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The Intimate Partner Violence Stigma Scale: Initial Development and Validation

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Abstract

The stigma associated with intimate partner violence (IPV) is a major challenge facing those in abusive and violent intimate relationships. This study explored the initial development and validation of the Intimate Partner Violence Stigma Scale, designed to measure stigma related to IPV. An exploratory factor analysis revealed four subscales including internalized stigma, anticipated stigma, perpetrator stigma, and isolation. The scale demonstrates evidence for clinical and research purposes to assess experiences of stigma related to IPV among survivors.

Keywords

intimate partner violence, domestic violence, stigma, assessment, integrated intimate partner violence stigmatization model

> The statement that I "got myself into it" was one I heard from many. My lawyer, my brother- and sister-in-law, and a couple of the very few friends I had left by the time the marriage ended . . . and I was too wounded and weak at that point to argue. I had heard so often that it was "my fault . . . you brought it on yourself" from my husband so many times that hearing it from them was not much different.
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> —Crowe & Murray, 2015, p. 171

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As this quote suggests, when survivors of intimate partner violence (IPV) reach out for help, they may be met with stigmatizing responses from people who are in positions that could offer support, whether informally (e.g., friends and family) or formally (e.g., professionals). There is an emerging body of literature related to the stigma that survivors of IPV experience (Crowe & Murray, 2015; Eckstein, 2016; Murray & Crowe, 2017; Murray, Crowe, & Akers, 2016; Overstreet & Quinn, 2013). Based on this growing literature, it is clear that stigma is an important phenomenon to be investigated because it has damaging internal (e.g., lowered self-esteem, shame) and external effects (e.g., decreased help-seeking) and is a barrier to recovery for those who are in an abusive relationship, are in the process of leaving the abuse, or are rebuilding their lives after the abusive relationship has ended.

The term *stigma* describes a social process in which a group of people is devalued based on some shared characteristic or attribute (Goffman, 1963). Link and Phelan (2001) offered a five-component conceptualization of stigma designed to present a cohesive definition of the term. The five components of stigma they outlined are as follows: (a) a label is placed on differences between people, (b) the labels are associated with negative stereotypes about the characteristics of people with those labels, (c) people create a sense of separation between themselves and those with the label (i.e., "separation of 'us' from 'them'"; Link & Phelan, p. 367), (d) the people who are labeled experience diminished status and discrimination from others, and (e) people with the stigmatized label are denied access to "social, economic, and political power" (Link & Phelan, p. 367). As such, stigma can be viewed as a process that occurs among groups of people that results in negative outcomes for stigmatized groups.

Although the concept of stigma has been researched for decades as it applies to other phenomena (e.g., HIV/AIDS and mental health disorders; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Rao, Angell, Lam, & Corrigan, 2008), researchers have only very recently begun to apply conceptual models of stigma to experiences of IPV (Murray, Crowe, & Overstreet, 2015; Overstreet & Quinn, 2013). Despite growing research on IPV stigma, there is a need for a formal measure that assesses stigmatization among those who experience IPV because no such measure exists. Empirical research on IPV stigma demonstrates that stigmatization complicates victims' and survivors' experiences of abuse, their mental health, and support-seeking, which suggests that stigma may actually place them at greater danger because it adds barriers to the ability to achieve safety. To guide research on stigma and IPV, scholars have proposed conceptual frameworks for describing IPV-related stigma, which are summarized in the next section. In the current research, we draw on these existing conceptualizations of IPV-related stigma

to develop the first measure to assess survivors' experiences of stigmatization, the Intimate Partner Violence Stigmatization Scale (IPVSS).

Conceptualizations of IPV Stigmatization

Two recent conceptual models were developed to understand people's experiences of IPV-related stigma. The Intimate Partner Violence Stigmatization Model is one of the first frameworks to outline how IPV-related stigma is associated with help-seeking behaviors (Overstreet & Quinn, 2013). The model describes three stigma components that shape the help-seeking process. Cultural stigma describes societal stereotypes and ideologies that delegitimize people experiencing IPV such as the belief that survivors are responsible for their victimization. Stigma internalization highlights the extent to which people come to believe (or even consider) that the negative stereotypes about those who experience IPV may be true of themselves. For instance, survivors may come to believe that they are responsible for their victimization, which can heighten feelings of guilt, shame, and self-blame. Finally, anticipated stigma emphasizes concern about what will happen once others find out about one's experiences of IPV such as social rejection or disapproval. The Integrated Intimate Partner Violence Stigmatization Model (Murray et al., 2015) builds on this initial model, but includes two additional processes of stigma (enacted and perpetrator stigma), and defines outcomes from each of these components such as blame, isolation, negative emotions (e.g., shame and guilt), and loss of status (e.g., being devalued). Finally, enacted stigma describes prejudice and discrimination experienced by survivors of IPV and perpetrator stigma captures stigmatizing messages from one's perpetrator. These messages can include emotional, verbal, and psychological abuse but may also be connected to isolation or devaluation of survivors, which are closely tied to stigma.

