The Association Between Sociotropy – Autonomy and Dyadic Coping with Relationship Commitment as a Potential Moderator

by

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A Thesis Presented in Partial Fulfillment
of the Requirements for the Degree
Master of Counseling

Approved April 2023 by the
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ARIZONA STATE UNIVERSITY

May 2023

ABSTRACT

Emerging adulthood (18 – 28 years) is a distinctive period in the life course where young people are involved in the process of transitioning to adult roles in their careers and social relationships. Due to the ongoing COVID- 19 pandemic, economic instability, and other social factors, emerging adults in the United States are experiencing greater stress and challenges than ever before. In this climate of high stress, personal characteristics such as an individual's propensity to endorse sociotropy (the tendency to focus primarily on relationships) or autonomy (the tendency to focus primarily on the self) may be associated with experiences of stress and resulting depressive feelings based on the diathesis-stress model of depression proposed by Beck in 1967. However, perceived partner's dyadic coping may buffer against the positive association between stress and depression. Despite this plausible link, not much is known about how personal characteristics (here sociotropy and autonomy) of emerging adults may influence their perceptions of their own as well as partner's dyadic coping. To address this gap, the present study used survey data from 269 emerging adults to examine whether personal characteristics such as sociotropy and autonomy are associated with their perceptions of dyadic coping and to examine if these associations are moderated by perceived relationship commitment, given commitment has been found to increase relationship maintenance behaviors. Results found that both sociotropy and autonomy were associated positively with positive dyadic coping by self and negatively with negative dyadic coping by partner. Relationship commitment partially moderated these associations. Results of this study have the ability to inform therapy for emerging adults in romantic relationships who may be experiencing higher stress, symptoms of depression, and those who may be

experiencing difficulties in their relationships. Limitations and future directions for research are discussed.

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CHAPTER 1

INTRODUCTION

According to APA (2019, 2020, 2021), those in the U.S. have been deeply impacted by the COVID –19 pandemic even as they continue to be impacted by stressors such as stress related to mass shootings, access to healthcare, climate change, abortion laws, immigration, discrimination, sexual harassment, and concerns surrounding political and economic outlooks. The APA (2021) reports that the long-term consequences of the stress and trauma created by the pandemic are particularly serious for the country's younger adults, who are experiencing elevated stress levels compared to all other generations, are struggling to make even basic decisions (e.g., what to wear, what to eat, etc.) and are already reporting symptoms of depression (APA 2020, 2021). Depression often follows periods of high stress (Anisman & Zacharko, 1982), and emerging adults are especially vulnerable to symptoms of depression (Ferrarelli, 2017). Further, personal characteristics such as *sociotropy* (high dependency on relationships) and *autonomy* (proneness to rejection of relationships and high self-criticism) are vulnerabilities that may predispose one to symptoms of depression.

Emerging adults (individuals between the ages of 18 to 28 years) are at a critical juncture in their lives wherein they may desire to simultaneously work towards establishing a professional identity as well as developing and maintaining a relationship with a romantic partner. Notably, emerging adults face many significant challenges in these two life tasks due to the current context of the world, and such experiences may be impacted by characteristics of sociotropy or autonomy. Not much is known about how emerging adults in romantic relationships may cope with their romantic partner in the

face of such stressors. Healthy romantic relationships, characterized by partners' knowledge of each other, interdependence, care, trust, responsiveness, utility, commitment (Miller, 2014), are thought to buffer against experiences of stress. However, individuals high in sociotropy or autonomy may face challenges in romantic relationships, particularly as it applies to their perception of coping with their romantic partner.

Taken together, the aim of the present study is to determine whether personal characteristic of sociotropy or autonomy may be associated with perceptions of partner's dyadic coping. Additionally, given that perceptions of relationship commitment are often associated with perceptions of relationship maintenance behaviors (Eycheverry et al., 2013), this study will also examine whether perceived relationship commitment will moderate the association between sociotropy/autonomy and dyadic coping.

Emerging Adulthood

Emerging adulthood is defined as the period from late teens through mid to late 20s (roughly 18 – 28 years of age; Arnett, 2004). In Western societies, such as the United States (U.S.), this period is characterized by distinctive developmental characteristics, such as exploring and clarifying identities, making choices in love and work, and navigating life transitions (Arnett, 2004; Arnett, 2007; Arnett et. al, 2015). During emerging adulthood, it is thought that individuals have left the dependency of childhood and adolescence but have not yet entered the enduring responsibilities that characterize "normative" adulthood, such as leaving home, completing, or extending their education, finding full-time employment, committing to long-term romantic relationship, starting a family, and developing independent beliefs and worldviews. Because of this, emerging

adulthood has been characterized as the most volitional years of life with a greater scope for exploration of life's possibilities (Arnett, 2000).

Emerging adulthood is a period during which individuals are faced with more life decisions than at any other stage of their lives, as exemplified above (Bangerter, Grob & Krings, 2001). Based on their degree of self-direction, emerging adults may choose a process of individualization (i.e., the process of identity formation) that at the two extremes reflect *default individualization* or *developmental individualization*. Default individualization refers to the "path of least resistance" wherein emerging adults may pursue a path dictated by impulse and circumstances and may choose a number of default options made available by consumer-corporate society with little agentic assertion (Côté, 2000). This path may leave the person unprepared to undertake adult roles such as marriage, fulfilling employment, or parenthood (Schwartz, et.al., 2005). Alternatively, *developmental individualization* is defined as the time in which emerging adults may exercise agentic capabilities and deliberately choose opportunities that lead to self-fulfillment in intellectual, occupational, or psychosocial areas (Côté, 2000). This path of individualization helps better prepare emerging adults to undertake adult roles (Schwartz, et. al, 2005).

Arnett (2004) proposed that emerging adulthood is characterized by five features: (1) The age of identity explorations where psychosocial moratorium as described by Erickson (1968) is now normative; (2) The age of instability where emerging adults have to navigate a higher number of choice-points than ever before as they make life decisions; (3) The self-focused age, where individuals focus on themselves as they develop the knowledge, skills, and self- understanding required for adult life; (4) The age of feeling

in-between, where emerging adults may feel they have more independence and responsibilities than adolescents but do not fully feel like adults; and (5) The age of possibilities and optimism where a variety of potential mates, job opportunities, social causes, and other commitments are perceived by emerging adults as being available. Taken together, these five features highlight the wide array of choices, challenges and tasks emerging adults must resolve, although the emerging adult phase may not be experienced similarly in all cultures.

Arnett (2000) notes that emerging adulthood may exist only in some cultures where young people may experience a prolonged period of independent role exploration. One explanation for this is that although emerging adults may have been granted legal adult status, economic realities in the U.S. have created a lingering dependency on parents (Aquilino, 2006). Changes in labor markets in the U.S have resulted in workers with fewer skills and educational credentials having less favorable career prospects, and many emerging adults have put off the role transitions to increase their education and training for which they may receive economic support from their parents (Furstenberg, 2000; Semyonov & Lewin-Epstein, 2001). During economic recessions, emerging adults are more vulnerable to unemployment due to a greater risk of losing their jobs, receiving lower pay, and an increased difficulty to enter the labor market (Marcus & Gavrilovic, 2010). Along these lines, Hendry and Kloep (2010) argue that the emerging adulthood period of exploration is largely available only to those who may be from the middle class and those who may be financially supported by parents to delay choices and yet gain access to consumer society. Alternatively, some young people may leave education at the minimum age without employment, education or training and thus may postpone other

responsibilities such as marital commitments and parenthood (Bynner & Parsons, 2002; Cote, 2006). In sum, emerging adults are a highly diverse group who take different pathways to reaching adulthood.

Romantic Relationships in Emerging Adulthood

Romantic relationships in emerging adulthood are developmentally important; they influence well-being and emotional adjustment and predict romantic relationships in later life stages (Fincham & Cui, 2010). Romantic relationships in emerging adulthood may be self-focused and unstable while individuals gain more relationship experience and discover what they look for in a romantic partner. However, Collins and van Dulmen (2006) point out that there is continuity between different stages of life, and establishing stability, satisfaction, and closeness in emerging adult's romantic relationships is essential for later development. As such, by late adolescence many relationships become steady - characterized by high levels of intimacy and a sense of commitment (Kefalas et al., 2011).

Irrespective of wants and desires, it is not uncommon for romantic relationships to dissolve during emerging adulthood. Relationship dissolution is thought to be attributed to low levels of commitment, low relationship efficacy, high levels of conflict, poor communication, aggression, and infidelity (Rodrigues et.al, 2006). One cause of relationship dissolution during emerging adulthood (and beyond) may be the experiences of stress originating outside the couple relationship (extra-dyadic stress), which may spill over into the couple relationship leading to intra-dyadic stress (i.e., conflict between partners) (Bodenmann, et al., 2007; Neff & Karney, 2009). Emerging adults in romantic relationships are more likely to seek support from their partner than turn to their parents

for support (Furman, 2002). Therefore, emerging adults' experiences and their ability to cope (or not cope) may be particularly salient for both individual and relationship functioning, especially in the context wherein one or both partners may be experiencing symptoms of psychological distress.

Associations between Stress and Sociotropy and Autonomy

Defining Stress

Stress has commonly been described as the strain or hardship that an individual experiences when their appraisal of their current situation exceeds their resources to cope (Lazarus & Folkman, 1984). Lazarus (1993) describes the stress process as occurring in four steps: (1) a stress or a stressor is discerned, (2) the mind and/or the body makes an appraisal that distinguishes the stressor as noxious or benign, (3) coping processes are engaged by the mind and/or body to deal with the stressor, and (4) a pattern of effects called stress reaction impacting the mind and/or body ensues.

Beck's (1967) diathesis–stress model of depression posits that symptoms of depression are the result of an interaction between a diathesis (pre-dispositional vulnerability) in the individual and a stress caused by a negative precipitating event in the environment. Using the diathesis -stress model of depression as a foundation, Beck (1983) postulated a cognitive theory of depression based on an individual's schemata or mental representations of the self and the world that are relatively enduring characteristics of a person's cognitive organization. An individual decodes a situation through the activation of the relevant cognitive schema which they use to perceive, encode, and retrieve information regarding the situation. Based on this conceptualization, Beck (1983) characterized *sociotropy* and *autonomy* as two personality characteristics

based on an individual's cognitive schemata that are related to their vulnerability to depression.

Sociotropy

Sociotropy or social dependency is described as ‘‘the person's investment in positive interchange with others’’ (Beck et al., 1996, p. 272) and its associated dysfunctional schemata being "If someone disapproves of me, I am unlovable." Sociotropic individuals are thought to be vulnerable to depression when they suffer a perceived loss within the interpersonal realm (Robins, 1990). Sociotropic individuals have heightened needs for support, guidance, understanding, and acceptance, so they try to ameliorate negative experience that could impact their self-esteem by establishing secure interpersonal relationships. Sociotropic individuals are excessively invested in having positive exchanges with others; however, when these relationships fail, it is thought that sociotropic individuals will experience symptoms of depression (Beck, 1983), which has been characterized by a preoccupation with themes of loss and abandonment and symptoms may include crying, mood variability and reactivity, and feelings of loneliness. (Robins & Luten, 1991).

