Investigation of Self-Compassion, Shame, and Self-Blame in Survivors of Intimate Partner Violence

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ABSTRACT

INVESTIGATION OF SELF-COMPASSION, SHAME, AND SELF-BLAME IN SURVIVORS OF INTIMATE PARTNER VIOLENCE

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This thesis investigated the relationship between self-compassion, shame, and self-blame in survivors of intimate partner violence and explored whether levels of self-compassion varied by violence type. Fifty-one female participants, 19 to 64 years of age (M_{age} = 30.60), who identified serious romantic relationship conflict within the last five years were recruited from women's shelters and related organizations, Kijiji online advertisements, a University campus, an online women's forum, and social media sites. Participants completed an online survey that asked women about the relationship violence and about their thoughts, feelings, and behaviours. Results indicated that women experiencing high levels of shame and self-blame possessed lower levels of self-compassion. Results also revealed that women exposed to intimate terrorism had significantly more difficulty experiencing self-compassion than those encountering situational couple violence. The results of this study suggest the importance of self-compassion to address the shame and self-blame that often plague survivors of IPV.

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Investigation of Self-Compassion, Shame, and Self-Blame in Survivors of Intimate Partner Violence

Introduction

Intimate partner violence (IPV) continues to be a serious problem in society today, often resulting in significant physical and psychological harm (Bachman & Saltzman, 1995; C. M. Barrett & Gray, 2013; Beck et al., 2011, 2015; Campbell, 2002; Campbell, Baty, Laughon, & Woods, 2009; Coker, 2002; Coker, Smith, Bethea, King, & McKeown, 2000; S. J. Woods, 2000). Considering the severity of this social issue, relatively large numbers of Canadians and Americans report IPV (Statistics Canada, 2013b; Tjaden & Thoennes, 2000), with figures indicating that 0.1% to 1.8% of individuals have experienced IPV within the previous year. According to police report data, women are more often victims of serious violence than men (Statistics Canada, 2013b), a disparity that is not unique to North America (Garcia-Moreno et al., 2006). Importantly, these figures may underestimate the problem, as the majority of IPV victimization goes unreported (Tjaden & Thoennes, 2000).

Intimate partner refers to current or former spouses (including common-law), partners, dating partners, boyfriends, or girlfriends and includes heterosexual and same-sex relationships (Saltzman, Fanslow, McMahon, & Shelley, 1999; Tjaden & Thoennes, 2000). Violence is frequently organized into three categories (Saltzman et al., 1999; Statistics Canada, 2013a, 2013b; Tjaden & Thoennes, 2000) that often occur in combination (Reich et al., 2014). First, physical violence, involving the deliberate use of physical force or the threat of force, may include actions ranging from pushing and shoving to punching with a fist or object or use of a weapon with the possibility of causing injury, harm, or even death. Second, sexual violence has been defined as the utilization of physical force, threats, or coercion (words, gestures, or

weapons) to compel a woman to engage in a sexual act without her willing consent. Finally, psychological or emotional abuse may involve acts such as humiliating the victim, destroying or damaging property belonging to the victim, controlling the actions of the victim, isolating the victim from outside contact with family and friends, or limiting access to transportation or money (Saltzman et al., 1999; Statistics Canada, 2013a, 2013b; Tjaden & Thoennes, 2000).

Previous research has distinguished the typology of intimate partner violence, with some claiming that various categories can be distinguished in terms of "partner dynamics, context, and consequences" (J. B. Kelly & Johnson, 2008, p. 476) of the violence (Graham-Kevan & Archer, 2003; M. P. Johnson, 1995; M. P. Johnson & Leone, 2005; J. B. Kelly & Johnson, 2008). Two of the main types involve *intimate terrorism (IT)* and *situational couple violence (SCV)*. Research has suggested that these two types represent different phenomena and possess very different characteristics, prevalence patterns, causes, and effects, making it critical that future studies specify the type of violence investigated (M. P. Johnson & Leone, 2005; M. P. Johnson, 2005; J. B. Kelly & Johnson, 2008; Leone, Johnson, & Cohan, 2007). According to Johnson and Leone (2005), IT, conceptually rooted in feminist theory, is thought to arise in a patriarchal society where male dominance is exerted through power and control (Gabriel, 1981). Johnson and Leone's (2005) research suggested that the effects of intimate terrorism on women are far more severe than for those experiencing situational couple violence. Specifically, IT is often associated with more severe violence that is generally male perpetrated within a context of coercive control, whereby many aspects of the woman's life are controlled through tactics such as isolation, psychological abuse, intimidation, and threats of violence (M. P. Johnson & Leone, 2005). SCV, on the other hand, is believed to result from discord and stresses between a couple that may or may not escalate into a violent episode, yet the coercive controlling element is not demonstrated

by either partner (J. B. Kelly & Johnson, 2008). Additionally, the violence present within SCV tends to be less severe and often does not result in the injuries and need for external services that is prominent with survivors of IT. Overall, SCV is deemed to be the most common form of violence noted in large general population surveys, accounting for the assertion of similar rates of perpetration among men and women (J. B. Kelly & Johnson, 2008).

A growing number of studies have linked IPV to physical health outcomes for women ranging from homicide (Bachman & Saltzman, 1995; Paulozzi, Saltzman, Thompson, & Holmgreen, 2001) to a variety of physical injuries and even an increased risk for developing a chronic health problem (Campbell, 2002; Campbell et al., 2009; Coker, 2002; Coker et al., 2000). Additionally, a wide range of interrelated mental health problems have been reported including posttraumatic stress disorder, depression, anxiety, substance abuse issues, self-criticism, guilt, shame, and self-blame (C. M. Barrett & Gray, 2013; Beck et al., 2011, 2015; Campbell et al., 2009; Coker, 2002; Mills, 2008; Rhatigan, Shorey, & Nathanson, 2011), remaining sometimes long after the physical assault has ended and injuries have healed (S. J. Woods, 2000). Golding's (1999) comprehensive meta-analysis found a strong association between IPV and the prevalence of depression, suicidality, PTSD (weighted means odds ratios: 3.55 - 3.80), and alcohol and drug abuse (weighted means odds ratios: 5.56 - 5.62). Further, in a community study of 160 women, Woods (2000) found that approximately 66% continued to experience PTSD symptoms even nine years (on average) after the end of the abusive relationship.

The negative emotion of shame (controlling for guilt, a related negative self-conscious emotion often confused with shame; Tangney & Dearing, 2002) has been increasingly implicated as a significant predictor of mental health outcomes, with studies revealing its moderating

influence on associations between victimization and depression, anxiety, and PTSD (Shorey, Sherman, et al., 2011), as well as its role as a mediator in a variety of relationships (Rhatigan et al., 2011; Street & Arias, 2001). Additionally, dysfunctional cognitions such as self-blame, in association with negative emotions such as shame, have also been implicated in the prediction of mental health outcomes (Beck et al., 2015). Therefore, the importance of addressing shame and self-blame has become increasingly apparent (Beck et al., 2011, 2015; Rhatigan et al., 2011; Shorey, Sherman, et al., 2011; Street & Arias, 2001). Recent research has examined negative emotions and self-appraisals, particularly shame and self-blame in the context of IPV (C. M. Barrett & Gray, 2013; Beck et al., 2011, 2015; Buchbinder & Eisikovits, 2003; Mills, 2008; O'Neill & Kerig, 2000; Othman, Goddard, & Piterman, 2014; Shorey, Sherman, et al., 2011).

In areas that have targeted shame and self-blame for intervention, attention has turned to understanding the role of self-compassion on shame reduction for those struggling with eating disorders (Gale, Gilbert, Read, & Goss, 2014; Goss & Allan, 2014; A. C. Kelly, Carter, & Borairi, 2014; A. C. Kelly, Carter, Zuroff, & Borairi, 2013), depression (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; E. A. Johnson & O'Brien, 2013; A. C. Kelly, Zuroff, & Shapira, 2009), smoking problems (A. C. Kelly, Zuroff, Foa, & Gilbert, 2010), substance use disorders (Luoma, Kohlenberg, Hayes, & Fletcher, 2012), and social anxiety disorders (Boersma, Håkanson, Salomonsson, & Johansson, 2015). Findings suggested that targeting shame early by increasing self-compassion may improve treatment outcomes (A. C. Kelly et al., 2014). Consequently, expanding the investigation of self-compassion to survivors of intimate partner violence may be crucial to mitigate the detrimental effects of shame and self-blame.

The current study proposed to merge and extend these distinct lines of research by determining whether a relationship exists between shame and self-blame and levels of self-

compassion in the context of IPV. To my knowledge, this is the first study to empirically examine self-compassion in the context of the shame and self-blame experienced by women subjected to intimate partner violence. In the following overview, I will outline the definitions and characteristics of shame, self-blame, and self-compassion before providing a brief review of the current literature surrounding these constructs in terms of intimate partner violence. With respect to hypotheses, I propose that shame and self-blame will be negatively associated with self-compassion, but guilt will demonstrate positive associations. Secondly, I hypothesize that, after taking into account their shared variance, shame and self-blame will contribute uniquely to the prediction of self-compassion. Thirdly, I hypothesize that levels of self-compassion vary with violence type. Lastly, I will explore the relationship between the study variables and the strategies women use to deal with the violence.

Origins of the Shame Construct

Conceptualizations of the origin of shame vary and emphasize different aspects of this self-conscious emotion. Gilbert's (1997) social rank theory highlighted the universality of shame (Pines, 1995) and its evolutionary origins as an alert mechanism to changes in social status during attempts to dominate or attract others in mate selection and alliance formation. According to Gilbert (1989, 1997, 2003), our identities are influenced by our perceptions of our social attractiveness to others: when we feel "devalued, unattractive, 'not worth bothering with'" (Gilbert, 1997, p. 116), excluded, or disapproved of by others , then shame predominates. K. C. Barrett (1995) proposed that socialization is a key factor in the development of the *social emotions* of shame and guilt because of its role in endorsing adherence to standards in behaviour. This functionalist perspective maintains that part of shame's role is to "maintain social

hierarchies" (K. C. Barrett, 1995, p. 57) and to provide important information to the individual regarding characteristics of the self.

Definitional Considerations

Shame versus Guilt

General agreement exists regarding the phenomenological experience of shame and the distinction between shame and guilt (H. B. Lewis, 1971; Lindsay-Hartz, de Rivera, & Mascolo, 1995; Tangney, 1992; Tangney & Dearing, 2002; Wicker, Payne, & Morgan, 1983). According to M. Lewis (1992) the word shame is derived from the word 'skam', an Indo-European word that means "to hide and implies fear of exposure" (Gilbert, 1997, p. 113). Shame is one of a number of self-conscious emotions (Fischer & Tangney, 1995; M. Lewis, 1992) involving an intense awareness and focus on the self (Van Vliet, 2009). In particular, the differentiation between shame and guilt has received extensive research attention using a wide variety of methodologies, including narrative content studies (Tangney, 1992), qualitative case studies (Helen B. Lewis, 1971; Lindsay-Hartz et al., 1995), and quantitative survey studies (Tangney, Miller, Flicker, & Barlow, 1996; Wicker et al., 1983). These diverse studies converge on the finding that shame and guilt are indeed very distinct emotions "with real implications for motivation and behaviour" (Tangney, Mashek, & Stuewig, 2005, p. 46)**.**

H. B. Lewis's (1971) theoretical account of shame and guilt highlighted that the function of the *self* differentiates these negative social emotions (Tangney, 1992). In shame, the focus is on the negative evaluation of the self; whereas in guilt, the behaviour of the individual, either a specific act or neglecting to act, is the focal point, with both leading to very different phenomenological experiences (Helen B. Lewis, 1971; Lindsay-Hartz et al., 1995; Tangney, 1992; Tangney, Miller, et al., 1996; Wicker et al., 1983). Shame is an extremely painful, even

excruciating, emotion in which the entire self is felt to be exposed, leading to feelings of worthlessness and shrinking, with an overall sense of powerlessness. As a result, the individual feels motivated to withdraw or hide from others, as the entire self is viewed as flawed and unworthy (H. B. Lewis, 1971; Tangney, 1992). Gilbert (1997; Gilbert et al., 2006) further proposed a distinction between external, preoccupation with others' negative and critical views of the self, and internal shame, where self-denigration and self-criticism are paramount. Conversely, guilt involves a sense of remorse for engaging in bad behaviour. However, these negative feelings prompt one to engage in reparation for the misdeed, an action that results in a resolution of the negative emotion. This behaviour is seen as separate from the self and the emotion of guilt is described as much less painful or overwhelming than shame, even adaptive (Tangney & Dearing, 2002). Generally, according to Lewis (1971), "the shame experience is more global, more primitive, and less verbal than the guilt experience" (Tangney, 1992, p. 205). Although the terms shame and guilt are often used interchangeably in common everyday speech (Tangney & Dearing, 2002), the above review highlights the importance of distinguishing between these related negative emotions. Accordingly, measuring the unique impact of shame (without guilt) is critical.

Shame-Proneness versus Guilt Proneness

H. B. Lewis (1971) suggested that individual differences in shame-proneness and guilt-proneness influence whether shame or guilt is experienced in life situations. We all may experience either emotion of state shame or state guilt in our lives. Some situations tend to elicit shame reactions while others tend to elicit guilt reactions, but the majority of situations are more ambiguous and can trigger either emotion (Tangney, 1990). According to the clinical observations of H.B. Lewis (1971), our proneness to one or the other often becomes apparent in

these more ambiguous situations. Earlier measurement difficulties in distinguishing states and dispositions of shame and guilt significantly impacted the confidence with which conclusions could be made (Tangney & Dearing, 2002). Subsequently, the development of targeted measures that assess shame and guilt separately prompted a dramatic increase in empirical studies revealing that, despite some degree of overlap, shame-proneness and guilt-proneness have very different phenomenological presentations and behavioural outcomes (Lindsay-Hartz et al., 1995; Tangney, 1992; Tangney & Dearing, 2002; Tangney et al., 1996).

Tangney, Wagner, and Gramzow (1992) examined the links between shame, guilt, attributional style, and psychopathology in two studies with undergraduate students. Shame-proneness predicted all indices of psychopathology when controlling for guilt-proneness, but the reverse was not true. Subsequent research has also indicated that shame-free guilt-proneness is commonly unrelated or negatively correlated with mental or physical health problems (Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002; Pineles, Street, & Koenen, 2006; Tangney, 1990; Tangney, Wagner, Fletcher, & Gramzow, 1992) and positively correlated with empathy and productive anger responses (Tangney, 1991; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). This is not the case with shame-proneness which is consistently positively related to a variety of mental health concerns (H. B. Lewis, 1971; Lindsay-Hartz et al., 1995; Tangney & Dearing, 2002; Tangney, Wagner, & Gramzow, 1992).

Cognitive Attributions - Self-Blame/Self-Criticism

Shame is frequently accompanied by an array of "cognitions, affects, sensations, behaviours, and impulses" (Van Vliet, 2009 p. 137). According to attribution theory, causal ascription helps us understand and put meaning to events in our lives, while simultaneously influencing the experience of emotions such as shame (Petrocelli & Smith, 2005; Weiner, 1985).