Since the emergence of these two conceptual models, there is growing empirical support that the aspects of stigma identified in the models are a detriment in the lives of survivors of IPV. In particular, researchers have found qualitative evidence of the damaging impact cultural stigma has on victims' and survivors' experiences of help-seeking, including stigmatization from family members, friends, and service professionals (Crowe & Murray, 2015, McCleary-Sills et al., 2016; Murray et al., 2016). For example, the cultural belief from others that survivors "must have done something to deserve the abuse" can lead to the negative outcome of status loss such as losing one's employment or housing or a decrease in one's respect within a particular community, once the survivor reveals the abuse. Across these studies, researchers have uncovered experiences of survivors in which stigma

prevents them from reaching out for help or hinders the quality of support they receive if they do reach out for support. Quantitative findings suggest that the stigma surrounding IPV also affects survivors' decisions to share their experiences of abuse at all. Not only does stigma affect the person's willingness to seek support, but it can also lead to increased levels of distress which has a damaging effect on psychological state, decreased levels of self-esteem, and increased levels of shame (Murray et al., 2016, Murray & Crowe, 2017; Murray, Crowe, & Brinkley, 2015).

Victim Blame, IPV Stigma, and Help-Seeking

A related concept to IPV stigma, *victim blaming*, is a well-established, negative societal attitude toward those who experience abuse (Eigen, & Policastro, 2016; Meyer, 2015). Scholars have found that myths about domestic violence, race of the victim, gender of the perceiver, a victim's decision to return to an abusive relationship, as well as the relationship status of the victim (dating or married to the abuser) affect one's propensity to blame the IPV victim (Esqueda & Harrison, 2005; Meyer, 2015; Yamawaki, Ochoa-Shipp, Pulsipher, Harlos, & Swindler, 2012). Furthermore, sociocultural attitudes, values, and norms may also shape justification of violence (Lelaurain et al., 2018; Meyer, 2015; Sylaska & Edwards, 2014). Knowledge of these beliefs may be a significant barrier to the help-seeking process among those who experience IPV (Crowe & Murray, 2015; Overstreet & Quinn, 2013). Recent research also has suggested that internalized stigma plays a detrimental role in survivors' help-seeking process (Murray et al., 2015, Murray & Crowe, 2017; McCleary-Sills et al., 2016). For instance, when people have internalized stigmatizing messages about IPV victimization, they are less likely to disclose their experiences of abuse to people in their lives (Murray & Crowe, 2017). The emerging evidence on internalized stigma and help-seeking coincides with the extant literature on the impact of shame, guilt, and self-blame on survivors' help-seeking process (see Dziegielewski, Campbell, & Turnage, 2005; Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Petersen, Moracco, Goldstein, & Clark, 2004; Williams & Mickelson, 2008). Thus, our conceptualization of internalized stigma not only accounts for self-blame but also includes feelings of shame and guilt that may be associated with a sense of self-blame. These aspects of IPV-related stigmatization are important to measure because they may silence survivors and prevent them from reaching out for the support they need and deserve (McCleary-Sills et al., 2016).

There is initial evidence to suggest that enacted stigma influences help-seeking processes and psychological distress among IPV survivors. One of the most common sources of enacted stigma among IPV survivors is stigmatizing

reactions to IPV disclosure, which has been shown to negatively affect survivors' psychological well-being (Murray et al., 2016; Sylaska & Edwards, 2014). Other types of discrimination such as being denied housing or employment opportunities are consequences of disclosing abuse—this has been described as a loss of status for the victim (Murray et al., 2015). If those who are experiencing IPV do not seek help due to the various types of stigmas described, this has major implications on the recovery process for those seeking to overcome abuse. When survivors do seek help and are met with stigmatizing responses, this also may have damaging effects to the survivor. The ability to assess the stigma that one is experiencing could assist survivors with understanding and ultimately overcoming the stigma associated with IPV, as professionals can use the measure to begin the conversation about stigma and IPV, assess the types and amounts the person has experienced, and explore ways to overcome and recover from IPV.

The Case for an IPV Stigma Measure

Although there is an empirical basis for the impact of stigma on the lives of IPV survivors, there is no comprehensive measure that captures survivors' experiences of IPV-related stigmatization (i.e., cultural, internalized, anticipated, enacted, and perpetrator stigma). Furthermore, there may be aspects of IPV stigmatization that are unique for survivors of IPV and not captured by current quantitative measures that are used to assess stigma in other groups (e.g., people living with HIV or people with mental illness). For instance, similar to other stigmatized groups, there is a robust literature on survivors' sense of self-blame and negative emotions when they experience IPV (Beaulaurier, Seff, & Newman, 2008; Beaulaurier, Seff, Newman, & Dunlop, 2005; Petersen et al., 2004; Sylaska & Edwards, 2014). These negative emotions may stem from one's own feelings about IPV (e.g., internalized stigma) or from the attitudes and beliefs of others (e.g., cultural, enacted, and perpetrator stigma). These aspects of stigma may be important predictors of health outcomes and behaviors for those who experience IPV, yet there is no formal measure to capture these experiences.

Moreover, while it is well-documented that self-blame and victim blame are components that contribute to less help-seeking and poorer mental health among people who experience IPV (Fugate et al., 2005; Kaukinen, Meyer, & Akers, 2013; Murray et al., 2016; Murray & Crowe, 2017), it should be noted that blame is but one component of the stigma process for those who are experiencing IPV (Murray et al., 2015; Overstreet & Quinn, 2013). For instance, few quantitative measures have tapped into the ways in which IPV shapes isolation and status loss. Crowe and Murray's (2015) qualitative

research explored isolation and loss of status among IPV survivors who had experienced stigma from professionals (e.g., law enforcement, medical professionals, courts), and many survivors described both of these components of the stigma process. The study was qualitative and asked only about stigma experienced when seeking help from professionals; therefore, a quantitative design is a natural next step in the IPV stigma body of literature. A measure of IPV stigmatization is needed to capture these aspects of stigma that go beyond blame, exploring all of the components that scholars have posited as being part of the stigma process.

