ABSTRACT

Title of Thesis:	SELF-COMPASSION AMONG WOMEN WITH ABUSE EXPERIENCES: THE ROLE OF SOCIAL SUPPORT
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Intimate partner violence (IPV) is a widespread issue that impacts the physical and mental health of its survivors. Because of the severity of the outcomes, it is important that clinicians understand potential risk and protective factors in regards to providing the best outcomes for their clients. Under the framework of the stress-buffering hypothesis, this study explored the impact of IPV on a woman's self-compassion, as well as on the impact of social support as a moderating variable. It was hypothesized that higher levels of IPV would be associated with lower levels of self-compassion among women with experiences of IPV. In addition, social support will weaken the impact IPV has on an individual's self-compassion. Data collected from a sample of women in abusive relationships *(n=61)* was analyzed using a linear regression and a test for moderation. Results indicated that there was no significant association between IPV and self-compassion. However, the interaction between IPV and social support tended towards significance. Contrary to the second hypothesis, among women with higher levels of social support, an increase in IPV was associated with lower levels of self-compassion. Implications for clinical practice when working with this population are discussed.

SELF-COMPASSION AMONG WOMEN WITH ABUSE EXPERIENCES: THE ROLE OF

SOCIAL SUPPORT

By

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Chapter 1: Introduction

Statement of the Problem

Intimate partner violence (IPV) is an important public health issue in the United States (U.S.). While both males and females can be perpetrators and victims of IPV, the numbers are disproportionate, with women more likely to be in the position of the latter (Breiding, Chen, & Black, 2014). Over one-third (nearly 36%) of U.S. women report experiences of IPV in the form of rape, physical violence, or stalking by intimate partners during their lifetime (Black et al., 2011; Breiding et al., 2014), and many more are victims to other types of abuse, including verbal, emotional, or financial. While more difficult to measure, it is estimated that nearly half (48.4%) of women in the U.S. have experienced an act of psychological aggression from their partner (Breiding et al., 2014).

IPV is a serious issue due to its prevalence and its impact on women's health. Women who have experienced IPV are more likely to be diagnosed with physical health conditions such as gastrointestinal disorders, sexually transmitted diseases, and chronic pain (Breiding et al., 2014; Dillon, Hussain, Loxton, & Rahman, 2013). These women are also more likely to engage in behaviors that could adversely affect their health, such as substance abuse and risky sexual acts (Breiding et al., 2014; Karakurt, Smith, & Whiting, 2014).

In addition, women with experience of IPV are at higher risk for having poor mental health as compared to women with no experiences of IPV. Depression, posttraumatic stress disorder (PTSD), anxiety, suicide, self-harm, and other forms of psychological distress are common among women who have experienced IPV (Breiding et al., 2014; Dillon et al., 2013).

Approximately half (51.4%) of women with an abusive relationship history have a depressive disorder (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). A study by Mertin and Mohr (2000) observed that approximately 45% of women in abusive relationships met diagnosable criteria for PTSD. Overall, this population is two to three times more likely to be diagnosed with PTSD than women who are in non-abusive relationships (Dillon et al., 2013). Suicide ideation and attempts are more prevalent among women who have experienced IPV (Dillon et al., 2013). Negative mental health outcomes in this population are too common to be ignored by researchers, clinicians, and other professionals working with those with experiences of IPV.

While significant gains have been made in victim-based services, we still do not fully understand the pathways linking IPV to poor mental health. However, researchers have identified several risk factors that may lead to the development of psychopathology in this population. Experience of childhood abuse is associated with symptoms of anxiety and PTSD in women experiencing IPV (Becker, Stuewig, & McCloskey, 2010; Shaikh, Pearce, & Yount, 2017). According to McFarlane, Nava, Gilroy, and Maddoux (2015), women who return to their abuser have a higher risk of developing poor mental health outcomes compared to women who do not return once they have left a violent relationship. Fear of past abusive partners significantly impacts development of PTSD symptoms, perhaps even more so than childhood abuse or current IPV (Jaquier & Sullivan, 2014). Overall, higher frequency and intensity of abuse put women more at risk for more severe mental health outcomes (Dillon et al., 2013).

One of the most researched risk factors for poor mental health outcomes among those with histories of IPV are negative coping responses, such as shame and self-blame. Women who experience IPV may feel shame about their situation (Buchbinder & Eisikovits, 2003). Shame has the potential to lead into self-criticism and blame, which may increase vulnerability for poor

mental health outcomes (Gilbert & Procter, 2006). Some women use self-blame as a coping mechanism while in psychologically abusive relationships. However, research findings show that even when self-blame seems positive for these women in the relationship by helping them not trigger the perpetrator, it leaves them at risk for developing negative mental health outcomes (Flicker, Cerulli, Swogger, & Talbott, 2012). While self-blame can be an effective tool to decrease conflict in IPV situations by deescalating the abusive partner's reactivity, it can have lasting impact on the woman by being internalized (Tesh, Learman, & Pulliam, 2013). Self-blame is associated with increased risk of post-traumatic stress disorder (PTSD), depression, anxiety, and other poor mental health outcomes (Tesh et al., 2013).

In order to reduce the impact of IPV on mental health outcomes among women with histories of abuse, interventions being provided to this population must address risk factors for adverse mental health outcomes and enhance protective factors that can buffer the impact of IPV. Most domestic violence programs and shelters primarily focus on addressing physical needs of survivors, providing food, emergency housing, and financial assistance (Tesh et al., 2013). There are some that offer both individual and group counseling, but there is little consistent research on the theoretical orientations and interventions used in these settings (Tesh et al., 2013).

One potential protective factor against negative mental health outcomes that has not received much attention is self-compassion. Self-compassion can be defined as an experience of providing caring toward oneself in moments of suffering (Neff, 2003). The concept of self-compassion has three main components: self-kindness, mindfulness, and common humanity. The most central aspect of self-compassion is treating oneself kindly in difficult moments (Neff, 2003). This requires a lack of self-criticism and the understanding that one's worth does not decrease due to failure (Valdez & Lilly, 2016). Self-compassion also includes approaching one's

own feelings of inadequacy with radical acceptance and non-judgmental acknowledgement (Neff, 2003; Valdez & Lilly, 2016). This mindfulness is helpful in ensuring that individuals do not over identify with their experience. The final aspect is having the understanding that everyone experiences suffering or difficult moments (Neff, 2003). These difficult moments should connect one to the common human experience, rather than lead to isolation.

