Comparing Abused and Non-Abused Women:

The Effects of Social Support on Mental Health

By

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Abstract

Experiencing intimate partner violence (IPV) is associated with suicidal tendencies, depression, PTSD and emotional distress. Research shows, too, that social support decreases the impact of IPV on mental health. This study used a 2 way Factorial MANOVA to analyze if there will be a difference between non-abused and abused women in levels of mental health (PTSD and depression) based on their social support structures. While no significant interaction was found for the impact of IPV and social support on mental health, separate analyses revealed IPV significantly increased levels of PTSD and depression and strong levels of social support significantly decreased the impact of IPV on mental health. The results of this study are important in order to provide effective interventions for women experiencing IPV. Also, further research is needed to investigate the complex role of social support and its impact on mental health among women who experienced IPV.

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Chapter I

Introduction

Intimate Partner Violence (IPV) has affected millions of women regardless of their age, socio economic status (SES), culture or ethnicity (Meadows, Kaslow, Thompson, & Jurkovic, 2005; Morrison, Luchok, Richter, & Parra-Medina, 2006). Sellers, Cochran and Branch (2005) reported that the study of violence and aggression within intimate relationships began in the 1970s. IPV has been defined "as a serious social concern and depicted victims of abuse not as responsible for the violence they experienced" (Leisenring, 2006, p. 310). Researchers began with the study of spousal abuse, focusing primarily on physical abuse. During this period, questions and studies began to include non-physical forms of aggression (i.e., emotional and sexual abuse), child abuse and neglect, elder abuse, abuse of parents, abuse among siblings, aggression within same-sex couples as well as dating violence (Sellers et al., 2005). Over 40 years of the study of all types of relationship violence has proven that it is a significant problem affecting millions each year.

Women are most often the victims of IPV. Catalano, Smith, Snyder and Rand (2009) collected data from various sources from the years 1993 to 2008 that included the Bureau of Justice Statistics' National Crime Victimization Survey, Federal Bureau of Investigation, Uniform Crime Reporting Program and Supplementary Homicide Reports. In 2008, 4.3 per 1,000 females ages 12 and older were victims of nonfatal IPV. Reports also stated that 99% of cases of IPV were against women. However, only 72% were ever reported to authorities. Women who were age 18 or older experienced IPV more than those ages 12-17. In 2007, IPV resulted in the death of 1,640 women in the US. When women and men were included, 14% of all homicides in the US were the result of IPV (Catalano et al., 2009). More recently, Truman and Planty (2011) reported over one million (1,114,170) cases of IPV were reported. This increased from 1,042,210 cases of IPV reported in 2010. This increased the number of women who experienced IPV from 3% to 3.3% (Truman & Planty 2011). The Bureau of Justice Statistics released that of over the one million cases of IPV reported in

2011, victimization was committed by intimate partners that were current or former romantic partners as well as family members. Of women who report IPV, 77% said that they experienced physical violence (Truman & Planty, 2011).

Experiencing physical, emotional and/or sexual violence has been identified as negatively affecting levels of mental health in victims of intimate partner violence (Lee, Pomeroy, & Bohman, 2007; Ludermir, Shcraiber, D'Oliveria, Franca-Junior, & Jansen, 2008; Morrison, et al., 2006). Mental health problems associated with IPV include depression, low self-esteem, psychological distress and post-traumatic stress disorder (PTSD) (DeJonghe, et al., 2008). Commonly, IPV results in victims' physical injury, immune disorders, sleep disorders as well as gastrointestinal (GI) problems (DeJonghe, et al., 2008). Krebs et al. (2011) also found these same negative consequences of IPV as well as the fact that victims exhibited a decreased ability to live their lives fully.

Lee, Pomeroy & Bohman (2007) state that, "The most frequent psychological problems reported among battered women are related to posttraumatic stress disorder." (p.710). Among battered women, the prevalence of PTSD ranges from 45-84% (DeJonghe, et al., 2008). They also found that the more types of IPV that are experienced (physical, sexual, and emotional), the more symptoms they had related to PTSD (DeJonghe, et al., 2008).

Depression has also been found to be a significant psychological symptom of IPV (Lee et al., 2007). Depression and PTSD are often ongoing mental health problems that continue to occur long after the abuse has ended (Iverson et al., 2011). Kennedy et al. (2010) found significant levels of depression associated with IPV. They found that depression increased with experiencing and witnessing IPV and, importantly, that depression levels decreased with social support.

Women may seek help through the use of formal or informal support and if they do, their mental health improves with either type (Liang, et al. 2005). Women who are abused may also engage in activities and strategies (i.e. family support, therapeutic services, support groups, community resources available to battered women) that can lessen or even eliminate threats to their physical and

emotional well-being (Kocot & Goodman, 2003). Overall, research has found that social support decreases the impact of IPV on mental health in abused women (Coker et al., 2003; Golding, 1999; Liang, et al., 2005).

Theoretical Framework

Ecological theory is one theory that is commonly used when studying intimate partner violence. This theory helps to explain the relationship between social support and levels of mental health through the interactions of the participant with her environment as well as the environment's interactions with her.

Heise (1998) built a framework that applies to all types of physical and sexual abuse in order to build a more integrated approach to the examination of abuse that is directed against women. Heise (1998) also stated that researchers and theorists are beginning to agree that in order to understand abuse against women, it is vital to understand factors that operate on multiple levels within the society or community. Heise (1998) bases her work on Belsky's (1980) ecological model framework.

Belsky's framework is made up of four levels: the ontogenetic level, the microsystem, the exosystem and the macrosystem. These levels are often described as individuals' near and far environments in the form of concentric circles. The ontogenetic level is the inner most level and includes the individual's development. The mircrosystem involves the family and relationship contexts. Formal as well as informal social structures within the community are explored within the exosystem. Finally, the macrosystem encompasses societal and cultural values or beliefs (Belsky, 1980).

Statement of the Problem

This study focuses on the relationship between abused and non-abused women's perceived levels of social support and the effect of social support on levels of post-traumatic stress disorder and depression. Upon a review of existing literature, further investigation is necessary.

Statement of the research question.

The primary research question to be addressed is:

1) What is the difference in the levels of social support and mental health of women who have been abused and those who have not?

Definition of Terms

Intimate Partner. Intimate partners include a married, divorced or ex-partner as well as boyfriends where in the relationship sexual relations are maintained (Ludermir, et al., 2008; Golding, 1999).

Physical Violence. "Slapping, hitting, kicking, burning, punching, choking, shoving, beating, throwing things, locking a person out of the house, restraining, and other acts designed to injure, hurt, endanger, or cause physical pain." (Nichols, 2006, p.5).

Psychological Abuse. "Consistently doing or saying things to shame, insult, ridicule, embarrass, demean, belittle, or mentally hurt another person." (Nichols, 2006, p.6).

Sexual Violence. A person is forcefully engaged into any type of sexual activity when they do not want to (Nichols, 2006).

Intimate Partner Violence. Violence that includes any or all of the following: physical, psychological and sexual violence by a current or former intimate partner (Beeble et al., 2008).

Social Support. Social support is also referred to as informal support. It is support that is potentially available to women who are abused by family, friends, coworkers and/or neighbors (Belknap et al., 2009).

Post-traumatic Stress Disorder (PTSD). "A psychological reaction occurring after experiencing a highly stressing event (as wartime combat, physical violence, or a natural disaster) that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event." (Merriam-Webster, 2009).

Depression. "A state of feeling sad that can accompany inactivity, difficulty in thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness." (Merriam-Webster, 2009).

Chapter II

Review of the Literature

Introduction

Intimate Partner Violence has affected millions of women regardless of their age, socio economic status, culture or ethnicity (Meadows, Kaslow, Thompson, & Jurkovic, 2005; Morrison, Luchok, Richter, & Parra-Medina, 2006). Experiencing forms of intimate partner violence (physical, emotional and sexual) has been identified as a cause of low mental health levels (Lee, Pomeroy, & Bohman, 2007; Ludermir, Shcraiber, D'Oliveria, Franca-Junior, & Jansen, 2008; Morrison, et al., 2006). When abused women have been compared to non-abused women, Kaslow et al. (2010) found that abused women had a higher rate of suicidal tendencies, depression, PTSD and emotional distress.