The Current Study

Our review of the literature points to a critical need to develop and validate a measure that captures IPV-related stigma experiences beyond victim blame to fully understand the consequences of stigmatization in the lives of survivors. Furthermore, there is a need to develop a measure to understand other IPV-related stigma processes such as anticipated stigma and perpetrator stigma, as these components are particularly new to the literature on IPV and understudied (Murray et al., 2016). Finally, in addition to the potential impact of stigma on individual survivors, the stigma surrounding IPV also affects how IPV is viewed and addressed at a societal level. Murray and colleagues (2015) conducted a modified Delphi study to learn from a national panel of IPV and sexual assault advocacy leaders about societal-level implications of the stigma surrounding IPV. The expert panel members indicated that societal messages affect the stigma that survivors face, and that this stigma makes it more difficult for survivors to access resources within their communities to achieve safety. Some potential changes they identified to work toward ending stigma included making resources and public policies more responsive to the needs and experiences of survivors, ensuring that professionals who work with victims and survivors receive adequate training, highlighting stories of survivors overcoming abuse, and addressing the unique needs of survivors who are members of marginalized populations.

Thus, research is needed to examine the nuanced experiences of stigma related to IPV. Implications range from internal to external, and survivors have reported experiencing stigma from sources such as friends and family, internal stigma places on oneself, and even professionals from whom they sought help (Crowe & Murray, 2015; McCleary-Sills et al., 2016; Murray et al., 2016). Although measures exist that assess stigma from other conditions or experiences, currently, there is no formal measure to assess IPV-related stigma. Thus, the current study sought to build on the recent literature to validate one such measure. The following section describes this process.

Method

Participants

A convenience sample of 204 participants completed the 52-item scale. Women represented approximately 78% of the sample ($N = 158$), and men made up approximately 14% ($N = 29$) of the sample. About 78% identified as Caucasian ($N = 159$), 7.4% African American ($N = 15$), 6.9% as Hispanic ($N = 14$), 2.5% as Native American ($N = 5$), 2% as Asian ($N = 4$), and 1% endorsed Other ($N = 2$). A total of 119 people had a child, whereas 68 did not, and 191 participants reported that they were with an intimate partner of the opposite gender during the abuse. We asked participants to describe their past experiences with IPV, including number of abusive relationships, length, type of abuse, as well as same-gender or different-gender relationships. If participants had experienced multiple abusive relationships, they were to report on the most recent experience when describing details about their past abusive relationship. Regarding the number of relationships in which they had experienced any form of IPV, the most common response was one relationship (45%), followed by two (30%) and three (11%) relationships of abuse. Most (94%) participants reported that their partners were a different gender, and 6% had same-gender partners. The average length of these relationships was 7.4 years ($SD = 11.8$). The vast majority of participants (81%) reported that they experienced physical abuse in those relationships, 99% reported emotional/psychological abuse, and 58% of participants reported sexual abuse.

Procedures

Prior to initiating research activities, Institutional Review Board approval was granted to complete this study. The purpose of this study was to develop an assessment tool to formally measure IPV stigma. We approached our instrument development process in two distinct phases. Phase 1 followed Crocker and Algina's (1986) 10-step process to instrument development to create the Intimate Partner Violence Stigma Scale (IPVSS), whereas Phase 2 examined the statistical properties of the survey items. The two phases are described in more detail below.

Phase 1: Initial survey development. To develop the IPVSS, we used Crocker and Algina's (1986) 10-step process to construct and test a valid instrument. These include the following: (a) identify the primary purpose of the instrument, (b) identify behaviors to represent the construct, (c) prepare a

set of test specifications, (d) construct an initial item pool, (e) review and revise items, (f) hold preliminary item tryouts, (g) field test the items, (h) determine statistical properties of items, (i) conduct reliability and validity studies, and (j) develop guidelines for administration, scoring, and interpretation. A brief description of Steps 1 to 7 is summarized next. The primary purpose of the instrument is to measure self-reported stigma experienced by survivors of IPV. Specifically, we aimed to measure the various types of stigma (anticipated, internalized, cultural, enacted, and perpetrator stigma), in addition to the four components of stigma (blame, isolation, negative emotions, and loss of status) identified in the two conceptual frameworks of IPV-related stigmatization. For Step 2, behaviors that represent each construct were taken from original quotes from actual survivors of IPV who had participated in earlier research from the authors. The researchers read through statements and matched quotes to each of the types and components of stigma. The majority of statements were original quotes, with a small number of statements constructed by the researchers to reflect the meaning of the category when an insufficient number of quotes were available. Next, we decided on test specifications, including that answers would be given on a 6-point Likert-type scale ranging from (1) *strongly disagree* to (6) *strongly agree* to statements about various types and sources of abuse. The initial item pool started with 52 items (see Table 1). Preliminary item tryouts were completed with a team of experts in the fields of stigma, IPV, and assessment. Two experts on stigma, two on IPV, and one for instrument development were given the scale and asked to complete two tasks. First, in Part 1, they looked at the overall scale clarity and language. Directions read,

> Thank you for agreeing to provide feedback on the survey we are developing. The survey measures experiences of stigma from survivors of intimate partner violence (IPV). The survey items are actual quotes from survivors as well as items we have constructed. We would like two types of feedback from you—feedback on the actual instrument (e.g., wording, length, clarity, and format) as well as feedback on whether the items seem to capture the essence of the various types of stigmas. Part I will ask you about the actual instrument and Part II about the items. Please provide feedback in whatever way is most convenient for you. We thank you for your willingness to assist us with this project.