While there is a lack of studies on self-compassion among women with exposure to IPV, there is a small body of literature on the positive effects of self-compassion among people dealing with eating disorders (Kelly & Carter, 2015; Kelly & Tasca, 2016; Taylor, Daiss, & Krietch, 2015), depression (Chung, 2016; Ehret et al., 2015; Koerner et al., 201; Muris et al., 2015; Stolow et al., 2016), psychological trauma (Hiroka et al., 2015; Maheux & Price, 2015; Seligowski, Miron, & Orcutt, 2014), and other mental health outcomes (Muris & Petrocchi, 2017; Trompetter et al., 2017; Yang & Mak, 2016). Several studies have investigated the relationship between self-compassion and negative emotional responses; higher self-criticism among people with depression is associated with lower levels of self-compassion (Ehret et al., 2015). In addition, self-compassion has been found to increase well-being and decrease feelings of guilt in survivors of trauma (Hiroka et al., 2015; Seligowski et al., 2014). Self-compassion has also been shown to lower experiences of shame, most notably in populations with eating disorders (Kelly & Tasca, 2015).

As aforementioned, there is evidence documenting the positive impact of self-compassion in populations with various mental health disorders. However, there has been little research on self-compassion among women with histories of IPV. Because of IPV's negative impact on overall mental health and self-compassion's ability to be a protective factor, the relationship between the two could have implications for future work with this population.

Further, it would be important to study factors that might enhance or reduce self-compassion among these women. Social support is a buffer against poor mental health outcomes among women with experiences of IPV (Goodkind, Gillum, Bybee, & Sullivan, 2003; Todahl, Olson, & Walters, 2017). Study findings show that positive responses from social support can increase psychological and physical health outcomes among this population as well (Cendejas, 2012; Sylaska & Edwards, 2014). Conversely, negative reactions from family and friends have been shown to lower the well-being of women experiencing IPV and to increase negative health outcomes (Goodkind et al., 2003; Sylaska & Edwards, 2014).

Due to what is known about the relationship between social support and mental health outcomes in this population, it would be important to examine self-compassion's connection to social support. The current research on the two is bidirectional. For example, according to a study by Maheux and Price (2016), social support increased levels of self-compassion in survivors of trauma, which in turn reduced trauma-induced psychopathology. Self-compassion places an emphasis on social connectedness by reminding one that all people experience suffering (Neff, 2003). Therefore, self-compassion may be strengthened by strong social support. Self-compassion is associated with lower levels of shame, which can make it easier for a one with experiences of abuse to access their social support (Tesh et al., 2013). Other research shows that even those who are aware of the perceived public stigma of reaching out for social support are more likely to do so with higher levels of self-compassion (Heath et al., 2016).

Theoretical Framework

The stress-buffering hypothesis, proposed by John Cassel and Sidney Cobb in 1976, provides the framework for this study. According to this framework, one's perception of social support buffers against the negative effects of life stressors on mental health outcomes (Cohen &

McKay, 1984). In other words, those who do not have "meaningful contact" with a support system are more at-risk for developing poor physical and mental health (Cassel, 1976).

Further, the stress-buffering hypothesis assumes that stressors occur when those who are faced with them do not have the coping ability to handle them (Cohen & McKay, 1984). Therefore, they look toward external resources to help them cope. When those resources are not there, it is confusing and isolating, which increases risk for poor outcomes (Cassel, 1976). Having network members who give help, feedback, and rewards are crucial in protecting against negative mental health outcomes (Cohen & Pressman, 2004).

According to this hypothesis, social support may be protective through three different processes (Cohen & Pressman, 2004). One, social support may alter the way one perceives the stress level of an event, and one with high levels of social support may not ever consider a typical stressor to be impactful. Second, if the event is appraised as a stressor, social support may lesson one's negative reaction to the stressor. Lastly, if the event is considered stressful and the reaction is negative, social support may buffer against the negative outcomes by providing different ways of coping.

This hypothesis considers three types of social support—emotional, informational, or appraisal, and tangible, or material (Cohen & McKay, 1984; Cohen & Pressman, 2004). The most useful type depends on the event and other contextual factors (Cohen & Pressman, 2004).

Figure 1. The stress-buffering hypothesis
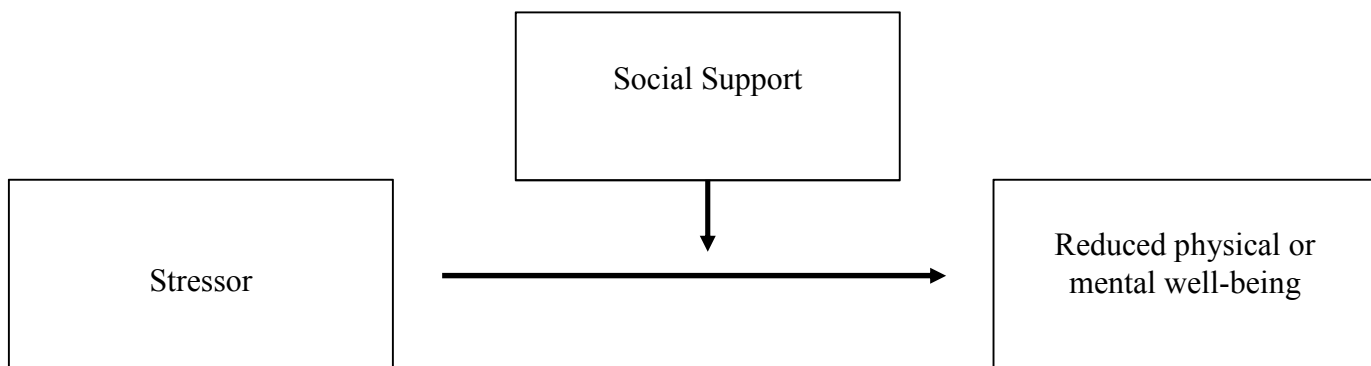
Purpose of the Study

      The present study will investigate the relationships among IPV victimization, self-compassion, and social support. The relationship between IPV victimization and self-compassion will be examined, followed by a test of how support from family and friends influences the association between IPV and self-compassion.

Chapter 2: Review of the Literature

Prevalence of IPV

IPV is a significant public health issue. There is a growing recognition of the economic costs and of the impact of IPV on health outcomes of women. IPV is associated with $4.1 billion of direct costs towards medical and mental health care services (National Center for Injury Prevention and Control, 2003). There is a large body of literature on the relationship between IPV and poor mental health outcomes among women (Ahmadzad et al., 2016; Beyodun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Carlson, McNutt, Choi, & Rose, 2002; DeJonghe, Bogat, Levendosky, & vonEye, 2008; Dillon et al., 2013; Karakula-Juchnowicz, Lukasik, Morylowska-Topolska, & Krukow 2017; Pill, Day, & Mildred, 2017). A study on the health of women with experiences of abuse in Australia documented that poor mental health contributed to 73% of the total disease burden among their sample (Vos et al., 2006). Further, depression alone accounted for nearly 35% of the total disease burden of IPV among these women. In order to reduce the impact of IPV on mental health outcomes among women with experiences of abuse, interventions must address risk and protective factors for adverse mental health outcomes. This literature review focuses on the IPV-mental health relationship, risk and protective factors of this relationship, and highlights gaps that this study will address.