Research has found that social support decreases the impact of IPV on mental health in abused women (Coker, Watkins, Smith, & Brandt, 2003; Golding, 1999; Liang, et al., 2005). Women who are abused that seek help may engage in activities and strategies that can lessen or even eliminate threats to their physical and emotional health (Kocot & Goodman, 2003). This review of the literature examined the effects of IPV on mental health status, coping styles, and social support as well as racial and ethnic differences. Belsky's (1980) ecological model influenced Heise's (1999) model to explore and better understand these issues.

This review of the literature covers: IPV, African American and Caucasian experiences within IPV, how mental health and IPV are related including discussions on PTSD and depression. Coping and social support were to be discussed, including how IPV may affect one's perception of social support as well as how social support may affect those who have endured or are currently enduring IPV. Different races also perceive and experience social support in different ways. A theoretical framework will also be reviewed and discussed in order to better understand IPV and its effects on abused and non-abused women.

Intimate Partner Violence

Intimate partner violence is "…characterized by threats of or actual physical, sexual or psychological harm inflicted by a current or former intimate partner…" (Beeble, Post, Byebee & Sullivan, 2008, p. 1713). It "…is a pattern of coercive behavior in which one person attempts to control another through threats or actual use of physical violence, sexual assault, and verbal or psychological abuse." (Gerber et. al, 2012, p.456). Tilley and Brackley (2004) stated "It is well documented that domestic violence is a significant health problem in the United States." (p.157). According to the Bureau of Justice statistics, in 2011 over one million (1,114,170) cases of IPV were reported. This increased from 1,042,210 cases of IPV reported in 2010 (Truman & Planty, 2011). Domestic violence does not discriminate; it exists in all socioeconomic classes, all ethnicities and all types and levels of intimate relationships. Physical and sexual violence, emotional abuse, verbal abuse and controlling behavior are all aspects of IPV (Tilley & Brackley, 2004). Intimate partner violence is defined by Sato-DiLorenzo and Sharps (2007) as a range of abusive behaviors in intimate partner relationships that includes intent to cause death, disability, injury, forcing sexual acts against one's will, as well as psychological harm in order to cause emotional trauma (Sato-DiLorenzo & Sharps, 2007).

Dejonghe, Bogat, Levendosky and von Eye (2008) stated that 20-64% of IPV against women resulted from romantic partners. The Bureau of Justice Statistics released that of over the one million cases of IPV reported in 2011, victimization was committed by intimate partners that were current or former romantic partners as well as family members (Truman & Planty, 2011). It is significant that more than 50% of these women experiencing IPV within their romantic relationships lived with children under the age of 12 years old and that IPV within romantic relationships was more common among women who were pregnant (DeJonghe, et al., 2008).

Violence perpetrated by men against women is much more common than violence against men by women. Male violence against women is much more likely to reoccur and result in injury or death. Of women who report IPV, 77% said

that they experienced physical violence. Also, women who experienced IPV increased from 3% to 3.3% from 2010 to 2011 (Truman & Planty, 2011). However, more than 1.7% of all intimate partner violence goes unreported (Truman & Planty, 2011). Negative impacts on mental and physical health as related to IPV resulted in death of 1,069 women in 2008, 35% of these deaths accounted for homicides involving women, according to the Federal Bureau of Investigation (Krebs et al., 2011).

Statistics consistently support that violence often begins in adolescence (Tilly & Brackley, 2004). In 2011, of the reported victims who were ages 12-17 years old, 37.7% reported experiencing violent crimes; 8.8% were reported to be victims of serious violent crimes (Truman & Planty, 2011). Nearly 25% of women have reported experiencing some type of IPV during their adolescence within romantic relationships (Tilly & Brackley, 2004). In fact, women are most likely and susceptible to sexual violence in their young adult years (Tilly & Brackley, 2004). Kwong et al. (2003) found that experiencing or witnessing IPV in childhood increased the likelihood of experiencing IPV in future adult relationships.

IPV: African American and Caucasian experiences.

Kaslow et al. (2010) states that violence against women is an international concern and should demand intervention and prevention. When Kaslow et al. (2010) compared African American women and Caucasian women, they found that African American women experienced higher levels of trauma within IPV. In addition, both physical and non-physical (i.e., psychological) forms of IPV were experienced at higher rates within the African American women studied than the Caucasian women who were studied, especially those of low SES (Kaslow et al. 2010). Lee, Pomeroy and Bohman (2007) also found that Caucasian women were less likely to be in a current relationship with their abuser.

Exposure of IPV increased levels of suicidal thoughts and attempts, depression, PTSD and psychological distress among African American women (Kaslow et al., 2010). They also found that African American women who a had history of suicidal tendencies and who experienced IPV within the past year were more depressed than other abused women in the study who had no history of

suicidal thoughts or attempts (Kaslow et al., 2010). The results of their study showed that African American women who were abused, suicidal, of low socioeconomic status responded well in a culturally informed, empowerment-focused group intervention and showed lower levels of mental health problems and emotional distress post-intervention (Kaslow et al., 2010).

Leiner et al. (2008) stated that IPV and suicidal tendencies are causing health problems among African American women. They stated that African American women who are young, of low-SES, divorced, separated and living within urban areas are the most frequent victims of IPV within their community. In over 50% of violent deaths of females, African American women are the victims with an intimate partner being the perpetrator. Furthermore, Leiner and associates (2008) also stated that African American women experience more negative mental and physical effects of IPV than Caucasian women.

IPV and mental health.

Intimate partner violence has several mental health problems associated with it, including depression, low self-esteem, psychological distress and PTSD (DeJonghe, et al., 2008). It most commonly results in physical injury, immune disorders, sleep disorders as well as GI problems (DeJonghe, et al., 2008). IPV activates the human body's stress system, which includes the hypothalamic-pituitary-adrenal (HPA) stress axis. This HPA axis produces the stress hormone, cortisol. Cortisol then naturally increases with stressful stimuli or in this case, IPV. This can result in metabolic and neural functions being altered. Prolonged stress, causing high cortisol levels, has proven to lower immunity and increase inflammation within the body and eventually can lead to psychological problems (DeJonghe, et al., 2008).

Krebs et al. (2011) found that those who experience IPV endure negative effects on their mental and physical health as well as their ability to live their lives fully. These effects can extend to family, friends, coworkers and others in society. They concluded, saying, "IPV has significant effect on physical and mental health…" (p. 487).

Post -traumatic stress disorder.

DeJonghe, Bogat, Levendosky and VonEye (2008) define PTSD as “a syndrome of intrusive re-experiencing, avoidance and emotional numbing, and hyper- arousal symptoms that occurs in some individuals in the aftermath of a traumatic event.” (p.294). Lee, Pomeroy and Bohman (2007) state that, “The most frequent psychological problems reported among battered women are related to posttraumatic stress disorder.” (p.710). According to DeJonghe et al. (2008), PTSD is commonly associated with several other types of mental health problems. There are several risk factors that can contribute to the development of PTSD coupled with intimate partner violence. These include revictimization or the fact that childhood abuse can increase the likelihood of abuse as an adult, the nature of the abuse (whether it be physical, sexual or emotional) and the timing and exposure to IPV (DeJonghe, et al., 2008).

The nature of abuse is such that typically more than one type of abuse is occurring at the same time. When multiple types of abuse are occurring simultaneously, the risk of developing PTSD and other mental health issues is increased (DeJonghe, et al., 2008). In this study, sexual assault by a romantic partner predicted higher negative mental health outcomes than physical abuse (DeJonghe, et al., 2008). Also, in PTSD caused by IPV, the occurrence of more than one abuse when sexual abuse was involved showed an increased rate of depression and suicidal tendencies (DeJonghe, et al., 2008). Within timing and exposure to IPV as associated as a risk factor, DeJonghe, et al., (2008) found that a history of exposure to IPV or ongoing IPV as well as experiencing IPV during pregnancy was negatively associated to mental health.

Among battered women, the prevalence of PTSD ranges from 45-84% (DeJonghe, et al., 2008). Many studies find that the more types of IPV that are experienced (physical, sexual, and emotional), the more of symptoms they had related to PTSD (DeJonghe, et al., 2008).

Depression.

Depression is found to be a significant psychological symptom of IPV (Lee, et al., 2007). IPV is linked to PTSD and depression. These are often

ongoing mental health problems that continue to occur long after the abuse has ended (Iverson, et al., 2011). Lee et al. (2007) stated that women who experience IPV are more at risk for psychological distress, including mental health disorders. Kennedy et al. (2010) found significant levels of depression associated with IPV. They found that depression increased with experiencing and witnessing IPV and, importantly, that depression levels decreased with social support. In Lee et al.'s study (2007), depression levels among women who experienced IPV ranged from 15% to 83%. The level of depression among non-abused women was significantly different ranging from 10.2% to 21.3% (Lee et. al., 2007).