Then, experts were asked to read the definition of each type of stigma and note whether each item seemed to represent that type of stigma. Directions for Part 2 read,

Table 1. Original 52 Items of the IPVSS.

I believed that if I shared details about my relationship with others I would be blamed.
If I told people about the abuse, I worried that they would think I "asked for it"
I was frightened of being singled out if I told many people about the abuse.
I kept the abuse a secret due to the fear of being isolated.
I kept the abuse a secret because I did not want to be judged by family and friends.
I didn't tell others about the abusive relationship because I felt ashamed of the abuse.
I didn't know whom I could tell without it being used against me.
I was afraid to tell because I did not want people labeling me as weak or a bad person.
I felt like I couldn't let anyone know because they would judge me.
Someone finding out would only mean more shame.
I hid the abuse from others because I was afraid they would tell me what to do.
I worried that people would feel sorry for me.
People blamed me for staying in the relationship.
People said the abuse was my fault.
My family and friends left me because of my relationship.
Several people have shunned me.
People treated me differently when they found out about the abuse.
People viewed me as "damaged goods" once I shared my experience.
People labeled me as a victim.
People saw me as inferior or less than.
Some people believed they were better than me because they did not go through such abuse.
People expressed their disapproval when I told them about my relationship.
I felt that the abuse was my fault.
I blamed myself.
I felt like I deserved it.
I isolated myself from others.
I felt as if no one wanted to be around me anymore.
I kept the abuse a secret.
I felt like worthless, like "damaged goods."
I felt like a bad person.
I didn't tell others about the relationship because I felt ashamed.
I felt stupid and weak.
Society tells people in abusive relationships that it is their fault for not leaving.
People think that there is something wrong with those who are in abusive relationships.

(continued)

Table 1. (continued)

Many feel that people who stay in abusive relationships have no self-esteem.
People see those in abusive relationships as weak.
People feel like I have done something to deserve abuse.
People think you can just walk away.
People don't think the abuse could happen to them.
Society is supportive of people who have experienced abuse.
My community encourages me to talk about my experiences.
The media shows negative views of people in abusive relationships.
My abuser convinced me that there was something wrong with me.
My abuser blamed me and made me feel like the abuse was my fault.
My abuser isolated me from family and friends.
I wasn't allowed to go anywhere or do anything.
My abuser monitored me.
My abuser told me not to tell others how he or she treated me.
My abuser made me feel like I was a worthless person.
My abuser made me ashamed of who I was.
My abuser made me feel less than.
My abuser made me feel like a bad person.

Note. IPVSS = Intimate Partner Violence Stigmatization Scale.

> Please read the definition of each type of stigma and note Yes or No whether the item listed under each type seems to represent that type of stigma. These are the same items from above, only they are placed under each corresponding stigma type. In this section, again using Track Changes, please indicate if there are any statements that do not seem to fit within the definition of the category in which we've placed the item (e.g., anticipated stigma, enacted stigma, etc.).

Based on the feedback from experts, the research team revised the scale. Changes were made in structure, format, language, and clarity based on received feedback.

Phase 2: Exploratory factor analysis. To field test the items and recruit a large enough sample of participants (following guidelines in Crocker and Algina (1986) and Johanson and Brooks (2010)), we first used Qualtrics (http://www.qualtrics.com), a secure electronic survey-hosting website platform, to recruit a panel of 100 respondents across the United States who met the following eligibility criteria: (a) be at least 21 years old, (b) self-report that they had been formerly abused (i.e., including physical, emotional, psychological, verbal, and/or sexual abuse) by an intimate partner (e.g., a boyfriend or girlfriend, life partner, or spouse), (c) self-report that they had been out of any

abusive relationship for at least 6 months, and (d) be able to complete the survey in the English language. We also emailed an invitation to personal and professional contacts and posted an electronic flyer about the study on Internet-based message boards and Facebook pages that reach survivor audiences. Participants met the same criteria as above were asked to complete the electronic survey via email. These recruitment materials included a link to the website where participants could complete the survey. A total of 104 participant responses were collected using these strategies, and all responses were anonymous. At the end of the survey, any participants recruited via this method who was interested in entering a drawing for one of two US$50 gift cards could send an email to the researcher's email address, thus ensuring anonymity of survey responses as emails were not linked to the actual survey results. To ensure safety, every participant who completed the eligibility questionnaire at the start of the survey received a list of national domestic violence resources. After data were collected, the research team reviewed all answers to ensure integrity of responses.

Measures

For validity purposes, we chose a number of established measures that we anticipated would correlate to the IPVSS, due to the previous literature on survivors' sense of self-blame and negative emotions when they experience IPV (Beaulaurier et al., 2008; Beaulaurier et al., 2005; Petersen et al., 2004; Sylaska & Edwards, 2014). The instruments used for validity and Cronbach's alpha levels included the Composite Abuse Scale (Hegarty, Sheehan, & Schonfeld, 1999; Cronbach's alpha in current study = .94), the Psychological Maltreatment of Women Inventory (Tolman, 1999; $\alpha = .89$), the Brief Fear of Negative Evaluation Scale (Leary, 1983; $\alpha = .82$), the Center for Epidemiologic Studies (CES) Depression Scale (Radloff, 1977; $\alpha = .78$), and the Rosenberg Self-esteem Scale ($\alpha = .42$) With the exception of the Self-esteem Scale, these alpha levels indicated evidence for internal consistency reliability (Streiner, 2003). We excluded the Rosenberg Self-esteem Scale from the validity test due to the low alpha level, but included the other scales.