Impact of IPV on Mental Health Outcomes

Experiences of IPV have been linked to multiple negative mental health outcomes. A recent comprehensive review of literature consisting of 75 studies documented the significant association between IPV and a range of mental health issues such as depression, anxiety, PTSD, and sleep disorders (Dillion et al, 2013). The authors also reported that the association between IPV and depression was the most researched out of all the mental health outcomes. A recent

meta-analysis suggests that 9%-28% of major depression and elevated depression symptoms among women can be attributed to their lifetime exposure of IPV (Beydoun et al., 2012). Further, women with histories of IPV are at a two- to three-fold increased risk for major depression and 1.5 to two-fold increased risk for elevated depressive symptoms compared to women without these experiences (2012).

A U.S.-based quantitative study by Rogers and Follingstad (2014) asked women in conflictual or problematic relationships *(n=361)* to fill out an online survey to look at the relationship between psychological abuse victimization and mental health outcomes, specifically depression and anxiety. The researchers found that there was a correlation between the degree of psychological abuse victimization and levels of depression and anxiety. Similarly, in a cross-sectional study of women seeking health services *(n=557),* 19.8% to 65% of those with an experience of abuse reported having symptoms of anxiety (Carlson et al., 2002). This is compared to 8% of the women the investigators surveyed who reported anxiety with no experiences of abuse. In a study of married women in Tehran, Iran ($n=615$), Ahmadzad-Asl et al. (2016) used quantitative means to determine the relationship between IPV and depression and anxiety. They found that women who experienced abuse overall were more likely to have depression and anxiety that women who did not have those experiences. Women who experienced both psychical and psychological aggression had the highest rates of depression. Karakula-Juchnowicz et al. (2017) found similar results in their study of risk factors contributing to severity of depression and anxiety in a sample of 102 women with experiences of abuse in Poland. They found that 68% of their sample had symptoms of anxiety.

PTSD is another common mental health outcome in women with experiences of IPV. In all 14 studies regarding PTSD reviewed by Dillon et al. (2013), there was a strong association

between IPV and PTSD symptoms and diagnoses. In a review of the literature compiled by DeJonghe et al. (2008), PTSD was prevalent in 45-84% of those with experiences of IPV. In a different review of the literature on IPV and PTSD, Pill et al. (2017) found that those with multiple experiences of trauma or more severe and frequent experience of IPV were more likely to have PTSD symptoms. The trauma symptoms can last even after the abuse has ended (Pill et al., 2017).

The relationship between IPV and negative mental health outcomes has been well documented, but for clinicians working with this population, it is crucial to understand the risk and protective factors associated with adverse mental health outcomes among women with experiences of IPV. One aspect that Dillon et al. (2103) found consistent throughout most of the literature they reviewed was that frequency and intensity of the IPV was positively associated with mental health symptom severity.

Risk Factors for Development of Mental Health Outcomes

There is little literature on the factors that enhance these women's risk for poor mental health outcomes, and the research that has been conducted is relatively scattered. These factors include: 1) returning to an abusive partner; 2) childhood physical and sexual abuse; 3) economic hardship; 4) physical ailments; 5) sleep disturbance; and 6) negative coping responses (Beck et al., 2011; Carlson et al., 2002; Flicker et al., 2012; Gartland et al., 2016; Karakula-Juchnowicz et al., 2017; Karakurt, Smith, & Whiting, 2014; Lalley-Chareczko, 2017; McFarlane et al., 2015; Rogers & Follingstad, 2014; Shaikh et al., 2017).

In a national longitudinal study of women using domestic violence services (*n=152*), McFarlane et al. (2015) examined the risk factors and outcomes for women who returned to their abuser after staying in a shelter as compared to women who did not return. They found that

women who returned to their abusers had higher levels of depression, PTSD, and anxiety over

women who did not go back to their abusive partners (McFarlane et al., 2015). These women

were also at higher risk of being killed by their partner.

Shaikh et al. (2017) conducted a study of women in Minya, Egypt (*n=608*), aimed to

examine the resources and risk factors for developing anxiety after an experience of IPV.

Through collecting quantitative data from women participating in a two-part health study, they

determined that childhood physical abuse from a brother was a risk factor for intensifying

experiences of anxiety after exposure to IPV. The authors suggest this may be a result of the

cultural expectation for brothers to be a source of protection for their sisters (Shaikh et al., 2017).

This is similar to findings from a study done in Australia looking at the consequences of

intergenerational patterns of abuse among pregnant women *(n=1507)* (Gartland et al., 2016).

They found that childhood physical and sexual abuse was associated with likelihood of

experiencing IPV and developing depression and anxiety (Gartland et al., 2016).

Struggling with finances may also be a risk factor for developing negative mental health

outcomes. Carlson et al. (2002) conducted a study of women seeking services at a primary care

center to examine protective factors against negative mental health outcomes in women with

different experiences of abuse, including IPV. They found that perceived economic hardship, in

the form of expected inadequate housing, food, or medical attention, may lead to higher levels of

both depression and anxiety in women with experiences of IPV (Carlson et al., 2002). Similarly,

in a study of women with abuse histories living in social, transition, or market housing *(n=41)* by

Daoud et al. (2016), poor mental health outcomes were also found to be associated with housing

insecurity. According to a quantitative study of women in Poland with experiences of IPV

(n=102) by Karakula-Juchnowicz et al. (2017), being unemployed heightened women's risk for developing depression and anxiety after an experience of IPV.

The same study found that chronic physical illness may also increase risk of development of negative mental health outcomes in women exposed to IPV (Karakula-Juchnowicz et al., 2017). In addition, a quantitative study using data from the 2006 Behavioral Risk Factor Surveillance System *(n=34,975)* found poor mental health outcomes were more common after an experience of IPV when there was significant sleep disturbance *(*Lalley-Chareczko et al., 2017).

Negative coping responses, such as self-blame and shame are among the most researched risk factors for poor mental health among women with IPV experiences. Karakurt, Smith, & Whiting (2014) conducted a study using both qualitative and quantitative data to look at similarities and differences in mental health needs of women in a domestic violence shelter. The participating women (*n=35*) were categorized into three groups based on their responses: ready to change, focused on negative symptoms, and focused on feelings of guilt and self-blame. Those in the third group took responsibility for the violence rather than attributing it to the abuser and consequently had the most severe negative mental health outcomes (Karakurt, Smith, & Whiting, 2014). Those with experiences of IPV who felt self-blame had more mental health issues, stayed in an abusive relationship for a longer period of time, and felt high levels of guilt for leaving their abusive partner (Karakurt, Smith, & Whiting, 2014).