Both internal and external events are evaluated by the individual and compared to a recognized standard (Kaufman, 1989; M. Lewis, 1992, 2008), such that when the individual's *actual self* does not meet the standards of the *ideal self*, the self is blamed and shame is experienced (Gilbert, 1997, 2003; Tangney & Dearing, 2002). A clarification of the terms, *self-blame* and *self-criticism,* is necessary before continuing this review. Some researchers use the term, *self-blame,* to refer to the process of attributing responsibility for situations or events to oneself in an unfavorable, disparaging manner (Janoff-Bulman, 1979; Helen B. Lewis, 1971; Tangney & Dearing, 2002; Terry & Leary, 2011), whereas others tend to use the term *self-criticism* to denote similar concepts (Gilbert & Procter, 2006; Neff, 2003b). Gilbert and Irons (2005) essentially integrated the two terms with a description of self-criticism as "self-critical blaming" (Gilbert, 2010, p. 101). For the purposes of this paper, these terms are interchangeable and the term "self-blame" is used, but when reviewing the work of others, their preferred term is used.

Research on Shame-Proneness, Guilt-Proneness, Self-Blame and Psychopathology

H. B. Lewis(1987) identified shame as a "sleeper in psychopathology" (p. 1) following her analysis of hundreds of psychotherapy sessions (Brown, 2006), in which she consistently observed the predominance of shame over other emotions. According to recent research, shame has been increasingly viewed as an integral factor in the development and maintenance of a variety of psychological and mental health problems (e.g., depression, alcoholism, eating disorders, posttraumatic stress disorder [PTSD], anxiety, and aggression) (Cheung, Gilbert, & Irons, 2004; Cook, 1991; Gilbert, 1997, 2000, 2003; Gilligan, 2003; A. C. Kelly, Carter, & Borairi, 2014; A. C. Kelly, Carter, Zuroff, & Borairi, 2013; Semb, Strömsten, Sundbom, Fransson, & Henningsson, 2011; Tangney & Dearing, 2002; Tangney, Wagner, Fletcher, & Gramzow, 1992; Van Vliet, 2009; Wong & Cook, 1992). In many of these studies shame was

found to be positively correlated with psychopathology and even non-disclosure of a mental health difficulty. Guilt, on the other hand, evidenced either no relationship or a negative relationship, suggesting that shame may be an important focus for treatment, while guilt may act as a protective factor (Dearing, Stuewig, & Tangney, 2005; Leskela, Dieperink, & Thuras, 2002; Swan & Andrews, 2003; Tangney, Wagner, et al., 1996; Tangney, Wagner, & Gramzow, 1992). Similarly, self-blame has showed strong positive associations with depressive symptoms and other negative experiences (Graham & Juvonen, 1998; Tangney, Wagner, & Gramzow, 1992; Wall & Hayes, 2000). Thus, shame and self-blame have been identified as trans-diagnostic factors, having been implicated in a variety of mental health/psychological problems (Gilbert & Irons, 2005; Gilbert & Procter, 2006; Tangney & Dearing, 2002).

Research on Shame, Guilt, and Self-Blame in Intimate Partner Violence

In the last 30 years, IPV research has increasingly focused on the impact of shame, guilt, and self-blame on women's sense of self (C. M. Barrett & Gray, 2013; Lynch, 2013; Plesset, 2007), barriers to disclosure (Hamberg, Johansson, & Lindgren, 1999; Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Limandri, 1989; Lutz, 2005; Othman et al., 2014; Swanberg & Logan, 2005; Weiss, 2010), and on the contribution to mental health problems (Beck et al., 2011, 2015; Rhatigan et al., 2011; Shorey, Sherman, et al., 2011). Since shame is thought to cross many diagnostic categories, it is not surprising that it is increasingly considered a vital contributing component (Beck et al., 2015; Rhatigan et al., 2011) to the difficulties experienced by victims of IPV.

Impact of IPV on Sense of Self

Barrett and Gray (2013) highlighted that physical and sexual violence often result in trauma-associated psychological consequences of which PTSD, depression, and anxiety are most

prominent. Nevertheless, "diverse emotional sequelae" (C. M. Barrett & Gray, 2013 p. 6), such as shame, that impact survivors' sense of self, self-efficacy, and self-worth (Aguilar & Nightingale, 1994; Lynch, 2013; Rhatigan et al., 2011; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Wesely, Allison, & Schneider, 2000) similarly require significant intervention. Women often blame themselves for the abuse because of justifications, accusations, and excuses made by the abuser (Landenburger, 1989) and as a potential coping mechanism in the hopes that, if they could possibly change their behaviour, the abuse would end (C. M. Barrett & Gray, 2013). Results from Weaver and Clum's (1995) meta-analysis revealed that self-blame along with other subjective factors (general appraisal, perception of threat) accounted for twice the amount of psychological distress than did more objective factors such as physical force, injury, or weapon use. A qualitative study investigating the impact of IPV on survivor's sense of self found that women in abusive relationships described themselves more negatively, reported identity loss, and overall interacted with less self-confidence and assertiveness than women with non-violent partners (Lynch, 2013).

Barriers to Help-Seeking and Disclosure of IPV

Shame and self-blame have been consistently identified in the literature as internal barriers to help-seeking and disclosure of IPV to family, friends or healthcare/mental health professionals (Buchbinder & Eisikovits, 2003; Hamberg et al., 1999; Liang et al., 2005; Limandri, 1989; Lutz, 2005; Plesset, 2007; Spangaro, Zwi, & Poulos, 2011; Swanberg & Logan, 2005; Sylaska & Edwards, 2014). It is understandable that feelings of shame and thoughts of self-blame are significant factors inhibiting disclosure for survivors of IPV considering the continued prevalence of victim-blaming attitudes across the world, despite great efforts to combat this problem in the last few decades (Bryant & Spencer, 2003; Gracia, 2004, 2014;

Hydén, 2005; Meyer, 2011). For example, a recent European Union survey revealed that on average 52% of those surveyed reported that the provocative behaviour of women was the cause of domestic violence (European Commission, 2010). Consequently, women continue to face stereotypical attitudes that either minimize or normalize the abuse or serve to blame them for its occurrence (Hamberg et al., 1999; Meyer, 2011; Othman et al., 2014). Othman and colleagues (2014) contended that values and beliefs regarding IPV that are embedded within society and culture are strongly associated with shame and self-blame. For example, the goal of maintaining the image of the good wife as well as the need to save face and avoid shame contribute to the development of these inner barriers, with some choosing to "suffer in silence" (Othman et al., 2014 p. 1507) rather than risking social criticism.

A significant amount of qualitative research has investigated women's reasons for disclosure and non-disclosure regarding IPV (Hamberg et al., 1999; Hydén, 2005; Knickmeyer, Levitt, & Horne, 2010; Limandri, 1989; Lutz, 2005; Spangaro et al., 2011). Spangaro et al.'s (2011) study investigating women's reasons and decision-making process in disclosure found that three important aspects of safety facilitated disclosure: safety from the abuser, safety from shame, and safety from institutional control (Spangaro et al., 2011). Participants in this study indicated that shame silenced them from even disclosing the abuse to a friend, with some reporting that feelings of shame were only alleviated once the abuse was addressed or had ended. Only at this point did they feel free to disclose the abuse. Common themes in much of this research involve shame and self-blame as contributors to reduced disclosure (Hydén, 2005; Knickmeyer et al., 2010; Laisser, Nyström, Lugina, & Emmelin, 2011; Liang et al., 2005; Limandri, 1989; Lutz, 2005; Plesset, 2007; Richardson & Feder, 1996; Swanberg & Logan, 2005; Sylaska & Edwards, 2014). Comments from women in these studies reflect deep levels of

shame and self-blame: "cause I was so damned stupid to let myself be treated like that," "I'm so ashamed," " I must have been an idiot," "the way that I acted showed that I allowed it indirectly," (Hydén, 2005, p. 180 - 181), and "[they would think] that I brought it on myself" (Knickmeyer et al., 2010, p. 106). Complex shame becomes so unbearable for many that they choose to remain silent (Plesset, 2007).

Shame/Guilt/Self-Blame and Mental Health Concerns in Survivors of IPV

Recent research has examined the role of shame, guilt, and self-blame in association with levels of violence and psychological symptoms, specifically PTSD, depression, and anxiety (Andrews & Brewin, 1990; Beck et al., 2011, 2015; Flicker, Cerulli, Swogger, & Talbot, 2012; O'Neill & Kerig, 2000; Rhatigan et al., 2011; Shorey, Sherman, et al., 2011; Street & Arias, 2001; Weiss, 2010). Some studies report a significant correlation between shame and PTSD symptoms for women seeking assistance for IPV including $r = .47$ (Street & Arias, 2001) and $r = .25$ (Beck et al., 2011), confirming previous research that identified an association between shame (but not guilt) and PTSD in a study of 107 Prisoner of War veterans who had been exposed to trauma (Leskela et al., 2002). Conversely, Kubany et al. (1995) found correlations between guilt and PTSD ranging from .51 to .80 in both combat veterans and women who had experienced IPV. However, these results should be interpreted with caution considering that this research did not address the issue of shame or distinguish clearly between shame and guilt, possibly confounding the results. Other studies have suggested that shame is the more harmful emotion, as it has been shown to be predictive of PTSD and depression in the presence of specific types of abuse (emotional/verbal, dominance/isolation), whereas guilt did not demonstrate this relationship (Beck et al., 2011; Street & Arias, 2001).

Rhatigan et al. (2011) contended that intra-individual factors such as shame have an important bearing on women's complex decision about whether to remain in or leave an abusive relationship. Their path analysis study that examined intra-individual factors such as posttraumatic stress, depression, shame, and self-efficacy in the prediction of commitment to an abusive relationship showed that higher levels of PTSD and depression were indirectly related to decreased perceptions of alternatives and increased satisfaction with the relationship through increased shame and lower levels of self-efficacy. In turn, decreased alternatives and increased satisfaction predicted increased commitment to the relationship (Rhatigan et al., 2011). Understandably, higher levels of shame and lower levels of self-efficacy could reduce one's ability to envision alternatives to an abusive situation, but it is somewhat counterintuitive that these variables could be associated with increased satisfaction with an abusive relationship. Various reasons could possibly explain this result: those with negative views of themselves choose partners who confirm these views (Rhatigan et al., 2011); the inability to generate alternate solutions could lead one to rationalize that this is the best solution; or increased feelings of shame and reduced self-worth cause women to believe they are defective, responsible for the violence, and require the abusive partner to "repair their deficiencies" (Beck et al., 2011, p. 356), thus increasing satisfaction and commitment to the relationship. Overall, shame could potentially restrict women's beliefs or perceptions about what they deserve or what is possible in a relationship.

Self-Compassion to Address Shame and Self-blame

Taken together, research regarding shame, guilt, self-blame, and IPV suggests the importance of addressing the debilitating shame and self-blame that contribute to poor adjustment and negative psychological symptoms (Beck et al., 2011, 2015; Frazier & Schauben,

1994; O'Neill & Kerig, 2000; Shorey, Sherman, et al., 2011). Recently, research regarding the development of self-compassion to address shame and the accompanying self-blame has received considerable attention for a number of mental health concerns, including addictions (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011), depression (A. C. Kelly et al., 2009; Van Dam, Sheppard, Forsyth, & Earleywine, 2011), anxiety (Boersma et al., 2015; Werner et al., 2012), PTSD (Thompson & Waltz, 2008) eating disorders (Goss & Allan, 2014; A. C. Kelly et al., 2014, 2013), and smoking problems (A. C. Kelly et al., 2010). There does not appear to be any published research to date that incorporates self-compassion within the context of IPV. However, taking into account the promising results found with other mental health concerns, its consideration for those who have experienced intimate partner violence is definitely warranted.

Definition of Self-Compassion

Self-compassion has recently become a prominent model for conceptualizing positive, resilient mechanisms to cope with stress, personal failures (Allen & Leary, 2010), and traumatic (Thompson & Waltz, 2008) or difficult (Neff & McGehee, 2010) life events. The definition of this construct can be examined from a couple of different perspectives. Gilbert's group (Catarino, Gilbert, McEwan, & Baião, 2014; Gilbert, 1989, 2010, 2011, 2014; Gilbert & Irons, 2005; Gilbert & Procter, 2006) has adopted an evolutionary model that incorporates social mentality theory, emphasizing the creation of role relationships whereby individuals send and receive social signals (threat, motivation, or soothing) which in turn stimulate the brain and biology of the recipients (Carter, 1998; Depue & Morrone-Strupinsky, 2005; Liotti & Gilbert, 2010; MacBeth & Gumley, 2012). The authors identified compassionate abilities that are critical for a positive relationship with oneself including the following: desire to care for one's own well-being; ability to detect and have sympathy for one's own distress rather than denying it; and the

ability to tolerate discomfort and pain, while showing oneself empathy, non-judgment, and warmth (Gilbert & Procter, 2006).

Neff (2003a, 2003b), who takes a social psychology and Buddhist approach, has related the definition of self-compassion to a general definition of compassion: the awareness of and connection with another's pain in a non-judgmental manner, with the belief in a "shared human fallibility" (Neff, 2003a, p. 86). Accordingly, self-compassion affords this same awareness and openness to one's own suffering and pain, extending kindness, warmth, concern toward oneself, and a desire to heal one's own distress and agony. Neff's (2003a; Neff & McGehee, 2010) model of self-compassion included three integral components: *self-kindness* (understanding given to oneself instead of harsh self-criticism); *common humanity* (understanding that one's experiences, failures, or inadequacies are shared by humankind, rather than feeling isolated or set apart by them); and *mindfulness* (interacting with experiences with a balanced awareness rather than exaggerating or over identifying with emotions or events) (Neff & McGehee, 2010; Neff, 2003a).

Measurement of Self-Compassion

Neff (2004) highlighted a distinction between mindfulness and self-compassion, suggesting that mindfulness is a component of the broader construct of self-compassion. Research has shown the positive benefits of mindfulness meditation practice (Arch & Ayers, 2013; Bostanov, Keune, Kotchoubey, & Hautzinger, 2012; Chiesa et al., 2015; Farb et al., 2010; Kristeller & Hallett, 1999; Marchand, 2012; Shapiro, Schwartz, & Bonner, 1998); however, a paucity of empirical investigations in self-compassion prompted Neff to develop a 26 item Self-Compassion Scale (self-report), to measure this construct and its links to psychological well-being (Neff, 2003b). This measure has been utilized in the recent self-compassion work of Neff

(2003a, 2003b, 2004; Neff & Beretvas, 2013; Neff, Rude, & Kirkpatrick, 2007) and Gilbert (Gilbert & Procter, 2006; A. C. Kelly et al., 2010; Liotti & Gilbert, 2010). Initial reliability and test-retest estimates were consistently strong and discriminant validity was robustly demonstrated (Neff & McGehee, 2010; Neff, 2003b). Furthermore, initial validation studies revealed a six factor structure (self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification), with a higher order factor of self-compassion emerging that explained the intercorrelations of the six identified factors (Neff, 2003b). The author contended that self-compassion is not a pre-existing unitary entity. Instead, it represents a "second order trait" (Neff, Kirkpatrick, & Rude, 2007, p. 144) that is attained by combining the six subtraits.

Trait Self-Compassion and Psychological Well-Being

Trait self-compassion has been associated with increased levels of social connectedness (r = .43 to .73; Neff & McGehee, 2010) and life satisfaction (r = .45; Neff, 2003b), emotional processing (Gilbert & Irons, 2005; Neff, 2003b), and positive coping (Allen & Leary, 2010). Additionally, significant positive associations (ranging from r = .26 to r = .62) have been found between self-compassion and various personality traits such as happiness, positive affect, optimism, wisdom, and conscientiousness. Interestingly, one of the largest correlations was observed between self-compassion and neuroticism (r = -.65), indicating that those higher in self-compassion exhibited lower levels of neuroticism (Neff, Rude, et al., 2007). Regression analyses demonstrated that self-compassion predicted unique variance in positive psychological health over and above that explained by personality, confirming the distinctness of the construct. Terry and Leary (2011) reviewed the associations between self-compassion and self-regulation regarding health concerns. They found that higher levels of self-compassion were associated

with lower levels of defensiveness, emotionality, and self-blame. Self-compassion has similarly been implicated in academic settings as a predictor of well-being for students as they cope with disappointment or failure (Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Neff, Hsieh, & Dejitterat, 2005). Moreover, evidence exists that self-compassion has positive implications for interpersonal relationships (Neff & Beretvas, 2013).