Data Analysis Plan

Prior to analyzing the data, we transferred it from Qualtrics to SPSS (Version 24). Before conducting the exploratory factor analysis (EFA), we evaluated the fitness of the data using the Kaiser–Meyer–Olkin (KMO) value (Kaiser, 1970, 1974) and Bartlett's test of sphericity (Bartlett, 1954). The KMO value was .73, which is considered acceptable (Tabachnick & Fidell, 2013). Bartlett's

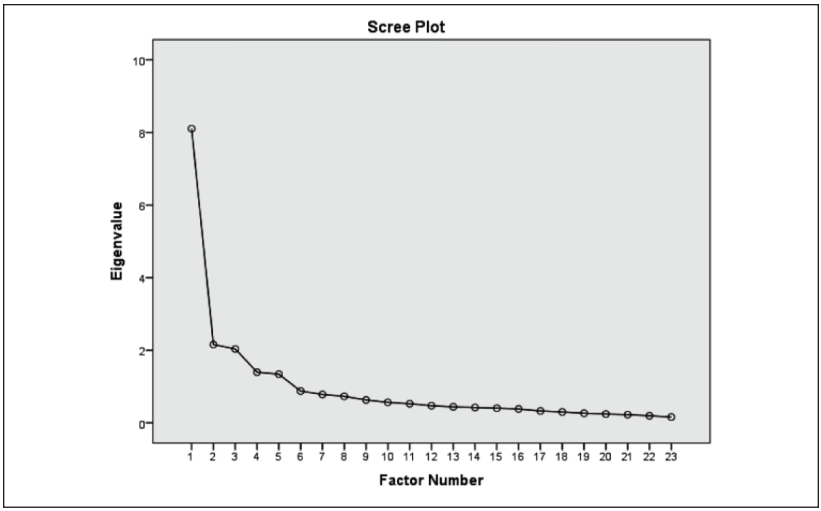

Figure 1. Scree plot.

test of sphericity achieved statistical significance ($p < .05$). Together, these two statistical values indicated that the data deemed satisfactory to undergo factor analysis. To examine the validity of the IPVSS, we looked at correlations between the scale and published assessments.

Results

EFA

The EFA resulted in the loading of five components with eigenvalues above 1, which described 65.37% of the cumulative variance. The scree plot (see Figure 1) indicated a gap between the fifth and the sixth components. Based on the researchers' interpretation of Cattell's (1966) scree test and variance explained by the components, five components were chosen for further investigation. A principal factor analysis for non-normal data was performed to assist with further understanding the components. Items that did not cross load on any factor and with coefficients greater than .4 were designated to be part of each component, resulting in 23 items.

Although the fifth factor had statistical strength, the fifth factor was deemed too weak conceptually to warrant a fifth factor, so these last three items were eliminated, leaving 20 items total which also assisted with the scale's parsimony. The remaining four components represented 59.53% of the cumulative

variance, with Components 1, 2, 3, and 4 contributing 35.2%, 9.38%, 8.86%, and 6.07%, respectively. Based on analysis of the items that loaded on each component, the researchers named the four subscales: Factor 1: internalized stigma, Factor 2: anticipated stigma, Factor 3: perpetrator stigma, and Factor 4: isolation. Table 2 includes factor loadings and communalities for the IPVSS scale's four factors.

Cronbach's alpha levels for each factor were as follows: Factor 1 (internalized stigma) $\alpha = .85$, Factor 2 (anticipated stigma) $\alpha = .88$, Factor 3 (perpetrator stigma) $\alpha = .83$, Factor 4 (isolation) $\alpha = .81$, and Total Scale $\alpha = .92$. The IPVSS can be administered as a paper and pencil survey for survivors who have been out of an abusive relationship for at least 6 months. It can also be given online for researchers or clinicians who wish to do so. Items are answered on a 6-point Likert-type scale ranging from 1 (*Strongly Disagree*) to 6 (*Strongly Agree*). Items are totaled and higher total scores indicate more experiences of stigma. The scale includes four subscale scores that represent one of four dimensions of stigma. A full list of items from the IPVSS can be found in Table 3.

Validity

With respect to concurrent validity with the IPVSS, we examined the relationships between the IPVSS total score and the Composite Abuse Scale (Hegarty et al., 1999), which had a significant positive correlation of .26**, the Psychological Maltreatment of Women Inventory (Tolman, 1999), which had a significant positive correlation of .58**, the Brief Fear of Negative Evaluation Scale (Leary, 1983) which had a significant correlation of .28**, and the CES Depression Scale (Radloff, 1977) which had a significant correlation of .18*. All relationships were significant at the .01 level (**) and .05 (*) levels. All correlations can be found in Table 4.

Discussion

The IPVSS demonstrated initial psychometric and conceptual strength for assessing the stigma that survivors of IPV experience. Four components including internalized stigma, anticipated stigma, perpetrator stigma, and isolation represent distinct types of stigma related to IPV. Internalized stigma items represent the stigma that one might internalize based on experiencing abuse from an intimate partner. This stigma concept is well established in the stigma literature (Crowe & Murray, 2015; Overstreet & Quinn, 2013). Similarly, anticipated stigma, or the expectation that one will experience bias because of their victimization, was the concept that most accurately

Table 2. Factor Loadings, Communalities, *M, SD*, and Range of 20-Item IPVSS.