Autonomy

Autonomy is described as ‘‘the person's investment in preserving and increasing his independence, mobility, and personal rights’’ (Beck et al., 1996, p. 272), and its associated dysfunctional schemata being "I must be good at everything I do, or I am a failure". Autonomous individuals are overly concerned with achieving personal goals and meeting personally held, and usually unreasonably high standards. When they fail to achieve such goals, they exhibit symptoms of depression, often characterized by a general

loss of interest or pleasure, loss of interest in people, self-blame, irritability, and concern about the inability to function (Clark et al., 1997; Robins & Luten, 1991). In romantic relationships, due to their evaluative and perfectionist concerns, autonomous individuals act competitively, control resources, and criticize and blame their partners, which may lead to confrontations and misunderstandings between romantic partners, rejection, a sense of relational failure, worthlessness, and increased self-criticism (Santor et al., 2000; Shahar et al., 2004).

Experiences of Stress and Depression in Emerging Adulthood

Emerging adulthood is a high-risk time for the development of depression due to a variety of significant stressors that emerging adults may experience such as a lack of structure, relationship instability, lack of economic independence, and uncertainty about one's competence and future (Rhode et al., 2013). Notably, most individuals who experience clinical depression have at least one episode of depression by emerging adulthood (Kessler et al., 2005). Although most emerging adults generally see their future as relatively bright and expansive in comparison to older age cohorts (Berntsen & Rubin, 2004; Carstensen et al., 2020; Demiray & Bluck, 2014), in the context of the pandemic, hopefulness for a positive trajectory into adulthood may have become even more complex and challenging (e.g., Kujawa et al.; 2020).

The ongoing COVID-19 crisis has changed the development and maintenance behaviors associated with emerging adults' interpersonal relationships (Goodboy et al.; 2021). Specifically, social distancing guidelines, the closure of public and educational facilities, and restricted mobility limited the amount of time spent with family members, peers, and partners. In particular, peer contacts and social integration into new

educational or occupational contexts were disrupted. Limited opportunities for in-person contacts and a lack of personal support have increased levels of loneliness, depression, and anxiety (Elmer et al., 2020). In these circumstances, a high-quality romantic relationship may be a resource when coping with COVID-19-related stress (Pietromonaco et al., 2019; Preetz et.al, 2021). Having an intimate relationship provides individuals with stability during times of unpredictability when partners may help keep each other grounded and reduce feelings of loneliness (Gomez-Lopez et.al., 2019). However, maintaining a high-quality relationship during the ongoing COVID-19 pandemic may have been challenging, as individuals reported greater negative evaluations of their relationship and more negative communication patterns with their partner during times of high-level stress (Neff & Karney, 2004; Williamson et al., 2013).

Given that emerging adults are at a greater risk for exhibiting symptoms of depression (Hankin et al., 1998), especially during the ongoing COVID-19 pandemic (Hawes et al., 2021), is it likely that characteristics of their romantic relationship have been affected as well. Indeed, individuals who exhibit symptoms of depression are at a greater risk for experiencing poorer romantic relationship quality during times of stress (Halliday Hardie & Lucas, 2010). Thus, although support from one's romantic partner can help mitigate experiences of stress (Revenson, Kayser, & Bodenmann, 2005), this may be a challenge for those who are highly sociotropic or autonomous due to the challenges they experience in interpersonal relationships (Zuroff & Fitzpatrick, 1991).

Coping with Stress: Role of Dyadic Coping

Originating from Lazarus and Folkman's (1984) conceptualization of individual stress, researchers have expanded their understanding of the impact of stress to consider

an individual's social systems, specifically one's romantic partner given their shared interdependence (e.g., Falconier et al., 2016). In this vein, while stress can be characterized as originating outside (external) or inside (internal) to one's romantic relationship (for a review see Randall & Bodenmann, 2009; 2017), external stressors that may originally impact only one partner can spillover into the relationship, causing the partner to feel stress as well (stress crossover; Bodenmann, 2007; Neff & Karney, 2009). Irrespective of the source of the stress, romantic partners can work together to cope with experiences of stress – commonly referred to as *dyadic coping* (Falconier et al., 2016).

According to the systemic-transactional model (STM; Bodenmann, 1995, 2005), dyadic coping is conceptualized as a process wherein Partner A (the stressed partner) communicates their stress to Partner B (the non-stressed partner), and the latter reacts to the stress signals. Following this interaction, Partner B interprets the stress of Partner A, which can result in the Partner B's own stress contagion, lack of response (negative dyadic coping), or engagement in positive, supportive dyadic coping. Partner B may engage in supportive dyadic coping (SDC) by supporting the stressed partner using unidirectional emotion-focused (e.g., show empathy), or problem-focused (e.g., understanding and analyzing the situation), or delegated dyadic coping behaviors (e.g., doing things for the partner). Alternatively, Partner B may mock or minimize Partner A's experience of stress, which is referred to as negative dyadic coping (Bodenmann, 1995, 2005).

Reports of partner positive dyadic coping have been found to be positively associated with couple satisfaction in studies on late adolescent / young adults' samples (e.g., Cramer, 2006; Papp et al., 2010; Pinquart & Fabel, 2009). These findings suggest

that dyadic coping may be of high relevance during emerging adulthood (Furman, 2002), especially in mitigating the partner's experiences of symptoms of distress; however, research is needed to determine how individuals high on sociotropy or autonomy may perceive dyadic coping with their partner.

Associations between Sociotropy/Autonomy and Perceptions of Dyadic Coping

In nonclinical samples, highly sociotropic individuals value emotional closeness and seek to establish and maintain good interpersonal relationships (Stegar et al., 2009). In clinical samples, sociotropy in depressed patients was associated with fears of abandonment and feelings of loneliness (Blatt et al., 1982). In another study conducted with a sample of 73 depressed patients (M = 39.98; SD = 10.93) Lynch and colleagues (2001) found that individuals who scored high on sociotropy rated themselves as being highly demanding and rated their partners as being withdrawing. Lastly, in a sample of female undergraduate students, sociotropic/dependent women used compromise in resolving conflicts with their boyfriends (Zuroff & Fitzpatrick, 1991) and displayed high levels of discomfort about feelings of hostility (Zuroff, et al., 1983). Taken together, prior research suggests that sociotropic individuals may perceive themselves to provide higher supportive dyadic coping and lower negative dyadic coping to their partners. Further, they may perceive their partners to provide lower supportive dyadic coping and higher negative dyadic coping to them.

In self-report studies of students (Gilbert et al., 2011, Gilbert et al., 2012) and depressed patients (Gilbert et al., 2014), those with high levels of autonomy/self-criticism reported higher fear of receiving compassion from others. In another sample of clinically depressed individuals, those scoring high on autonomy reported themselves as

withdrawing while rating their partners as demanding (Lynch et al., 2001). Further, Zuroff, Moskowitz, and Cote (2012) found that in a non-clinical sample autonomy/self-criticism predicted lower rates of agreeable behavior and higher rates of quarrelsome behavior. Lastly, highly autonomous, or self-critical individuals make fewer requests for social support and perceive less support than what is available to them (Mongrain, 1998). Taken together, these studies suggest that individuals high on autonomy may perceive themselves to provide lower supportive dyadic coping and higher negative dyadic coping. Further, individuals high on autonomy may perceive lower supportive dyadic coping from their partners and higher negative dyadic coping from their partners.

Although personal characteristics such as sociotropy and autonomy may determine how partner's cope dyadically, an individual's level of commitment to the relationship may also influence their perceptions of dyadic coping.

Moderating Role of Relationship Commitment

Commitment in a romantic relationship refers to the long-term orientation toward the maintenance of the relationship and is a consequence of increasing dependence between the partners (Rusbult, Martz, & Agnew, 1998). In this regard, commitment can be considered an emotional or physical investment by one or both partners in the relationship (Rusbult & Buunk, 1993). However, both partners may have different degrees of relationship commitment, especially with respect to how it may be perceived, experienced and expressed by partners differently (Hughes, 2014; Stanley et al., 2010). When one romantic partner is more invested in the relationship than the other, it is described as an asymmetrically committed relationship (Stanley et.al, 2016). These asymmetrical commitments may present as stable and secure in the short term but present

with significant challenges to each partner in the long run due to risks of exploitation, entrapment, and an unhealthy distribution of power (Stanley et al., 2017).

According to Blatt (2008), although individuals who do not endorse sociotropy or autonomy are able to become involved in relationships; this may be challenging for emerging adults given they may have not yet gained the competencies to successfully navigate romantic relationships. Sociotropic individuals are commonly positively biased in their views of their romantic partners and their romantic relationships (Zuroff & de Lorimier, 1989). Conversely, autonomous individuals are greatly concerned about a need for personal control, and defensive separation from others (Coyne & Whiffen, 1995; Robins et al., 1990).

In sum, emerging adults' perceptions of their relationship commitment may differentially impact the association between sociotropy or autonomy and dyadic coping. Sociotropic individuals may be inclined to be more committed to their romantic relationship, whereas autonomous individuals may report lower commitment. Because relationship commitment has been found to be positively associated with positive dyadic coping (Marion, et al., 2014), it is hypothesized that relationship commitment will moderate the association between individual's characteristics of sociotropy/autonomy and dyadic coping.

Present Study

Based on the diathesis – stress theory of depression (Beck, 1967) and the cognitive theory of depression (Beck, 1983), individuals high on characteristics of sociotropy and autonomy may be vulnerable to symptoms of depression following experiences of adversity, such as the deleterious effect of the pandemic. Emerging adults

have been negative impacted by the ongoing COVID-19 pandemic (Hawes et al., 2021), which calls into question whether characteristics of sociotropy and autonomy may be associated with how emerging adults cope with their romantic partner.

For emerging adults in a romantic relationship, little is known about how the characteristics of sociotropy, and autonomy may be associated with partner's reports of dyadic coping, which has been found to be an important relationship maintenance behavior when one or both partners are experiencing stress external to the relationship (Randall & Messerschmitt, 2020). As such, one goal of the present study was to collect data from emerging adults in a relationship who are exhibiting high levels of depressive symptoms, as measured by the CES-D (Radloff, 1977), to examine how characteristics of sociotropy or autonomy may be associated with perceptions of their partner's dyadic coping, and whether their perceived romantic commitment may moderate this association.

Based on the research presented above, it was hypothesized (H) that for depressed individuals, operationally defined as those who score greater than 16 on the CES-D (Radloff, 1977), sociotropy would be associated with:

H1. Higher perceptions of positive dyadic coping by oneself (H1A), and lower perceptions of positive dyadic coping of the partner (H1B).

H2. Lower perceptions of negative dyadic coping by oneself (H2A) and higher perceptions of negative dyadic coping of the partner (H2B).

Furthermore, for depressed individuals, autonomy will be associated with:

H3. Lower perceptions of positive dyadic coping by oneself (H3A), and lower perceptions of positive dyadic coping of the partner (H3B).

H4. Higher perceptions of negative dyadic coping by oneself (H4A), and higher perceptions of negative dyadic coping of the partner (H4B).

Lastly, based on research to suggest relationship commitment is positively associated with dyadic coping (Marion, et al., 2014), it was hypothesized that relationship commitment will positively moderate the association between sociotropy or autonomy and dyadic coping by oneself and one's partner (H5A, H5B).