Women who are victims of IPV experience abuse that directly correlates to higher levels of anxiety and depression. Anxiety and depression often lead to physical illness as well as injury (Beeble, et al., 2008). Depression over time was associated with being a witness or victim of IPV or other community based violence. Depression was found to decrease with changes when social support levels increased (Kennedy, et al., 2010). When experiencing or witnessing IPV reduced over time, lower levels of depression were reported as well. When IPV was no longer occurring and social support increased, depression levels also decreased. However, the levels differed when extreme cases of IPV were reported. In these cases, depression levels were higher and overtime decreased less than their counterparts even when increased social support was reported (Kennedy, et al., 2010).

In a study by Bonomi, Anderson, Rivara and Thompson (2007), the authors studied health outcomes in women who experienced IPV. Their results indicated that when compared to non-abused women, women who were victims of IPV had increased health problems that included depressive and severe depressive symptoms. Women who were reported having severe depressive symptoms often experienced more than one type of abuse (i.e. physical and sexual IPV). These women also were found to have lower overall physical health scores as a result (Bonomi, et al., 2007).

Symptoms of both depression and PTSD are higher in pregnant women who report sexual coercion (DeJonghe, et al., 2008). In addition, physically and psychologically abused women reported higher rates of depression, anxiety and suicidal thoughts when compared to non-abused women (DeJonghe, et al., 2008).

Coping with IPV and the Role of Social Support

There are several ways these abused women are able to cope. Coping is defined as directing one's responses toward the stressor (Krause, Kaltman, Goodman & Dutton, 2008). These behaviors include problem solving strategies and seeking social support. Avoidant coping is when one directs their behavior away from the stressor. This includes denial and avoidance and can lead to unhealthy mental status (Krause, et al., 2008). A longitudinal study by Krause, Kaltman, Goodman and Dutton (2008) found that those who suffered from PTSD also had avoidant coping behaviors.

Reviere et al. found that among a sample of low income African American women, those who had suicidal tendencies had coping strategies that focused on pleasing their abusers (DeJonghe, et al., 2008). Those who did not have these tendencies used strategies that focused on leaving or avoiding harm. This seemed to have better outcomes as compared to avoidance (DeJonghe, et al., 2008).

DeJonghe and his associates (2008) stated that it is evident that women who experience IPV are at much more heightened risk of developing PTSD. They state that IPV impacts its victims profoundly. Also, factors such as: abuse in childhood, sexual abuse, the type or types of abuse that occur, and the timing in which it occurs increases the likelihood of developing PTSD. However, DeJonghe, Bogat, Levendosky and von Eye (2008) also found that there are factors that can reduce the chance that women develop PTSD as a result of IPV. In closing, the authors stated that social support and coping styles reduced the likelihood of PTSD or other mental health disorders occurring (DeJonghe, et al., 2008).

Social support.

Coping resources include perceived social support levels as well as use of professional or formal services. These types of support affect the types of coping responses used as well as the ability of the victim to cope. Professional support services such as: mental health, shelters and religious services can also lessen the impact of IPV on mental health levels (Krause, Kaltman, Goodman & Dutton, 2008).

In coping, Lakey and Orehek (2011) stated that stressful life events can cause one to believe that she is unable to deal with the event itself. In addition, the event (IPV) puts her at risk for increased poor mental health status depending upon her coping ability. Lakey and Orehek (2011) state that coping involves: problem solving, revisiting the stressful event, avoidance as well as seeking support. They found that social support served as a buffer for stress and aids coping ability and strategy. In addition, social support included what friends and family members say and do in order to help the victim's perception of the support that is available to them.

Social and emotional support has been defined as resources and assistance exchanged through social relationships and interpersonal interactions, and serves four major functions: emotional, informational, instrumental, and appraisal (Strine, Chapman, Balluz & Mokdad, 2008). Emotional functions include sharing problems and venting emotions. Informational functions include advice and guidance. Instrumental functions are providing resources such as a car and the appraisal function is comparing you to others. Social support is linked to reduced risk of mental illness and death. It can also change the way people deal with stress, behave and make critical decisions (Strine, et al., 2008).

Social support and IPV.

Beeble, Bybee, Sullivan and Adams (2009) interviewed 160 IPV survivors six times over a period of two years. Their findings unveiled a complex role played by social support on women's well-being and mental health. Social support positively related to quality of life and negatively to depression (Beeble, et al., 2009). "Social support also partially explained the effect of baseline level

and subsequent change in physical abuse on quality of life and depression over time, partially mediated the effects of change in psychological abuse and moderated the impact of abuse on quality of life" (Beeble, et al., p718). However, the positive effects of social support levels were the most high at low levels of reported abuse (Beeble, et al., 2009).

In addition, there are protective or resilient factors for the development of PTSD (DeJonghe, et al., 2008). While women who are victims of IPV are at high level of risk to develop PTSD, not all women do. There are several resilience factors in relation to experiencing IPV and developing mental health problems. Social support and personal characteristics are among these (DeJonghe, et al., 2008). Social support has been linked to directly affecting mental health within the trauma of IPV as well as play a role in IPV and mental health outcomes (DeJonghe, et al., 2008). Martin and Hesselbrock found that social support heightened the resiliency of women who had been victimized (DeJonghe, et al., 2008). Several personal characteristics include: control, commitment, goal orientation, self-esteem, adaptability, social skills and sense of humor. These were associated with resilience among women who are experiencing or have experienced IPV as well as greater levels of mental health (DeJonghe, et al., 2008).

Race and social support.

Intimate partner violence, social support, mental health and culture are significantly intertwined. To demonstrate, Lee, Pomeroy and Bohman (2007) studied the levels of social support and coping among a group of Asian and Caucasian women in their levels of social support and coping. The authors studied the effects of social support and coping strategies in relation to IPV and mental health outcomes. The study included 100 Caucasian women and 61 Asian women. These women and their information were acquired from various domestic violence agencies. Combined, the two groups revealed there "…was an indirect effect of the level of violence on psychological outcomes via the mediating variables of perceived social support and passive coping strategies." (Lee, et al., 2007, p 709). The findings indicate also that outcomes and coping

strategies varied within the ethnic groups. The amount of violence experienced did not directly affect mental health levels in association with perceived social support and coping strategies in the Caucasian group. However, the results indicated a direct relationship with the level of violence on mental health among Asian women. When Asian women's levels of violence were more severe, the support levels and coping strategies were not found to be significant (Lee, et al., 2007).

Hollenshead, Dai, Ragsdale, Massey and Scott (2006) studied community response to victims of domestic violence. They found that positive community response is critical in order to reduce violent events and educate the community in order to replace violence with conflict management skills. The authors of this study identified and examined the IPV victims' methods of seeking help such as: assistance of law enforcement and/or services from domestic violence centers. They found that African American victims most often sought support from law enforcement and the opposite was true for Euro-Americans or Caucasians (Holleshead, et al., 2006). Paranjape and Kaslow (2010) found that spirituality and social support are two factors of health status for older African American women. They found that mechanisms that are culturally appropriate were needed to enhance these two factors in order to explore them as potential interventions to improve mental health status of those exposed to IPV (Paranjape & Kaslow, 2010).

Paranjape and Kaslow (2010), who studied protective roles in African American women, stated "Our data about the link between social support and health status are consistent with the work of Sherbourne et al., who demonstrated that community-dwelling people with higher levels of social support enjoy better health status. Specific to abused women, Coker et al. were the first to how that higher levels of social support are associated with better physical and mental health status among abused women." (p 1902). Paranjape and Kaslow (2010) also found that there was a correlation of reduced levels of social support to psychological distress in the African American women they studied of low socioeconomic status.

Constantino, Kim and Crane (2005) tested effectiveness of social support intervention with 24 women while they were in a domestic violence shelter. The intervention group saw greater improvement in mental health levels and perceived social support levels. They found that social support intervention for women who are victims of IPV was effective in improving mental health status (Constantino, et al., 2005).

Another form of social support was identified by Wang, Levitt, Horne and Klesges (2009) as they examined Christian women's religious beliefs and practices in relation to their intimate relationships where IPV was present. Many women in this study reported seeking help within their church community and religious leaders' guidance in leaving their abusive relationships. Women who have strong religious beliefs and relationships with their church state that these relationships affect their decision in leaving their abusive partner (Wang, et al., 2009).