A negative association is consistently found between self-compassion and mental health difficulties such as depression , anxiety, rumination, and perfectionism (Neff, 2003b; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010). Neff (2003b) found that lack of self-compassion remained a significant predictor in depression and anxiety after controlling for self-criticism, suggesting that self-compassion may provide an avenue to "counter chronic self-criticism" (Neff, Kirkpatrick, et al., 2007, p. 145) by developing the ability to consider negative events or emotions with kindness and an acknowledgement of common humanity. Macbeth and Gumley's (2012) meta-analysis revealed the robustness of the Self-Compassion Scale, reporting a large effect size regarding the relation between self-compassion and psychopathology (Cohen, 1992) of r = -.54 (95% CI = -0.57 to -0.51; Z = -34.02; $p < .0001$).

Self-Compassion and IPV

Previously, I reviewed the significant impact of shame and self-blame on women who experience IPV in terms of mental health concerns (Andrews & Brewin, 1990; Beck et al., 2011, 2015; O'Neill & Kerig, 2000; Semb et al., 2011; Shorey, Sherman, et al., 2011; Street & Arias, 2001) and the effects on help seeking (Rhatigan et al., 2011) and potentially on revictimization (Rhatigan et al., 2011; Shorey, Sherman, et al., 2011). Considering the seriousness of this social problem and the long-term impact on survivors, it is crucial that shame and self-blame are addressed to decrease vulnerability and increase survivors' well-being and quality of life. To my

knowledge, there have been no published studies examining self-compassion as it pertains to shame, self-blame, or other correlates of mental health in victims of IPV, although recent qualitative research has started to examine the experience of self-compassion and empowerment in survivors of sexual assault, as presented at recent conference proceedings (Dicks, Van Vliet, & Budzan, 2015). Participants in this study reported that self-compassion allowed them to experience empowerment, healing, and fighting back so that they were no longer defined by the sexual assault.

Two recent review articles advocate for the application of Mindfulness Based Stress Reduction (MBSR; M. A. Dutton, Bermudez, Matás, Majid, & Myers, 2013) and Mindful Self-Compassion (Tesh, Learman, & Pulliam, 2015) with survivors of intimate partner violence. Dutton et al. (2013) proposed the use of MBSR as a community-based intervention program for low-income, predominantly African American women who have PTSD and a history of IPV. The authors presented their rationale and feasibility for this program noting that the results of a pilot randomized clinical trial were to be forthcoming (Dutton et al., 2013). However, to my knowledge, this has not yet occurred. Additionally, Tesh and colleagues (2015) published a paper regarding the use of Mindful Self-Compassion (MSC; Neff & Germer, 2013) for survivors of Intimate Partner Abuse (IPA). The authors reviewed relevant research regarding the merits of using MSC in the reduction of shame, self-blame, depression, anxiety, suicide, and PTSD. They proposed that future research should empirically investigate the benefits of mindful self-compassion for survivors of IPV. Tesh et al. (2015) further provided strategies, recommendations, and sample sessions for domestic violence practitioners. However, it is apparent that basic research into the association between shame, self-blame, and self-compassion for survivors of intimate partner violence would be an appropriate first step before intervention

studies are further developed. This population presents unique characteristics that may influence whether these variables function in a similar or dissimilar fashion to other groups (addictions, eating disorders, smoking). In contrast to these other populations, IPV survivors experience deliberate intent from an intimate partner to induce shame and self-blame and the behaviour is done to them rather than resulting from their own initiation. Consequently, this distinctive population merits more exploratory investigation to determine the relationship between these variables.

The Current Study

This study aimed to investigate the relationship between shame, self-blame, and levels of self-compassion in survivors of IPV. Shame and self-blame have been identified in the moderation and mediation of relationships between IPV and depression, anxiety, PTSD, and commitment to abusive relationships (Andrews & Brewin, 1990; Beck et al., 2011; O'Neill & Kerig, 2000; Rhatigan et al., 2011; Shorey, Sherman, et al., 2011; Street & Arias, 2001), but the relationship to self-compassion has not yet been explored with survivors of intimate partner violence. Considering that research has demonstrated a relationship between self-compassion, shame, and self-blame for other populations (eating disorders, depression, anxiety, substance use, and smoking issues) (Boersma et al., 2015; Gilbert et al., 2006; E. A. Johnson & O'Brien, 2013; A. C. Kelly et al., 2014, 2013, 2010; Luoma et al., 2012), the current investigation was warranted to determine whether these relationships will hold for IPV survivors. Previous research and theory have suggested that shame and self-blame are maladaptive, while guilt appears to be more adaptive (Gilbert & Procter, 2006; Helen B. Lewis, 1971). Given that Tangney and Dearing (2002) strongly suggest that any research investigating shame-proneness

should distinguish between shame and guilt to avoid confounded or null results, guilt-proneness was also examined. As such, the following hypotheses were made:

H1: Shame and self-blame were expected to show significant negative correlations with self-compassion, whereas guilt was expected to be positively correlated.

H2: Shame and self-blame were expected to contribute uniquely to the prediction of self-compassion when their shared variance was taken into account.

Additionally, taking into account the identification of IPV typologies, distinguishing between intimate terrorism (IT) and situational couple violence (SCV) was warranted (Hardesty et al., 2015; M. P. Johnson & Leone, 2005; M. P. Johnson, 2005; J. B. Kelly & Johnson, 2008). It was hoped by investigating the relationship between self-compassion and IPV types that we would obtain further evidence regarding the distinction between IT and SCV that may inform future research and targets for intervention. Since research suggests that IT involves the strategic and intentional subordination, disempowerment, and blame of women (M. P. Johnson & Leone, 2005; M. P. Johnson, 1995), the following hypothesis was made:

H3: Women who experience IT were expected to have lower levels of self-compassion compared to women in SCV relationships.

Lastly, shame and self-blame often inhibit women from disclosing the abuse and seeking help (Liang et al., 2005; Limandri, 1989; Plesset, 2007; Spangaro et al., 2011). Since self-compassion has been shown to reduce shame and self-blame (Gale et al., 2014; Goss & Allan, 2009; A. C. Kelly et al., 2014, 2013), it may accordingly reduce the internal barriers to help-seeking and decrease placating behaviours. Thus, an exploratory investigation into the relationship between the study variables (shame, guilt, self-blame, and self-compassion) and the strategies women use to handle the violence (e.g., external help-seeking and placating) was

conducted. Considering the paucity of research that links self-compassion with help-seeking and other strategies to deal with the violence, the following exploratory hypothesis was based on accumulating research that demonstrates the positive impact of self-compassion on psychological well-being (Allen & Leary, 2010; Gilbert & Irons, 2005; Neff & McGehee, 2010; Neff, 2003b):
H4: Higher levels of shame and lower levels of self-compassion were expected to be associated with decreased utilization of external help-seeking and increased placating strategies in women who are survivors of IPV.

Methods

Participants

Participants were recruited via a number of different sources including women's shelters, University postings, an online Women's forum, Kijiji, social media sites, community programs, hospital-based sexual assault and domestic violence programs, and through the sharing of recruitment documents between various organizations across Ontario. Inclusion criteria specified that adult females who experienced serious conflict in their intimate relationships were eligible to participate. Broad inclusion criteria were utilized with the aim to attract women who may have experienced violence in their intimate relationship, but did not explicitly identify it as such. Participation was voluntary and confidential. Of the 66 women who completed the online or hard copy survey, 51 who identified at least one act of violence in their intimate relationship or scored 19 or greater on the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999), a measure of coercive control, were included in the analyses. This ensured that participants had experienced either overt violence or a high level coercive control (cut off of 19), as outlined by Hardesty, Crossman, Haseschwerdt, Raffaelli, Ogolsky, & Johnson (2015) in their study seeking to operationalize coercive control in order to classify violence types.

Participants all identified as female and ranged in age from 19 to 64 years, M_{age} = 30.60; SD_{age} = 11.28 (one respondent did not indicate age). The majority of the sample (approximately 73%) identified with English Canadian culture with representation also from Aboriginal, European, British, French Canadian, African, Middle Eastern, and Nordic cultures. Approximately 63% (*n* = 32) of women indicated that they were no longer with the abusive partner, while 37% (*n* = 19) continued to be in a relationship with the abusive partner. Relationship length with a partner who used violence in the relationship varied. Approximately 8% of respondents reported being in this relationship for less than one year, 51% for 1-5 years, 27% for 6-9 years, and 14% for 10 years or greater. Ninety-two percent (*n* = 47) of participants indicated that the abusive partner was male, while 6% (*n*=3) indicated the partner was female and 2% (*n* = 1) identified no gender. Approximately 65% of the women indicated that at least one incident of violence occurred within the past year or the last year of the relationship. See Tables 1 and 2 for additional demographic characteristics. Consent to participate was demonstrated by the individual's voluntary completion and submission of the online or hard copy survey (see Appendix A for information and consent letter).

Measures

Revised Conflict Tactics Scales (CTS2) (Appendix B)

Elements of the CTS2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) were used to assess the presence of violence, the frequency and severity of the violence, and the number of injuries sustained. In accordance with the method used by Hardesty and colleagues (2015) to classify relationships as violent or non-violent, eleven items from the Physical Assault subscale and two items from the Sexual Coercion subscale or the CTS2 were utilized to assess the frequency of violence (e.g., "Has that partner ever pushed or shoved you?"). Of these items, nine

were used to measure severe violent acts (e.g., "Has that partner ever used a gun or knife on you?", "Has that partner ever used force [like hitting, holding down, or using a weapon] to make you have sex?"), and six items from the Injury subscale (e.g., "Did you ever have a broken bone from a fight with that partner?") were used to ask participants about injuries related to the violence. Women were asked to indicate whether they experienced any of the violent acts or injuries during the course of their entire relationship. If they responded affirmatively, they were asked how often these acts occurred. The range of responses included: "once," "twice," "3-5 times," "6-10 times," and "10 or more times." Response ranges were averaged and then totaled for a maximum score of 130 for physical violence frequency and 60 for violence injuries. Severity was scored by summing "yes" responses for a maximum score of 9. Internal consistency reliability of the CTS2 scales calculated during the initial validation of the scale ranged from .79 to .95. Only portions of some of these original scales were used and internal consistency for the subscales used ranged from .72 to .85 in this study. The information obtained from the CTS2 in the current study was used primarily to identify women who have experienced violence in their intimate relationships and provided descriptive information about the respondents.

Psychological Maltreatment of Women Inventory (PMWI) (Appendix C)

Coercive control was measured using the Dominance-Isolation subscale of the Psychological Maltreatment of Women Inventory - Short Form (PMWI; Tolman, 1999). Johnson (1995) contended, in his research regarding the classification of violence types, that the measurement of physical violence was not necessary in this categorization process. According to Johnson, previous research has suggested that non-violent control tactics are more informative than violence severity or frequency. Thus, the PMWI has been recently used by Hardesty and colleagues (2015) to operationalize coercive control and classify violence types. The authors

compared previous methods used by other researchers (frequency versus number of tactics) using hierarchical and k-means cluster analyses and determined the advantages of measuring coercive control using the frequency of control tactics approach (Hardesty et al., 2015). In addition, the authors examined the data in order to determine a cutoff (score of 19 or greater) to distinguish between groups that were high and low in coercive control with the smallest degree of misclassification (2.1%) possible. Further analyses that compared the groups on variables relevant to IPV (harassment, perceived future threat, and fear during marriage), controlling for age and violence, revealed a main effect of violence type and indicated that group differences on these variables were indicative of differences in control rather than violence. The small sample size in the current study precluded the classification of violence types using the dual cluster analysis technique suggested by these authors, but their established cutoff score of 19 (suggested score to minimize misclassification) on the Dominance/Isolation subscale of the PMWI was used to divide the sample into the two types. Seven acts of coercion were rated by women in terms of how often they experienced each one in their intimate relationship (e.g., "My partner monitored my time and made me account for my whereabouts"). Items were rated on a scale from 1 (never) to 5 (always), and responses were summed for a maximum score of 35. The initial validation study reported good reliability with a Cronbach's alpha of .88 (Tolman, 1999). The Dominance/Isolation subscale was found to have excellent internal consistency (Cronbach's alpha = .90) with this sample.

Shame and Guilt (TOSCA-3) (Appendix D)

Despite the shared variance noted between shame and guilt (Tangney & Dearing, 2002; Tangney, Wagner, & Gramzow, 1992), previous research has indicated that each of these self-conscious emotions produce distinct and divergent outcomes: shame is positively related to

maladaptive psychological outcomes, whereas guilt is positively related to more adaptive indicators of well-being (Tangney & Dearing, 2002). According to Tangney and Dearing (2002) it is important to distinguish between shame and guilt in research measuring these constructs, as "residualized shame and guilt are better predictors than the original variables" (Paulhus, Robins, Trzesniewski, & Tracy, 2004, p. 311). Consequently, this study used the Test of Self-Conscious Affect (Tangney & Dearing, 2002; TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000), a measure that includes subscales of both shame-proneness and guilt-proneness in order to determine the unique effects of these emotions. The TOSCA-3 consists of a 16-item measure in which the participant was presented with various negative scenarios (e.g., "you walk out of an exam thinking that you did extremely well, then you find out you did poorly"; or "you make a big mistake on an important project at work. People were depending on you, and your boss criticizes you") for which they were responsible and asked the individual to rate the likelihood of possible responses (e.g., "you would feel as if you wanted to hide" or "you would feel stupid"). The TOSCA-3 is rated on a 5-point Likert scale from 1 (not likely) to 5 (very likely) and subscales of shame, guilt, externalization, detached, alpha-pride and beta-pride are summed. Only the results from the shame and guilt subscales were used in this study. Reported internal consistency estimates ranged from coefficient alphas of .76 to .88 (shame) and .70 to .83 (guilt) (Tangney & Dearing, 2002). In this sample, the TOSCA3 shame and guilt subscales were found to have adequate internal consistency with Cronbach's alphas at .76 and .73, respectively for the original 16 item scale. Three items were included in the measure written by this author to reflect scenarios of relationship violence. With these three items included the resultant Cronbach's alphas for the shame and guilt scales maintained adequate internal consistency at .78 and .71,

respectively. The small sample size precluded a factor analysis including these items, so the Original 16 item scale was used.

Self-Blame (Posttraumatic Cognitions Inventory, PTCI) (Appendix E)

The Self-Blame Subscale from the Posttraumatic Cognitions Inventory (PTCI; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) was used to measure self-blame. The PTCI scale itself includes three subscales: Negative Cognitions about the Self (e.g., "I can't trust that I will do the right thing"); Negative Cognitions about the World (e.g., "people can't be trusted); and Self-Blame (e.g., "the event happened to me because of the sort of person that I am"). The 5-item Self-Blame subscale used in this study is rated on a 7-point Likert scale ranging from 1 (totally disagree) to 7 (totally agree). Initial reliability and validity studies demonstrated good internal reliability ($\alpha = .86$). The measure also showed good convergent and discriminant validity (Foa et al., 1999). The self-blame scale was found to have good internal consistency (Cronbach's alpha = .83) with this sample.