Similarly, Flicker et al. (2012) found that self-blame, compared to other responses such as denial and disengagement, was associated with higher levels of depressive and PTSD symptoms. Their study looked at women who were seeking a protection order against the abuser (*n=131*). The researchers considered that these responses were coping mechanisms that were perhaps beneficial for women while in the abusive relationship, but were later detrimental for the

mental health of women after leaving their partners (Flicker et al., 2012). This finding is consistent with results of a study of female survivors of IPV seeking services at a research clinic *(n=80),* that examined self-blame as a moderator between abuse and psychological adjustment (Reich et al., 2015). The researchers found that high levels of self-blame resulted from high levels of physical abuse, which led to higher levels of PTSD symptoms.

Rogers and Follingstad (2014) conducted an online study to examine what risk factors impact mental health outcomes in women who experienced psychological abuse. The women surveyed were U.S. citizens who had been cohabitating with an intimate partner for at least two years and self-reported that the relationship was problematic or conflictual (*n=361*) (Rogers & Follingstad, 2014). It was found that perceived negative coping strategies, such as self-blame for what occurred, and problematic relationship schemas, were indicative of risk for negative mental health outcomes (Rogers & Follingstad, 2014).

In a qualitative study of females with histories of IPV (*n=63*) conducted by Beck et al. (2011), the researchers interviewed the participants, who were all seeking services at a university-based research clinic, about their experiences of IPV and other stressful life events, their symptomology, and their levels of shame and guilt. They found that shame and guilt-related distress and cognitions were positively associated with PTSD.

As stated earlier, there is a small body of literature on the risk factors for and the pathways linking IPV and poor mental health outcomes. The studies reviewed above help in elucidating the connection between IPV and mental health outcomes, especially in regards to negative coping responses of shame and self-blame. They provide better insight into determining how these negative responses develop and can contribute to our overall understanding of the link to poor mental health outcomes. To better understand how to lower the risk for these outcomes,

we need more information on what factors might be able to buffer the harmful effects of negative coping responses.

Potential Protective Factor of Self-Compassion

Self-compassion can be defined as treating oneself kindly in moments of failure and acknowledging negative feelings with openness and acceptance (Neff, 2003). It may be a protective factor against negative coping such as shame and self-blame and act as buffer against poor mental health outcomes. However, the study of self-compassion as it relates to women with experiences of IPV is relatively new. A recent study by Erb (2016) investigated the relationship between self-compassion and the negative coping responses of shame and self-blame among those with histories of IPV in an online survey or hard-copy survey (*n=66*). The study reported a strong negative relationship between self-compassion and shame and self-blame.

Self-compassion has the potential to reduce rumination and self-criticism, as determined by a study by Trompetter, de Kleine, & Bohlmeijer (2017). In an online exploratory study of the general population in Netherlands (*n=349*), Trompetter et al. (2017) found that self-compassion and negative mental health outcomes of depression and anxiety were negatively correlated. They also conducted a moderator analysis, determining that the relationship between negative affect and anxiety and depression was not as strong in people with high self-compassion (Trompetter et al., 2017).

Similarly, in a sample of patients with eating disorders (*n=78*), Kelly and Tasca (2016) found that self-compassion interrupted the cyclical nature of shame and eating disorder symptoms. Using quantitative data collected over the course of a twelve-week treatment period, the researchers noticed that after moments of increased shame, eating disorder symptoms would increase in severity. However, the opposite occurred after moments of increased self-compassion

(Kelly & Tasca, 2016). From this we learn that shame and self-compassion have opposite effects, with both positively or negatively impacting psychopathology symptoms.

Eating disorders are not the only mental health disorders that have been found to benefit from raising patients' levels of self-compassion. High levels of self-criticism may put individuals at higher risk for experiencing depression (Ehret, Joormann, & Berking, 2015). In a sample of major depressive disorder patients in Germany (*n=101*), both those with current and remitted depression had higher levels of self-criticism and lower levels of self-compassion respectively (Ehret et al., 2015). Though only a cross-sectional study, these results give us insight into the crucial role of self-compassion in reducing depressive symptoms, a large burden for IPV survivors. It is additionally important to note that those with depression may have an impaired ability to access their own self-compassion due to their symptoms (Trompetter et al., 2017). This should be kept in mind when working with those with experiences of IPV suffering from depressive disorders.

Self-compassion may also be protective against the risk of suicide. There is a strong association between experiences of IPV and greater suicide ideation and attempts (Dillon et al., 2013). Nearly half (42%) of women in a domestic violence shelter reported suicide ideation (Karakurt et al., 2014). However, in a study of undergraduate college students (*n=331*) experiencing negative life events, self-compassion was found to mediate the relationship between the event and suicide risk, decreasing the significance of the relationship substantially (Chang et al., 2016). This same study found that lack of the third component of self-compassion, common humanity, was specifically a mediator of the relationship between negative life events and suicidal ideation, meaning that those who cannot see themselves as similar to others are more likely to have suicidal thoughts after experiencing something difficult (Chang et al., 2016).

If expanded to the current study, women with experiences of IPV who have lower levels of self-compassion may feel isolated in their experience and therefore be at higher risk for poor mental health.

Research studies also suggest that higher levels of self-compassion can buffer against symptoms of PTSD. In two separate studies, researchers looked at PTSD symptoms in both civilian community members (Maheux & Price, 2015) and war veterans (Hiraoka et al., 2015), all with experiences of trauma, to see how self-compassion impacted their symptoms. In the study of community members (*n=152*), self-compassion was lower among those who had more symptoms of PTSD than in those who were more unlikely to meet the diagnostic criteria, allowing the researchers to speculate that self-compassion may be protective against symptoms of PTSD (Maheux & Price, 2015). The study of Iraq and Afghanistan war veterans with at least one traumatic experience (*n=115*) also found a strong negative association between self-compassion and symptoms of PTSD, after controlling for level of combat exposure (Hiraoka et al., 2015). Because of the traumatic nature of IPV, these studies give us important insight into the potential of self-compassion to prevent symptoms into developing into PTSD.

Overall, self-compassion is important for one's well-being (Zessin, Dickhäuser, & Garbade, 2015). A meta-analysis of 65 articles with 79 samples (*n=16,416*) confirmed a relationship between self-compassion and well-being, which was categorized by cognitive well-being, positive affective well-being, negative affective well-being, and psychological well-being, (Zessin et al., 2015). The authors suggested that with future research, the relationship may even be found to be causal.

From these studies, it seems that self-compassion is protective against the effects of negative coping responses and mental health outcomes. However, only one of the studies

examined self-compassion in those experiencing IPV. While studying this relationship could be useful, as demonstrated by its effect within other populations, there is a large gap in the research. Further research needs to be done to gain a deeper understanding of the impact of IPV on self-compassion and the subsequent outcomes for suvivors.