CHAPTER 2

METHODS

Recruitment

This study was approved by Arizona State University's Institutional Review Board (IRB; ID: STUDY00016088) in July 2022. Participants were recruited through university listservs and ResearchMatch, an online nonprofit program funded by the National Institutes of Health (NIH) that helps connect people interested in research studies with researchers across the U.S. Additionally, snowball sampling techniques were used by asking participants to share this study upon completion with their own networks. Data collection took place from August 1, 2022, to October 31, 2022.

Participants

Participants had to meet the following criteria to participate: (1) be between the age of 18 – 28 and (2) currently be in a romantic relationship for at least 6 months[1].

Seven hundred and seventy-one participants expressed interest in participating in the study. One participant was removed for not providing consent, one hundred and one were removed for not being in the age range, twelve were removed for not being in a relationship, fourteen were removed for responding to age with year born, one was removed for providing an unrealistically high relationship length, one was removed for providing unrealistically high partner age, three were removed for failing attention checks, and 211 were removed for large number of missing data. Of the remaining 427 participants one hundred and fifty-eight did not meet the cut-off score for CES-D, which

[1] These inclusion criteria are consistent with prior studies (e.g., Butler, Young, & Randall, 2010), a minimum relationship length of 6 months was chosen to ensure participants had established interdependence within their romantic relationship.

provides a cutoff score of 16 or higher for identifying individuals at risk for clinical depression (Lewinsohn et al., 1997). The final sample consisted of 269 participants.

The mean age of participants was 24.01 years (SD = 2.46). A majority of the participants identified as a cisgender woman (*n* = 182, 67.10%), heterosexual (*n* = 119, 44.20%) or bisexual (*n* = 67, 24.90%).

Most participants identified as White (*n* = 170, 63.20%), followed by Hispanic (*n* = 28, 10.40%), Black (*n* = 25, 9.30%), Asian American (*n* = 23, 8.60%), multi-racial (*n* = 18, 6.70%), and different identity (*n* = 5, 1.90%). Overall, the sample was highly educated with 91.90% (*n* = 247) reporting at least some college experience, an undergraduate, or a graduate degree.

Participants reported being in their current relationship for an average of 2.71 years (SD = 2.41). The majority of the participants reported their relationship status as 'in a committed relationship' (*n* = 197, 73.20%). Thirteen participants (4.80%) reported having children.

Please refer to Table 1 for complete descriptive information.

Procedure

Participants were recruited using a study flyer that had a link to the online survey, which was housed on Qualtrics. The survey contained a consent form and a screening survey to ensure participants meet the eligibility requirements (listed above; see Appendix A). Eligible participants were automatically directed to the research survey (see Appendix B). On average, participants took approximately 35 minutes to complete the survey. Participants were not compensated for their participation.

Measures

Screening

Interested participants were administered a screening questionnaire to determine their eligibility before answering the research survey.

Demographics

Participants answered standard demographic questions that assessed characteristics such as age, gender identity, sexual orientation, race, education, and income. Additionally, participants were also asked questions about their romantic relationship (e.g., relationship length, relationship status, cohabitation, and number of children).

Symptoms of depression.

Depression was measured with the Center for Epidemiological Studies Depression (CES-D; Radloff, 1977) scale. The CES-D is a 20-item self-report measure used to determine depressive symptoms and has been shown to correlate well with clinical ratings of the severity of depression. The CES-D asks participants to rate how often they have experienced depression symptoms "over the past week or so" using a 4-point scale ranging from (0 = "Not at all or less than one day" to 3 = "Nearly every day for 2 weeks"). Some sample items on the measure are: '*I felt that I could not shake off the blues even with the help from my family or friends*', '*I felt everything I did was an effort*'), and '*I had trouble keeping my mind on what I was doing*'. Scores range from 0 to 60, with higher total scores representing greater symptom severity. In the current sample, the CES-D showed high internal consistency of α =.85.

Sociotropy – Autonomy Scale

Sociotropy and autonomy were measured with the 60-item Sociotropy Autonomy Scale (Beck, 1983; Bieling, 2000). Each subscale contains 30 items and asks participants to respond to items using a 5-point scale ranging from (0 = "strongly disagree" to 4 = "strongly agree"). The items of the Sociotropy Scale reflect concern with disapproval by others, and efforts to secure attachment to others. Examples are *"I am afraid of hurting other people's feelings," "Having close bonds with other people makes me feel secure," and "It is important to me to be liked and approved of by others"* (Bieling, 2000). The items of the Autonomy Scale reflect achievement orientation, concerning the possibility of personal failure and maximization of control over the environment. Examples include *"I am not influenced by others in what I decide to do," "It is more important to get a job done than to worry about people's reactions," and "I prefer to make my own plans, so I am not controlled by others"* (Bieling, 2000). The scores for the sociotropy and autonomy subscales were calculated with total score for each subscale being 120. The sociotropy scale and the autonomy scale showed high internal consistency of α =.86 and α =.80, respectively.

Dyadic Coping

Dyadic coping was measured with the English version of the Dyadic Coping Inventory (DCI: Randall et al., 2016). The DCI is a 31-item instrument designed to evaluate romantic partners' perceptions of stress communication and coping behaviors when one or both partners are stressed. Additionally, participants can rate their own (self) and perceptions of their partner's (partner) behavior.

For the purpose of this study, sixteen items related to supportive (self and partner) dyadic coping and the eight items related to negative dyadic coping (self and partner) were administered. The positive subscale (6 items) comprised of three subscales – emotion focused (2 items), problem focused (2 items) and delegated dyadic coping (2 items). A sample item that measures one's own positive coping is *"What I do when my partner is stressed?"* and an item that measures the partner's supportive coping is *"What does my partner do when I am stressed?".* The negative dyadic coping subscale includes four items as measures hostile, ambivalent, and superficial actions/words that have deleterious intentions. A sample item that measures one's own negative dyadic coping is, *"I blame my partner for not coping well enough with stress"* and a sample item that measures partner's negative dyadic coping is *"My partner blames me for not coping well enough with stress."* Items are answered on 5-point scales ("0 = never" to "4 = very often").

The DCI sub-scale scores are calculated by averaging subscale item scores after reverse coding negatively keyed items. In the current sample, the DCI showed good internal consistency across the subscales; stress communication by self (α =.80), perceptions of partner's stress communication (α =.81), positive dyadic coping by self (α =.61), negative dyadic coping by self (α =.66), perceptions of partner positive dyadic coping (α =.80), perceptions of partner negative dyadic coping by partner (α =.81).

Relationship Commitment

Relationship commitment was measured with the seven-item Commitment subscale of the Investment Model Scale (Rusbult et al., 1998). Participants respond to items using a 9-point scale (1= "disagree completely"; 9 = "agree completely"). Sample

items include *''I want our relationship to last for a very long time''* and *''I am committed to maintaining my relationship to my partner''.* The relationship commitment score is calculated by summing the scores for the seven items with possible total scores ranging from 0 to 56 and higher scores indicating greater commitment. In the current sample, the relationship commitment scale showed high internal consistency (α =.82).

Control Variables

Control variables are used to minimize the effect of variables other than the independent variables on the dependent variable(s) (Nelson, 2017). In conducting the analyses, it is important that variables that may confound the results are held constant across the models. For the purpose of this study, participants' reports of stress communication, as measured by the DCI (Randall et al., 2016), and relationship length were included in the models as control variables.

Partners who can communicate their worries, feelings, and needs are able to engender joint coping efforts and report higher relationship functioning (Badr et al., 2010; Traa et al., 2015). Controlling for stress communication would ensure that the dependent variable (i.e., dyadic coping) varies due to the independent variable (i.e., sociotropy/autonomy). Perceptions of partner's stress communication was controlled when testing for perceptions of dyadic coping by self. Perceptions of stress communication by self was controlled for when testing for perceptions of partner's dyadic coping. Additionally, given relationship length is a positive predictor of relationship functioning (Karney & Bradbury, 1995), relationship length as measured in months was controlled for in the analyses. In all the eight models, perceptions of stress communication by self or perceptions of stress communication by partner were

significant. Relationship length was not significant in any of the models and was subsequently removed from the model testing for parsimony.

Data Analysis

Prior to running the proposed analysis, data was checked for missing values and normalcy (i.e., skewness and kurtosis). Data is considered normal if skewness is between -2 and +2 and kutosis is between -7 and +7 (Bryne, 2010, Hair et al., 2010). Skewness and kurtosis values of the study variables fell within the acceptable range (see Table 2). Mean centering was done to reduce the threat of multicollinearity between variables and to provide clearer interpretations (Shieh, 2011).

Prior to hypotheses testing, correlational analyses were conducted using SPSS version 28 (IBM Corp., 2021). Bivariate Pearson correlations were used to test the strength ofcorrelations among study variables. Taking the absolute value of the correlation coefficient allowed for the associations to be classified as small, moderate, and large if the values were above 0.10, 0.30, and 0.50, respectively (Dancey & Reidy, 2007). Following this, a hierarchical multiple regression analysis was conducted using SPSS 28 (IBM Corp., 2021) to test for the possible main effect of sociotropy or autonomy on dyadic coping (H1, H2, H3, H4), and the interaction of sociotropy or autonomy and relationship commitment on dyadic coping (H5). Utilizing multiple models in hierarchical multiple regression will allow for analysis of the moderating effect of relationship commitment if present (Kleinbaum et al., 2013). PROCESS (Hayes, 2013) was used to decompose any significant interactions.

CHAPTER 3

RESULTS

Results showed that in the sample of 269 participants with CES-D depression scores >16, the CES-D score had a significant positive correlation with sociotropy (r = 0.22, $p < 0.01$), but did not have a significant correlation with autonomy (See Table 3). Results showed there was no significant correlation between sociotropy and positive or negative dyadic coping by self or partner (See Table 3). There was a significant positive association between autonomy and positive dyadic coping by self ($r = 0.25$, $p < 0.01$) and perceptions of partner negative dyadic coping ($r = 0.18$, $p < 0.01$). There was a significant negative association between autonomy and relationship commitment ($r = -0.15$, $p < 0.05$), which suggests that those higher sores in autonomy were associated with lower relationship commitment. It is important to note that the values of the correlation terms were low, which reflects weak associations among the study variables.

Hypothesis Testing

H1A hypothesized that for depressed individuals, sociotropy will be associated with higher perceptions of positive dyadic coping by self. As expected, results showed that there was a significant positive main effect of sociotropy on perceptions of positive dyadic coping by self ($\beta = 0.14$, $p = 0.03$), such that higher reported levels of sociotropy were associated with higher perceptions of positive dyadic coping by self. H1B hypothesized that depressed individuals, sociotropy will be associated with lower perceptions of partners' positive dyadic coping. Contrary to H1B, results showed that there was no main effect of sociotropy on perceptions of partner positive dyadic coping ($\beta = -0.02$, $p = 0.76$).

H2A hypothesized that for depressed individuals, sociotropy will be associated with lower perceptions of negative dyadic coping by self. Contrary to H2A, results showed that there was no main effect of sociotropy on perceptions of negative dyadic coping by self ($\beta = 0.08$, $p = 0.22$). H2B hypothesized that for depressed individuals, sociotropy will be associated with higher perceptions of partner negative dyadic coping. As expected by H2B, results showed that there was a significant positive main effect of sociotropy on negative dyadic coping by the partner ($\beta = 0.16$, $p = 0.01$), such that higher reported levels of sociotropy were associated with higher perceptions of partner negative dyadic coping.