Subscale and Item	Factor Loadings 1/2/3/4 (Communalities)	*M*	*SD*	Range
Factor 1 (internalized stigma; eigenvalue = 8.10)				
I knew the abuse was not my fault.	**.851**/.000/.000/.000 (.70)	3.56	1.52	1-5
People blamed me for staying in the relationship despite the abuse I experienced.	**.714**/.000/.000/.000 (.52)	3.60	1.56	1-5
People said the abuse was my fault.	**.711**/.000/.000/.000 (.70)	4.30	1.37	1-5
I felt the abuse was my fault.	**.645**/.000/.000/.000 (.41)	4.36	1.42	1-5
I felt like I deserved it.	**.557**/.000/.000/.000 (.47)	3.23	1.63	1-5
People viewed me as damaged once I shared my experience with the abuse.	**.446**/.000/.000/.000 (.48)	4.05	1.49	1-5
Factor 2 (anticipated stigma; eigenvalue = 2.16)				
If I told people about the abuse, I worried that they would think I "asked for it."	.000/**.892**/.000/.000 (.77)	4.68	1.50	1-5
I hid the abuse from others because I was afraid they would tell me what to do.	.000/**.840**/.000/.000 (.74)	4.80	1.36	1-5
People supported me when I told them about the abuse.	.000/**.670**/.000/.000 (.51)	4.98	1.22	1-5
People in my community encourage me to talk about my experiences.	.000/**.663**/.000/.000 (.53)	4.76	1.55	1-5
I believed that if I shared details about my relationship with others I would be blamed for the abuse.	.000/**.654**/.000/.000 (.58)	4.88	1.21	1-5
Factor 3 (perpetrator stigma; eigenvalue = 2.04)				
My abuser convinced me that there was something wrong with me.	.000/.000/**.743**/.000 (.60)	4.65	1.24	1-5
My abuser made me feel inferior.	.000/.000/**.723**/.000 (.45)	4.18	1.13	1-5
My abuser blamed me.	.000/.000/**.654**/.000 (.52)	4.47	1.24	1-5
My abuser isolated me from family and friends.	.000/.000/**.653**/.000 (.58)	4.88	1.09	1-5
My abuser monitored my activities.	.000/.000/**.535**/.000 (.52)	5.21	0.95	1-5

(continued)

Table 2. (continued)

Subscale and Item	Factor Loadings 1/2/3/4 (Communalities)	*M*	*SD*	Range
Factor 4 (isolation; eigenvalue = 1.40)				
My abuser told me not to tell others how he or she treated me.	.000/.000/.000/**.84** (.62)	4.79	1.33	1-5
I wasn't allowed to go anywhere or do anything by my abuser.	.000/.000/.000/**.82** (.69)	4.65	1.36	1-5
I didn't know whom I could tell about the abuse without it being used against me.	.000/.000/.000/**.67** (.53)	4.09	1.46	1-5
I didn't tell others about the abusive relationship because I felt ashamed of the abuse.	.000/.000/.000/**.41** (.44)	4.20	1.37	1-5

Note. Major loadings for each item are represented in bold. IPVSS = Intimate Partner Violence Stigmatization Scale.

reflected many of the items in Factor 2 of the IPVSS and established in the stigma literature (Crowe & Murray, 2015; Overstreet & Quinn, 2013; Quinn et al., 2014).

Perpetrator stigma, or the stigma that a survivor experiences from his or her abuser, is a newer concept in the stigma literature, with researchers (Murray et al., 2016; Murray et al., 2015) only beginning to distinguish this from abuse from the perpetrator. We chose to include this type of stigma in the IPVSS to assess stigma one experiences from their abuser and continue the research on this concept. Items such as *My abuser convinced me that there was something wrong with me* and *My abuser blamed me* represent this dimension of IPV-related stigma. We suggest that perpetrators of IPV may contribute to survivors' experiences of IPV-related stigma through behaviors and messages such as these. Thus, research is needed to understand how perpetrator stigma is linked to emotional and psychological IPV. Finally, isolation was a component that was part of the overall stigma associated with IPV, and this is again established as something that survivors experience as part of the stigma process (Crowe & Murray, 2015; Overstreet & Quinn, 2013; Quinn et al., 2014).

The Intimate Partner Violence Stigmatization Model (Overstreet & Quinn, 2013) and the Integrated Intimate Partner Violence Stigmatization Model (Murray et al., 2015) were concepts we drew from as we developed and validated the IPVSS. Stigma internalization and anticipated stigma, as discussed

Table 3. The Intimate Partner Violence Stigma Scale (IPVSS).