Impact of Social Support

While discussing protective factors for better outcomes in those experiencing IPV, it would be important to consider the impact of social support. A review of the literature on disclosure of IPV to social support members and adverse mental health outcomes compiled by Sylaska and Edwards (2014) found that disclosure of IPV as well as the subsequent support received, buffered against the development of negative mental health outcomes among women with a history of abuse. This is in agreement with the research done by Cendejas (2012) which found that social support from family and friends lowered levels of depression in Latina women who had experienced IPV *(n=86)*. Participants were recruited for this quantitative study from general mental health and domestic violence facilities in California, and they completed questionnaires about their relationships, both with intimate partners and family and friends (Cendejas, 2012).

Shaikh et al. (2017) found that, from a survey of women with experiences of IPV in Minya, Egypt (*n=608*), proximity to family of origin was protective against developing anxiety after abuse. This includes both living near social support and meeting frequently (Shaikh et al., 2017).

The Sylaska and Edwards (2014) review of 41 articles looking at disclosure and help-seeking behavior among those with experiences of IPV also found that friends and female family members are the most accessed and most helpful source of support. Many survivors of IPV turn

exclusively to family and friends (Latta & Goodman, 2011) and believe that their social support

networks are able to help them heal better than the general public (Todahl et al., 2017).

However, in a study by Dodson and Beck (2017), higher levels of PTSD were associated with

higher levels of shame, which then were associated with more negative attitudes toward the

helpfulness of social support. From this quantitative study of women with experiences of IPV

(*n=202*), the researchers suggest that this lack of help-seeking can perpetuate the symptoms of

PTSD and lead to further isolation and poor mental health outcomes (Dodson & Beck, 2017).

A cross-sectional study by Coker, Smith, Thompson, McKeown, and Bethea (2002)

gathered data from women receiving primary care (n=1152). Of the 53.9% of the sample who

were identified to have experiences of IPV, it was found that receiving social support reduced

risk of developing mental health outcomes (Coker et al., 2002). They distinguished that simply

disclosing the IPV was not inherently helpful, however, it was the support received that was

significant in lowering risk for poor outcomes relating to mental health, such as suicide ideation

and action (Coker et al., 2002).

While many studies support the idea that higher social support is associated with lower

mental health issues among women with IPV experiences, there are inconsistencies in literature

on the nature of support that is most beneficial to women. Goodkind et al. (2003) found that,

from quantitative data taken from women exiting a domestic violence shelter program *(n=137)*,

tangible support from family and friends was significantly related to well-being, but positive

emotional support was not. This same study found that negative emotional support was

significantly related to a lower quality of life, suggesting that both offering tangible support and

not expressing negative feedback are most beneficial in supporting women with experiences of

IPV (Goodkind et al., 2003). Conversely, Cendejas (2012) found that positive emotional support

from family and friends lowered levels of depression in women with experiences of IPV. A quantitative study of women *(n=600)* who had just given birth at a hospital in Tehran, Iran conducted by Abadi et al. (2012) found that despite how much social support was given, perceived quality of the social support was what contributed to overall well-being and de-stigmatized the process of reaching out for help.

Overall, the literature is in agreement that social support has the potential to be a protective factor against negative mental health outcomes in women with experiences of IPV. Given the protective influence of social support on mental health outcomes and of self-compassion on adverse mental health issues, it is important to study the relationship between social support and self-compassion.

Social Support and Self-Compassion

There is a very small body of literature on social support and self-compassion. A study by Heath et al. (2016) found that, among undergraduate students (*n=369*), those with greater self-compassion felt more able reach out for help, even if they understood that there was a social stigma around help-seeking. The researchers propose that this is because being self-compassionate makes them less likely to apply these negative messages to themselves (Heath et al., 2016).

More directly, self-compassion may be the link between social support and its positive impact on mental health outcomes. This was suggested by Maheux and Price (2015), who examined the mediating relationship of self-compassion in participants who had experienced at least one traumatic event (*n=599*), as self-reported in an online survey. Their findings showed that self-compassion was negatively correlated with PTSD, anxiety, and depressive symptoms, and that self-compassion mediated the relationship between social support and PTSD symptoms

(Maheux & Price, 2015). The authors suggest that this means that greater external support leads to greater inner support, though more research needs to be done to enhance the validity of this claim (Maheux & Price, 2015).

Though there is only a small body of literature on self-compassion and social support, and the research is inconsistent with regards to directionality, the studies that exist suggest potential for an important relationship between the two variables that may be essential in working with many populations. Among women who have experiences of IPV, this link could be especially critical to explore further.

Objectives and Hypotheses

The purpose of this cross-sectional study was to address the gap in the literature regarding the role of self-compassion in women who have experiences of IPV and how social support may have served as a buffer. Specifically, it examined the relationship between IPV and self-compassion as moderated by social support. A better sense of the role of family and friends as it relates to self-compassion can lead to speculation about its role in protecting against negative mental health outcomes.

To address the question of the relationship between IPV and self-compassion, it was hypothesized that higher levels of abuse will be associated with lower levels of self-compassion. Because frequency and intensity of IPV is associated with more severe mental health outcomes (Dillon et al., 2013), it was assumed that self-compassion, which is associated with positive mental health (Chang et al., 2016; Hiraoka et al., 2015; Maheux & Price, 2015; Trompetter et al., 2017) will be lower in those with worse IPV experiences.

When factoring in social support as a moderating variable, it was hypothesized that social support will buffer the relationship between IPV and self-compassion. Past research has been

conducted to show that self-compassion leads to better ability to access social support and may mediate the relationship between social support and positive mental health outcomes (Heath et al., 2016; Maheux & Price, 2015). While this current study is only looking at the moderation effect and from a different direction, it was predicted that the association between IPV and self-compassion will be weaker among women who report high levels of social support compared to those who report low social support in response to previous research.

Chapter 3: Methods

Sample

This study is a secondary data analysis of data collected as part of a randomized, exploratory clinical trial (RCT) in upstate New York. Sixty-five women were recruited from various women's health organizations, DHHS, and family court for the parent study. Inclusion criteria included: 1) over age 18; 2) heterosexual; 3) self-reported HIV negative; 4) experienced IPV in the last 3 months; and 5) engaged in sexual risk behavior in the last 3 months.

Procedure

Participants were approached in community meetings, support groups, and waiting rooms of social service agencies by a research assistant, who explained the study to interested women and screened them for inclusion criteria. Those who were eligible and willing to participate scheduled an appointment at a future date to complete the study.

At their appointment, participants signed the informed consent, filled out a calendar of the last three months with activities related to the study for better recall, and completed the self-report survey. The survey consisted of multiple measures and was delivered via an audio, computer-based format. Upon completion of the survey, participants were compensated and given a list of community resources and compensated for their time. All study procedures were approved by the Institutional Review Board of the participating organization.

