance behaviors and infidelity. I was tasked with mentoring the undergraduate research assistants involved with the study by showing them how to compute data analyses and disseminate information.

Bowling Green State University

Avian Memory Lab **2016 – 2017**

Undergraduate Research Assistant

Advisor: Dr. Verner Bingman

Role: I assisted a graduate student in investigating wall-length discrimination in homing pigeons. My responsibilities included weighing and feeding the pigeons daily and conducting relevant reviews of the literature.

Clinical-Community Psychology Lab **2016 – 2017**

Undergraduate Research Assistant

Advisor: Dr. Catherine Stein

Role: I primarily worked with a graduate student to review and present literature regarding sibling bereavement to the research lab. Additionally, I aided in developing a qualitative study on serious mental illnesses.

Youth, Communities, and Crime Research Group **2016**

Undergraduate Research Assistant

Advisor: Dr. Carolyn Tompsett

Role: I conducted community interviews alongside a graduate student, input quantitative and qualitative data, and utilized ArcMap to map neighborhood information onto a collective map and chart participant's daily routes and locations. At the undergraduate conference, my poster won an excellence award.

CLINICAL EXPERIENCE

Behavioral Activation Practicum **2017 – 2019**

St. Vincent de Paul Homeless Shelters

Supervisor: Dr. Roger Reeb

Role: I was charged with running various sessions (e.g., job training, support groups, social activities, etc.) at the local homeless shelters. I collected participant data and maintained both a qualitative and quantitative data set. Additionally, I was responsible for overseeing undergraduate students at the shelters and the

dissemination of research findings. Through this practicum, I have presented the findings at multiple local, regional, and national conferences.

Mental Health Internship **2016**
Eden Springs Healthcare Center
Supervisor: Dr. William O'Brien

Role: I was responsible for meeting with seven clients on a weekly basis for supportive listening and implementing a token economy. Likewise, I observed and assisted with therapy sessions between a graduate student and her clients.

Mental Health Internship **2016**
National Alliance on Mental Illness (NAMI) Wood County
Supervisor: Dr. Carolyn Tompsett

Role: My duties included preparing for community programs and support groups, assisting in Crisis Intervention Training for police officers, researching mental health facts for social media, and inputting police reports involving mental health crises into a database.

AWARDS

University of Dayton Graduate Student Summer Fellowship	2019
Segal AmeriCorps Education Award	2018
University of Dayton Department of Psychology Graduate Assistantship	2017 - 2019

LEADERSHIP AND SERVICE

AmeriCorps, Dayton, OH 2018
Service Member
Mortar Board Honor Society 2015 – 2016
Chapter Delegate to Annual National Convention
Secretary
Psi Chi Psychology Honor Society 2015 – 2016
Member

CERTIFICATION

Green Dot Training (Sexual Violence Awareness)	2019
Hospice Grief Education Training	2019
Mental Health First Aid Training	2018
NAMI Connections Support Group Facilitator	2018