Self-Compassion (Appendix F)

Self-compassion was assessed with Neff's (2003b) Self-Compassion Scale (SCS), the most commonly used scale that measures this construct (Neely et al., 2009; Neff et al., 2005; Neff, Kirkpatrick, et al., 2007; Neff & Vonk, 2009; Van Dam et al., 2011). The measure consists of 26 items including the 5 item Self-Kindness subscale (e.g., "I try to be loving towards myself when I'm feeling emotional pain"), the 5 item Self-Judgment subscale (e.g., "when times are really difficult, I tend to be tough on myself"), the 4 item Common Humanity subscale (e.g., "when I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people"), the 4 item Isolation subscale (e.g., "when I fail at something that's important to me, I tend to feel alone in my failure"), the 4 item Mindfulness subscale

(e.g., "when I'm feeling down, I try to approach my feelings with curiosity and openness"), and the 4 item Over-Identification subscale (e.g., "when I'm feeling down, I tend to obsess and fixate on everything that's wrong "). The SCS is rated on a 5-point Likert scale from 1 (Almost never) to 5 (Almost Always). Negative items are subsequently reverse coded and the subscale scores are averaged to generate a composite self-compassion score that has primarily been used in self-compassion research.

Reliability estimates from the initial validation study with undergraduate students were consistently strong (α = .90 and higher) (Neff, 2003b) and comparable to reliability estimates attained in a later study comparing self-compassion levels between adolescents (α = .90) and young adults (α = .93) (Neff & McGehee, 2010). A further series of 5 studies demonstrated acceptable internal consistency with values ranging from .73 to .91 (Leary, Tate, Adams, Batts Allen, & Hancock, 2007). Discriminant validity was demonstrated by comparing the levels of self-compassion between a group of practicing Buddhists and college undergraduates, groups hypothesized to have very different levels of the construct (Neff, 2003b). Confirming predictions, practicing Buddhists scored significantly higher in overall self-compassion, as well as significantly higher in the three positive subscales and significantly lower in the negative subscales, than the undergraduate students, after controlling for self-esteem. Additionally, larger group differences in effect sizes regarding self-compassion (R^2 = .46) compared with self-esteem (R^2 = .01) were noted, indicating the greater influence that Buddhist practice has on levels of self-compassion and suggesting a distinction between these constructs (Neff, 2003b). The overall self-compassion scale utilized in this study was found to have excellent internal consistency (Cronbach's alpha = .95). Internal consistency for the subscales was also good with values ranging from .81 to .88.

Strategies to Handle the Violence (Appendix G)

The Intimate Partner Violence Strategies Index (Goodman, Dutton, Weinfurt, & Cook, 2003), designed to measure a range of strategies utilized by IPV survivors in response to the violence they experience, was used to measure help-seeking and other strategies to deal with the violence. The items of this 39 item self-report scale fall under six categories including the following: *Formal Network* (nine items; e.g., "called a mental health counselor for yourself"), *Legal* (four items; e.g., "filed or tried to file criminal charges"), *Safety Planning* (ten items; e.g., "developed code so others would know I was in danger"), *Informal Network* (four items; e.g., "stayed with family or friends"), *Resistance* (seven items; e.g., "fought back physically"), and *Placating* (five items; e.g., "did whatever he wanted to stop the violence"). These six categories represent private (safety planning, resistance, and placating) and public (formal network, legal, and informal network) strategies to keep themselves safe. Each item is rated dichotomously (1 = yes, 2 = no). Of interest in this study will be the items of the Informal subscale combined with seven of the nine items of the Formal subscale (excluding items concerning help-seeking for the partner) to give an external measure of help-seeking behaviour (Cronbach's Alpha = .94), while the Placating subscale (Cronbach's Alpha = .88) was used to give an indication of private strategies to deal with the violence.

Depression Scale (Appendix H)

The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was used to measure depressive symptoms. The CES-D consists of a 20-item measure that asks questions about how the individual has felt or behaved during the past week (e.g., "I was bothered by things that usually don't bother me"). The CES-D is rated on a 4-point Likert scale from 0 (Rarely or none of the time [less than 1 day]) to 3 (All of the time [5-7 days]). Internal

consistency measured by coefficient alpha, Spearman-Brown, and split-halves methods in the initial validation study ranged from .85 to .90. The CES-D showed excellent internal consistency (Cronbach's Alpha = .94) with the current sample. Information from the CES-D was used to describe the sample in this study and was not used in the quantitative analysis.

Demographics Questionnaire (Appendix I)

The last section of the survey consisted of demographic questions asking participants to indicate age, gender, ethnicity, income, education, employment, and relationship status and length.

Procedure

The study received clearance from the University of Guelph's research ethics board prior to its commencement. The study consisted of an online, anonymous survey on Qualtrics web survey software (with the option for hard copy completion) that took participants approximately 25 minutes to complete. Qualtrics is considered the gold standard in survey software that ensures the secure storage of sensitive material, with encryption over the entire process of collection, storage, and analysis.

Prospective participants were presented with a description of the aims of the study and an information and consent form. The measures appeared in the order listed in the "Measures" section above. For those completing the online survey, implicit consent was given with the completion and submission of the survey. For those completing the hard copy, implicit consent was given with the completion and mailing or delivering of the survey to the researcher. At the end of the survey, participants were debriefed in a thank-you letter regarding the purpose of the research study. Contact information for the researcher was provided, along with instructions regarding an opportunity to enter a draw for a $25.00 gift card in appreciation for participation.

A list of community resources (Appendix J) was supplied for women who may have required follow-up services, considering the sensitive nature of intimate partner violence.

Results

Analysis

Apriori power analyses were conducted using the safeguard method for multiple predictors from R statistical software (R Core Team, 2011) in conjunction with Cohen's (1992) method for determining sample size. A review of the literature (Johnson & O'Brien, 2013; Woods & Proeve, 2014) suggested medium to large effect sizes ranging between r = -.46 to r = -.59 for correlations between shame and self-compassion and self-blame and self-compassion suggesting sample sizes from 30 to 80 to achieve adequate power. A hierarchical regression study investigating the prediction of shame proneness from self-compassion and mindfulness (controlling for guilt and gender) obtained an R^2 of .44, representing a large effect size (Cohen, 1992) which suggested a sample size of approximately 30-35, according to both Cohen's (1992) guidelines and a safeguard power analysis in R statistical software. The more conservative estimate of 80 participants was used as the minimum sample size required for adequate power, considering the varied nature of the variables used in these studies.

Following data collection, CTS2 and PMWI results from 66 respondents who completed the survey were inspected to ensure each participant endorsed at least one violent act 'ever' within the intimate relationship or had a score of 19 or greater in terms of coercive control. Fifteen women were excluded from the study based on this eligibility criterion, leaving a final sample size of 51 participants.

All questionnaires on the survey were inspected for missing data using Little's (1988) Missing Completely at Random (MCAR) test in SPSS Version 23 to ensure that no patterns

existed in the missing data. Missing data were determined to be completely at random according to a non-significant value of the chi-square statistic for the TOSCA-3 (0.7% missing, chi-square = 1.851, *df* = 463, *p* = 1.000), and the Self-Compassion Scale (0.3% missing, chi-square = 110.732, *df* = 100, *p* =.218). Missing data were noted on the CTS2 (0.5%) and PMWI (0.3%), but were not replaced, as these scales were only described qualitatively and used to determine group membership in the study. For scales with missing data completely at random (TOSCA3 and the SCS), the data was replaced using the Expectation Maximization algorithm (Enders, 2003; Tabachnick & Fidell, 2007) in SPSS. This two-step iterative process involved an imputation of missing values followed by the estimation of a covariance matrix and mean vector in order to arrive at a predicted value for the missing items. A visual scan of the replaced data revealed one item that was replaced with a value outside of the range of values for the affected scale. An average of the other items replaced was used for this missing value. All other values appeared to be in accordance with the data. All other scales did not contain any missing data.

Correlation and regression analyses were conducted on the composite scales measuring shame, guilt, self-blame, and self-compassion to measure the associations between these variables and the prediction of self-compassion from shame, guilt, and self-blame. In line with recommendations from previous research, bivariate correlations were reported in conjunction with part (semi-partial) correlations for shame and guilt, as these negative emotions are consistently shown to be moderately associated with one another (Dearing et al., 2005; Shorey, Cornelius, et al., 2011; Tangney, 1991). The use of part correlations (calculated in the multiple regression process) when examining the associations of shame and guilt with other constructs such as self-compassion has been recommended to remove the effect of shared variance and allow for the unique variance of shame-free guilt and guilt-free shame to be accounted for in

relation to other constructs (Dearing et al., 2005). Additionally, in light of the moderate to large correlations observed in the literature regarding shame and self-blame (Beck et al., 2015; A. C. Kelly et al., 2009; Tangney, Wagner, & Gramzow, 1992), part correlations have been reported for self-blame for the same reasons.

Prior to conducting the analyses, study variables were examined for normality, outliers, linearity, independence of observations, homoscedasticity, and multicollinearity to ensure that they met required assumptions (Laerd Statistics, 2015). Univariate normality was assessed by a visual examination of the histogram and Q-Q Plots for all variables, as well as an examination of skewness and kurtosis values (Tabachnick & Fidell, 2007) and the Shapiro-Wilk (Field, Miles, & Field, 2012) test of normality results in SPSS. The Shapiro-Wilk test is recommended for small sample sizes of less than 50 participants (Laerd Statistics, 2015). The current sample size of 51 should be within range of a small sample size for the Shapiro-Wilk test in combination with the other methods used. All variables were normally distributed, as assessed by the Shapiro-Wilk test (Shame Subscale: $W = .969$, $df = 51$, $p = .210$; Guilt Subscale: $W = .971$, $df = 51$, $p = .236$; Self-Blame Scale: $W = .984$, $df = 51$, $p = .720$; and Self-Compassion Scale: $W = .965$, $df = 51$, $p = .135$), *z* score values, and a visual examination of the plots. The presence of univariate outliers was assessed using the outlier labeling rule (Hoaglin & Iglewicz, 1987; Iglewicz & Banerjee, 2001) recommended for normal distributions. The process involves the calculation of the upper and lower bounds in the distribution by multiplying the interquartile range by 2.2 in order to determine a significant outlier. No outliers were detected for all above variables, and this was confirmed by a visual inspection of boxplot results. A visual inspection of bivariate scatterplots revealed linear distributions for all combinations of variables.

An examination of the relationship between the dependent variable (self-compassion) and the independent variables (shame, guilt, and self-blame) both individually (bivariate scatterplots) and collectively (a scatterplot of studentized residuals against the unstandardized predicted values) revealed linearity and homoscedasticity. There was independence of residuals, as assessed by a Durbin-Watson Statistic of 2.001. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. Casewise diagnostics did not identify any outliers, no leverage values were greater than 0.2, and no values for Cook's distance were greater than 1. The assumption of normality of residual errors was met as assessed by the Q-Q Plot. All assumptions were met, confirming that a multiple regression analysis was appropriate.

A *t*-test was used to explore the hypothesis that levels of self-compassion would be lower in the intimate terrorism (IT; $n = 19$) group than in the situational couple violence (SCV; $n = 30$) group. The first three assumptions of this test were met: the dependent variable was continuous; the independent variable was categorical involving two groups; and there was independence of observations. Boxplot examination revealed four outliers for the IT group, but a follow-up comparison using the outlier labelling rule (Hoaglin & Iglewicz, 1987; Iglewicz & Banerjee, 2001) revealed no outliers. Self-compassion scores at each level of violence were normally distributed as assessed by the Shapiro-Wilk test ($p > .05$). The assumption of homogeneity of variance was violated as assessed by Levene's test for equality of variance ($p = .007$). The *t*-test was conducted with and without the outliers in the analysis to determine if this affected the homogeneity of variance. As the equality of variances assumption remained violated, a Mann-Whitney *U* test was conducted. A visual inspection of the population pyramid revealed greater variability in scores for the SCV group. The additional tests did not change the results. Thus, Welch *t*-test results are reported that correct for violations of homogeneity of variance.

A separate exploratory correlational analysis was conducted to examine the relationships between the variables of self-compassion, shame, guilt and self-blame with the variables of interest involving external help-seeking and private placating strategies. Prior to conducting the analysis, the variables were examined to ensure all assumptions were met for the Pearson Product moment correlational analysis. All variables were continuous and involved pairings between all study variables. Scatterplots were visually inspected showing a linear relationship between all variables to be entered into the correlational analysis. No outliers were identified, as assessed by visual examination of the scatterplots. The assumption of bivariate normality was violated with both the external help-seeking and placating variables as assessed by the Shapiro-Wilk test (External help-seeking: $W = .907$, $df = 51$, $p = .001$; Placating strategies: $W = .833$, $df = 51$, $p < .001$) A number of transformations were attempted to correct for the positive skew on the external help-seeking and placating variables, but were unsuccessful. Since the assumptions for the Pearson's correlation were not all met, Spearman's rank correlation test, a non parametric test was considered. Further visual examination indicated that all bivariate combinations met the monotonic relationship assumptions of the Spearman's rank correlation non-parametric test as assessed by visual examination of the scatterplots. Since all assumptions were met for the Spearman's rank correlation test, it was used to examine the correlations between these variables.

Descriptive Statistics

The Conflict Tactics Scale 2nd Edition gathered information from respondents about the frequency of physical violence they experienced, the severity of this violence and the frequency of injuries they sustained through the violence (see Table 3). The frequency of violence was measured by summing the average responses for 13 items for a maximum possible score of 130. Approximately forty-five percent of respondents experienced less than five incidents of violence

in the course of their relationship, while 33% experienced 5-19 incidents. The balance (approximately 22%) experienced twenty or more violent incidents. Of the 13 items measuring physical violence, nine of these items are categorized as severe violence, including use of a weapon, choking, and other methods of extreme physical force. Thirty-five percent of respondents did not experience any severe violent acts within their intimate relationship; whereas 55% experienced one to 10 acts of severe violence and 10% reported 20 or more acts of severe violence. In terms of injuries sustained during the violence, 43% of respondents reported no injuries and the greatest proportion (approximately 47%) sustained from one to ten injuries throughout the course of the relationship.

The Psychological Maltreatment of Women Inventory measured the level of coercion experienced by women in their relationship with their intimate partner. This measure has been used to develop an approach to operationalizing coercive control in the classifying of violence types (Hardesty et al., 2015). The sample size of the current study did not allow the clustering of respondents into violence types, but the cutoff score of 19 on this measure suggested by the authors as a useful metric was used to divide the current sample into three groups (see Table 4). Accordingly, 30 (59%) respondents fell under the cutoff score of 19. All of these women also experienced violence which placed them in the category of situational couple violence. Nineteen (37%) women fell under the intimate terrorism violence type (a score of 19 or greater on the PMWI and physical violence), and 2 (4%) women fell under the non-violent/high coercive control group.

The CES-D provided information about the degree to which women in the current study experienced difficulties with depressive mood. Scores on the measure ranged from 0 to 50, with a total possible score of 60. According to the test developers, a score of 16 or higher is

considered to be indicative of depressed mood (Radloff, 1977). Approximately 70% of the sample reported significant symptoms of depressed mood. See Table 5 for descriptive statistics regarding the frequency of depressed mood for participants.

The Intimate Partner Violence Strategies Index was used to measure strategies that women use to deal with violence in their intimate relationships. Items from the Formal and Informal subscales were used to indicate External help-seeking, and the items from the Placating subscale were used to indicate Private strategies in this study. Total scores were calculated as a percentage with overall means and standard deviations reported (External: Mean = 31.73, *SD* = 27.11; Placating: Mean = 60.39, *SD* = 38.68). Approximately 18% of women in the study did not seek external help for the conflict or violence in their relationship, whereas 82% accessed some form of external help-seeking as measured by these items. Similarly, approximately 18% of women did not engage in any type of placating behaviour strategies to stop the violence, while 82% engaged in at least one form of placating behaviour.