Measures

Independent variable: Intimate partner violence (IPV)

IPV was assessed using a modified version of the Abuse Behavior Inventory (ABI), created by Shepherd and Campbell (1992). The revised measure consists of 29 items (Zink et al., 2007). The items within ABI focus on women's experiences of physical, sexual, and

psychological violence during the past 3 months. Respondents answered the 29 items on a 4-point Likert scale from 0 (*never*) to 4 (*very frequently*). Items were summed to produce a total ABI score with a possible range of 0-116. A cutoff value of 10 or higher is used to denote experiences of IPV ($\alpha = .96$). Internal consistency for the current sample was excellent, $\alpha = .968$.

Dependent variable: Self-compassion

To assess for participants' levels of self-compassion, respondents answered questions on the Self-Compassion Scale – Short Form (SCS). This measure is a 12-item version of the 26-item original self-compassion questionnaire (Raes et al., 2011). The positive subscales include self-kindness, common humanity, and mindfulness; the negative subscales include self-judgment, isolation, and over-identification. Items are designed to capture how respondents perceive their actions toward themselves in difficult times (e.g., "When times are really difficult, I tend to be tough on myself") and are rated using a Likert-type scale ranging from 1 (almost never) to 5 (almost always). The six items associated with the negative subscales are reverse coded. Higher scores reflect higher self-compassion. Internal consistency for the current sample was $\alpha = .678$.

Moderating variable: Social support

Social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS has 12-items divided into 3 subscales of family, friends, and significant other (Zimet et al., 1988). For the purposes of this analysis, the 4 items in the significant other subscale will be dropped because they do not pertain to this study, and only the family and friends subscale will be used. Items in the family subscale include "My family really tries to help me" and "I can talk about my problems with my family". Items in the friends subscale include, "I can count on my friends when things go wrong" and "I have friends with whom I can share my joys and sorrows" (Zimet et al., 1988). Scoring is done on a 5-point Likert-

type scale ranging from strongly disagree (1) to strongly agree (5). Individual item scores will be summed for the total and subscale scores and divided by the number of items. The higher the mean score, the greater the social support reported by the participants. Internal consistency for the current sample was excellent, $\alpha = .908$.

Data Analysis

Linear Regression

To assess for the impact of IPV on self-compassion in women, all predictor variables were centered preceding analysis.

Test for Moderation

Social support was analyzed as a moderator for the relationship between IPV and self-compassion. The analysis for the moderation effect involved running the regression model in three sequential steps and the change in the variance explained at each step is tabulated. These two steps included: (1) add the independent variable and the moderator variable, and (2) add the independent variable-by-moderator interaction variable in addition to the independent variable and the moderator variable.

The independent variable of IPV and the moderating variable of social support were both centered at the mean. This was done by finding the mean of each variable and subtracting it from the total score of the items. The purpose of centering the data was to give the variables a meaningful zero and to best interpret the interaction. A two-step model was conducted with the centered variables. In the first step, IPV and social support were added. In the second step, the interaction between the two, which involved multiplying both centered variables, was entered.

Chapter 4: Results

The purpose of this study was to explore the relationship between IPV and self-compassion and understand social support's role as a moderator. The mean age of the participants in this study was 34 (SD = 8.18, range = 19-49). Approximately half (49%) of the participants were Black and 31% were White. One-fifth of the sample (20%) had a college degree or higher. The majority of the sample was unemployed (59%), with the other 41% working both part or full time (see Table 1).

For the sample, the mean score on the ABI was 54 (SD = 30). The scores ranged from 0 to 116, which is considered to be the full range of the measure. A score of 10 denotes IPV, indicating that this sample was highly abused. On the social support measure, participants scored with an approximate mean of 3 (SD = .7). Scores ranged from 1 to 4.2. The mean score of the self-compassion was 26 (SD = 8). Scores of the sample encompassed the range of 8 to 40 (see Table 2).

The two main hypotheses tested in this study include:

1. High experiences of violence among women will be associated with lower levels of self-compassion.

2. Social support will act as a protective buffer between IPV and self-compassion. Therefore, the relationship between IPV and self-compassion will be weaker in women with high levels of social support.

Hypothesis 1

The first hypothesis, looking at the relationship between IPV and self-compassion, was tested using simple linear regression. Results from the linear regression model showed the

relationship between IPV and self-compassion was not significant ($B = .022$, $p = .867$); therefore, the first hypothesis was not supported.
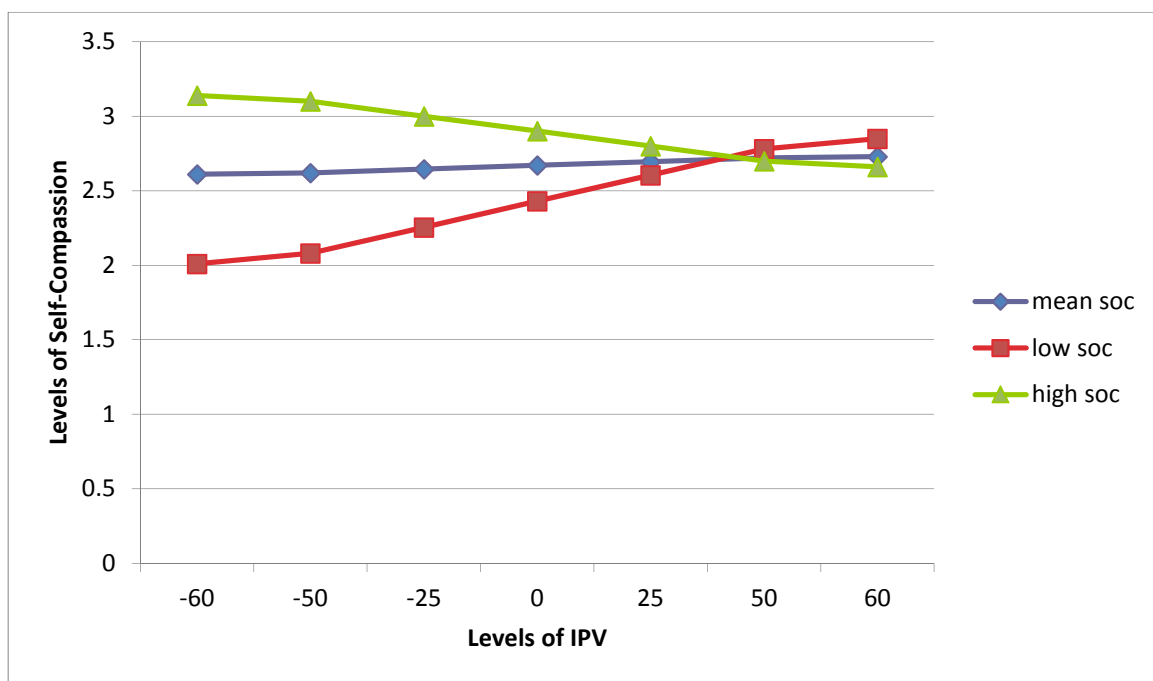
Hypothesis 2

To test the second hypothesis, looking at the moderating effect of social support on the relationship between IPV and self-compassion, a step-wise multiple regression was conducted. In the analysis for the main effects of IPV and social support and the interaction of IPV and social support, the main effect for social support was significant ($\beta = .350$, $p = .010$). There was no significant main effect for IPV. However, the interaction between IPV and social support tended toward significance ($\beta = -.230$, $p = .080$).