Ecological Theory

"An ecological approach to abuse conceptualizes violence as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors." (Heise, 1998, p.262). Heise (1998) built a framework that applies to all types of physical and sexual abuse of women in order to build a more integrated approach to abuse against women. Heise (1998) also stated that researchers and theorists are beginning to agree that in order to understand abuse against women, it is vital to understand factors that operate on multiple levels within the society or community. Stith et al. (2004) stated that perspectives of IPV have shifted to "multifactor frameworks" (p. 67). These frameworks involve several variables or factors that can include: societal beliefs, cultural beliefs, family relationships, education, age, personal characteristics and socio-economic status. This change in perspective reinforces Heise's (1998) perspective that abuse must involve the interaction between the individual and the environment.

Heise (1998) based her work on Belsky's (1980) ecological model framework. Belsky's framework is made up of four levels: the ontogenetic level,

the microsystem, the exosystem and the macrosystem. These levels are most often seen as four concentric circles (Heise, 1998). Belsky (1980) used this framework to describe social and psychological phenomenon in which several factors are working. Within this phenomenon, both the family and the victim are large components (in our case, IPV). The individual is within the ontogenetic level, the family is the microsystem, and the community is the macrosystem (Belsky, 1980). He reinforces his framework with the work of Bronfenbrenner, who studies and built a framework around the environment which development occurs (Belksy, 1980).

According to Belsky and Pluess (2009), the model reinforced the fact that due to both environmental and biological factors, individuals vary in how they interact with their environmental influences. Some may be more susceptible to negative influences (abuse, negative social influences, etc.) while some may be more resilient and seem to benefit more from different types of supportive social experiences. Kennedy et al. (2010) emphasize the need for a theoretical basis that takes into account the occurrence of family and community violence. Such an approach has research focusing on risk factors such as environmental conditions (i.e. low socioeconomic status) and family-level interactions and the nature of the relationships within the family group.

The macrosystem.

The outermost, or fourth, level of the framework is the macrosystem which represents the culture, community or society's general views (Heise, 1998). This includes cultural values and beliefs (Stith et al., 2004). One such example is patriarchy (i.e., a belief of men's dominance) (Brownridge, 2006). The patriarchal culture, which promotes gender inequality, encompasses the subordination and reinforcement of power over women (Ludermir et al., 2008). The macrosystem level holds answers to the question of why IPV exists in today's society and may help in the understanding of abuse against women. Our "…society encompasses a number of values, beliefs, attitudes and behaviors that act as risk factors by directly or indirectly promoting intimate partner violence." (Begun, 1999, p.5). Barner and Carney (2011) suggested IPV is rooted in our patriarchal

society's way of learning. This includes attitude toward gender. It was noted that gender inequality reinforces the notion of having power over a person or group as well as subordination (Ludermir, et al., 2008). For example, the head of household who is male uses violence as a means of gaining a woman's compliance. This is a form of coercive power forced upon the subordinate figure, in this case, the woman.

The exosystem.

The third level is called the exosystem and it consists of the social structures within the community (i.e., work, social services, and social networks) (Heise, 1998). Stith et.al, 2004 also identifies friendships, the work place, legal institutions and educational systems as part of this level. The exosystem allows for the examination of the significance of social support among women who are abused and can be viewed as the interaction between the abused and their social networks. For example, Begun (1999) stated that women may stay in a relationship that is abusive because they have limited options or resources necessary to create a new social network. Heise (1998) stated that often access to resources or options to the relationship may be severely limited because the abuser often isolates the victim from their social environment or networks. Although victims of IPV have smaller social networks due to the isolation caused by their abuser, Brownridge (2006) stated that they still have the ability to build new supportive networks.

Social support is a major focus of this research. As such, this interactive level of the ecological model is particularly important to understanding the prevalence of IPV. There are several key factors that determine the effect of social support of abused women: support from friends, family and the community (Begun, 1999). The support of friends, family and community can have positive effects on the mental health of women who have experienced IPV (Coker, et al., 2003; Kocot & Goodman, 2003; Lee, et al., 2007; Meadows, et al. 2005). However, the type and quality of the support given is vital and may be helpful or harmful to the individual (Morrison, et al., 2006) as can the responses of the people in a person's social network (i.e. family, friends, peers, coworkers) to IPV

(Begun, 1999). Morrison and his colleagues stated that extensive professional training is essential in order to provide formal kinds of support to effectively help deal with the mental health status of the abused individuals (2006).

The microsystem.

The second level, the microsystem, helps researchers and practitioners to examine the context in which abuse takes place; in this case, an intimate partner relationship (Heise, 1998). At the microsystem level, the experiences, consequences and types of violence that occurs can be scrutinized, thereby providing an explanation for the cause of mental health problems (i.e. depression and PTSD) caused by IPV.

It is also possible at the microsystem level to observe the dynamics of the violence. The identification of the type of abuse in the relationship is important because intimate partner violence can include physical, emotional and sexual abuse. Each type of abuse is associated with several mental health problems that include PTSD and depression (Coker, et al., 2002). Beeble et al. (2008), hold that having only experienced physical and psychological, or emotional, abuse correlates to high levels of mental distress.

The ontogenetic level.

The innermost level or the ontogenetic level is made up of an individual's personal history, behaviors and characteristics (Heise, 1998). Individuals' behaviors and characteristics influence their response to stressors that are occurring within their social networks as well as other levels of the framework (Stith, et al., 2004). An individual's personal or developmental history can help us understand the occurrence of IPV among a certain population (i.e. younger women).

Begun (1999) stated that there are many reasons why individuals may become victims of IPV. For example, Brownridge (2006) stated that age may be a factor because younger women are more likely to be at risk for violence. Literature supports the existence of violence among adolescents (Dutton, et al, 2006; Holt & Espelage, 2005; Keenan-Miller, Hammen, & Brennan, 2007) as well as among college age individuals (Fincham, et al., 2008; Hines, 2007; West &

Wandrei, 2002). Since this research will focus on college females' experiences of IPV, factors encompassed in the ontogenetic level are important to consider.

Age has important implications that are associated with the consequences of IPV as well. The interaction between the individual (the ontogenetic level) and their social networks (the exosystem level) is particularly interesting. Belknap et al. (2009) speculated that younger women may have less established support networks that result in more severe consequences of IPV. As research of young women has increased, it is vital to understand the implications of age on other factors associated with IPV.

Conclusion

It is vital to inform society of the psychological effects of IPV. IPV not only affects the victim, but the community as a whole. If members of the community are aware of IPV as a violent crime that causes detrimental effects on mental health (PTSD and depression) as well as the documented effects on physical health (immune disorders, GI problems, inflammation, high cortisol levels), then the community may become more involved in taking action against the perpetrators of IPV as well as reducing the prevalence of it (Lee, et al., 2007).

Kaslow et.al. (2010) stated "Compared with non-abused women, abused women have a higher incidence and severity of suicidal attempts and ideation, symptoms of depression and PTSD, and overall emotional distress" (p.449). It is clear that further research is needed regarding women's mental health disorders such as: PTSD and depression as a result of intimate partner violence. Comparing abused and non-abused women in this study can help determine if and what levels of perceived social support exist between the two groups and how they affect mental health.

Statement of Hypothesis

Hypothesis: There will be a difference between non-abused and abused women in levels of mental health (PTSD and depression) based on their use of social support structures.

Chapter III

Methods

This study analyzed the relationships between perceived social support levels and mental health disorders among abused and non-abused women. The design is quantitative in nature and was used to determine the effect of women's use of social support structures on their mental health. The hypothesis stated that there will be a difference between non-abused and abused women in levels of mental health (PTSD and depression) based on their use of social support structures.

Participants

This study used an existing data set that was collected from a sample of women who attended Middle Tennessee State University. The number of women who completed questionnaires was 408. These participants were enrolled in courses in Human Sciences, Health and Human Performance as well as University 1010 courses. These courses were selected because the students who were enrolled represented a diverse selection of majors. Some female students were also included from the Psychology Subject Pool. While the original research focused only on the abused women, this study uses the existent data to compare all of the women sampled. This included those who had experienced IPV (*n* = 181 or 44.4% of the original sample) and those who had not (*n* = 227 or 55.6% of the original sample).

Approval and permissions were obtained from the research pool director (see Appendix A) as well as classroom professors to administer the surveys to the female students (see Appendix B). Also, approval for the current study was granted by the Institutional Review Board of Middle Tennessee State University (see Appendix C).