Complex statistical analyses comparing violence types in terms of violence and relationship variables and other study variables were beyond the scope of this study. Considering the importance of these relationships in understanding violence types, the means and standard deviations for these comparisons are included in Table 6.

Associations between Shame, Guilt, Self-Blame, and Self-Compassion

Pearson's product moment correlations were run to assess the relationships between shame, guilt, self-blame, and self-compassion in women who have experienced violence in their intimate relationship (See Table 7). Shame showed a moderately positive correlation with guilt, $r = .42$, $p = .002$, 95% CI [$\rho = .16$, $\rho = .62$] such that as shame increased so did guilt. The confidence interval indicates any population correlation between .16 and .62 between shame and

guilt could have plausibly created the sample correlation, $r = .42$. Shame similarly showed a moderately positive correlation with self-blame, $r = .32$, $p = .021$, 95% CI [$\rho = .05$, $\rho = .55$]. On the other hand, shame showed a moderately negative correlation with self-compassion, $r = -.43$, $p = .002$, 95% CI [$\rho = -.63$, $\rho = -.18$]. Guilt did not associate statistically significantly with self-blame ($p > .05$) or self-compassion ($p > .05$), indicating no evidence of a linear relationship between these variables. As noted above, guilt was positively correlated with shame. Self-blame showed a strong negative correlation with self-compassion $r = -.48$, $p < .001$, CI [$\rho = -.67$, $\rho = -.24$].[1]

The Prediction of Self-Compassion from Shame, Guilt, and Self-Blame

A multiple regression analysis was conducted to examine the extent to which levels of shame, guilt, and self-blame predicted levels of self-compassion for women in this study that have experienced intimate partner violence/conflict in the past five years. Overall, the variables accounted for 31% of the variance in self-compassion, Adjusted $R^2 = .31$, $F(3, 47) = 8.37$, $p < .001$. After accounting for the shared variance between shame, guilt, and self-blame, shame was found to uniquely predict self-compassion, $\beta = -.396$, $t(49) = -2.91$, $p = .006$, $sr^2 = .12$, indicating that high levels of shame predicted lower levels of self-compassion. Self-blame also uniquely predicted self-compassion, $\beta = -.376$, $t(49) = -3.02$, $p = .004$, $sr^2 = .13$ such that high levels of self-blame predicted lower levels of self-compassion (see Table 7). These results are consistent with the hypotheses that shame and self-blame would be negatively correlated with and uniquely

[1] Considering that Judgment subscale items in the SCS may measure self-blame, correlations were rerun with those items removed. Results were similar to those run with the whole SCS: shame and self-compassion ($r = -.41$**), guilt and self-compassion ($r = .007$), and self-blame and self-compassion ($r = -.47$**).

predict self-compassion. The null results for guilt, $\beta = .21$, $t(49) = 1.60$, $p = .116$, did not support the hypothesis of a positive association.[2]

The Effects of Self-Compassion by Violence Type

An independent samples *t*-test was conducted to examine whether levels of self-compassion varied by violence type: intimate terrorism (IT) and situational couple violence (SCV). With the violation of the assumption of homogeneity of variances, the Welch *t*-test (test for unequal variances) results were employed and indicated that participants in the SCV group ($M = 2.97$, $SD = .90$) scored significantly higher on self-compassion than those in the IT group ($M = 2.25$, $SD = .51$), -.72 (95% CI, -1.13 to -.32), $t(46.654) = -3.60$, $p = .001$. These results support the third hypothesis that women in the IT group would have lower levels of self-compassion than those in the SCV group.

Investigation of the Relationships between Shame, Guilt, Self-Blame, and Self-Compassion with External Help-Seeking and Placating Behaviour

An exploratory correlational investigation was conducted into the relationship between the study variables of shame, guilt, self-blame, and self-compassion with those of external help-seeking and placating strategies. Specifically, the hypothesis involved the prediction that self-compassion would be positively related to external help-seeking and negatively related to placating strategies, where as shame would show the opposite effect. Hypotheses were not proposed for the other study variables. According to the Spearman correlation results (see Table 8), there were strong positive correlations between self-blame and external help-seeking, $r_s = .42$, $p = .002$. A strong negative correlation was observed between self-compassion and external help-

[2] A separate regression exploring the prediction of self-compassion from shame and guilt revealed semi-partial correlations of -.47** (shame) and .19 (guilt), with the overall model accounting for 19% of the variance. A separate regression exploring the prediction of self-compassion from shame and self-blame revealed semi-partial correlations of -.29* (shame) and -.36** (self-blame), with the overall model accounting for 28% of the variance.

seeking, $r_s = -.39$, $p = .005$, such that individuals low in self-compassion were more likely to seek help than those high in self-compassion. Results were not supportive of the proposed hypothesis.

Discussion

This was the first study, to my knowledge, to empirically examine self-compassion as it relates to the shame and self-blame experienced by survivors of intimate partner violence. The results suggest that self-compassion will be an important area for ongoing investigation for IPV survivors. As predicted, and consistent with research involving other populations (Gilbert & Procter, 2006; A. C. Kelly et al., 2014, 2010; Leary et al., 2007), this study revealed a negative relationship between self-compassion and both shame and self-blame. Consistent with predictions, women who have experienced intimate terrorism (IT) demonstrated significantly lower levels of self-compassion compared to women who have experienced situational couple violence (SCV), supporting the importance of distinguishing between violence types in IPV research (Graham-Kevan & Archer, 2003; M. P. Johnson, 1995; M. P. Johnson & Leone, 2005; J. B. Kelly & Johnson, 2008).

The first and second hypotheses predicting strong associations and predictive relationships between shame, self-blame, and self-compassion were supported. These results are consistent with those found in studies using zero-order correlations (Barnard & Curry, 2012; E. A. Johnson & O'Brien, 2013; Reid, Temko, Moghaddam, & Fong, 2014), as well as with studies using partial correlations (Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011; H. Woods & Proeve, 2014). The samples in the above studies varied widely with recruitment ranging from the general population (undergraduate students), to a group of young women athletes, to those struggling with mental health or physical illness (men exhibiting behavioural dysregulation in the form of hypersexual behaviour and a primarily female sample of individuals with a chronic

illness). Thus, the current findings make a considerable contribution to the growing self-compassion research base by indicating that these relationships extend to IPV survivors.

Not only were shame and self-blame highly correlated with self-compassion, but when the shared variance between them was accounted for, they both predicted unique variance. It is understandable that a woman exposed to IPV, who is actively denigrated and shamed by her intimate partner's violence and coercive control, may have significant difficulty experiencing or demonstrating compassion towards herself as a direct result of the abuse. In addition to these intense feelings of shame, it makes sense that a woman engaging in self-blaming and self-critical thoughts that hold her responsible for the violence inflicted by her intimate partner would similarly struggle to generate feelings of warmth and compassion for herself. Considering that levels of shame and self-blame each exert unique influence over the ability to be self-compassionate, one often influencing the other (Petrocelli & Smith, 2005; Weiner, 1985), and that they both have been associated with a variety of mental health issues (Abramson et al., 1978; Cheung et al., 2004; Gilbert, 1996, 2000; Gilbert et al., 2006; Graham & Juvonen, 1998; J. P. Tangney, Wagner, & Gramzow, 1992), it will be important for future intervention research to explore how a self-compassion intervention may be incorporated to target both the shame and self-blame experienced by survivors of intimate partner violence.

Of note, as with other work that has investigated shame, guilt, and self-blame, these variables were found moderately related to each other in an IPV population. These results provide further confirmation that shared variance among these variables should be accounted for in future research on self-compassion. Bearing in mind the complexity of the relationships between these variables (Beck et al., 2015; Rhatigan et al., 2011; Shorey, Sherman, et al., 2011; Street & Arias, 2001), it would also have been informative to conduct more complex analyses

(e.g., mediation, moderation, or structural equation modeling). The sample size of the current study limited the types of analyses that could be conducted, but future research that aims to further elucidate these relationships as they relate to self-compassion would be useful.

Contrary to predictions, guilt was not significantly associated with self-compassion, and the direction of the bivariate correlation was in opposite direction of the hypothesis. The prediction was based on previous research findings regarding the adaptive nature of guilt and its frequent positive relationship with psychological well-being and health, including empathy and self-compassion (Mosewich et al., 2011; Tangney, 1991; Tangney, Burggraf, & Wagner, 1995; H. Woods & Proeve, 2014), and its negative relationship to psychopathology, including anger and aggression, anxiety, depression, obsessive-compulsive traits, and psychoticism (Tangney et al., 1995; Tangney, Wagner, Fletcher, et al., 1992; Tangney, Wagner, & Gramzow, 1992). However, when shame was factored out from guilt in the semi-partial correlation, the direction of the correlation changed to a positive one. Although the association was not significant, it was larger than that observed in the zero-order correlational analysis.

According to Tangney and colleagues (1995) it is common for bivariate correlations between shame and guilt to be consistent in sign, but this frequently changes when shame is factored out of guilt. It is possible that a larger sample size may have allowed for a significant relationship to emerge between guilt and self-compassion. However, it could also be that guilt functions differently in this population because it is not the woman's behaviour that causes the abuse. Alternatively, she could feel guilty about not having left sooner or for getting into the relationship in the first place, but the dynamics are still different than in situations such as smoking or eating that only involve one person. Thus, it will be important to continue to include a measurement of guilt when examining shame in relation to self-compassion in IPV research,

not only to obtain a measure of guilt-free shame, but also to confirm whether guilt indeed demonstrates a positive association with self-compassion, as some have suggested (Mosewich et al., 2011; H. Woods & Proeve, 2014). It is of note that the semi-partial correlation for guilt (.19) obtained in the current study fits within the confidence intervals for both the Mosewich et al. (2011; 95% CI [0.10 - 0.40]) and Woods & Proeve (2014; 95% CI [0.02 - 0.29]) studies.

The current study makes another important contribution to IPV research with the finding that women experiencing intimate terrorism possessed significantly lower levels of self-compassion than women in the situational couple violence group, confirming the third hypothesis of the study. This finding extends other research suggesting that IT is associated with more severe difficulties because it often results in a greater number of injuries and post-traumatic symptoms than are noted with SCV (M. P. Johnson & Leone, 2005; J. B. Kelly & Johnson, 2008). The results here also suggest that IT is associated with more difficulties because it is more strongly related to lower levels of self-compassion. Notably, the variance of self-compassion scores was greater for the SCV group, indicating a wide range of self-compassion scores. The scores for the IT group were more clustered at the lower end of the scale.

This would indicate that women experiencing IT involving both violence and coercive control within their intimate relationships struggle more consistently to demonstrate a compassionate, accepting attitude towards themselves and the pain they experience. It is possible that women who experience SCV, with coercive control scores below the cutoff, are more able to experience self-compassion. This may in turn allow for more variability in the experience of compassion, as they may not blame themselves for the violence. These results, however, should be interpreted with caution because the small sample size in this study may limit the

generalizability of the results. Replication with a larger sample of both IT and SCV groups will be useful to confirm the current findings.

Lastly, the final hypothesis regarding help-seeking and utilization of other strategies was not supported. Shame was not related to external help-seeking or placating strategies, and contrary to prediction, lower levels of self-compassion significantly predicted more external help-seeking. One explanation for these results could be related to the high percentage of women in this study (82%) who reported utilizing some form of help-seeking or other strategy for the conflict/violence in their intimate relationship. It is possible that the study's specific recruitment strategy attracted women willing to complete the survey who were farther along the healing process (Catallo et al., 2012; Schrager, Smith, Heron, & Houry, 2013), potentially skewing the results. Alternatively, violence type could be affecting the results, as differences have been observed between individuals experiencing IT versus SCV: women with IT have been shown to be more likely to access formal help (Leone et al., 2007). It could also be possible that more severe violence leads to both lower self-compassion and more help-seeking. Or it could be that other variables such as fear of the abuser or safety concerns override the capacity for self-compassion and motivate women to seek help and gain safety from the violence. In interpreting the results, it is important to keep in mind that only bivariate correlations were calculated given the exploratory nature of the hypotheses and the limited sample size. Thus, the shared variance between shame and guilt was not accounted for in this analysis. Replication is necessary to clarify the relationship between self-compassion and help-seeking.

Implications

Shame and self-blame have been consistently identified as persistent difficulties for women experiencing violence in their intimate relationships (Beck et al., 2011, 2015; Rhatigan et

al., 2011; Shorey, Sherman, et al., 2011). Self-compassion interventions have been successful and have been suggested for other populations experiencing high shame and self-criticism (Boersma et al., 2015; Gilbert et al., 2006; E. A. Johnson & O'Brien, 2013; A. C. Kelly et al., 2014, 2013, 2009; Luoma et al., 2012), but have not yet been explored with survivors of IPV. The results of this study suggest that self-compassion is important to this population and might be promising as an intervention to address both the shame and self-blame that can plague survivors of IPV (Andrews & Brewin, 1990; Beck et al., 2011, 2015; Flicker et al., 2012; Rhatigan et al., 2011; Shorey, Sherman, et al., 2011).

Specifically, researchers have begun to examine the merits of training or teaching individuals self-compassion skills and the effects on mental health (Arch et al., 2014; Gilbert & Procter, 2006; Jazaieri et al., 2013; E. A. Johnson & O'Brien, 2013; Leary et al., 2007; Neff & Germer, 2013; Neff, Kirkpatrick, et al., 2007; Pace et al., 2009; Van Dam et al., 2011). Some programs specifically target the development of compassion directed towards oneself (Gilbert & Procter, 2006; Neff & Germer, 2013). For example, Neff and Germer (2013) developed *Mindful Self-Compassion* (MSC), an 8-week workshop program that incorporates formal and informal self-compassion approaches in its design to accommodate both clinical and non-clinical populations. Paul Gilbert and colleagues (2009; Gilbert & Procter, 2006) developed a self-compassion therapeutic approach called Compassion-Focused Therapy (CFT) that incorporates activities of Compassionate Mind Training (CMT), specifically designed to encourage the development of self-compassion by increasing self- soothing, self-warmth, and self-kindness skills in individuals high in shame and self-criticism. Recently, investigations of self-compassion have ventured into the area of trauma by Germer and Neff (2015) in their conceptual exploration of the implications of cultivating self-compassion with trauma survivors and by

Dahm et al.'s (2015) findings that demonstrated the unique contribution of mindfulness and self-compassion, controlling for PTSD, to disability among war veterans.

Accordingly, the application of self-compassion training or therapy for IPV survivors may prove to be a useful adjunct to current approaches in work with survivors. In line with research that advocates the tailoring of interventions according to violence type (J. B. Kelly & Johnson, 2008), the current finding that self-compassion varied as a result of IPV type further suggests that self-compassion training may be especially useful for women experiencing intimate terrorism, as levels of self-compassion appeared to be significantly lower for this group in this sample. However, the small sample size of this study precluded the investigation of all of the variables (shame, guilt, and self-blame) in terms of violence type and may limit the generalizability of the conclusions. Future research regarding these constructs with a larger sample size would be beneficial to establish whether differences in self-compassion between the two groups can be confirmed and to provide additional evidence regarding the distinction of the types of violence (Graham-Kevan & Archer, 2003; Hardesty et al., 2015; M. P. Johnson, 1995; M. P. Johnson & Leone, 2005; J. B. Kelly & Johnson, 2008).