H3A hypothesized that for depressed individuals, autonomy will be associated with lower perceptions of positive dyadic coping by self. Contrary to H3A, results showed that there was a significant positive main effect of autonomy on perceptions of positive dyadic coping by self ($\beta = 0.25$, $p < 0.001$), such that higher reported levels of autonomy were associated with higher perceptions of positive dyadic coping by self. H3B hypothesized that for depressed individuals, autonomy will be associated with lower perceptions of partner positive dyadic coping. Contrary to H3B, results showed that there was no significant main effect of autonomy on perceptions of partner positive dyadic coping ($\beta = -0.02$, $p = 0.75$).

H4A hypothesized that for depressed individuals, autonomy will be associated with higher perceptions of negative dyadic coping by self. Contrary to H4A, results showed that there was no significant main effect of autonomy on perceptions of negative dyadic coping by self ($\beta = 0.90$, $p = 0.17$). H4B hypothesized that for depressed individuals, autonomy will be associated with higher perceptions of partner negative

dyadic coping. As expected by H4B, results showed that there was a significant positive main effect of autonomy on perceptions of partner negative dyadic coping, ($\beta = 0.22$, $p < 0.001$), such that higher reported levels of autonomy were associated with higher perceptions of partner negative dyadic coping.

Moderating Role of Commitment

It was hypothesized that relationship commitment would moderate the association between sociotropy or autonomy and positive or negative coping by self or partner (H4A, H4B).

Moderating role of commitment on the association between sociotropy and dyadic coping

Model 1. Model 1 tested the moderation of relationship commitment on the association between sociotropy and positive dyadic coping by self. Results showed there was no significant main effect of relationship commitment on positive dyadic coping by self ($\beta = 0.10$, $p = .10$), and the moderation effect of relationship commitment was non-significant ($\beta = -.03$, $p = .56$). See Table 4.

Model 2. Model 2 tested the moderation of relationship commitment on the association between sociotropy and perceptions of partner positive dyadic coping. Results showed there was a positive significant main effect of relationship commitment on partner positive dyadic coping ($\beta = 0.26$, $p < .001$), such that higher reported levels of relationship commitment were associated with higher perceptions of partner positive dyadic coping. Further, results showed that there was a significant negative interaction between relationship commitment and sociotropy ($\beta = -.12$, $p = .03$), indicating that

relationship commitment moderated the negative association between sociotropy and partner positive dyadic coping. See Table 5.

High levels of relationship commitment significantly strengthened the negative association between sociotropy and perceptions of partner positive dyadic coping (β = -.03, 95% CI [-.07, 0.00]). Low levels of relationship commitment did not significantly moderate the association between sociotropy and perceptions of partner positive dyadic coping. As shown in Figure 1, higher sociotropy predicted lower levels of perceptions of partner positive dyadic coping, and this effect was stronger for those who reported higher relationship commitment.

Model 3. Model 3 tested the moderation of relationship commitment on the association between sociotropy and negative dyadic coping by self. Results showed there was a significant negative main effect of relationship commitment on negative dyadic coping by self (β = - 0.27, p <.001), such that higher reported levels of relationship commitment were associated with lower perceptions of negative dyadic coping by self; however, this association was not moderated by relationship commitment (β = -.07, p = .27). See Table 6.

Model 4. Model 4 tested the moderation of relationship commitment on the association between sociotropy and perceptions of partner negative dyadic coping. Results showed there was a significant negative main effect of relationship commitment on perceptions of partner negative dyadic coping (β = - 0.33, p <.001), such that higher reported levels of relationship commitment were associated with lower perceptions of negative partner dyadic coping. Further, results showed that there was no significant

interaction between relationship commitment and sociotropy (β = .01, *p* = .85). See Table 7.

Moderating role of commitment on the association between autonomy and dyadic coping

Model 5. Model 5 tested the moderation of relationship commitment on the association between autonomy and positive dyadic coping by self. Results showed there was a positive significant main effect of relationship commitment on positive dyadic coping by self (β = 0.16, *p* <.01), such that higher reported levels of relationship commitment were associated with higher perceptions of positive dyadic coping by self. Further, results showed that there was a significant positive interaction between relationship commitment and autonomy (β = .13, *p* = .04), indicating that relationship commitment positively moderated the positive association between autonomy and positive dyadic coping by self. See Table 8.

Both high (β = .06, 95% CI [.01, 0.09]) and low (β = .10, 95% CI [.06, 0.14]) levels of relationship commitment significantly strengthened the positive association between autonomy and perceptions of positive dyadic coping by self. As shown in Figure 2, higher autonomy predicted higher levels of perceptions of positive dyadic coping by self, and this effect was stronger for those who reported lower relationship commitment.

Model 6. Model 6 tested the moderation of relationship commitment on the association between autonomy and perceptions of partner positive dyadic coping. Results showed there was a positive significant main effect of relationship commitment on partner positive dyadic coping, (β = 0.23, *p* <.001), such that higher reported levels of relationship commitment were associated with higher perceptions of partner positive

dyadic coping. Further, results showed that there was a significant positive interaction between relationship commitment and autonomy (β = .13, p = .02), indicating that relationship commitment positively moderated the negative association between autonomy and perceptions of partner positive dyadic coping. See Table 9.

Low levels of relationship commitment significantly strengthened the negative association between autonomy and perceptions of partner positive dyadic coping (β = -.05, 95% CI [-.10, 0.00]). Low levels of relationship commitment did not significantly moderate the positive association between autonomy and perceptions of partner positive dyadic coping. As shown in Figure 3, higher autonomy predicted lower levels of perceptions of partner positive dyadic coping, but only for those low on relationship commitment. For those high on relationship commitment, higher autonomy was predicted higher perceptions of partner positive dyadic coping, although this association was insignificant.

Model 7. Model 7 tested the moderation of relationship commitment on the association between autonomy and negative dyadic coping by self. Results showed there was a significant negative main effect of relationship commitment on negative dyadic coping by self, (β = -0.32, p <.001), such that higher reported levels of relationship commitment were associated with lower perceptions of negative dyadic coping by self. Further, results showed that there was a significant positive interaction between relationship commitment and autonomy (β = .17, p = .02), indicating that relationship commitment positively moderated the positive association between autonomy and negative dyadic coping by self. See Table 10.

High levels of relationship commitment significantly strengthened the positive association between autonomy and negative dyadic coping by self (β = .04, 95% CI [.00, 0.08]). Low levels of relationship commitment did not significantly moderate the association between autonomy and negative dyadic coping by self. As shown in Figure 4, higher autonomy predicted higher levels of negative dyadic coping by self, and this effect was stronger for those who reported higher relationship commitment.

Model 8. Model 8 tested the moderation of relationship commitment on the association between autonomy and perceptions of partner negative dyadic coping. Results showed there was a significant negative main effect of relationship commitment on perceptions of partner negative dyadic coping, (β = -0.32, p <.001), such that higher reported levels of relationship commitment were associated with lower perceptions of partner negative dyadic coping. Further, results showed that there was no significant interaction between relationship commitment and autonomy (β = -.06, p = .32). See Table 11.

Taken together, the hypothesis that relationship commitment would positively moderate the association between sociotropy and dyadic coping by self and partner (H5A), and between autonomy and self and partner dyadic coping (H5B), were only partially supported.

CHAPTER 4

DISCUSSION

Emerging adulthood (18-28 years) is a distinctive period in the lifespan in which individuals are clarifying identities and navigating choices with respect to their romantic interests and other domains of life (Arnett, 2004). In the current context of the United States, emerging adults are experiencing elevated levels of stress due to the aftermath of the pandemic as well as social, political, and economic contexts (APA, 2022). Symptoms of depression are often triggered following periods of high stress (Ferrarelli, 2017). Beck's (1967) diathesis - stress model of depression proposes that depression is the result of an interaction between predisposition vulnerability and stress caused by life events and factors.

Two personality characteristics associated with depression are *sociotropy* - a high dependency on positive exchanges with others and *autonomy* - a high needs to achieve personal goals and unreasonably high standards (Robins & Luten, 1991). For emerging adults in a romantic relationship, dyadic coping between partners maybe helpful in ameliorating the harmful effects of stress (Breitenstein et al., 2018). But little is known about how personal characteristics such as sociotropy and autonomy may be associated with stress communication and subsequent coping behaviors for emerging adults experiencing higher symptoms of depression. As such the purpose of this study was to examine how personality characteristics (here sociotropy and autonomy) would be associated with perceptions of self and partner dyadic coping for emerging adults who reported high levels of depression. Results from this study could help inform mental health practitioners about how sociotropic and autonomous individuals may perceive

dyadic coping by self and partner, and this may inform ways to improve dyadic coping to decrease the deleterious effects of stress and depression.

Sociotropy and Dyadic Coping

Based on research to suggest that sociotropic individuals are highly dependent on relationships (Zuroff & Fitzpatrick, 1991) and experience discomfort with hostility in relationships (Zuroff, et al., 1983), it was hypothesized that sociotropic individuals will report higher perceptions of positive dyadic coping by self, lower perceptions of partner positive dyadic coping, lower perceptions of negative dyadic coping by self and higher perceptions of partner negative dyadic coping. Results indicated that those who report higher levels of sociotropy had higher perceptions of positive dyadic coping by oneself and higher perceptions of partner negative dyadic coping. Contrary to the hypotheses, there was no significant association between sociotropy and perceptions of partner positive dyadic coping and no significant association between sociotropy and perceptions of negative dyadic coping by self. This suggests that sociotropic individuals perceive themselves in a more positive light, providing positive coping to their partner when they are stressed. Furthermore, sociotropic individuals perceive their partner in a more negative light; reporting higher instances of negative dyadic coping when they, themselves, are stressed.

Highly sociotropic individuals place a great value over close relationships (Stegar et al., 2009) and are invested in positive exchanges with others (Blatt et al., 1982). In line with past research, the present study found that individuals higher on sociotropy perceive themselves as providing higher positive dyadic coping. It was expected that highly sociotropic individuals would perceive themselves to engage in lower negative dyadic

coping and this expectation was not met. These results may be attributed to the measurement of such perceptions. For example, item 17 of the DCI "*I blame my partner for not coping well enough with stress*." may measure a different aspect of negative dyadic coping than "*When my partner is stressed, I tend to withdraw*." Sociotropic individuals may be less likely to withdraw but may be more likely to blame partners for not coping well with stress, as sociotropic individuals have been found to be less likely to withdraw from their partners (Lynch, 2001). Prior research by Toru and Gonzalez (2009) conducted with non-clinical samples of undergraduate students found that highly sociotropic individuals display more resentful and mistrusting behaviors compared to those low in sociotropy. These results suggest that sociotropic individuals may perceive their partner to offer less positive coping, more negative coping, which is in line with the study's current findings.