Question	Response Prompt
1. If I told people about the abuse, I worried that they would think I "asked for it."	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
2. People blamed me for staying in the relationship despite the abuse I experienced.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
3. I felt that the abuse was my fault.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
4. My abuser convinced me that there was something wrong with me.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
5. I believed that if I shared details about my relationship with others I would be blamed for the abuse.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
6. People said the abuse was my fault.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
7. I knew the abuse was not my fault.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
8. My abuser blamed me.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
9. People supported me when I told them about the abuse.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
10. I felt like I deserved it.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
11. My abuser isolated me from family and friends.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
12. I wasn't allowed to go anywhere or do anything by my abuser.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
13. I didn't know whom I could tell about the abuse without it being used against me.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*
14. People viewed me as damaged once I shared my experience with the abuse.	*Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree*

(continued)

Table 3. (continued)

Question		Response Prompt
15.	My abuser told me not to tell others how he or she treated me.	*Strongly Disagree*/*Disagree*/*Somewhat Disagree*/*Somewhat Agree*/*Agree*/*Strongly Agree*
16.	I hid the abuse from others because I was afraid they would tell me what to do.	*Strongly Disagree*/*Disagree*/*Somewhat Disagree*/*Somewhat Agree*/*Agree*/*Strongly Agree*
17.	People in my community encourage me to talk about my experiences.	*Strongly Disagree*/*Disagree*/*Somewhat Disagree*/*Somewhat Agree*/*Agree*/*Strongly Agree*
18.	I didn't tell others about the abusive relationship because I felt ashamed of the abuse.	*Strongly Disagree*/*Disagree*/*Somewhat Disagree*/*Somewhat Agree*/*Agree*/*Strongly Agree*
19.	My abuser made me feel inferior.	*Strongly Disagree*/*Disagree*/*Somewhat Disagree*/*Somewhat Agree*/*Agree*/*Strongly Agree*
20.	My abuser monitored my activities.	*Strongly Disagree*/*Disagree*/*Somewhat Disagree*/*Somewhat Agree*/*Agree*/*Strongly Agree*

Note. Scoring: Using the scoring key (*Strongly Disagree* = 1, *Disagree* = 2, *Somewhat Disagree* = 3, *Somewhat Agree* = 4, *Agree* = 5, *Strongly Agree* = 6), sum the corresponding numbers with each item for the particular subscale: Internalized stigma—Items 2, 3, 6, 7, 10, 14; anticipated stigma—Items 1, 5, 9, 16, 17; perpetrator stigma—Items 4, 8, 11, 19, 20; isolation—Items 12, 13, 15, 18.

in the IPVS model, were both concepts found in our scale. Cultural stigma, however, was not a concept that emerged in this scale development process. The Integrated Intimate Partner Violence Stigmatization Model, which builds on the previous model, included two additional processes of stigma (enacted and perpetrator stigma). In addition, isolation was a component of this instrument and also discussed in the integrated model (Murray et al., 2015). One difference is that in the model, isolation was conceptualized as an outcome, whereas in the current scale, it is part of the stigma experience.

The IPVSS demonstrated strong relationships with related concepts. The Composite Abuse Scale (Hegarty et al., 1999) and the IPVSS had a significant positive relationship suggesting that stigma is in fact related to experiencing abuse. Similarly, the Psychological Maltreatment of Women Inventory (Tolman, 1999), and the IPVSS had a significant positive relationship suggesting that stigma is also related to psychological abuse in particular, and that when someone experiences this, they also tend to experience stigma related to this. The Brief Fear of Negative Evaluation Scale (Leary, 1983) also had a significant positive relationship with the IPVSS, demonstrating

Table 4. Concurrent Validity Between IPVSS and CAS, PMWI, BFNE, and Depression.

Variable	CAS	PMWI	BFNE	Depression	Factor 1 IPVSS	Factor 2 IPVSS	Factor 3 IPVSS	Factor 4 IPVSS	Total IPVSS
Factor 1	.35**	.47**	.18*	.22**	1	.41**	.53**	.42**	.81**
Factor 2	.14	.42**	.32**	.12	.41**	1	.51**	.52**	.78**
Factor 3	.06	.33**	.15*	.09	.53**	.51**	1	.45**	.78**
Factor 4	.24**	.66**	.20**	.12	.42**	.52**	.45**	1	.69**
Total IPVSS	.26**	.58**	.29**	.18*	.81**	.78**	.78**	.69**	1
CAS	1	.43**	.06	.17*	.35**	.14	.06	.24**	.26**
PMWI	.43**	1	.16*	.20**	.47**	.42**	.33**	.66**	.58**
BFNE	.06	.16*	1	.38**	.18*	.32**	.15*	.20**	.28**
Depression	.17*	.20**	.38**	1	.22**	.12	.09	.12	.18*

Note. IPVSS = Intimate Partner Violence Stigma Scale; CAS = Composite Abuse Scale; PMWI = Psychological Maltreatment of Women Inventory; BFNE = Brief Fear of Negative Evaluation Scale.
*Correlation is significant at the .05 level (two-tailed). **Correlation is significant at the .01 level (two-tailed).

that stigma is related to a fear of being negatively evaluated by others. We also included a depression measure to assess how stigma from IPV might relate to these affective states. Depression and stigma had a positive relationship suggesting that the stigma experience may be related to feelings of depression. These relationships are noteworthy, as stigma from IPV seems to be an important variable that relates to many concepts and consequences.

Implications for Research and Practice

We constructed the IPVSS with the goal of clinical application in mind. Clinicians who are working with diverse groups of survivors of IPV can easily use and score the IPVSS with clients to assess the level of stigma the person has faced to measure and discuss this with those who have been affected by IPV. After measuring the stigma that one has experienced with IPV, the clinician may use the total stigma score, or the particular subscale scores to begin a conversation about the role stigma has played in the person's experience, and what tools and resources may be needed to overcome the stigma. The assessment results may shed light on the particular type of stigma that the person has most been affected by, which can then be factored into the treatment and interventions the clinician might use. For example, if the subscale, internalized stigma was the highest, suggesting that the person is experiencing a lot of this type of stigma, then the clinician might want to work with the survivor to decrease this in ways that are helpful to the person who is experiencing it. For the person who scores highest on the isolation

subscale, for example, the clinician might assist this person with exploring ways to find social support and decrease isolation, for example, through joining a support group to meet other IPV survivors.