Limitations and Future Directions

There are a number of limitations that should be taken into account when interpreting the results of the current study. First, the small sample size may limit the generalizability of results. Broad recruitment strategies from a variety of sources were employed to obtain a cross section of women who experienced a wide range of violence and coercive control in their intimate relationships. Women's shelters and related organizations were very supportive and promoted the study widely across Ontario. However, obtaining a large enough sample of women from these agencies proved to be challenging. Meeting with women in person in order to establish

rapport and develop trust appeared crucial to gaining participation. The researcher met with women at shelters in two different communities, but limitations of time and opportunity restricted the ability to offer this broadly. Other recruitment sources such as Kijiji, an online women's forum, and University advertisements yielded more participants, but overall participant numbers were still lower than anticipated. It is also important to keep in mind that the correlational nature of the study does not allow for the inference of causality in the relationships between the study variables.

Secondly, the wording on the recruitment poster ("serious conflict in your romantic relationship) was intended to also attract women who did not necessarily identify the violence in their relationship as abuse. However, this may have led to a biased sample that included more women who experienced less severe forms of violence or no violence at all, while it may have alienated some women who experienced severe violence because they may have felt it did not apply to their situations. The sample obtained could also be biased by the inclusion of such a high percentage of women (82%) who were already in the help-seeking process or were no longer in the abusive relationship (two thirds). The possibility that these women may have been farther along in healing may have had an impact on their levels of self-compassion. The inclusion of more women who had not yet accessed help may have yielded quite different results, potentially more consistent with predictions. Future research that attempts to sensitively gain the participation of women who have not disclosed the abuse or who are silenced by shame (e.g., distribution of posters in community centres, doctor's offices, or grocery stores) could provide valuable contributions to the questions addressed in this research study.

Thirdly, the small sample size and limited power placed constraints on conducting more complex analyses. The sample size of 51 obtained in this study was 29 participants short of the

goal of 80 participants to achieve the power necessary for the analyses of the main hypotheses (H1 and H2). The current study examined the correlational and predictive relationships between the variables of shame, guilt, self-blame, self-compassion, and help-seeking and placating strategies in various combinations. Results revealed medium to large effect sizes for both correlational and semi-partial correlational associations between shame and self-compassion (r = -.43; sr = -.34), as well as between self-blame and self-compassion (r = -.48; sr = -.36). However, guilt did not significantly predict self-compassion, nor were predictions confirmed regarding the help-seeking hypotheses. It is likely that more complex relationships exist, with other factors including depression, fear, anxiety, and PTSD affecting the ability to demonstrate compassion towards oneself and to seek the necessary assistance to deal with the violence. According to Westfall and Yarkoni (2016), more complex statistical procedures such as Structural Equation Modeling (SEM) are critical in establishing incremental validity and controlling for confounding constructs. As such, the small sample size in this study did not allow for this type of analysis. Although depression was measured, it was only addressed in a descriptive manner because of the small sample size. Future research with a larger sample size that elucidates the nature of these more complex relationships would be beneficial to understanding the difficulties that women face that experience violence in their intimate relationships in an effort to determine appropriate targets for intervention. Nevertheless, the current study yielded a number of significant findings with important implications, despite the limited sample.

Fourth, the survey method of collecting data may have limited the accuracy of information that could be obtained. In general, participants who completed the online survey were unable to clarify questions regarding particular items on the survey, thus potentially

limiting the accuracy of responses. Hard copy surveys were available to women accessing services in shelters, with some having the opportunity to ask questions and obtain assistance. One comment on a hard copy survey indicated confusion regarding the meaning of a question. Although the survey was created to be appropriate for those with an eighth grade education and provisions were made for individuals to obtain assistance if necessary, it is possible that some misunderstanding of questions may have occurred and possibly affected response accuracy.

Additionally, with survey methodology, it is possible for individuals to provide the same answer for a question, but upon further questioning, they may have completely different reasons for their answers. For example, the Intimate Partner Violence Strategies Index (Goodman et al., 2003) used in this study may have limited the ability to draw conclusions regarding the association between study variables and help-seeking behaviours and other strategies to deal with the violence. Participants were asked to indicate whether they had used each strategy or not, but they were not required to rate the helpfulness of the strategy. Moreover, there could be variability in how women engage in these strategies and what they could mean to each participant, which 'yes' or 'no' responses may not provide. Alternatively, the external help-seeking grouping utilized here was very broad. A help-seeking measure specifically designed to differentiate the type of help-seeking someone would engage in if they were high in shame versus high in self-compassion may have been helpful. Thus, it may be beneficial for future research to include either a qualitative portion to augment the information gathered through quantitative methods or maybe even develop a more targeted measure from this qualitative information.

Lastly, the current study did not include a control group comparison. Future research that includes such a control may be useful to compare levels of shame, guilt, self-blame, and self-

compassion between IT and SCV groups, as well as with control groups who have experienced no violence. Specifically low violence/low control and low violence/high control groups, as investigated by Hardesty et al. (2015) would provide useful comparisons to determine the unique needs of the various groups. Additionally, since the current study did not assess whether higher levels of violence predicted self-compassion beyond the IT versus SCV groupings, more research regarding this distinction would be warranted.

Conclusion

Despite the above limitations, the current study provides preliminary evidence regarding the relationships between shame, guilt, self-blame, and self-compassion for survivors of IPV. Overall, women experiencing high levels of shame and self-blame tend to possess lower levels of self-compassion, with shame and self-blame each making a unique contribution to the variability in levels of self-compassion. These results combined with previous research regarding the utility of self-compassion training to combat shame, self-blame, and self-criticism provide support for the investigation of the impact of self-compassion interventions for survivors of intimate partner violence, in particular women experiencing intimate terrorism. Future research is necessary to replicate these findings and to elucidate more complex relationships between the variables in this study and other factors that may impact the development of self-compassion. Although current findings did not provide evidence that levels of self-compassion are related to help-seeking or other strategies to deal with the violence, further investigation of the direct or indirect effect of these relationships with a more targeted measure would be warranted.

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Table 1.

Demographic characteristics of study sample.

Level of Education	*N*	%
Elementary	1	2.0
Secondary	4	7.8
College	12	23.5
University	33	64.7
Missing	1	2.0
Total	51	100.0
Employment Status	***N***	**%**
Full-time	12	23.5
Part-time	15	29.4
Not Currently Employed	23	45.1
Missing	1	2.0
Total	51	100.0
Level of Income (per year)	***N***	**%**
Less than $20,000	36	70.6
$20,000 - $49,000	9	17.6
$50,000 - 79,000	5	9.8
Missing	1	2.0
Total	51	100.0

Table 2.

Frequencies of recruitment sources by violence type.

	Women's Shelter or Community-Based Program	Other Recruitment Sources	Total
IT	11	8	19
% Total	21.57%	15.69%	37.25%
SCV	5	25	32
% Total	9.80%	49.02%	58.83%
LV/Hi Control	0	2	2
% Total	0%	3.92%	3.92%
Total	16	35	51
	31.37%	68.63%	100%

Note: IT = intimate terrorism; SCV = situational couple violence; LV/Hi Control = low violence/high control.

Table 3.

Frequency of violence, frequency of violence severity, and frequency of injuries sustained.

Violence Frequency[a]	*N*	%
< 5 times	23	45.1
5 - 9 times	9	17.7
10 - 19 times	8	15.7
20 - 29 times	5	9.8
30 - 39 times	4	7.8
40 times or greater	2	3.9
Total	51	100.0
Violence Severity[b]	*N*	%
0	18	35.3
1	15	29.4
2	10	19.6
3	3	5.9
4	5	9.8
Total	51	100.0
Violence Injuries[c]	*N*	%
No injuries	22	43.1
1 - 5 injuries	21	41.2
6 -10 injuries	3	5.9
11-15 injuries	3	5.9
16 or greater injuries	2	3.9
Total	51	100.0

[abc]Based on the endorsement of items in the Conflict Tactics Scale, 2nd Edition (CTS2).

Table 4.

Frequency of coercive control tactics endorsed.

Frequency of Coercion	*N*	%
7-10 times	18	35.3
11-14 times	6	11.8
15-18 times	6	11.8
19-22 times	9	17.5
23-26 times	6	11.8
27 times or greater	6	11.8
Total	51	100.0

Table 5.

Frequency of depressive symptoms.

Depressive Mood Score	*N*	%
None	2	3.9
1-15	12	23.5
16-30	18	35.3
31-45	14	27.5
46 or greater	4	7.8
Missing	1	2.0
Total	51	100.0

Table 6.

Means and standard deviations of descriptive variables comparing violence types.

Variables	IT	SCV
	M (SD)	*M (SD)*
Depression	34.44 (11.12)	19.98 (13.42)
Violence Frequency	24.11 (18.62)	4.63 (3.97)
Violence Severity	9.05 (10.53)	1.50 (2.60)
Violence Injury Frequency	4.63 (5.89)	1.87 (2.86)
Coercion	24.79 (4.92)	11.00 (3.22)
Relationship Length	3.32 (1.16)	3.07 (1.17)

Note: IT = intimate terrorism; SCV = situational couple violence. Relationship length measured on the following scale: 1 = < 1 year; 2 = 1-2 years; 3 = 3-5 years; 4 = 6-9 years; 5 = 10 years or greater.

Table 7.

Descriptive statistics, zero-order correlations, and multiple regression results.

	Zero-Order Correlations (*r*)						
Variable	Shame	Guilt	SB	SC	*β*	*sr*	*sr²*
SB				-.48**	-.38**	-.36**	.13**
Guilt			.13	-.01	.21	.19	.04
Shame		.42**	.32*	-.43**	-.40**	-.34**	.12**
						Intercept = 3.63	
Mean	52.67	67.44	3.91	2.69		R^2=.35***	
SD	9.86	6.89	1.44	0.85		Adjusted R^2 = .31***	

Note: SB = self-blame; SC = self-compassion; *SD* = standard deviation.
* $p < .05$; ** $p < .01$; *** $p < .001$

Table 8.

Correlations for study variables with external help-seeking and placating strategies.

Variable	External Help-Seeking	Placating Strategies
Shame	.18	.12
Guilt	.02	.14
Self-Blame	.42***	.36*
Self-Compassion	-.39***	-.23
External Help-Seeking	n/a	.69***

Note: Spearman's rho correlations reported
* p <.05; ** p < .01; *** p < .005 (Bonferroni correction)

Appendix A

Information and Consent Letter

You are invited to take part in a study carried out by ***Sandra Erb (Graduate Student Researcher)***, under the supervision of ***Dr. Paula Barata (Associate Professor) in the Psychology Department at the University of Guelph***. The Research Ethics Board (REB) at the University of Guelph has reviewed and given clearance for this research study to take place.

If you have any questions or concerns about the research, please feel free to contact *Dr. Paula Barata* at pbarata@uoguelph.ca or 519-824-4120 ext. 56562 or ***Sandra Erb*** at serb@uoguelph.ca or 519-824-4120 ext. 56567.

PURPOSE OF THE STUDY:

- The study will look at the thoughts and feelings women have about themselves when they have serious conflict in their romantic relationship
- This study will also look at the how these thoughts and feelings may affect how women get help

PROCEDURES:

If you volunteer for this study, you will be asked to:

- Answer questions in a 25-minute online survey on a computer, tablet, or mobile phone
- The survey will ask you questions about:
    - Conflict in your romantic relationship
    - Violence in the relationship
    - Your thoughts, feelings, and actions
    - Some general questions
- If you want to fill out the survey on paper, you may ask your support agency for a copy or phone Sandra Erb(Graduate Student Researcher) at the above phone number
- If you need help to read the survey, you may ask someone at your agency for help **or** phone **Sandra Erb** to do it over the phone

POTENTIAL RISKS AND DISCOMFORTS:

- You may feel upset when you answer the questions
- You can skip any question that you do not wish to answer
- You can choose to stop answering questions at any time in the survey by clicking "End Survey Now"
- If you become upset and would like help, please click the "End Survey Now" button
- This will take you to the last page of the survey and the Community Resource List
- You can get to the Community Resource List on any page of the online survey by clicking on the link **"End Survey Now"** button at the bottom of each section
- If you do the survey by phone and become upset, we will provide you a list of resources where you can get help

Privacy Suggestions:

- Someone may watch you take a link from a poster or may watch over your shoulder as you do the survey
- The romantic partner you have conflict with may be able to see the sites that you visit on your computer
- If these things happen, you could be at risk of being physically or emotionally hurt
- You may want to do the survey at the agency you are working with or on the computer of a trusted friend or family member or at a local library
- Be sure to delete your browser history after doing the survey (instructions below)
- If you are concerned about your safety and privacy, you may want to leave the phone number or email address of a trusted friend or family member when you enter the Gift Card Draw. If that would not work for you, you could instead leave the phone number or email address of the service organization that you are connected with so that we could call them if you win the draw.

Option to Print Information/Consent Form:

- You can print this consent form if you would like, but considering the sensitive nature of this project, we advise caution when printing and /or storing any of the information contained within it. Otherwise, it could put you at risk from those coming across this information
- If you want to make sure no one knows you took part in this study, the information/consent form will be posted at your agency or you can go to the following website to see it: Link to Consent Form
- You could also write down the contact information in order to call the researchers if you have questions or comments later

Deleting Browser History:

Take the following steps to clear information from the computer you use to do the survey

1. Clear the browsing history
2. Clear the cache
3. Clear the cookies
4. Clear the authenticated session
5. LOG OFF

If you are using Internet Explorer, the first 4 steps can be done by going to Tools and clicking Delete Browsing History.

Below are more directions that may be helpful:

Internet Explorer:

1. In the menu, click on Tools.
2. Click on Internet Options.
3. In the General tab under Temporary Internet Files, click on Delete Files.
   This will clear your browser's cache.
4. Under History, Click on Clear History.
   This will clear pages you have visited lately.

Mozilla Firefox:
1. In the menu, click on Tools.
2. Click on Clear Private Data.
3. Check the boxes beside Browsing History and Cache.
You can check Saved Form Information, Saved Passwords, Cookies, and Authenticated Systems if you logged into any services (with a user name and password)
4. Click Clear Private Data Now

Chrome:
Clear All History

1. In the top-right corner of the browser window, click the Chrome menu
2. Click **History and recent tabs** > **History**.
3. Click the button **Clear browsing data**. A dialog will appear.
4. From the drop-down menu, select how much history you want to delete. To clear your entire browsing history, select the **beginning of time**.
5. Check the boxes for the data you want Chrome to clear, including "browsing history." Learn more about the types of browsing data you can delete
6. Click the button **Clear browsing data**.

Delete Specific Items

1. In the top-right corner of the browser window, click the Chrome menu
2. Click **History and recent tabs** > **History**.
3. Check the box next to each webpage that you want to remove from your History.
4. At the top of the page, click the button **Remove selected items**.
5. A confirmation box will appear. Click **Remove**.

Remove specific thumbnails from New Tab page. To see your most frequently visited sites, open a New Tab page. To remove a thumbnail, hover over it and click the X in the top-right corner.

Safari:

Clear All Items
1. Choose History
2. Clear History, then click clear
3. Safari also clears caches and the list of recent searches, and removes the website icons that appear in the search and address field.