Autonomy and Dyadic Coping

Based on research to suggest that autonomous individuals experience higher fear of receiving compassion from others (Gilbert et al., 2014) and engaged in lower rates of agreeable behavior and higher rates of quarrelsome behavior (Zuroff et al., 2012), it was hypothesized that autonomy would be associated with lower perceptions of positive dyadic coping by self, and lower perceptions of partner positive dyadic coping, higher perceptions of negative dyadic coping by self, and higher perceptions of partner negative dyadic coping. Results from this study indicate that those reporting higher on autonomy had higher perceptions of positive dyadic coping by self and higher perceptions of partner negative dyadic coping. There was no significant association between autonomy and negative dyadic coping by self and no significant association between autonomy and

perceptions of positive dyadic coping by partner. This suggests that autonomous individuals perceive themselves as providing positive dyadic coping and their partners as engaging in negative dyadic coping.

Toru and Gonzales (2006) based on research conducted on non-clinical samples of undergraduate students suggested that highly autonomous individuals display more socially avoidant and unresponsive behaviors than individuals low in autonomy. Based on these results, it could be argued that highly autonomous individuals may report lower positive dyadic coping by self; however, results from the current study did not find such associations. Furthermore, highly autonomous individuals reported higher fear of receiving compassion from others (Gilbert et al., 2014), which may explain the lack of significant association between autonomy and perceptions of partner positive coping; however, future research is needed to replicate this finding. Lynch and colleagues (2001) studying depressed in-patients and out-patients at a University Medical Center found that those scoring high on autonomy reported themselves as withdrawing while rating their partners as demanding. This may suggest that autonomy may be associated with higher negative dyadic coping by self and higher negative dyadic coping by partner. In the current sample, higher autonomy was associated with higher perceptions of negative dyadic coping by partner in line with expectations based on previous research.

Role of Relationship Commitment

Relationship commitment, defined as the long-term orientation toward the maintenance of the relationship due to increasing dependence between partners (Rusbult, Martz, & Agnew, 1998), has been found to be associated with higher relationship maintenance behaviors (Marion, et al., 2014). As such, it was hypothesized that

relationship commitment will positively moderate the association between sociotropy or autonomy and dyadic coping by oneself and one's partner.

Results showed that there was no significant main effect of relationship commitment on positive dyadic coping by self which is contrary to prior research that suggests that the level of commitment to a relationship influences the motivation of a person to offer more positive dyadic coping (Kuppler and Wagner, 2022). Results showed that there was a significant positive main effect of relationship commitment on perceptions of partner positive dyadic coping, such that higher reported levels of relationship commitment were associated with higher perceptions of partner positive dyadic coping. These results suggest that as relationship commitment increased individuals viewed partner more positively which confirms past research that indicates relationship commitment brings forth the willingness to positively cope dyadically (Marion et al., 2014). Further, there was a significant negative main effect of relationship commitment on negative dyadic coping by self and perceptions of partner negative dyadic coping, such that higher reported levels of relationship commitment were associated with lower perceptions of negative dyadic coping by self and lower perceptions of partner negative dyadic coping. Research that has looked at the role of relationship commitment on negative dyadic coping by self or partner has been scant, but the current results suggest that as relationship commitment increases, individuals view themselves and their partner as engaging is lower levels of negative dyadic coping.

High levels of relationship commitment significantly strengthened the negative association between sociotropy and perceptions of partner positive dyadic coping, whereas low levels of relationship commitment did not moderate the association. This

result is in line with past research by Sato and McCann (2007) on a non-clinical sample of undergraduate students, who found that when highly sociotropic individuals are not close to someone, they may behave in warm and nurturant ways to experience a high level of relatedness with that person. Contrarily, when highly sociotropic individuals are already close to someone and feel that the sense of relatedness can be maintained even without warmth and nurturance, they may behave in demanding, arrogant, calculating, and vindictive ways (Sato and McCann, 2007). Results from the present study suggest that individuals who are high on commitment may demand more from their partners and may perceive them to be less supportive.

Both high and low levels of relationship commitment significantly strengthened the positive association between autonomy and perceptions of positive dyadic coping by self. Based on a study on a non-clinical sample of undergraduate students, Bieling and Alden (2001) suggested that highly autonomous individuals tend to withdraw from social interaction if they feel that a high level of collaboration (i.e., relinquishing personal control) is required. Working with close others such as one's romantic partner requires a high level of collaboration, therefore autonomous individuals may be more likely to withdraw from the interaction, making them more aloof, introverted, and avoidant (Bieling and Alden, 2001). Nevertheless, in the current sample higher autonomy was associated with higher perceptions of positive coping by self, irrespective of relationship commitment.

In the current study, higher autonomy predicted lower levels of perceptions of partner positive dyadic coping, but only for those low on relationship commitment. In a sample of undergraduate students, Campbell and his colleagues (2003) found that highly

autonomous individuals have adjustment problems with family. In a sample of undergraduate students, Mongrain and Zuroff (1994) found that highly autonomous or self-critical individuals make fewer requests for social support and perceive less support than what is available to them. Taken together, the current study results suggest that autonomous individuals may perceive their partner as engaging in less positive coping, in line with prior research.

Finally, higher autonomy predicted higher levels of perceptions of negative dyadic coping by self, and this effect was stronger for those who reported higher relationship commitment. Zuroff and colleagues (2012) found that in a non-clinical sample autonomy predicted higher rates of quarrelsome behavior. In the current study sample, higher perceptions of negative dyadic coping (self) provide support for the argument that highly autonomous individuals engage in negative coping behavior with close others.

Overall, results from the present study shed some light on the dyadic coping behaviors of sociotropic and autonomous individuals. Specifically, both higher levels of sociotropy and autonomy were associated with higher perceptions of positive dyadic coping by self and higher perceptions of partner negative dyadic coping. Further, results showed that there was a significant positive main effect of relationship commitment on perceptions of partner positive dyadic coping and significant negative main effect of relationship commitment on negative dyadic coping by self and perceptions of partner negative dyadic coping. High levels of relationship commitment significantly strengthened the negative association between sociotropy and perceptions of partner positive dyadic coping. Both high and low levels of relationship commitment

significantly strengthened the positive association between autonomy and perceptions of positive dyadic coping by self. Higher autonomy predicted lower levels of perceptions of partner positive dyadic coping for those low on relationship commitment and higher autonomy predicted higher levels of perceptions of negative dyadic coping by self for those higher on relationship commitment.

Limitations

The present study is notwithstanding limitations. First, the study utilized a self-report methodology that relied on participant recall and was retrospective in nature. Furthermore, participants were also able to complete the survey in multiple sittings (vs. all at once). Limitations to self-report measures include the potential for dishonesty, social-desirability bias, and response-shift bias (Rosenman et al., 2011). Additionally, it is important to consider that data this study were collected entirely online. While there are benefits to online research, such as avoidance of experimenter biases (e.g., Reips, 2002), there are potential concerns to consider, such as validity of the data collection as well as the data itself (Schillewaert & Meulemeester, 2005). While primary investigator took additional means in order to address these confounds (e.g., screening survey), it is still important to be aware of the possible limitation of online data collection (e.g., multiple responses, technical error).

It is important to note that the majority of the sample identified as White (63.2%) and cisgender woman (67.7%) which may limit the generalizability of the findings in this study to other samples or the general population of emerging adults. While the results of the study are not anticipated to be different based on racial or ethnic identity, it may be important to analyze the hypothesis for gender diverse and sexual minority individuals

before generalizing the results, which may be a notable next step. The final sample in this study experiencing elevated levels of depression based on their CES-D scores consisted of a significant proportion of sexual minority individuals (55.8%) and gender diverse individuals (20.4%). In the United States, political and social climate impacting the wellbeing of sexual minority and gender diverse individuals has been volatile due to changes in the administration at the federal, state, or municipal level, which have resulted in these individuals' experiencing uncertainty on impending policy changes that may impact their wellbeing (Veldhuis et al., 2018). A limitation of the current study is that it did not assess if there may be a higher incidence of stress and depressive symptoms among the sexual minority and gender diverse population and how these individuals may be coping with these social stressors based on their propensity to endorse sociotropy or autonomy.

It is also important to consider limitations that may exist due to the present study being conducted in the context of the COVID-19 pandemic. The COVID-19 pandemic exacerbated the mental health crisis (Breslau et al., 2021) and research is still lagging on the multiple ways individuals may have coped with the pandemic. The present study did not assess for influences of the pandemic, a potentially significant contributor to participants' symptoms of distress, relationship perceptions, and coping practices, which is a notable limitation.

Lastly, this study utilized cross-sectional data from one partner in a romantic relationship, which may limit the validity of the present study due to understanding one partner's perceptions alone. Much of the literature on understanding moderating associations of dyadic coping have been examined within a dyadic context (see Falconier

et al., 2015, for a review). By collecting data from both partner reports, researchers are able to assess both actor (effects of perceived DC on own reported outcomes) and partner (effects of actual reported DC on their partner's outcomes) effects. Researchers can then compare these perceptions of partner to self-report from the partner, which may lead to a better understanding of how the couple copes with the stressor. Collecting dyadic data on personal characteristics such as sociotropy or autonomy, relationship commitment and dyadic coping of the partners to examine how personal characteristics of both partners influence their perceptions of dyadic coping based on their respective commitment is a notable area for future research.

Future Directions

Despite its limitations, this study offers promising directions for future research. First, this is one of the few studies that has examined personality characteristics such as sociotropy or autonomy and perceptions of dyadic coping. Having such data is important because it allows researchers and clinicians working with couples to enhance their relationship functioning to cope with depressive symptoms or buffer against vulnerabilities for depression. Further, while data for this study was collected during a notable area wherein many were experiencing elevated symptoms of psychological distress (APA, 2022), this study did not directly assess the level of stress or the sources of stress that emerging adults are experiencing; having such information may shed light on how emerging adults coping with romantic partners when experiencing specific stressors.

The interaction of life events on personal characteristics may inform how couples cope (Hamidou et al, 2018; Wang et al., 2020). Particularly, it may be informative to examine how a large scale stressful social situation, such as a pandemic, may be

associated with perceptions of partner's coping behaviors based on individual vulnerabilities. Also, it is important to consider additional populations (e.g., demographic differences such as race, religion, sexual identity, etc.) who may experience additional levels of stress per APA's guideline that one's research take into consideration historically marginalized groups and the entire human experience, while being mindful about who is conducting the research and the potential for study bias (Santoro, 2023).

While the findings of this study provide a glimpse into the romantic relationship experiences of emerging adults experiencing elevated levels of depressive feelings, they are unable to provide a comprehensive exploration of perspectives. As such, it would be helpful to consider qualitative methods of data collection such as dyadic stress conversations or interviews with individuals in romantic relationships that would allow for an in-depth investigation of current experiences of stress, impact of depressive feelings in their functioning in romantic relationships, relationship patterns such as couple coping based on personality characteristics. The use of qualitative methods allows for greater depth when it comes to people's attitudes and experiences (Griffin, 2004). Teasing apart the influence of personality characteristics such as sociotropy or autonomy could further help identify the influence of personal characteristics on specific components of dyadic coping.

A longitudinal, dyadic, mixed methods approach could be utilized to study changes in experiences of stress over time, the associated changes in depressive feelings, the couple's dyadic coping, and commitment based on their personal characteristics utilizing both quantitative and qualitative methods. Studying both partners in a romantic relationship across time can shed light on the dynamics that may lead to stress

exacerbation or amelioration based on personal characteristics as well as external events. The results from such a study can inform strategies for mental health practitioners to enhance couple coping in the face of stress to decrease depressive symptoms and improve resilience as well as relationship satisfaction.