Since the interaction term of IPV and social support was tending toward significance, at .08, additional analyses were conducted. Two additional variables were created for social support, one variable reflected the values of social support one standard deviation above the mean and the other was representative of the values of social support one standard deviation below the mean. Both of these variables were centered, and two new interaction terms were created: the interaction of IPV and social support one standard deviation above the mean and the interaction of IPV and social support one standard deviation below the mean. Using these variables, two other regressions were conducted.

Results of the regression model with social support values one standard deviation above the mean indicate that in this group, higher abuse was associated with lower levels of self-compassion ($\beta = -.203$, $p = .261$). Results of the regression model with social support values one standard deviation below the mean indicate that in this group, higher abuse was associated with higher levels of self-compassion ($\beta = .239$, $p = .179$) (see Table 3).

Figure 2. IPV and self-compassion, with social support as moderator

Chapter 5: Discussion

The purpose of the study was to explore the relationship between IPV and self-compassion, as well as to understand the role of social support as a moderator of the aforementioned relationship. It was hypothesized that higher levels of IPV would be associated with lower levels of self-compassion. It was also hypothesized that social support would serve as a buffer between that relationship. This study intended to address the gap in the literature in regards to these variables.

Summary of Results

The results of this study indicated that there was an insignificant association between experiences of IPV and self-compassion, which does not support the initial hypothesis. However, contrary to our second hypothesis, the moderation results showed that higher social support did not weaken the relationship between IPV and self-compassion. Lower levels of social support allowed for stronger self-compassion in women with histories of IPV.

Discussion of Findings

The finding that in this sample there is no statistically significant relationship between IPV and self-compassion is interesting to explore. It is possible, given our small sample size we were not powered to detect differences. However, the result among women with lower levels of social support indicating that as IPV increases, self-compassion also increases in them is surprising. This contradicts the second hypothesis; it is important to consider potential reasons for these results

One possibility for the lack of connection is the help-seeking nature of the sample. Participants in this study were recruited from sites in the community where women were

accessing health and wellbeing oriented services (e.g., mental health, orders of protection, and physical health). It can be assumed that those seeking services to improve their health and wellbeing have a greater sense of agency and are less likely to experience shame and self-blame, negative coping responses that might create a false attribution.

Another possibility is that the measure used for social support, the MSPSS, was not a useful or accurate tool for measuring the specific social support needed by women with experiences of IPV. The current quantitative research on social support and IPV uses the Social Support Questionnaire (Abadi et al., 2012; Coker et al., 2002), the Network Orientation Scale (Dodson & Beck, 2017), Perceived Social Support-from friends and Perceived Social Support-from family (Cendejas, 2012) or uses measures created by the researchers (Goodkind et al., 2003; Wright 2015). Only the study by Maheux & Price (2016) used the MSPSS. The items in the MSPSS only measure emotional support. According to the stress-buffering hypothesis, is only one of the ways social support can be conveyed, the other two being tangible support and appraisal support (Cohen & McKay, 1984; Cohen & Pressman, 2004). The helpfulness of each type of support is determined by the stressor and contextual factors (Cohen & Pressman, 2004). Therefore, emotional support may not be what is needed by this population. This is reflective of the literature which is inconsistent in regards to which type of social support is most helpful (Abadi et al., 2012; Cendejas, 2012: Goodkind et al., 2003).

Another interpretation is that social support from family and friends may not be as helpful as hypothesized. A study by Todahl et al. (2017) of survivors of violence *(n=351)* found that while 81% of participants felt they were listened to with compassion when talking about their experience of abuse, 56% of respondents answered "Agree" or "Strongly Agree" to the question that the people in their lives did not know how to help them heal from the trauma. This

suggests that while family and friends may be able to provide a safe space for those with experience of violence to process the trauma, their ability to be helpful is limited.

In a mixed-methods study conducted in Mexico, researchers used surveys *(n=13,459)* and conducted focus groups *(n=64)* with women in abusive relationships to better understand family support (Frías & Agoff, 2015). They found that approximately one-third (41%) of women reached out to public authorities or law enforcement and did not tell their families. Frías and Agoff interpreted this to be related to the stigma associated with IPV. In their focus groups, they found common themes of family members telling participants it was their job to keep the family together, justifying the abuse, or advising women to tolerate the violence as part of being in a relationship with the perpetrator (Frías & Agoff, 2015). These family morals and norms, while sometimes based in cultural values, can impact social support's helpfulness, if accessed.

In addition, other contextual factors were not addressed in this study. A secondary study using data collected for the Project on Human Development in Chicago Neighborhoods found that social support had a weaker effect on women with experiences of IPV living in more disadvantaged neighborhoods *(n=4,645)* (Wright, 2015). The study, which found that social support from family diminished the likelihood and frequency of IPV while social support from friends led to higher frequency of IPV, discovered that both results were lessened by the context of living in a disadvantaged neighborhood.

A study by Goodkind et al. (2003) of women leaving a shelter *(n=137)* found that the more times a woman leaves and returns to the perpetrator, the less likely her family and friends are to offer emotional support. However, the same study found that women who were married to the abuser were more likely to receive that same kind of support (Goodkind et al., 2003). Neither variable was looked at in the current study, which did not address contextual factors.

Clinical Implications

The intention of this study was to better understand protective factors that could buffer against the negative mental health impacts of IPV. By knowing this, we can be better able to assist clients with experiences of IPV by helping increase their protective factors. Given the small sample size, clinicians should use caution when drawing clinical implications based on the study results.

Firstly, even though the association between IPV and self-compassion was not significant, moderation analysis results indicated that among women with high levels of social support, IPV was associated with less self-compassion. It might be important for clinicians to recognize that clients with more severe histories of IPV may have less self-compassion. This is important because of what we know about self-compassion's relationship with poor mental health outcomes. Clinicians can be aware that building self-compassion might be an important intervention to use with this population.

Because in the low social support group, the relationship between IPV and self-compassion was stronger, it can be interpreted that social support is an unhelpful influence on self-compassion in women with experiences of IPV. It might be important for clinicians working with women with abuse histories not to rely on social support as a resource to build self-compassion as an internal coping strategy in their clients.

Limitations and Implications for Future Study

This study was a secondary analysis of a preexisting data set. Therefore, the selection of measures and information available was limited to what had already been collected. This study also had a relatively small sample size which limited the power to detect differences and may impact the generalizability of the findings. In addition, contextual factors, such as age,

socioeconomic status, length of time in the relationship, or relationship status might need to be controlled for or addressed in future studies.