Measures and Instruments

The survey packet contained five sections: demographics, Abusive Behavior Inventory, Post-Traumatic Stress Disorder Checklist – Civilian Version, Center for Epidemiologic Studies Depression Scale and Multidimensional Scale of Perceived Social Support. These instruments measured the frequency of

abuse (physical, emotional and sexual violence), mental health problems such as PTSD and depression as well as how social support networks were perceived. Permission to use these instruments was not needed as they are easily accessible.

Intimate partner violence.

The Abusive Behavior Inventory (ABI) was used to measure levels of intimate partner violence (Shepard & Campbell, 1992). This survey contains 30 questions in a self-reporting format using a five-point Likert scale to measure the frequency of IPV, with 1 as “never” and 5 as “very frequently”. Questions 1-5, 8-13, 15-17, 19, 22 and 23 were part of the psychological subscale. The physical subscale included questions 6, 7, 14, 18, 20, 21, and 24-30. Of these questions within the physical subscale, questions 18, 26, and 28 related to sexual abuse. Scores were summed and divided to determine frequency of IPV for each participant.

The ABI scale has been noted to have good reliability. In a study by Shepard and Campbell (1992), the alpha coefficient ranged from .79 to .92 of a sample of both males and females in both abusive and non-abusive relationships. In addition, Holt and Espelage (2005) reported findings in their study of an alpha coefficient of .80 for middle school age students and alpha of .90 for high school age students.

As the ABI scale was used to determine whether or not the participant had experienced IPV, the sample included only participant responses of “rarely” experienced physical violence, sexual abuse, and/or emotional abuse to “very frequently” experienced these types of violence. The existent data included questions that indicated threats of violent behavior (i.e., question #11 and #25). These questions were omitted from the original analysis because the study was concerned with women who had been abused, not just threatened. There were also questions that involved parenting (i.e., question #16 and #27). As the sample was that of college students, most participants did not have children. To control for missing data, if the response indicated that the participant had no children, question #27 was given the response as “Never”.

Mental disorders.

Two instruments were used to collect data regarding the mental disorders of depression and PTSD. The Post-Traumatic Checklist – Civilian Version or PCL-C (Weathers, Litz, Herman, Huska & Keane, 1993) is a 17 item self-report scale that uses a 5 point Likert scale. The scale ranged from 1- “not at all” to 5 – “extremely” to measure PTSD levels in participants (See Appendix D). Higher scores indicated presence of more PTSD symptoms within a range of 18-85.

The Post-Traumatic Checklist-Civilian Version’s purpose is to measure reoccurring symptoms that relate to any traumatic event. It is reported to have a test-restest reliability of .96 and an internal consistency of .97. Also, in a study by Lee et al. (2007), the Cronbach’s alpha was .94 for Caucasians and .91 for Asians. Weathers and associates (1993) confirmed convergent validity, a type of construct validity that indicates a scale correlates well with others that are similar, with high correlation of .85 between the Mississippi Scale, which is another stress scale, and the PCL-C.

Depression is measured by the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1997). This measurement tool consists of a 20-item survey with a four-point Likert scale that ranged from, 0-“rarely or none of the time” to 3-“most of or all of the time”. It is a self-reporting measure of the symptoms of depression with higher scores again indicating the presence of more symptoms of depression. The sum of the scores can range from 0 to 60.

The Center for Epidemiologic Studies Depression Scale’s purpose is to help measure the depression symptoms (also present among a clinical diagnosis) among the general population. It is reported to have high discriminate validity, which is a type of construct validity that indicates non-correlation between unrelated scales, between the patient and the general population. It has good internal consistency of .85 for the general population and .90 for patients who have clinical diagnosis (Radloff, 1977) and Lee and associates (2007) found the Cronbach’s alpha in their study to be .93 for Caucasians and .86 for Asians.

Social support.

The Multidimensional Scale of Perceived Social Support (MSPSS) was used to measure perceived social support from family, friends, and significant others (Zimet, Dahlem, Zimet & Farley, 1988). This is a 12 item self-reporting scale that uses a seven point Likert scale. A ranking of 1 indicated the participant "very strongly disagreed". A ranking of seven indicated that the participant "very strongly agreed". Higher scores indicate higher levels of perceived social support. The range of scores is 1 to 84.

This scale has been noted to have good internal reliability within each subscale. The alpha coefficients were as follows: significant other .91, family .87 and friends .85. Test-retest reliability included: significant other .72, family, .85 and friends .75. Zimet and associates (1998) concluded that MSPSS has moderate construct validity by investigating the correlation between perceived social support levels, anxiety and depression symptoms.

Procedure

These surveys were self-administered paper-and-pencil surveys. The surveys took about 25 minutes to complete. When the participants were given the packet, they were informed that their participation was voluntary and their identity anonymous. Participants were given a written consent form that was collected and stored separately from the survey responses. Participants were asked not to provide their names on the questionnaire packet and were informed that they had the ability to stop participation at any time. The packet also included a list of resources and agencies that students could use for support if they experienced any stress, anxiety or other problems as a result of completing the questionnaire.

Data Analysis

Descriptive statistics are used to determine the percentages and means of demographic information such as age, race and school classifications. The hypothesis in this study states that there will be a difference between non-abused and abused women's' levels of mental health (PTSD and depression) based on their use of social support structures. Data will be analyzed by SPSS 20 using a

2- way factorial multivariate analysis of variance (MANOVA). This two-way design will simultaneously test the joint effect of independent variables on dependent variables. The independent variables (IV) are categorical and include intimate partner violence (abused and non-abused women) and social support (no, mild and strong levels) while the dependent variable (DV) is mental health (a continuous variable) measured by the PTSD and depression scores.

Chapter IV

Results

In the present study, support was sought for the hypothesis stating that there will be a difference between women who have experienced IPV and those who have not in levels of mental health (PTSD and depression) based on their use of social support structures.

A 2-way between groups factorial Multivariate Analysis of Variance (MANOVA) was conducted with the dependent variable as mental health measured by posttraumatic stress disorder (PTSD) and depression and the independent variables being abuse and social support. Preliminary assumptions testing were conducted and found no serious violations for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity.

The results of the analysis indicated no statistical significance for the interaction effect between social support and abuse. The interaction effect with PTSD was F (2, 401) = 1.24, p = .29; Wilks' Lambda = .56; partial eta squared = .01 and for depression, F (2, 401) = 1.19, p = .31; Wilks' Lambda = 56; partial eta squared = .01. There were statistically significant interaction effects on PTSD and depression when social support and abuse were examined separately.

Social support was found to have a significant impact on levels of PTSD, F (2, 410) = 18.11, p = .00; Wilks' Lambda = .00; partial eta squared = .08. The mean scores for PTSD indicated that women who had no social support had the highest levels of PTSD (M = 42.11, SD = 17.83), females with mild social support had intermediate scores (M = 41.76, SD = 14.98) and females with strong social support had the lowest PTSD scores (M = 32.76, SD = 12.23). Post hoc tests revealed there were significant differences between the PTSD scores of women with no social support and strong social support, p = .01 and between the PTSD scores of women with mild social support and strong social support, p = .000. There were no significant differences between the scores of women who had no social support and those who had mild social support, p = .99.

Significance was also shown for the impact of social support on levels of depression, F = (2, 401) = 18.21, p = .00; Wilks' Lambda = .00; partial eta squared = .08. The mean scores for depression showed that women who reported no social support had the highest depression scores (M = 42.37, SD = 15.41), women who had mild social support had intermediate depression scores (M = 40.30, SD = 11.62), and women who had strong social support had the lowest depression scores (M = 33.44, SD = 9.83). Post hoc tests revealed that there were significant differences between the depression scores of women who had no social support and those who had strong social support, p = .001 and between the depression scores of those who had mild social support and those who had strong social support, p = .000. Post hoc tests did not show significant differences between the depression scores for women with no social support and mild social support, p = .70.

Abuse was also found to have a significant impact on levels of PTSD, F = (1, 401) = 4.9, p = .03; Wilks' Lambda = .03; partial eta squared = .01. The mean scores for PTSD revealed that women who had experienced IPV had higher levels of PTSD (M = 41.99, SD = 16.46) than the women who had not experienced IPV (M = 36.85, SD= 13.88). Significance was shown for the impact of IPV on levels of depression as well, F (1, 401) = 6.9, p = .01; Wilks' Lambda = .03; partial eta squared = .02. The mean scores for depression indicated that women who had experienced IPV had higher levels of depression (M = 41.62, SD = 13.21) than women who had not experienced IPV (M = 36.78, SD = 11.56).