Conclusion and Implications for Counselors

First, mental health practitioners must take note that in the current global context, emerging adults are experiencing elevated levels of stress which may lead to depressive symptoms (APA, 2022). Second, it is important to consider that personal characteristics are linked to individual coping because personal characteristics influences the type of events experienced, which in turn influence coping (Bouchard et al., 2004; Penley & Tomaka, 2002). Further, personal characteristics emanate from core beliefs of the self and the world which are important to consider (Beck, 1983). Third, for those in romantic relationships, the current study highlights those personal characteristics such as sociotropy and autonomy that may influence dyadic coping, which may in-turn influence well-being. Therefore, for mental health practitioners offering individual as well as couple counseling, it would be important to take into consideration personal characteristics and couple coping.

Healthy relationship with one's romantic partner when facing stress can positively impact well-being such as physical and mental health (e.g., Shmaling & Goldman-Sher, 2000; McShall, 2015). Additionally, dyadic coping has been shown to be effective in treatment of relationship distress (Randall et al., 2010). Mental health practitioners may utilize intervention programs focused on preventing and alleviating stress between partners, such as the Couples Coping Enhancement Training (CCET; Bodenmann &

Shantinath, 2004). The CCET focuses on developing six areas for couples in order to improve couple relationship: knowledge of stress and coping, improvement of individual coping, enhancement of dyadic coping, exchange and fairness in the relationship, improvement of communication, improvement of problem-solving skills (Bodenmann & Shantinath, 2004). Further, with the understanding that perception of self and partner's dyadic coping is associated with one's own symptoms of distress (Regan et al., 2014), components of CCET may be useful in individual counseling as well.

Coping-Oriented Couples Therapy (COCT; Bodenmann, et al., 2009) is based in cognitive behavioral marital therapy, based on the systemic-transactional model (Bodenmann, 1997) that highlights working with techniques in communication and problem solving. COCT has been shown to be an effective means of lowering psychological distress as well as producing significant improvements in partners' expressed emotions in couples where one partner was clinically depressed (Bodenmann et al., 2009). A main goal of COCT is to foster a better understanding of individual as well as joint stress reactions and how to cope more effectively (Bodenmann et al., 2009). While COCT has been identified as a couples' therapy (Bodenmann et al., 2009), there are components of this approach that may be beneficial in individual counseling. These components are similar to those found in CCET, such as teaching clients about the systemic approach to stress communication. This systemic approach to stress communication acknowledges and teaches couples about the give-and-take influence of the stress and coping process that partners undergo in order to deal with stressors. Depressed as well as non-depressed emerging adults may benefit from understanding individual and joint stress reactions and learn to cope with stressors more effectively.

Other than the clinical implications of considering personal characteristics and dyadic coping in the treatment of depressive symptoms for emerging adults, implications of this work also include future directions for research that may look into the dyadic experiences of stress, depressive symptoms, and coping over time to understand the relationship dynamics of sociotropic and autonomous individuals leading to stress exacerbation or amelioration.

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APPENDIX A

TABLES AND FIGURES

Table 1. *Sociodemographic characteristics of participants*

Demographic		**N**	**%**
Gender Identity			
	Cisgender man	32	11.90
	Cisgender woman	182	67.70
	Gender fluid	1	0.40
	Gender queer	1	0.40
	Non-binary	33	12.30
	Transfeminine	1	0.40
	Transgender man	11	4.10
	Transgender woman	1	0.40
	Transmasculine	3	1.10
	Different identity	2	0.70
Sexual Orientation			
	Asexual	13	4.80
	Bisexual	67	24.90
	Demisexual	4	1.50
	Gay	6	2.20
	Heterosexual	119	44.20
	Lesbian	8	3.00
	Pansexual	21	7.80
	Queer	27	10.00
	Different Identity	3	1.10

Race			
	Asian American	23	8.60
	Black	25	9.30
	Hispanic	28	10.40
	Multi-racial	18	6.70
	Non-Hispanic White	170	63.20
	Different Identity	5	1.90
Education			
	Graduate degree	49	18.20
	High school	16	5.90
	Professional program	6	2.20
	Some college	68	25.30
	Undergraduate degree	130	48.30
Feeling secure about financial future			
	Completely	21	7.80
	Not at all	19	7.10
	Somewhat	119	44.20
	Very little	59	21.90
	Very well	51	19.00
Relationship Status			
	Engaged	27	10.00
	Committed relationship	197	73.20

	Married	43	16.00
	Other	2	0.70
Cohabitating			
	Yes	143	53.20
	No	126	46.80
Children			
	Yes	13	4.80
	No	256	95.20

Table 2. *Descriptive, skewness, and kurtosis values for study variables*

Variable	Mean	Std Dev	Skewness	Kurtosis
CES-D score	28.83	9.57	.92	.18
Self-Stress Communication	4.11	.80	-.87	.36
Partner-Stress Communication	3.69	.95	-.64	-.08
Rel Length in months	41.94	30.40	1.01	.56
Sociotropy	65.85	15.65	-.20	-.19
Autonomy	62.77	11.43	.01	-.35
Self-Positive DC	3.85	.52	-.03	-.37
Partner-Positive DC	3.79	.71	-.64	.36
Self-Negative DC	1.72	.65	1.51	3.11
Partner-Negative DC	1.90	.86	1.32	1.34
Rel Commitment	50.35	8.13	-1.74	2.89

Note. Rel = relationship; DC = dyadic coping

Table 3. *Correlations among study variables*

Cor	1	2	3	4	5	6	7	8	9	10	11
CESD	1										
S-Str	-.09	1									
Com											
P-Str	-.24*	.29*	1								
Com											
R Len	.02	.04	-.10	1							
Socio	.22*	.08	-.05	-.03	1						
Auton	.06	.03	.14	.01	-.26*	1					
S Po DC	.06	.42*	.36*	.01	.09	.25*	1				
P Po DC	-.19*	.48*	.48*	.05	.04	-.01	.37*	1			
S Ne DC	.05	-.19*	-.18*	-.04	.04	.09	-.15	-.18*	1		
P Ne DC	.21*	-.28*	-.40*	-.03	.07	.19*	-.09*	-.58*	.53*	1	
Rel Cmt	-.13	.24*	.16*	.16	.14	-.15	.16*	.41*	-.30*	-.39*	1

Note. CESD = CES-D Depression score. Cor = Correlations. Com = Communication. S = Self. P = Partner. Po = Positive. N = Negative. R = relationship. DC = dyadic coping. Cmt = Commitment. Str = Stress. Socio = Sociotropy. Auton = Autonomy. *Correlation is significant at the 0.01 level (2-tailed).

Table 4. *Model 1 - Regression with positive dyadic coping by self as the outcome*

Effect	Standardized Coefficient - Beta	*t*	Sig.
Control			
Partner Stress Comm	.33	5.48	<.00**
Rel Length	.03	.46	.65
Autonomy	.27	4.37	<.00**
Independent Variable			
Sociotropy	.14	2.26	.03*
Moderator			
Rel Commit	.10	1.67	.10
Interaction			
Sociotropy * Rel Commit	-.03	-.58	.56

Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.22	.20	10.78	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Table 5. *Model 2 - Regression with perceptions of partner positive dyadic coping as the outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Self-Stress Comm	.46	8.38	<.00**
Rel Length	-.02	-.33	.74
Autonomy	-.03	-.56	.57
Independent Variable			
Sociotropy	-.02	-.31	.76
Moderator			
Rel Commit	.26	4.57	<.00**
Interaction			
Sociotropy * Rel Commit	-.12	-2.22	.03*
Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.35	.34	21.40	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Table 6: *Model 3 - Regression with negative dyadic coping by self as outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Partner Stress Comm	-.15	-2.28	.02*
Rel Length	-.01	-.19	.85
Autonomy	.07	1.13	.26
Independent Variable			
Sociotropy	.08	1.24	.22
Moderator			
Rel Commit	-.27	-4.07	<.00**
Interaction			
Sociotropy * Rel Commit	-.07	-1.11	.27
Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.11	.08	4.71	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Table 7: *Model 4 - Regression with perceptions of partner negative dyadic coping as outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Self-Stress Comm	-.22	-3.70	<.00**
Rel Length	.04	.67	.50
Autonomy	.23	3.82	<.00**
Independent Variable			
Sociotropy	.16	2.62	.01*
Moderator			
Rel Commit	-.33	-5.32	<.00**
Interaction			
Sociotropy * Rel Commit	.01	.19	.85
Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.24	.22	12.62	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Table 8: *Model 5 - Regression with positive dyadic coping by self as outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Partner Stress Comm	.32	5.48	<.00**
Rel Length	.03	.57	.57
Sociotropy	.13	2.20	.02*
Independent Variable			
Autonomy	.25	4.16	<.00**
Moderator			
Rel Commit	.16	2.50	.01*
Interaction			
Autonomy * Rel Commit	-.13	-2.10	.04*

Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.23	.21	11.64	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Table 9: *Model 6 - Regression with perceptions of partner positive dyadic coping as outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Self-Stress Comm	.45	8.32	<.00**
Rel Length	-.02	-.40	.69
Sociotropy	-.02	-.28	.78
Independent Variable			
Autonomy	-.02	-.32	.75
Moderator			
Rel Commit	.23	3.73	<.00**
Interaction			
Autonomy * Rel Commit	.13	2.28	.02*
Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.35	.34	21.47	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Table 10: *Model 7 - Regression with negative dyadic coping by self as outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Partner Stress Comm	-.14	-2.24	.03*
Rel Length	-.02	-.28	.78
Sociotropy	.08	1.30	.19
Independent Variable			
Autonomy	.90	1.38	.17
Moderator			
Rel Commit	-.32	-4.62	<.00**
Interaction			
Autonomy * Rel Commit	.17	2.44	.02*

Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.12	.10	5.58	<.00

Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

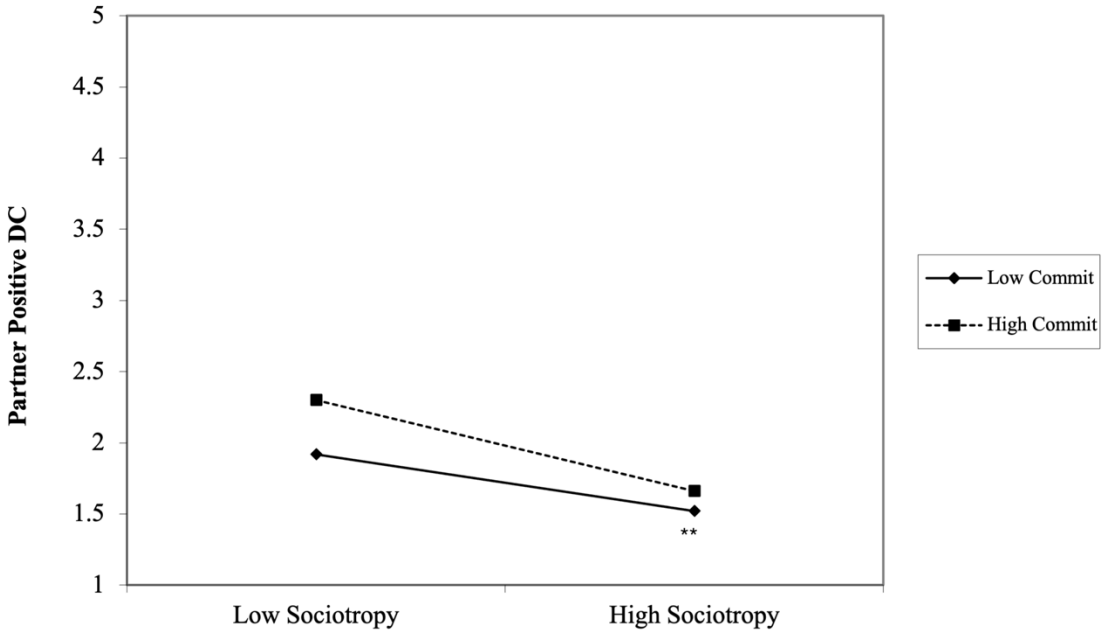
Table 11: *Model 8 - Regression with perceptions of partner negative dyadic coping as outcome*