Due to the limitations of the current study, any future studies may want to increase sample size for added power and generalizability. It may also be interesting to use multiple different measures to assess for social support, to see if another measure, more geared toward the needs of this specific population, would be helpful.

Future studies addressing self-compassion within women with experiences of IPV should be a priority for the field due to what is known about self-compassion's buffering impact on poor mental health outcomes. Understanding what factors can strengthen or weaken the relationship between IPV and self-compassion are important. In addition, future research might want to look at the three specific components of self-compassion, self-kindness, mindfulness, and common humanity, as well as the three opposite aspects, self-criticism, over-identification, and isolation, and see if there what specific areas are most impacted by IPV.

Conclusion

Because of the negative mental health impact that can potentially arise from experiences of IPV, it is important for researcher to address protective factors against mental health outcomes, such as negative coping strategies. The growing body literature on self-compassion among those with experiences of IPV is helpful in informing clinicians about what protective factors they can access to improve self-compassion in their clients. While social support was found to have an unhelpful effect on the relationship between IPV and self-compassion, this information is also helpful when understanding how to best serve and support those with experiences of IPV.

Table 1. Descriptive Information on Variables

Variable	N (%)
Age	34.36 (8.18) (M, SD)
Race	
African American/Black	30 (49.2%)
White	19 (31.1%)
Other	12 (19.7%)
Education	
<High school	16 (26.2%)
High school or equivalent (GED)	15 (24.6%)
Some college	18 (29.5%)
College degree or higher	12 (19.7%)
Employment	
Full-time	17 (27.9%)
Part-time	8 (13.1%)
Unemployed	36 (59%)

Note. n=61

Table 2. Descriptive Statistics for Measures

Measure	Mean	Standard Deviation	Potential Range	Actual Minimum	Actual Maximum
Abuse Behavior Inventory (ABI)	54.2	30.2	0-116	0	116
Self-Compassion Scale (SCS)	2.7	.66	1-5	1	4.2
Multidimensional Scale of Perceived Social Support (MSPSS)	25.6	8.4	8-40	8	40

Note. n=61

Table 3. Interaction Models Predicting Self-Compassion

Parameter	Estimate	95% CI	p-value
Centered Variables			
Intimate Partner Violence	0.018	-.005, .006	0.887
Social Support	0.350	.007, .047	0.010
Interaction	-0.230	-.001, .000	0.080
Variables One SD Above Mean			
Intimate Partner Violence	-0.203	-.012, .003	0.261
Social Support	0.350	.007, .047	0.010
Interaction	-0.331	-.001, .000	0.080
Variables One SD Below Mean			
Intimate Partner Violence	0.239	-.003, .013	0.179
Social Support	0.350	.007, .047	0.010
Interaction	-0.306	-.001, .000	0.080

Appendix I

Abuse Behavior Inventory

Circle a number for each of the items listed below to show your closest estimate of how often it happened in your relationship with your partner during the past year.

    0 = never, 1 = rarely, 2 = occasionally, 3 = frequently, 4 = very frequently

1. Called you a name and/or criticized you
2. Tried to keep you from doing something you wanted to do (example: going out with friends, going to meetings)
3. Gave you angry stares or looks
4. Prevented you from having money for your own use
5. Ended a discussion with you and made the decision himself
6. Threatened to hit or throw something at you
7. Pushed, grabbed, or shoved you
8. Put down your family and friends
9. Accused you of paying too much attention to someone or something else
10. Put you on an allowance
11. Used your children to threaten you (example: told you that you would lose custody, said he would leave town with the children)
12. Became very upset with you because dinner, housework, or laundry was not ready when he wanted it or done the way he thought it should be
13. Said things to scare you (example: told you something bad would happen, threatened to commit suicide)
14. Slapped, hit, or punched you
15. Made you do something humiliating or degrading (example: begging for forgiveness, having to ask his permission to use the car or do something)
16. Checked up on you (examples: listened to your phone calls, checked the mileage on your car, called you repeatedly at work)
17. Drove recklessly when you were in the car
18. Pressured you to have sex in a way that you didn't like or want
19. Refused to do housework or childcare
20. Threatened you with a knife, gun, or other weapon
21. Told you that you were a bad parent
22. Stopped you or tried to stop you from going to work or school
23. Threw, hit, kicked, or smashed something
24. Kicked you
25. Physically forced you to have sex
26. Threw you around
27. Physically attacked the sexual parts of your body
28. Choked or strangled you
29. Used a knife, gun, or other weapon against you

Psychological abuse scale: Items 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 15, 16, 17, 19, 21, 22
Physical abuse scale: Items 6, 7, 14, 18, 20, 23, 24, 25, 26, 27, 28, 29

Appendix II

Self-Compassion Scale – Short Form
How I Typically Act Towards Myself in Difficult Times
Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				*Almost Always*
1	*2*	*3*	*4*	*5*

____1. When I fail at something important to me, I become consumed by feelings on inadequacy.

____2. I try to be understanding and patient towards those aspects of my personality I don't like.

____3. When something painful happens I try to take a balanced view of the situation.

____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

____5. I try to see my failings as part of the human condition.

____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

____7. When something upsets me, I try to keep my emotions in balance.

____8. When I fail at something that's important to me, I tend to feel alone in my failure.

____9. When I'm feeling down, I tend to obsess and fixate on everything that's wrong.

____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

___11. I'm disapproving and judgmental about my own flaws and inadequacies.

___12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Self-Kindness Subscale: Items 2, 6
Self-Judgment Subscale: Items 11, 12
Common Humanity Subscale: Items 5, 10
Isolation Subscale: Items 4, 8
Mindfulness Subscale: Items 3, 7
Over-identified Subscale: Items 1, 9

Appendix III

Multidimensional Scale of Perceived Social Support

We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

1 = very strongly disagree, 2 = strongly disagree, 3 = mildly disagree, 4 = neutral, 5 = mildly agree, 6 = strongly agree, 7 = very strongly agree

1. There is a special person who is around when I am in need.
2. There is a special personal with whom I can share joys and sorrows.
3. **My family really tries to help me.**
4. **I get the emotional help and support I need from my family**
5. I have a special person who is a real source of comfort to me.
6. **My friends really try to help me.**
7. **I can count on my friends when things go wrong.**
8. **I can talk about my problems with my family.**
9. **I have friends with whom I can share my joys and sorrows.**
10. There is a special person in my life who cares about my feelings.
11. **My family is willing to help me make decisions.**
12. **I can talk about my problems with my friends.**

Significant Other Subscale: Items 1, 2, 5, 10
Family Subscale: Items 3, 4, 8, 11
Friends Subscale: Items 6, 7, 9, 12

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