The IPVSS may be something that is administered on multiple occasions to assess how the person's stigma experiences change over time. Perhaps, a clinician may give the assessment during the initial intake session with someone who is seeking services and then measure the level of stigma again after the person has been seeking services and support for a number of sessions. Perhaps, seeing the stigma score decrease as the person makes progress with the clinician will be a positive outcome and a portion of the person's recovery from abuse and stigma.

For researchers interested in further exploring stigma related to IPV, we encourage the use of the IPVSS to do so. Future research with even larger, more diverse samples will assist in further demonstrating its psychometric strength in measuring stigma. About 78% of the current sample identified as female and Caucasian, so future research using the IPVSS with more gender, racial, and ethnic diversity is warranted to assess whether the IPVSS remains valid and reliable among a variety of survivors. Similarly, an overwhelming majority of the current study sample (191 participants) reported that they were with an intimate partner of the opposite gender during the abuse, so future research might test the IPVSS with samples who are in same-sex relationships.

In the current study, we examined the relationships between the IPVSS and three other abuse-related measures for concurrent validity purposes, and all relationships were found to be in the hypothesized direction with significance. It would be interesting to look further at the relationship between victim blaming and stigma, for example, as the concept of victim blame is well established in the literature, to explore how it relates to IPV stigma. As well, the IPVSS may be useful in researching which types of abuse (e.g., verbal, physical, sexual) are associated with greater experiences of stigma. Researchers interested in IPV stigma may also investigate whether more stigmatizing experiences affect the process of recovery. Perhaps, recovery is more difficult when one experiences a lot of stigma.

Perpetrator stigma is another area that is ripe for future research. Stigmatization is a process based on power inequities, whereby stigmatized groups experience social disadvantage and restricted access to societal resources (Link & Phelan, 2001). Stigma can be enacted in a number of ways, including bias in interpersonal encounters (e.g., family, friends, physicians; Major, Dovidio, Link, & Calabrese, 2018). However, unlike other stigmas, IPV may involve frequent instances of enacted stigma from one's partner because of power inequities within the relationship. Although we have attempted to capture some of these interpersonal forms of stigma by perpetrators in the

IPVSS, it is possible that perpetrator stigma is difficult to distinguish from psychological abuse. Despite this, it is important to recognize the role perpetrators play in sustaining the stigma IPV survivors face and we encourage future research in this area (see Murray et al., 2015). Finally, future research might also investigate stigma's relationship to some of the particular psychological distress that is common to those experiencing IPV (e.g., post-traumatic stress disorder, anxiety, depression) to understand the impacts of IPV stigma on diagnosable mental health concerns.

Limitations

As with all research, this study is not without limitations. First, we sampled participants using two methods, which may have affected the results and resulted in a convenience sample. Future research studies might seek to include non-convenience samples to assist with generalizability. Next, we had very few men who participated—14% (N = 29). It would be interesting to study the stigma process for male survivors of IPV, but to so, scholars would need to consider recruitment procedures that could target this sample in particular. Perhaps, men feel an extra stigma related to IPV, due to their gender, so we were not able to assess this as we did not have enough male participants in our sample. A similar lack of racial and ethnic diversity existed in the current study. About 78% of the sample identified as Caucasian (N = 159), so researchers are encouraged to sample those in nonmajority groups to examine how the stigma related to IPV may change based on demographic factors.

Another noteworthy limitation of this research relates to the stigma concept. Our EFA did not reveal a separate factor for enacted stigma, even though this type of stigma is well established in the literature on IPV. Factor 1 of the IPVSS had some items that seemed to describe enacted stigma (e.g., *People said the abuse was my fault*), so this concept was included in this component, but it was interesting that enacted stigma did not appear to be a unique and separate factor in this study. Future research might include a closer investigation into this to further explore whether enacted and internalized stigma appear to hold together as one concept or whether they are indeed separate components of the stigma experience, as previous scholars have posited. Perhaps, discrimination-based scales that include more action-oriented or behavioral responses where IPV survivors indicate whether discrimination occurred would capture this portion of the stigma process in ways that a stigma scale cannot.

Finally, this research used an electronic survey and participants had to have access to a computer to take part in the research. Those survivors without access to a computer may have different experiences with stigma related

to IPV, especially if one assumes that lack of computer access may also suggest lower income levels. Participants may have responded differently to an online survey than they might have if surveyed or interviewed in a face-to-face environment. Future research should consider this when exploring stigma or similar concepts with this population.

Conclusion

This study involved the initial development and validation of the self-report measure, the IPVSS. This measure is needed to fill a gap in the existing literature on stigma related to IPV. Although researchers have begun to explore this topic more extensively in recent years, to date, there is not a quantitative measure to provide an objective measure of survivors' experiences of stigma. With the development of the IPVSS, researchers and clinicians now have a tool for measuring stigma experiences among survivors of IPV in both future research and clinical practice. The IPVSS reflects overall experiences of stigma, as well as specific subtypes that survivors may encounter. Continuing to move toward, a better understanding of these experiences ultimately can help to identify solutions to stopping and overcoming this stigma that survivors face.

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