Effect	Standardized Coefficient - Beta	t	Sig.
Control			
Self-Stress Comm	-.22	-3.75	<.00**
Rel Length	.04	.72	.48
Sociotropy	.15	2.61	.01*
Independent Variable			
Autonomy	.22	3.71	<.00**
Moderator			
Rel Commit	-.30	-4.59	<.00**
Interaction			
Autonomy * Rel Commit	-.06	-1.00	.32

Model Summary		ANOVA	
R2	Adjusted R2	F statistic	Sig.
.25	.23	12.83	<.00

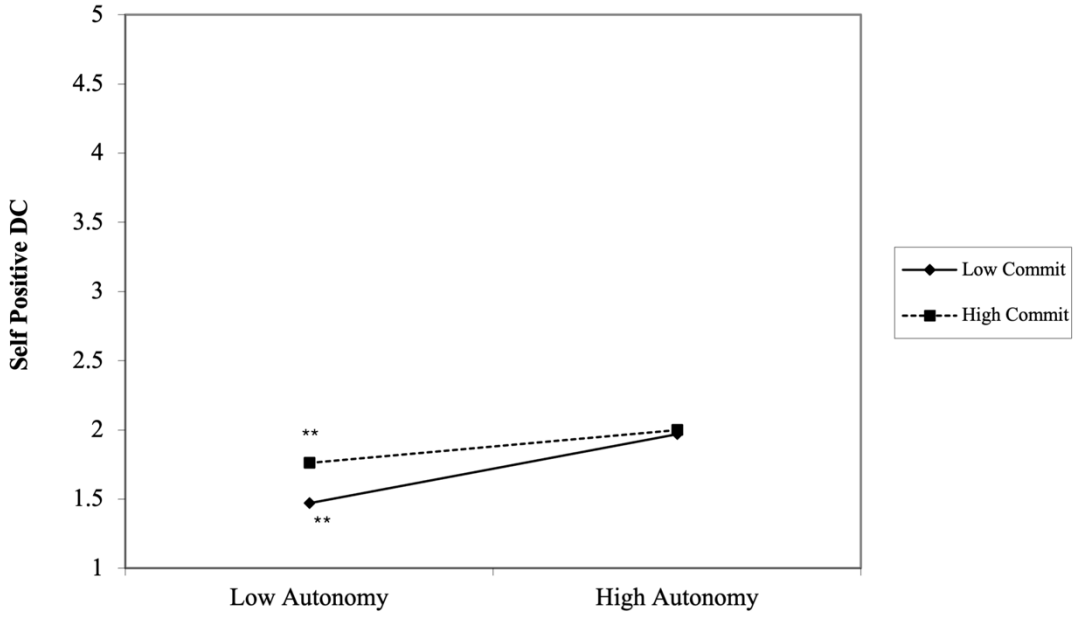
Note. Rel = relationship. Comm = communication. Commit = commitment. ** significant at the 0.001 level (2-tailed), * significant at the 0.05 level (2-tailed).

Figure 1. Relationship commitment moderates the negative association between sociotropy and perceptions of partner positive dyadic coping.



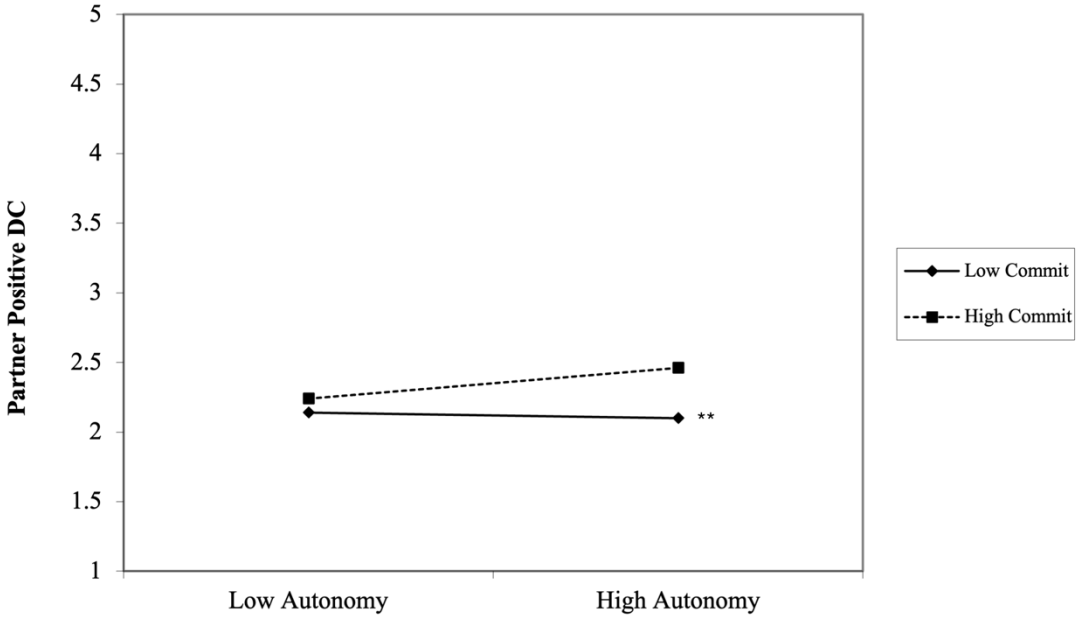
Note. DC = Dyadic coping. Commit = Relationship commitment. ** = significant slope.

Figure 2. Relationship commitment moderates the association between autonomy and perceptions of positive dyadic coping by self.



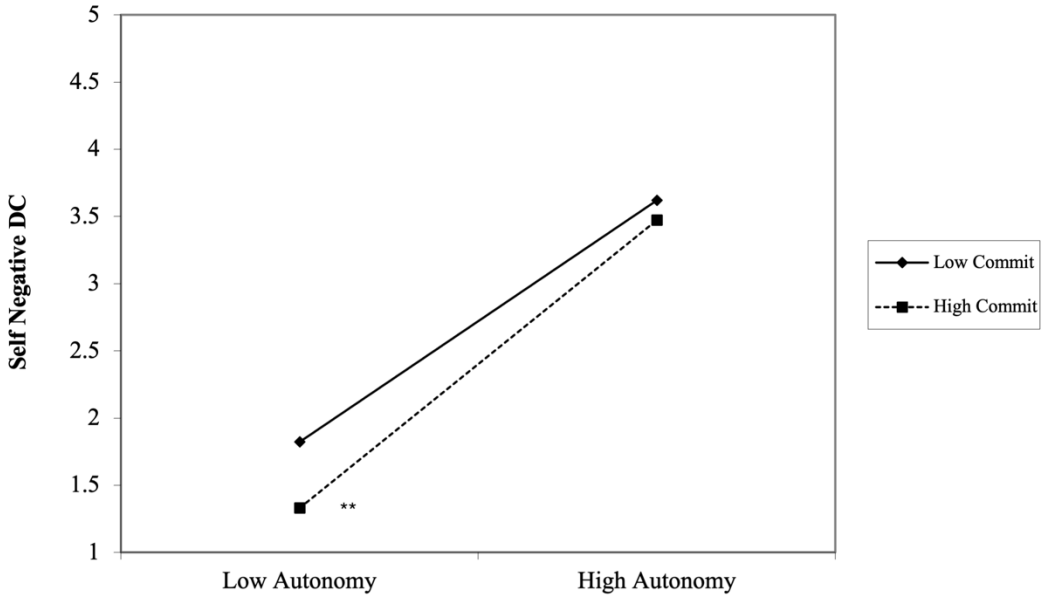
Note: DC = Dyadic coping. Commit = Relationship commitment. ** = significant slope.

Figure 3. Relationship commitment moderates the association between autonomy and perceptions of partner positive dyadic coping.



Note: DC = Dyadic coping. Commit = Relationship commitment. ** = significant slope.

Figure 4. Relationship commitment moderates the association between autonomy and perceptions of negative dyadic coping by self.



Note: DC = Dyadic coping. Commit = Relationship commitment. ** = significant slope.

APPENDIX B

SCREENING QUESTIONNAIRE

1. Are you at least 18 years of age? Y/N

2. Have you been in your current romantic relationship for at least 2 months? Y/N

*If participants indicate “No” on questions 1-2 they will be ineligible and directed to the end of the survey wherein they will be provided a list of national Mental Health resources.

APPENDIX C

DEMOGRAPHICS

1. How old are you?

    a. _____ years

    b. _____ months

2. What is your gender identity? (Check all that apply)

    a. Man

    b. Woman

    c. Transgender man

    d. Transgender woman

    e. Non-binary

    f. Transmasculine

    g. Transfeminine

    h. Agender

    i. Gender fluid

    j. Gender queer

    k. Different identity

3. If you could only select ONE label for your sexual orientation, which would you choose? (Note: This is for data collection purposes only and is not intended to invalidate your sexual orientation(s))

    a. Asexual

    b. Bisexual

    c. Demisexual

    d. Gay

    e. Heterosexual

f. Lesbian

g. Pansexual

h. Queer

i. Different identity

4. Which best describes your racial background:

a. Asian American

b. Black/African American

c. Hispanic or Latin American origin

d. Native American/American Indian

e. Native Hawaiian or Pacific Islander

f. Non-Hispanic White

g. Multiracial

h. Different identity

5. What is your typical yearly individual income before taxes?

a. $0 - $24,999

b. $25,000 - $ 49,999

c. $50,000 - $74,999

d. $75,000 - $ 99,999

e. $100,000 - $149,999

f. $150,000 or more

6. What is the highest level of education you have completed?

a. Less than high school

b. High school

c. Professional program

d. Some college

e. Undergraduate degree

f. Graduate degree

g. Other

7. Are you currently a student?

a. Yes; 2-year college

b. Yes; 4-year college

c. Yes; Graduate student

d. No

8. Are you currently in any romantic relationships?

a. Yes, just one.

b. Yes, more than one.

c. No.

Note: For option B: Skip logic will be entered into Qualtrics to display the following: For the remainder of the survey, please choose ONE of your relationships when answering questions related to a romantic relationship and/or your partner. That is, please do not respond to these types of questions with multiple relationships/partners in mind. Please note, this is in no way intending to invalidate your other relationships, rather this is a way to best assess our research question.