Chapter V

Discussion

This study focuses on the relationship between abused and non-abused women's perceived levels of social support and the effect of social support on levels of post-traumatic stress disorder and depression. The hypothesis stated that there would be a difference between non-abused and abused women's levels of mental health (PTSD and depression) based on their use of social support structures. Heise's (1998) ecological framework was used to examine the relationship between abuse, social support and mental health status. This chapter discusses the findings and limitations of the study, suggestions for future research and, finally, the implications the study has shown.

A 2-way factorial MANOVA (multivariate analysis of variance) was used to determine the relationship between the interaction effect of partner violence or IPV (abused and non-abused women) and social support (No Social Support, Moderate Social Support, and Strong Social Support) on mental health (PTSD and depression). The results of this study showed that IPV and social support had significant impacts on mental health. These findings are consistent with existing literature on IPV that associate it and strong levels of social support with fewer mental health problems (Belknap et al., 2009; Holt & Espelage, 2005; Kocot & Goodman, 2003; Meadows et al., 2005).

Social Support and Mental Health

The women in this study who reported they had been abused also reported higher levels of mental health problems (i.e. exhibiting more symptoms of PTSD and depression). This is consistent with studies by Belknap et al. (2009) and Ludermir et al. (2008) that found abuse was related to mental health problems. Ecological theory, specifically the microsystem, can be helpful in explaining the effect of IPV on mental health levels. The microsystem helps researchers and practitioners to examine the context in which abuse takes place; in this case, an intimate partner relationship (Heise, 1998). This also includes the dynamics of the intimate partner relationship. For example, the experiences and consequences of IPV, including physical, emotional and/or sexual abuse, are

part of the relationship dynamic (Stith et al., 2004). These violent acts are linked to mental health outcomes that include PTSD and depression (Coker et al., 2002). At this level the experiences, consequences and types of violence that occurs can be scrutinized, thereby providing an explanation to for the cause of mental health problems (i.e. depression and PTSD) caused by IPV. Therefore, it is vital to understand and identify the role social support played with those who had experienced violence in relation to their mental health outcomes.

This study's findings also emphasize the importance of women's abilities to cope with the violence they have experienced. Literature has suggested that social support may change how one perceives or experiences a stressor as well as assist in accessing coping strategies. The mediation that social support provides serves as a buffer, moderating the effect abuse has on mental health outcomes. Further, it has been found that women can address their mental health problems as related to IPV successfully when social support plays a significant role in their environment; reducing the sense of hopelessness and despair that may result from experiencing IPV (Kocot & Goodman, 2003). In the study mentioned, successfully addressing violence and the outcomes was not defined; however, it potentially refers to leaving a violent relationship as well as learning how to cope with IPV experiences.

It has been found that social support decreases the negative effects IPV has on mental health outcomes. However, research also shows that social support may play a role in decreasing alienation attempts by the abuser, affecting the level of personal relationships and social networks (Coker et al., 2002). The exosystem level of ecological theory is helpful in understanding the importance of these personal relationships and social networks among victims of IPV. The exosystem involves one's social networks such as family and friends, coworkers, support groups, schools, and other societal institutions. With IPV, isolation is commonly used by abusers in order to control their partner (Belknap et al., 2009; Brownridge, 2006; Heise, 1998; Liang et al. 2005). For example, Brownridge (2006) stated that women who experienced IPV reported that their partner limited them or did not permit them to have friends, work, attend school, or engage in

social activities. This obviously would prevent the abused women from participating in, continuing, or creating social relationships or networks. This reinforces the importance of findings of this study in that without having access to social support networks, it does have high negative effects on the mental health status of victims of IPV.

Stith et al. (2004) found that women stay in abusive relationships because of their lack of social support, which may lead to social isolation. Also, it is important to state that women who experience IPV may also be ashamed to disclose abuse to support resources or networks and that may further increase isolation (Belknap et al., 2009). A victim of IPV may feel that others (i.e. potential support resources) may find talking about the abuse uncomfortable or may even blame the victim for putting themselves in the relationship. This can prevent her from disclosing her abuse to others in order to not feel judged or stigmatized by others (Coker et al., 2002).

It is possible that the interconnection between the microsystem and ontogenetic levels of the ecological model can help to further explain the findings of this research. Since this research focused on college females' social support networks, and experiences of IPV and its impact on them (i.e., mental health), it would seem important to consider an individual's personal history, behaviors and characteristics (Heise, 1998) in relation to the dynamics of the relationship, which in this case includes abuse. Individuals' behaviors and characteristics influence their response to stressors that occur at all levels of the ecological model (Stith et al., 2004). For example, an individual's personal or developmental history can help to explain the occurrence and impact of IPV among a certain population. Brownridge (2006) stated that age may be a factor because younger women are at risk for violence. Literature supports the existence of violence among adolescents (Dutton et al, 2006; Holt & Espelage, 2005; Keenan-miller, Hammen, & Brennan, 2007) as well as among college age individuals (Fincham et al., 2008; Hines, 2007; West & Wandrei, 2002). While some research speculates that younger women may have less established support networks that result in more severe consequences of IPV (Belknap et al., 2009), the findings of this study

seem to contradict that assertion in that many of these college women who experienced IPV did have strong support networks.

It is important to note that most existing research making such statements consist of samples of women who are not solely from a university population. This represents a very different population from the current study. Colleges and universities provide an environment in which peer relationships are abundant. Students are involved in classes and extracurricular activities such as sports, social events, as well as various campus organizations. In the current study, the women who reported strong social support levels comprised over half of the sample (256 of 407). Thus, it is logical to assume that there may be much more social support available to college students. The findings of this study indicate that college females while young and at risk for IPV may have the advantage of greater access to a resource that can counteract the negative effects of abuse.

PTSD and depression.

The most common mental problems associated with IPV are PTSD and depression. Research has found that social support plays a significant role in the level of each of these mental disorders. For example, Kocot and Goodman (2003) found that women who had higher levels of both perceived and tangible social support networks were less likely to experience symptoms of PTSD and depression. Also, it was found that levels of low social support were directly associated with higher symptoms of PTSD (Taft, Vogt, Mechanic & Resick, 2007).

In this study, social support has also been shown to have an impact on PTSD and depression. As stated before, there were three groups (no social support, mild social support, and strong social support) that indicated level of social support. Significant differences for both PTSD and depression were found between those who reported no social support and those who reported strong levels of social support. In other words, those women who had no social support had the highest levels of both PTSD and depression while women with strong social support had the lowest levels of PTSD and depression. There was no significant difference in levels of mental health between those who reported no

social support and those who reported mild social support. These findings reinforce previous research emphasizing the important benefit of having strong social support and its impact on mental health status.

IPV and Mental Health

It was found in the current study that women who experience IPV had significantly higher levels of PTSD and depression that those women who did not experience IPV. The microsystem level of the ecological model allows researchers to analyze the dynamics of the relationship or the IPV that these women experienced. IPV can include physical, emotional and sexual abuse and is associated with several mental health problems that include PTSD and depression (Coker et al., 2002). Beeble et al. (2008), hold that having experienced physical and psychological, or emotional, abuse (this includes experiencing one type or all types of abuse) correlates to high levels of mental distress. Several studies have linked IPV to mental health disorders such as PTSD and depression (Lee, Pomeroy, & Bohman, 2007; Ludermir et al., 2008; Morrison, et al., 2006). The findings of this study support and are supported by these earlier studies.

Limitations

There are limitations to the study that should be mentioned. Certain aspects of the research design must be considered first. Conclusions about the causality of this study cannot be made due to it being a cross-sectional research design. It was not possible to establish the sequence of variables; that is if PTSD, depression or IPV occurred first and strong social support networks followed or vice versa. The data that was collected for this study was self- reported. Therefore, there is possibility that there is a misclassification of scores in perceived health, social support, and partner violence due to issues of social desirability. In other words, some women could have felt stigmatized and ashamed that this abuse occurred to them. This could lead to underreporting of violence that has occurred (Ludermir, et al., 2008). Additionally, women could have mislabeled their responses regarding the symptoms of mental health that could have skewed the results.

The sample from this study, as previously stated, consisted of college women. This sample cannot be generalized to the overall non-college populations. Again, young women within the college population may have a stronger support system than the general population.