Clear Specific Items
1. Choose History
2. Show History
3. Select History entries and daily sets of entries
4. Then press delete

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY:

- Taking part in this research will likely not help you directly
- But, you may feel good about helping with research on how women deal with conflict in their romantic relationships
- We hope to better understand women's thoughts, feelings, and behaviours towards themselves when they have serious conflict in their romantic relationships
- By taking the time to answer these questions, you will be helping us with this goal

COMPENSATION FOR PARTICIPATION:

- As a thank-you for your time, you can enter into a draw for a $25.00 dollar Gift Card to either Starbucks or Tim Horton's
- Your chances of winning a gift card are about 1 in 25
- For those doing the online survey, you will see a link to enter the draw

CONFIDENTIALITY AND PRIVACY:

General Privacy Information:

- You may have learned about this study through a Women's Shelter or other support organization
- It is important for you to know that these organizations are not running the study
- They will not know that you are taking part in the study unless you choose to tell them or ask them for help with the survey
- The services you are getting from these organizations do not depend on whether you do the survey

Privacy of Data:

- It is important for you to know that we will not connect your name or email address to your answers
- The survey uses **Qualtrics survey software** that meets very high standards of storing sensitive material
- Nothing will be gathered that can connect your name, email address, or computer information to your answers
- Names or email addresses gathered for the draw will be separated from your answers and will be destroyed following the draw.
- But, winners' first name/last initial and Gift Card Numbers will be sent to Financial Services at the University of Guelph for record-keeping purposes
- The data collected from this study will be kept on secure, password-protected computers used only by the researchers in this study

PARTICIPATION AND WITHDRAWAL:

- Participation in this study should be of your own free will - no one can tell you that you must take part
- You may refuse to answer any questions that you do not wish to answer
- You may stop answering questions at any time and leave the survey without sending your answers

- To do this, just click the **"End Survey Now"** button at the bottom of a section or do not mail the hard copy to the researcher
- You will be directed to the last page that gives information about:
    - The Gift Card Draw
    - Community Resource List with numbers you can call if you are upset by the questions in the survey
- After you click submit and send your answers, you cannot remove your answers from the study because we cannot link your answers to your name
- After you click submit, you will be given a different link to enter the Gift Card Draw and you will be directed to the Community Resource List

FEEDBACK OF THE RESULTS OF THIS STUDY TO PARTICIPANTS:

- You will be given the option at the end of the study to contact the researchers if you would like to receive a summary of the results of this study.

SUBSEQUENT USE OF DATA:

- The data gathered in this study may be used at any time in future studies, education, and presentations about conflict in romantic relationships
- This is so that we can use the data collected here to answer possible future research questions
- This is also so that we can give the results of this data to other people in different formats

RIGHTS OF RESEARCH PARTICIPANTS:

- You may change your mind about taking part in this study at any time without losing the chance to win a Gift Card
- You are not waiving legal claims, rights or remedies because of your participation in this research study
- This project has been reviewed by the Research Ethics Board for compliance with federal guidelines for research involving human participants.

- If you have questions regarding your rights as a research participant, please contact Sandra Auld at:

Director, Research Ethics
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
Email: sauld@uoguelph.ca
Fax: (519) 821-5236

Thank you for thinking about joining this study.

CONSENT TO PARTICIPANT:

- I understand that by completing and sending the survey, I am giving my willing consent to taking part in this study
- With full knowledge of everything in this information and consent letter, I agree, of my own free will, to take part in this study

[ ] "I agree to take part."

[ ] "I do not wish to take part ." Clicking this button will take them to the end of the survey.

Appendix B

Revised Conflict Tactics Scales (CTS2; Straus et al., 1996)

Please do NOT include your name or any identifying information on this survey.

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want things different from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. PLEASE THINK ABOUT A ROMANTIC RELATIONSHIP IN WHICH YOU HAVE HAD SERIOUS CONFLICT IN THE LAST 5 YEARS.
Please indicate whether THAT partner (ex-partner) EVER did these things to you OVER THE COURSE OF YOUR ENTIRE RELATIONSHIP by checking "Yes" or "No" for each item. For each item, you will be asked how often this occurred. If your partner did not ever do one of these things, choose "This has never happened". You will then be asked if this happened in the past year or the last year you had contact with your partner (ex-partner).

1. Has THAT partner (ex-partner) EVER twisted your arm or hair?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
2. Has THAT partner (ex-partner) EVER pushed or shoved you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
3. Has THAT partner (ex-partner) EVER grabbed you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
4. Has THAT partner (ex-partner) EVER slapped you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
5. Has THAT partner (ex-partner) EVER used a gun or knife on you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
6. Has THAT partner (ex-partner) EVER punched or hit you with something that could hurt you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
7. Has THAT partner (ex-partner) EVER choked you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
8. Has THAT partner (ex-partner) EVER slammed you against a	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No

wall?			
9. Did THAT partner (ex-partner) EVER beat you up?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
10. Has THAT partner (ex-partner) EVER burned or scalded you on purpose?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
11. Has THAT partner (ex-partner) EVER kicked you?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
12. Has THAT partner (ex-partner) EVER used force (like hitting, holding down, or using a weapon) to make you have oral or anal sex?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
13. Has THAT partner (ex-partner) EVER used force (like hitting, holding down, or using a weapon to make you have sex?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
14. Did you EVER have a sprain, bruise, or small cut because of a fight with THAT partner (ex-partner)?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
15. Did you EVER feel physical pain that still hurt the next day because of a fight with THAT partner (ex-partner)?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
16. Did you EVER pass out from being hit on the head by THAT partner (ex-partner) in a fight?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
17. Did you EVER see a doctor because of a fight with THAT partner (ex-partner)?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
18. Did you EVER need to see a doctor because of a fight with THAT partner (ex-partner), but I didn't?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No
19. Did you EVER have a broken bone from a fight with THAT partner (ex-partner)?	Ever? 0___Yes 1___No	How many times did this happen? 1___Once 4___6-10 times 2___Twice 5___10 or more times 3___3-5 times 6___This has never happened	In the last year? 0___Yes 1___No

For all the items you indicated happened at least once, think about the item that you believe to be the most serious. For that item, please answer the following questions about that partner:

20. Are you still with this partner? ___Yes ___No

21. How long have you been (or were you) with this partner? Please specify weeks, months, or years. _____

22. What is the gender of this partner?

    Male ___ Female___ Other, please specify_____

23. If you indicated one or more for any of the above items, how long ago did the last incident occur? Please specify days, weeks, months, or years. _____

Appendix C

Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999)

Please circle how often you have experienced the following acts by THAT partner (ex-partner) in the past year or in the last year you had regular contact.

	Never	**Sometimes**	**Often**	**Almost Always**	**Always**
1. My partner monitored my time and made me account for my whereabouts.	1	2	3	4	5
2. My partner used our money or made important financial decisions without talking to me about it.	1	2	3	4	5
3. My partner was jealous or suspicious of my friends.	1	2	3	4	5
4. My partner accused me of having an affair.	1	2	3	4	5
5. My partner interfered in my relationships with other family members.	1	2	3	4	5
6. My partner tried to keep me from doing things to help myself.	1	2	3	4	5
7. My partner restricted my use of the telephone.	1	2	3	4	5

For all the items that you answered as greater than Never, think about the item that you believe to be the most serious. For that item, please answer the following questions about that partner:

Are you still with this partner? ___Yes ___No

How long have you been (or were you) with this partner? Please specify weeks, months, or years._____

What is the gender of this partner?

Male ___ Female___ Other, please specify_____

Appendix D

Test of Self-Conscious Affect, Version 3 (TOSCA-3; Tangney & Dearing, 2002)

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

a) You would telephone a friend to catch up on news.

Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely

b) You would take the extra time to read the paper.

Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	**Very likely**

c) You would feel disappointed that it's raining.

Not likely	Somewhat unlikely	**Neither likely or unlikely**	Somewhat likely	Very likely

d) You would wonder why you woke up so early.

Not likely	Somewhat unlikely	Neither likely or unlikely	**Somewhat likely**	Very likely

In the above example, I've rated ALL of the answers by choosing an option. I chose "Not likely" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning -- so it's not at all likely that I would do that. I chose "Very likely" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I chose "Neither likely of unlikely" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't -- it would depend on what I had planned. And I chose "Somewhat likely" for answer (d) because I would probably wonder why I had awakened so early.

Please circle your responses to each item in the following scenarios:

1. You make plans to meet a friend for lunch. At five o'clock, you realize you have stood your friend up.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "I'm inconsiderate."	1	2	3	4	5
b) You would think: "Well, my friend will understand."	1	2	3	4	5
c) You'd think you should make it up to your friend as soon as possible.	1	2	3	4	5
d) You would think: "My boss distracted me just before lunch."	1	2	3	4	5

2. You break something at work and then hide it.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "This is making me anxious. I need to either fix it or get someone else to."	1	2	3	4	5
b) You would think about quitting.	1	2	3	4	5
c) You would think: "A lot of things aren't made very well these days."	1	2	3	4	5
d) You would think: "It was only an accident."	1	2	3	4	5

3. You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "I should have been aware of what my best friend was feeling."	1	2	3	4	5
b) You would feel happy with your appearance and personality.	1	2	3	4	5
c) You would feel pleased to have made such a good impression.	1	2	3	4	5
d) You would think your best friend should pay attention to his/her spouse.	1	2	3	4	5
e) You would probably avoid eye contact for a long time.	1	2	3	4	5

4. At work, you wait until the last minute to plan a project, and it turns out badly.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would feel incompetent.	1	2	3	4	5
b) You would think: "There are never enough hours in the day."	1	2	3	4	5
c) You would feel: "I deserve to be reprimanded for mismanaging the project."	1	2	3	4	5
d) You would think: "What's done is done."	1	2	3	4	5

5. You make a mistake at work and find out a co-worker is blamed for the error.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think the company did not like the co-worker.	1	2	3	4	5
b) You would think: "Life is not fair."	1	2	3	4	5
c) You would keep quiet and avoid the co-worker.	1	2	3	4	5
d) You would feel unhappy and eager to correct the situation.	1	2	3	4	5

6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "I guess I'm more persuasive than I thought."	1	2	3	4	5
b) You would regret that you put it off.	1	2	3	4	5
c) You would feel like a coward.	1	2	3	4	5
d) You would think: "I did a good job."	1	2	3	4	5
e) You would think you shouldn't have to make calls you feel pressured to.	1	2	3	4	5

7. While playing around, you throw a ball, and it hits your friend in the face.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would feel inadequate that you can't even throw a ball.	1	2	3	4	5
b) You would think maybe your friend needs more practice at catching.	1	2	3	4	5
c) You would think: "It was just an accident."	1	2	3	4	5
d) You would apologize and make sure your friend feels better.	1	2	3	4	5

8. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would feel immature.	1	2	3	4	5
b) You would think: "I sure ran into some bad luck."	1	2	3	4	5
c) You would return the favor as quickly as you could.	1	2	3	4	5
d) You would think: "I am a trustworthy person."	1	2	3	4	5
e) You would be proud that you repaid your debts.	1	2	3	4	5

9. You are driving down the road, and you hit a small animal.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think the animal shouldn't have been on the road.	1	2	3	4	5
b) You would think: "I'm terrible."	1	2	3	4	5
c) You would feel: "Well, it was an accident."	1	2	3	4	5
d) You'd feel bad you hadn't been more alert driving down the road.	1	2	3	4	5

10. You walk out of an exam thinking you did extremely well, then you find out you did poorly.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "Well, it's just a test."	1	2	3	4	5
b) You would think: "The instructor doesn't like me."	1	2	3	4	5
c) You would think: "I should have studied harder."	1	2	3	4	5
d) You would feel stupid.	1	2	3	4	5

11. You and a group of coworkers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would feel the boss is rather short-sighted.	1	2	3	4	5
b) You would feel alone and apart from your colleagues.	1	2	3	4	5
c) You would feel your hard work had paid off.	1	2	3	4	5
d) You would feel competent and proud of yourself.	1	2	3	4	5
e) You would feel you should not accept it.	1	2	3	4	5

12. While out with a group of friends, you make fun of a friend who's not there.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "It was all in fun; it's harmless."	1	2	3	4	5
b) You would feel small...like a rat.	1	2	3	4	5
c) You would think that perhaps that friend should have been there to defend himself/herself.	1	2	3	4	5
d) You would apologize and talk about that person's good points.	1	2	3	4	5

13. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think your boss should have been more clear about what was expected of you.	1	2	3	4	5
b) You would feel as if you wanted to hide.	1	2	3	4	5
c) You would think: "I should have recognized the problem and done a better job."	1	2	3	4	5
d) You would think: "Well nobody's perfect."	1	2	3	4	5

14. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would feel selfish, and you'd think you are basically lazy.	1	2	3	4	5
b) You would feel you were forced into doing something you did not want to do.	1	2	3	4	5
c) You would think: "I should be more concerned about people who are less fortunate."	1	2	3	4	5
d) You would feel great that you had helped others.	1	2	3	4	5
e) You would feel very satisfied with yourself.	1	2	3	4	5

15. You are taking care of your friend's dog while they are on vacation. and the dog runs away.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think, "I am irresponsible and incompetent."	1	2	3	4	5
b) You would think your friend must not take very good care of her dog or it wouldn't have run away.	1	2	3	4	5
c) You would vow to be more careful next time.	1	2	3	4	5
d) You would think your friend could just get a new dog.	1	2	3	4	5

16. You attend your co-worker's housewarming party, and you spill red wine on a new cream-colored carpet, but you think no one notices.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You think your co-worker should have expected some accidents at such a big party.	1	2	3	4	5
b) You would stay late to help clean up the stain after the party.	1	2	3	4	5
c) You would wish you were anywhere but at the party.	1	2	3	4	5
d) You would wonder why your co-worker chose to serve red wine with the new light carpet.	1	2	3	4	5

17. You have a big disagreement with your romantic partner about how to spend some extra income. Your partner criticizes you and tells you that you and your ideas are stupid.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would think: "My partner is right. I am no good, and I never have any ideas that are worth anything."	1	2	3	4	5
b) You would think: "Oh there you go again. Always worrying unnecessarily about money.	1	2	3	4	5
c) You would just walk away from your partner and start to read a book.	1	2	3	4	5
d) You would feel bad that you didn't realize how important this was to your partner and you try to make it up to your partner.	1	2	3	4	5

18. During a heated argument with your romantic partner, about whether to go to a family reunion, you try to leave the room, and your partner hits you.

	Not likely	Somewhat unlikely	Neither likely or unlikely	Somewhat likely	Very likely
a) You would continue walking and think: "It's not worth talking to you about this."	1	2	3	4	5
b) You would feel upset and try to make it up to your partner.	1	2	3	4	5
c) You would think: "Why do I always set my partner off like that? I should know better than to talk so much."	1	2	3	4	5
d) You would think: "You are really short-tempered, and I don't deserve this kind of treatment."	1	2	3	4	5

19. Your romantic partner is jealous of the time you spend with your girlfriend and has called her to tell her you cannot go to the movies.

	Not likely	**Somewhat unlikely**	**Neither likely or unlikely**	**Somewhat likely**	**Very likely**
a) You would think: "I cannot bear to see my friend. She must think I am a terrible person."	1	2	3	4	5
b) You would tell yourself that your friend will understand.	1	2	3	4	5
c) You would call your friend to explain the situation and let her know you would like to get together for the movie as planned.	1	2	3	4	5
d) You would feel that your partner is very controlling and needs to get a grip.	1	2	3	4	5

Appendix E

Post-Traumatic Cognitions Inventory (PTCI; Foa et al., 1999)

We are interested in the kind of thoughts which you may have had after experiencing serious conflict in your romantic relationship Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement by circling your response. People react to serious relationship conflict in many different ways. There are no right or wrong answers to these statements.