9. What is your relationship status?

a. In a committed relationship

b. Engaged

c. Married

d. Other

10. Do you currently live in the same home as your partner?

a. Yes

b. No

11. How long have you and your partner been in a romantic relationship together?

a. Years _____

b. Months _____

12. If you are married to your significant other, how long have you and your significant other been married?

a. Years _____

b. Months _____

13. Do you have any children (under 18) living at home full time?

a. Yes

b. No

14. How old is your partner?

a. _____ years

b. _____ month

15. What is your partner's gender identity? (Check all that apply)

a. Man

b. Woman

c. Transgender man

d. Transgender woman

e. Non-binary

f. Transmasculine

g. Transfeminine

h. Agender

i. Gender fluid

j. Gender queer

k. Different identity

16. If you could only select ONE label for your sexual orientation, which would you choose? (Note: This is for data collection purposes only and is not intended to invalidate your sexual orientation(s))

a. Asexual

b. Bisexual

c. Demisexual

d. Gay

e. Heterosexual

f. Lesbian

g. Pansexual

h. Queer

i. Different identity

17. Which best describes your partner's racial background:

a. Asian American

b. Black/African American

c. Hispanic or Latin American origin

d. Native American/American Indian

e. Native Hawaiian or Pacific Islander

f. Non-Hispanic White

g. Multiracial

h. Other _____

18. Did your partner already participate in the survey?

a. Yes

b. No

c. Don't know.

APPENDIX D

RESEARCH SURVEY

Center for Epidemiologic Studies Depression (CES-D; Radlof, 1977)

Directions

Below is a list of some ways you may have felt or behaved. Please indicate how often you have felt this way during the last week by checking the appropriate space. Please only provide one answer to each question. During the past week:

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
14. I felt lonely.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.

18. I felt sad.

19. I felt that people disliked me.

20. I could not get going.

Scaling

Items are scored as: 0 - Rarely (Less than 1 day), 1 - Some (1-2 days), 2 - Occasionally (3-4 days), and 3 - Most (5-7 days)

Scoring

The score is the sum of the 20 questions. Questions 4, 8, 12, and 16 are reverse scored. Possible range is 0-60. If more than four questions are missing answers, do not score the CES-D questionnaire. A score of 16 points or more is considered depressed.

Sociotropy – Autonomy Scale (Beck, 1983)

Directions

Please indicate what percentage of the times each of the statements below applies to you, by using the scale to the left of the items. Choose the percentage that comes closest to how often the item describes you.

1. I feel I have to be nice to other people. S

2. It is important to me to be free and independent. A

3. It is more important that I know I've done a good job than having others know it. A

4. I enjoy doing things more when I am with other people. S

5. I am afraid of hurting other people's feelings. S

6. It bothers me when people try to direct my behavior or activities. A

7. I find it difficult to say "no" to people. S

8. I feel bad if I do not have some social plans for the weekend. S

9. I like being a unique individual more than being a member of a group. A

10. When I feel sick, I like to be left alone. A

11. I am concerned that if people knew my faults or weaknesses, they would not like me. S

12. If I think I am right about something, I feel comfortable expressing myself even if others don't like it. A

13. When visiting people, I get fidgety just sitting around talking and would rather get up and do something. A

14. It is more important to meet your own goals on a task than to meet another person's goals. A

15. I do things that are not in my best interest in order to please others. S

16. I like to take long walks by myself. A

17. I am more concerned that people like me than I am about making important achievements. S

18. I would be uncomfortable dining out in a restaurant by myself.

19. I don't enjoy myself when I feel that someone in my life doesn't really care about me.

20. I am not influenced by others in what I decide to do. A

21. It is very important that I feel free to get up and go wherever I want. A

22. I value work accomplishments more than I value making friends. A

23. I find it important to be in control of my emotions. A

24. I get uncomfortable when I am not sure how I am expected to behave in front of others. S

25. I feel more comfortable helping others than receiving help. A

26. It would not be much fun for me to travel to a new place all alone. S

27. If a friend has not called for a while, I get worried that he or she has forgotten me.

28. It is more important to be active and doing things than being close with other people. A

29. I get uncomfortable around a person who clearly does not like me. S

30. If a goal is important to me, I try for it even if it makes other people uncomfortable. A

31. I find it difficult to be separated from people I love. S

32. When I achieve a goal, I get more satisfaction from achieving the goal than from praise I might get from others. A

33. I am careful about what I say because I am concerned that others may disapprove or disagree. S

34. I get lonely when I am home by myself at night. S

35. I often find myself thinking about friends or family. S

36. I prefer to make my own plans, so I am not controlled by others. A

37. I can comfortably be by myself all day without feeling a need to have someone around.

38. If somebody criticizes how I look, I feel I am not attractive to other people. S

39. It is more important to get a job done than to worry about other people's reactions. A

40. I like to spend my free time with others. S

41. I don't like to answer personal questions because it feels like an invasion of my privacy. A

42. When I have a problem, I like to go off on my own and think it through rather than being influenced by others. A

43. In relationships, people often are too demanding of each other. A

44. I am uneasy when I cannot tell whether or not someone, I've met likes me. S

45. I set my own standards and goals for myself rather than accepting those of other people. A

46. I apologize to others more than I need to. S

47. It is important for me to be liked and approved by others. S

48. I enjoy accomplishing things whether or not I get credit for them. A

49. Having close ties with other people makes me feel secure. S

50. When I am with other people, I look for signs of whether or not they like being with me. S

51. I like to go off on my own, exploring new places – without other people. A

52. If I think somebody may be upset at me, I want to apologize. S

53. I like to be certain that there is somebody close can contact in case something unpleasant happens to me. S

54. I feel trapped when I have to sit through a long meeting. A

55. I don't like people to invade my privacy. A

56. I feel uncomfortable when I feel I am not like everyone else. S

59. I worry that somebody I love will die. S

58. The worst part about growing old is being left alone. S

60. The possibility of being rejected by others for standing up for my rights would not stop me. A

57. The worst part about being in jail would be not being able to move around freely. A

Scaling

To score each scale, assign points to the individual's responses as follows:

Response	Points
0%	0
25%	1
50%	2
75%	3
100%	4

Scoring

The following 30 items comprise the Sociotropy scale:

1,4,5,7,8,11,15,17,18,19,24,26,27,29,31,33,34,35,38,40,44,46,47,49,50,52,53,56,58,59

The following 30 items comprise the Autonomy Scale:

2,3,6,9,10,12,13,16,20,21,22,23,25,28,30,32,36,37,39,41,42,43,45,48,51,54,55,57,60

14

Compute an arithmetic sum for the Sociotropy items, and another for the autonomy items.

Dyadic Coping Inventory – English Version (Randall et al., 2016)

Directions

The next questions are designed to measure how you and your partner cope with stress.

Please indicate the first response that you feel is appropriate. Please be as honest as possible.

This section is about how YOU communicate your stress to your partner.

1. I let my partner know that I appreciate his/her practical support, advice, or help

2. I tell my partner openly how I feel and that I would appreciate his/her support.

This section is about what YOUR PARTNER does when you are feeling stressed.

3. My partner shows empathy and understanding.

4. My partner expresses that he/she is on my side.

5. My partner blames me for not coping well enough with stress.

6. My partner helps me to see stressful situations in a different light.

7. My partner does not take my stress seriously.

8. My partner provides support, but does so unwillingly and without enthusiasm.

9. My partner takes on things that I normally do in order to help me out.

10. My partner helps me analyze the situation so that I can better face the problem.

11. When I am too busy, my partner helps me out.

12. When I am stressed, my partner tends to withdraw.

This section is about how YOUR PARTNER communicates when he/she is feeling stressed.

13. My partner lets me know that he/she appreciates my practical support, advice, or help.

14. My partner tells me openly how he/she feels and that he/she would appreciate my support

This section is about what YOU do when your partner is stressed.

15. I show empathy and understanding.

16. I express to my partner that I am on his/her side.

17. I blame my partner for not coping well enough with stress.

18. I tell my partner that his/her stress is not that bad and help him/her to see the situation in a different light.

19. I do not take my partner's stress seriously.

20. When my partner is stressed, I tend to withdraw.

21. I provide support but do it so unwillingly and without enthusiasm because I think that he/she should cope with his/her problems on his/her own.

22. I take on things that my partner would normally do in order to help him/her out.

23. I try to analyze the situation together with my partner in an objective manner and help

him/her to understand and change the problem.

24. When my partner feels he/she has too much to do, I help him/her out.

This section is about what YOU and YOUR PARTNER do when you are both feeling stressed.

25. We try to cope with the problem together and search for shared solutions.

26. We engage in a serious discussion about the problem and think through what has to be done.

27. We help one another to put the problem in perspective and see it in a new light.

28. We help each other relax with such things like massage, taking a bath together, or

listening to music together.

29. We are affectionate to each other, make love and try that way to cope with stress.

This section is about how you evaluate your coping as a couple.

30. I am satisfied with the support I receive from my partner and the way we deal with stress together.

31. I am satisfied with the support I receive from my partner, and I find as a couple, the way we deal with stress together is effective.

Scaling

1=Very Rarely

2=Rarely

3=Sometimes

4=Often

5=Very Often

Scoring the DCI-Revised Version

Dyadic Coping by Self:

Stress Communication - Items 1, 2

Supportive Dyadic Coping:

Emotion-Focused - Items 15, 16

Problem-Focused - Items 18, 23

Delegated Dyadic Coping - Items 22, 24

Negative Dyadic Coping - Items 17, 19, 20, 21

Dyadic Coping by Partner:

Stress Communication - Items 13, 14

Supportive Dyadic Coping:

Emotion-Focused - Items 3, 4

Problem-Focused - Items 6, 10

Delegated Dyadic Coping - Items 9, 11

Negative Dyadic Coping - Items 5, 7, 8, 12

Note: r = reverse code.

APPENDIX E

IRB APPROVAL

APPROVAL:
MODIFICATION

Ashley Randall

CISA: Counseling and Counseling Psychology 480/727-5312

Ashley.K.Randall@asu.edu

Dear Ashley Randall:

On 8/10/2022 the ASU IRB reviewed the following protocol:

Type of Review:	Modification / Update
Title:	The Association Between Sociotropy – Autonomy and Dyadic Coping and Relationship Commitment as a Potential Moderator
Investigator:	Ashley Randall
IRB ID:	STUDY00016088
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• IRB Social Behavioral 2019 Thesis_Ver3docx.docx, Category: IRB Protocol; • Research Match Email.pdf, Category: Recruitment Materials;

The IRB approved the modification.

When consent is appropriate, you must use final, watermarked versions available under the "Documents" tab in ERA-IRB.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

REMINDER - Effective January 12, 2022, in-person interactions with human subjects require adherence to all current policies for ASU faculty, staff, students and visitors. Up- to-date information regarding ASU's COVID-19 Management Strategy can be found here. IRB approval is related to the research activity involving human subjects, all other protocols related to COVID-19 management including face coverings, health checks, facility access, etc. are governed by current ASU policy.

Sincerely,

IRB Administrator

cc: Yuvamathi Gandhi
Yuvamathi Gandhi