Implications for Research

Researchers have recently begun to study the effects of IPV women's mental health levels (Forte, Cohen, Du Mont, Hyman, and Romans, 2005; Ludermir, et al., 2008, Taft & Vogt, 2007). As a result of these studies and the findings of this research, it is apparent that further research is necessary in order to learn more about the effects of social support on mental status. Some researchers have suggested that a longitudinal method of studying the results of IPV, mental health and social support should be used (Holt & Espelage, 2005 Kocot & Goodman, 2003; Lee et al., 2007). This method would clarify the casual order of violence, mental health outcomes, and social support. In addition, qualitative studies that utilize in-depth interviews could provide more detailed information as to why social support was significant. This would provide a better understanding of the abusive relationships and the social support dynamics. In addition, future research should include a comparative study that relates college samples to general population samples in order to generalize for broader populations.

Implications for Interventions

This study has important implications for the development of interventions regarding IPV and the resulting mental health problems. Intimate partner violence is not the result of a single factor, but from the interaction between an individual's personal characteristics and their environment (Stith, et al., 2004). IPV not only affects women and families, but also the community. Therefore, it is important to provide education to various members and groups within the community so that lay-people and practitioners alike are knowledgeable about the significant effect IPV has on mental health. Members of the community could then begin to be able to have positive, preventative and supportive roles in the lives of those who

have experienced IPV (Lee et al., 2007). This research has proven that support networks are an important factor in lessening the impact of IPV on mental health.

With this information, professionals (i.e. social service workers, doctors, counselors and other advocates) can provide encouragement to victims of IPV to reconnect with support networks such as family and friends. Making a point to ask about the victim's support system, providing strategies and service should be part of a professional's agenda. Women can be empowered to take action to ensure their health and well-being with this ongoing and support (Kocot & Goodman, 2003).

In conclusion, Coker et al. (2002) stated that, "to adequately address partner violence and its long-term sequelae of societal impacts for women and children, there must be an environment of support rather than blame for victims, accountability and early interventions for abusive partners, and a societal commitment to zero tolerance for partner abuse". What we learn from this study as well as past, present and future studies should be made available to the professionals, practitioners and advocates we charge with the responsibility of providing appropriate support and service to victims of intimate partner violence.

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Appendices

Appendix

A

Institutional Review Board Authorization Documents

March 12, 2013

Patricia Lyle, Beth Emery Department of Human Sciences

peg2f@mtmail.mtsu.edu, Beth.Emery@mtsu.edu

MIDDLE TENNESSEE

STATE UNIVERSITY

Protocol Title: "Comparing Abused and Non-Abused Women: The Effects of Social Support on Mental

Health"

Dear Investigator(s),

The exemption is pursuant to 45 CFR 46.101(b) [4]. This is because the research being conducted involves the collection or study of existing data, documents, records, pathological specimens or diagnostic specimens, if these sources are publicly available or If the information is recorded by the Investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to subjects.

You will need to submit an end-of-project report to the Compliance Office upon completion of your research. Complete research means that you have finished collecting data and you are ready to submit your thesis and/or publish your findings. Should you not finish your research within the three (3) year period, you must submit a Progress Report and request a continuation prior to the expiration date. Please allow time for review and requested revisions. Your study expires on March 12, 2016.

Any change to the protocol must be submitted to the IRB before implementing this change. According to MTSU Policy, a researcher is defined as anyone who works with data or has contact with participants. Anyone meeting this definition

needs to be listed on the protocol and needs to provide a certificate of training to the Office of Compliance. If you add researchers to an approved project, please forward an updated list of researchers and their certificates of training: to the Office of Compliance before they begin to work on the project. Once your research completed, please send us a copy of the final report questionaire to the Office of Research Compliane. This form can be located at www.mtsu.edu/irb on the forms page.

Also, all research materials must be retained by the PI or faculty advisor (If the PI Is a student) for at least three (3) years after study completion. Should you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Compliance Office
615-494-8918
Compliance@mtsu.edu

Appendix

B

Questionnaire Packet

Debriefing Material

Psychology Pool Description: All women who may have experienced stressful situations

The purpose of this study is to examine the relationship between social support, mental health, and stressful situations.

The current study will consist of questions about demographic information, stressful situations, posttraumatic stress disorder, depression, and social support. It should take approximately 25 minutes to complete.

Risks for participation in this study are minimal. You may experience some distress as a result of reliving and disclosing sensitive and/or painful information. However in the present study, these risks can be minimized by contacting someone from the list of agencies provided at the end of the survey. You may also withdraw from the study at any time without explanation, prejudice or penalty.

Benefits to participating in this present study include the opportunity to disclose information about stressful situations *by* completing specified surveys. As a result of this study, you may experience a sense of relief and empowerment in that you will be helping others by sharing your experiences.

Oral Description of Study for Classroom Participants

I will be conducting a study for my thesis looking at social support, mental health, and stressful situations. I am looking for females who are at least 18 years of age to participate in my study, who may or may not have experienced intimate partner violence *in* a heterosexual relationship.

The study will be a self-administered paper-and-pencil questionnaire packet consisting of questions about demographic information, stressful situations, posttraumatic stress disorder, depression, and social support that will take approximately 25 minutes to complete. By participating in this survey, you will help us to better understand issues related to mental health and social support as well as stressful situations.

This is an opportunity to disclose information about stressful situations that may ultimately give you a sense of relief and empowerment and that will help others. It is also possible to experience some distress as a result of reliving and disclosing sensitive and/or painful information. However, these risks can be minimized *by* contacting someone from the list of various agencies provided for additional help if any distress is experienced. You *may* also withdraw from study participation without explanation, prejudice or penalty.

Contact information:

Primary Investigator: Antranette Stringer

Faculty: Dr. Beth Emery

Office: Ellington Human Science Annex, Rm # 121

Number: 615 898-2468

Principal Investigator: Antranette Stringer

Study Title: Stressful situations: The effects of social support on mental health

Institution: Human Science

Name of participant:---------- Age:

The following information is provided to inform *you* about the research project and your participation in it. Please read this form carefully and feel free to ask *any* questions *you* may have about this study and the information given below. You will be given an opportunity to ask questions, and your questions will be answered. Also, *you* will be given a copy of this consent form.

Your participation in this research study is voluntary. You are also free to withdraw from this study at any time. In the event new information becomes available that may affect the risks or benefits associated with this research study or your willingness to participate in it, you will be notified so that you can make an informed decision whether or not to continue your participation in this study.

For additional information about giving consent or your rights as a participant in this study, please feel free to contact Leigh Gostowski at the Office of Compliance at (615) 494-8918.

1. Purpose of the study:

The purpose of this study is to examine social support, mental health, and stressful situations.

2. Description of procedures to be followed and approximate duration of the study:

I understand that this study is an anonymous paper-and-pencil survey consisting of a questionnaire packet that includes questions about demographic information, social support, posttraumatic stress disorder, depression, and stressful situations. It should take approximately 25 minutes to complete.

3. Expected costs:

I understand that there are no expected financial costs involved in participating in this study.

4. Description of the discomforts, inconveniences, and/or risks that can be reasonably expected as a result of participation in this study:

I understand that risk for participation in this study is possible distress as a result of reliving and disclosing sensitive and/or painful information. However, this risk can be minimized by contacting someone from the list of various agencies provided for additional help if any distress is experienced.

5. Unforeseeable risks:

There are no unforeseeable risks.

6. Compensation in case of study-related injury: There will be no compensation in the case of study related injury.

7. Anticipated benefits from this study

Benefits to participating in this present study include the opportunity to disclose information about stressful situations by completing specified surveys. As a result of this study, you may experience a sense of relief and empowerment in that you will be helping others by sharing your experiences.

8. Alternative treatments available:

Not applicable

9. Compensation for participation:

I understand that there is no expected financial compensation involved in participating in this study.

1 0. Circumstances under which the Principal Investigator may withdraw you from study participation:

I may be withdrawn from study participation if *1* am unable to complete the surveys provided in the study because of any distress.

11. What happens if you choose to withdraw from study participation:

I may withdraw from the study at any time without explanation, prejudice or penalty.

12. Contact Information.

If you should have any questions about this research study or possibly injury, please feel free to contact Antranette Stringer at (706}399-0653 or my Faculty Advisor, Dr. Beth Emery at (615) 898-2468

13. Confidentiality.

All efforts, within reason, will be made to keep the personal information in your research record private but total privacy cannot be promised. Your information may be shared with MTSU or the government, such as the Middle Tennessee State University Institutional Review Board, Federal Government Office for

Human Research Protections, if you or someone else is in danger or if we are required to do so by law. In order to further protect your confidentiality, your consent form will be separated from the survey data when you hand in the completed survey. It will be stored separately from the data in a secure location.