	Totally Disagree	**Disagree Very Much**	**Disagree Slightly**	**Neutral**	**Agree Slightly**	**Agree Very Much**	**Totally Agree**
1. The serious relationship conflict happened because of the way I acted.	1	2	3	4	5	6	7
2. The serious relationship conflict happened to me because of the sort of person I am.	1	2	3	4	5	6	7
3. Somebody else would have stopped the serious relationship conflict from happening.	1	2	3	4	5	6	7
4. Somebody else would not have gotten into this situation.	1	2	3	4	5	6	7
5. There is something about me that made the serious relationship conflict happen.	1	2	3	4	5	6	7

Appendix F

Self-Compassion Scale (SCS; Neff 2003b)

Please read each statement carefully before answering. Please circle how often you behave in the stated manner, using the following scale:

	Almost Never	**Sometimes**	**About half the time**	**Most of the time**	**Almost Always**
1. I'm disapproving and judgmental about my own flaws and inadequacies.	1	2	3	4	5
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.	1	2	3	4	5
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.	1	2	3	4	5
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	1	2	3	4	5
5. I try to be loving towards myself when I'm feeling emotional pain.	1	2	3	4	5
6. When I fail at something important to me I become consumed by feelings of inadequacy.	1	2	3	4	5
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.	1	2	3	4	5
8. When times are really difficult, I tend to be tough on myself.	1	2	3	4	5
9. When something upsets me I try to keep my emotions in balance.	1	2	3	4	5
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	1	2	3	4	5
11. I'm intolerant and impatient towards those aspects of my personality I don't like.	1	2	3	4	5
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.	1	2	3	4	5
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.	1	2	3	4	5
14. When something painful happens I try to take a balanced view of the situation.	1	2	3	4	5
15. I try to see my failings as part of the human condition.	1	2	3	4	5
16. When I see aspects of myself that I don't like, I get down on myself.	1	2	3	4	5
17. When I fail at something important to me I try to keep things in perspective.	1	2	3	4	5
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.	1	2	3	4	5
19. I'm kind to myself when I'm experiencing suffering.	1	2	3	4	5
20. When something upsets me I get carried away with my feelings.	1	2	3	4	5
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.	1	2	3	4	5
22. When I'm feeling down I try to approach my feelings with curiosity and openness.	1	2	3	4	5

	Almost Never	Sometimes	About half the time	Most of the time	Almost Always
23. I'm tolerant of my own flaws and inadequacies.	1	2	3	4	5
24. When something painful happens I tend to blow the incident out of proportion.	1	2	3	4	5
25. When I fail at something that's important to me, I tend to feel alone in my failure.	1	2	3	4	5
26. I try to be understanding and patient towards those aspects of my personality I don't like.	1	2	3	4	5

Appendix G

The Intimate Partner Violence Strategies Index (Goodman et al., 2003)

Please indicate whether you have used each of the strategies below to get assistance for the conflict/violence you have experienced in your romantic relationship. Please circle "YES" or "NO" for each item below.

	PLEASE CIRCLE YOUR RESPONSE BELOW	
1. Tried to get help from clergy.	**YES**	**NO**
2. Tried to get help from your employer or co-worker.	**YES**	**NO**
3. Talked to a doctor or nurse about abuse.	**YES**	**NO**
4. Called a mental health counsellor for yourself.	**YES**	**NO**
5. Tried to get your partner counselling for violence.	**YES**	**NO**
6. Stayed in a shelter.	**YES**	**NO**
7. Talked to someone at a domestic violence program, shelter, or hotline	**YES**	**NO**
8. Tried to get help for *yourself* for alcohol or substance abuse.	**YES**	**NO**
9. Tried to get help for *your partner* for alcohol or substance abuse.	**YES**	**NO**
10. Filed a petition for Civil Protection Order (CPO).	**YES**	**NO**
11. Filed or tried to file criminal charges.	**YES**	**NO**
12. Sought help from Legal Aid.	**YES**	**NO**
13. Called Police.	**YES**	**NO**
14. Hid car or house keys.	**YES**	**NO**
15. Kept money and other valuables hidden.	**YES**	**NO**
16. Developed code so others would know I was in danger.	**YES**	**NO**
17. Worked out escape plan.	**YES**	**NO**
18. Removed or hid weapons.	**YES**	**NO**
19. Kept important phone numbers I could use to get help.	**YES**	**NO**
20. Kept extra supply of basic necessities for myself/children.	**YES**	**NO**
21. Hid important papers from my partner.	**YES**	**NO**
22. Put a knife, gun, or other weapon where I could get it.	**YES**	**NO**
23. Changed locks or somehow	**YES**	**NO**

improved security.		
24. Talked with family or friends about what to do to protect myself/children.	**YES**	**NO**
25. Stayed with family or friends.	**YES**	**NO**
26. Sent kids to stay with friend or relatives.	**YES**	**NO**
27. Made sure there were other people around.	**YES**	**NO**
28. Fought back physically.	**YES**	**NO**
29. Slept separately.	**YES**	**NO**
30. Refused to do what my partner said.	**YES**	**NO**
31. Used/threatened to use weapon against my partner.	**YES**	**NO**
32. Left home to get away from my partner.	**YES**	**NO**
33. Ended (or tried to end) relationship.	**YES**	**NO**
34. Fought back verbally.	**YES**	**NO**
35. Tried to keep things quiet for my partner.	**YES**	**NO**
36. Did whatever my partner wanted to stop the violence.	**YES**	**NO**
37. Tried not to cry during the violence.	**YES**	**NO**
38. Tried to avoid my partner.	**YES**	**NO**
39. Tried to avoid an argument with my partner.	**YES**	**NO**

Appendix H

The Centre for Epidemiologic Studies Depression Scale (CES-D: Radloff, 1977)

Below is a list of some of the ways you may have felt or behaved. Please circle how often you've felt this way during the past week.

Please indicate your answer in the appropriate column. **During the past week...**	**Rarely or none of the time (less than 1 day)**	**Some or a little of the time (1-2 days)**	**Occasionally or a moderate amount of time (3-4 days)**	**All of the time (5-7 days)**
1. I was bothered by things that usually don't bother me.	1	2	3	4
2. I did not feel like eating; my appetite was poor.	1	2	3	4
3. I felt that I could not shake off the blues even with help from my family.	1	2	3	4
4. I felt that I was just as good as other people.	1	2	3	4
5. I had trouble keeping my mind on what I was doing.	1	2	3	4
6. I felt depressed.	1	2	3	4
7. I felt that everything I did was an effort.	1	2	3	4
8. I felt hopeful about the future.	1	2	3	4
9. I thought my life had been a failure.	1	2	3	4
10. I felt fearful.	1	2	3	4
11. My sleep was restless.	1	2	3	4
12. I was happy.	1	2	3	4
13. I talked less than usual.	1	2	3	4
14. I felt lonely.	1	2	3	4
15. People were unfriendly.	1	2	3	4
16. I enjoyed life.	1	2	3	4
17. I had crying spells.	1	2	3	4
18. I felt sad.	1	2	3	4
19. I felt that people disliked me.	1	2	3	4
20. I could not "get going."	1	2	3	4

Appendix I

Demographics Questionnaire

Please answer the following questions about yourself:

What is your age? _____

In what year were you born? _____ In what month were you born? _____

What is your gender? Male_____ Female_____ Other, please specify_____

Where did you hear about this study? Please check all that apply.

- On-line Women's Forum/Website
- Women's Shelter Program
- Community Based Women's Program
- Hospital Sexual Assault/Domestic Violence Care Centre
- University Advertisement
- Kijiji
- Social Media Site (e.g., Facebook, Twitter)
- Other, please specify _____

What is your sexual identity?

- Heterosexual
- Lesbian/Gay
- Bisexual
- Not sure
- Other, please specify _____

Which ethnic or cultural group do you identify with? (Check all that apply)

- Aboriginal (e.g., Métis, status/nonstatus Indian)
- Central American (El Salvador, Honduras, etc.)
- Scandinavian (Denmark, Sweden, Norway)
- French Canadian
- English Canadian
- British (Scotland, Wales, England, N. Ireland)
- W. European (France, Germany, Holland, etc.)
- E. European (Russia, Poland, Baltic States, Hungary, etc.)
- S. European (Italy, Spain, Portugal, Greece, etc.)
- Far Eastern (Japan, China, etc.)
- African (specify if North, South, East, West) _____
- South Asia (Pakistan, India, etc.)
- Caribbean
- Middle Eastern (Israel, Lebanon, Iraq, Iran, etc.)
- Latin America
- Other, please specify _____

What is your employment status?

Full-time_____ Part-time _____ Not Currently Employed____

What is your current level of education? (Please indicate highest level only)

- Elementary
- Secondary
- College
  - If yes, what is your level of study?
    - 1st year
    - 2nd year
    - 3rd year
    - College Diploma
- University
  - If yes, what is your level of study?
    - Undergraduate 1st year
    - Undergraduate 2nd year
    - Undergraduate 3rd year
    - Undergraduate 4th year
    - Undergraduate Degree
    - Master's Studies
    - Master's Degree
    - PhD Studies
    - PhD Degree
- Other, please specify _____

What is your current level of income per year?

- Less than $20,000
- $20,000 - $49,999
- $50,000 - $79,999
- $80,000 - $99,999
- Over $100,000

In the past 5 years, have you been in a relationship with a romantic partner (boyfriend, girlfriend, partner, husband, wife)? The relationship may or may not have been sexual.

Yes _____ No _____

If yes, how many months/years have/had you been in this relationship? _____

Please tick the boxes below that identify the sex of your current or previous intimate partners within the last year. Please check all that apply.

- Male
- Female

Other, please specify _____

Appendix J

GENERAL COMMUNITY RESOURCE LIST - ONTARIO

Call 911 if in immediate danger

ASSAULTED WOMEN'S HELPLINE CONTACT NUMBERS:
Toll Free 1-866-863-0511
GTA (416) 863-0511
Toll Free TTY 1-866-863-7868
TTY (416) 364-8762
Mobile #SAFE(#7233)

ONTARIO NETWORK OF SEXUAL ASSAULT/DOMESTIC VIOLENCE TREATMENT CENTRES:
www.sadvtreatmentcetnres.net
(416) 323-7327

OTHER HELPLINES:
Lesbian/Gay/Bisexual Youth Line
1-800-268-9688

Victim's Support Line
1-888-579-2888

Fem'Aide: Francophone Women's Support Line
1-877-336-2433

GUELPH AND SURROUNDING AREA:

EMERGENCY SERVICES:
Guelph-Wellington Women in Crisis
Sexual Assault Centre, Marianne's Place, Rural Women's Centre, Transition Program
(519) 836-5710 TOLL FREE 1-800-265-7233

POLICE SERVICES:
University of Guelph Police (519) 824-4120 ext. 2000

Guelph-Wellington Sexual Assault Care & Treatment Centre, Guelph General Hospital
(519) 837-6440 ext. 2758 After Hours ext. 2210

Family & Children's Services of Guelph & Wellington County
(519)824-2410 TOLL FREE 1-800-265-8300

OTHER SERVICES:
Citizens Concerned with Crime Against Children
Guelph - (519) 767-9967 or (519) 744-5042

Community Mental Health Clinic
(519) 821-2060

Family Counselling and Support Services
(519) 824-2431

Guelph Wellington Dufferin Health Unit - Sexual Health Clinic
(519) 821-2370

Homewood Health Centre
(519) 824-1010

University of Guelph (519) 824-4120
Human Rights & Equity Office ext. 3000
Counselling Services ext. 3244
Student health Services ext. 2131
Wellness Centre ext. 3327

Victim Services Wellington
Guelph (519) 824-1212 ext. 205 or 304
Mount Forest (519) 323-9660

HELP LINES:
Distress Centre Wellington-Dufferin
(519) 821-3760
InfoAbility Line 1-800-66?-9092
Kids Help Phone 1-800-668-6868

Lesbian/Gay/Bisexual Youth Line
1-800-268-9688
OUTline (519) 836-4550
S.O.S. Femmes 1-800-387-8603

Youth Support Line
(519) 821-5469

HAMILTON AND SURROUNDING AREA

Good Shepherd - Women's Services - Hamilton
Mary's House - Martha's House
Women's Services Crisis Line (905) 523-6277
Mental Health Crisis Support (905)529-7878

Women's Centre of Hamilton
Shelter, Housing, Counselling Services
Crisis Line (905) 387-8881

Hamilton Health Sciences Sexual Assault/Domestic Violence Care Centre - McMaster University Medical Centre
(905) 521-2100 ext. 73557

Hamilton Interval House
Crisis Line: (905) 387-8881

Mission Services Inasmuch House
Crisis Line: (905) 529-8600

Native Women's Centre Hamilton
1-888-308-6559

Catholic Family Services - Abuse and Violence Intervention and Prevention
TOLL Free 1-877-527-3823
(905) 527-3823

Nova Vita - Brantford
Residential and Counselling Services for Abused and Homeless Women
24 Hour Crisis Line (519) 752-4357
24 Hour TTY Crisis Line (519) 752-2403

Halton Women's Place
Shelter and Support Services
Crisis Lines: (905) 878-8555 or (905) 332-7892

KITCHENER/WATERLOO AND SURROUNDING AREA

Women's Crisis Services of Waterloo Region
Anselma House - Kitchener-Waterloo 24 Hour Crisis Line (519) 742-5894
Haven House - Cambridge 24 Hour Crisis Line (519) 653-2422
TOLL Free 1-800-410-4482

Waterloo Region Sexual Assault/Domestic Violence Treatment Centre - St. Mary's Hospital
(519) 749-6994

The Canadian Mental Health Association Waterloo Wellington Dufferin Crisis Services
Crisis Line/Crisis Mobile Team (844) 437-3247 TOLL FREE 1-866-366-4566
Distress Centre Phone (519) 745-1166
Youth Line (519) 745-9909
Mental Health And Addictions Data Base (519) 744-5594

Emily Murphy Centre - Stratford Second Stage Housing
TOLL Free 1-888-826-8117
(519) 273-7350

Domestic Abuse Services Oxford (daso) - Woodstock
Crisis Line: 1-800-265-1938

OWEN SOUND AND SURROUNDING AREA

Women's House Serving Bruce & Grey
Counselling, Shelter Services, Transitional Support, Sexual Assault Services
24/7 Crisis & Support 1-800-265-3026
Sexual Assault Line 1-800-578-5566

The Women's Centre (Grey & Bruce) Inc.
Shelter Services, Counselling
24/7 Crisis Help Lines (519) 371-1600
TOLL FREE 1-800-265-3722

Sexual Assault & Partner Abuse Care Centre
Nearest emergency department or Owen Sound Emergency Department
(519) 367-2121 ext. 2458

Kabaeshiwim Respite Women's Shelter
Saugeen First Nation
Housing, Legal & Social Support, Referrals, etc.
Crisis Line (519) 797-3577

D'binooshnowin Crisis Centre
Women's Shelter on Chippewas of Nawash Unceded First Nation
24 Hour Crisis Line (519) 534-4338

Appendix K

List of Abbreviations

1. CES-D……..Center for Epidemiologic Studies Depression Scale
2. CTS2..... Revised Conflict Tactics Scale
3. IPV……... Intimate Partner Violence
4. IT…….... Intimate Terrorism
5. MBSR……..... Mindfulness Based Stress Reduction
6. MCAR……...……. Missing Completely at Random
7. MSC…… Mindful Self-Compassion
8. PMWI……..…….**.....** Psychological Maltreatment of Women Inventory
9. PTCI ……..... Post Traumatic Cognitions Inventory
10. PTSD ……..…… Post Traumatic Stress Disorder
11. ……...……. Self-Blame
12. SC ……...…….. Self-Compassion
13. SCS ……...…….. Self-Compassion Scale
14. SCV……..……... Situational Couple Violence
15. SPSS……..…….. Statistical Package for Social Sciences
16. TOSCA-3……..……. Test of Self-Conscious Affect-3