STATEMENT BY PERSON AGREEING TO PARTICIPATE IN THIS STUDY

I have read this informed consent document and the material contained in it has been explained to me verbally. I understand each part of the document, all my questions have been answered, and I freely and voluntarily choose to participate in this study.

I have read this informed consent document for this study and understand my rights as a research participant. Further, I understand that information I provide is only intended for research purposes and is not intended to establish a patient/psychologist relationship between me and the researchers/university or to be used for diagnostic purposes. A list of referral counseling services was provided to me. Should I become distressed at any time while participating in this study and feel the need that I need psychiatric/medical or other emotional assistance, I will contact one of the referral counseling services.

Date _____ _____

Signature of patient/volunteer

Consent obtained by:

Date _____ _____

Signature

_____

Printed Name and Title

NOTE: All resources are in Murfreesboro unless indicated otherwise.

MENTAL HEALTH PROFESSIONAL RESOURCES

MTSU Counseling Services 898-2670 (KUC 329)

VIOLENCE & ABUSE

Sexual Assault Center (Nashville) 259-9055

1-800-879-1999 (24 hr. hotline)

First Call for Help (Murfreesboro) 907-lll4

Life Management Center (Nashville) 269-0803

Domestic Violence Hotline 356-6767 (serving Nashville area) Exchange Club Family Center for the Prevention of Child Abuse (Murfreesboro) 890-4673

Murfreesboro Domestic Violence Program 896-2012 or 896-7377

YWCA Domestic Violence Program (Nash.) Domestic Violence Prog./Sexual Aggression Hope House- Maury County

Miriam's Place (Nashville) Prevention Child Abuse *TN*

(615) 242-1199 or 1-800-334-

2648

896-9542

(931) 381-8580

292-3500

383-0994

Appendix

C

Survey

Part I. Demographic Information

1. Age: _____

2. Classification:

I Freshman

2 Sophomore

3 Junior

4 Senior

5 Graduate

3. Race/Ethnicity:

IAfrican American or Black

2 American Indian or Alaska Native

3 Asian

4 Native Hawaiian or other Pacific Islander

5 Hispanic/Latino

6 White/Caucasian

4. Number of Children:

0

1

2

3

4

5 or more

5. Relationship Status:

I Single

2 Partner (Boyfriend)

3 Married

4 Divorced

Part IL Circle the number that best represents your closest estimate of how often each of the behaviors happened in your relationship with your partner or former partner.

I Never; 2 Rarely; 3 Occasionally; 4 Frequently; *5* Very frequently

6. Called you a name and/or criticized you. 1 2 3 4 5

7. Tried to keep you from doing something you wanted to

do (e.g., going out with friends, going to meetings). 1 2 3 4 5

8. Gave you angry stares or looks. 1 2 3 4 5

9. Prevented you from having money for your own use. 1 2 3 4 *5*

10. Ended a discussion with you and made

the decision himself. 1 2 3 4 5

II. Threatened to hit or throw something at you. 1 2 3 4 5

12. Pushed, grabbed, or shoved you. 1 2 3 4 5

13. Put down your family and friends. 1 2 3 4 *5*

14. Accused you of paying more attention to

someone/something else. 1 2 3 4 *5*

I 5. Put you on an allowance. 1 2 3 4 5

16. Used your children to threaten you (e.g., told you that you would

lose custody, said he would leave town with the children). I 2 3 4 5

17. Became very upset with you because dinner *I* housework, was not done when he wanted it or the way he thought

it should be. 1 2 3 4 *5*

18. Said things to scare you (e.g., told you something "bad" would

happen, threatened to commit suicide). 1 2 3 4 *5*

19. Slapped, hit, or punched you. 1 2 3 4 *5*

20. Made you do something humiliating or degrading (e.g., beg for forgiveness, ask for permission to use the car or

to do something). 1 2 3 4 *5*

21. Checked up on you (e.g., listened to your phone calls, checked the mileage on your car, called you repeatedly at wort).	2	3	4	*5*
22. Drove recklessly when you were in the car.	2	3	4	5
23. Pressured you to have sex in a way you didn't want.	2	3	4	5
24. Refused to do housework or child care.	2	3	4	5
25. Threatened you with a knife, gun, or other weapon.	2	3	4	5

26. Spanked you.	2	3	4	5
27. Told you that you were a bad parent.	2	3	4	5
28. Stopped /tried to stop you from going to work/school.	2	3	4	5
29. Threw, hit, kicked, or smashed something.	2	3	4	5
30. Kicked you.	2	3	4	5
31. Physically forced you to have sex.	2	3	4	*5*
32. Threw you around.	2	3	4	*5*
33. Physically attacked the sexual parts of your body.	2	3	4	*5*

34. Choked or strangled you.	2	3	4	5
35. Used a knife, gun, or other weapon against you.	2	3	4	*5*

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

1 Very Strongly Disagree; 2 Strongly Disagree; 3 Mildly Disagree; 4 Neutral; *5* Mildly
Agree; 6 Strongly Agree; 7 Very Strongly Agree

36. There is a special person who is around when I am in 2 3 4 *5* 6 7 need.

37. There is a special person with whom I can share my joys 2 3 4 *5* 6 7 and sorrows.

38. My family really tries to help me. 2 3 4 5 6 7

39. I get the emotional help and support I need from my 2 3 4 *5* 6 7 family.

40. *1* have a special person who is a real source of comfort to 2 3 4 *5* 6 7 me.

41. My friends really try to help me. 2 3 4 5 6 7

42. I can count on my friends when things go wrong. 2 3 4 *5* 6 7

43. I can talk about my problems with my family. 1 2 3 4 *5* 6 7

44. I have friends with whom I can share my joys and 2 3 4 *5* 6 7 sorrows.

45. There is a special person in my life who cares about my 2 3 4 5 6 7
feelings.

46. My family is willing to help me make decisions. 2 3 4 *5* 6 7

47. I can talk about my problems with my friends. 2 3 4 5 6 7

Part IV. Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully. Circle the response that indicates how much you have been bothered by that problem in the past month.

1 Not at all; 2 A little bit; 3 Moderately; 4 Quite a bit; 5 Extemely

48. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience?

2 3 4 5

49. Repeated, disturbing *dreams* of a stressful experience?

2 3 4 *5*

50. Suddenly *acting foretelling* as if a stressful experience *were happening again (*as if you were reliving it)?

2 3 4 *5*

51. Feeling *very upset* when *something reminded you* of a stressful experience?

2 3 4 *5*

52. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when

something reminded you of a stressful experience?

2 3 4 5

53. Avoiding *thinking about* or *talking about* a stressful experience or avoiding *having feelings related* to it?

1 2 3 4 5

54. Avoiding *activities or situations* because *they reminded you* of a stressful experience?

2 3 4 *5*

55. Trouble *remembering important parts* of a stressful experience?

1 2 3 4 5

56. *Loss of interest* in activities that you used to enjoy?

2 3 4 5

57. Feeling *distant* or *cut off* from other people?

- .

1 2 3 4 5

58. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?

2 3 4 5

59. Feeling as if your *future* will somehow be *cut short?*

2 3 4 5

60. Trouble *falling* or *staying asleep?*

2 3 4 5

Part V. Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this in the past month.

1 Rarely or none of the time (less than1 day/ per week)

2 Some or a little of the time (1-2 days/ per week)

3 Occasionally or a moderate amount of time (3-4 days/ per week)

4 Most or all of the time (5-7 days/ per week)

65. I was bothered by things that usually don't bother me.

1 2 3 4

66. 1 did not feel like eating; my appetite was poor.

1 2 3 4

67. I felt that I could not shake off the blues even with help from my family or friends.

1 2 3 4

68. I felt I was just as good as other people.

1 2 3 4

69. I had trouble keeping my mind on what I was doing.

1 2 3 4

70. I felt depressed.

I 2 3 4

71. I felt that everything I did was an effort.

I 2 3 4

72. I felt hopeful about the future.

1 2 3 4

73. 1 thought my life had been a failure.

1 2 3 4

74. I felt fearful.

1 2 3 4

75. My sleep was restless.

I 2 3 4

76. I was happy.

I 2 3 4