Sources and components of stigma experienced by survivors of intimate partner violence

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Abstract:

Previous research suggests that survivors of intimate partner violence (IPV) experience stigma, which may affect their willingness to seek help and their recovery process following the end of the abusive relationship. This article presents the Integrated IPV Stigmatization Model, which integrates previous research on the components and sources of the stigma surrounding IPV. Content analysis procedures were used to examine the applicability of the model to qualitative data from an electronic survey with 279 survivors of past abusive relationships. The results demonstrated the most common components and sources of stigma experienced by the participants, as well as the patterns of which components were most common among the various sources of stigma. Implications for future research and clinical practice are discussed.

Keywords: intimate partner violence | domestic violence | stigma | Integrated Intimate Partner Violence Stigmatization Model

Article:

Although the concept of stigma is not a new one, with some of the earliest writings on the topic dating back to the 1960s (Goffman, 1963), stigma as it relates to intimate partner violence (IPV) has only recently gained the attention of researchers (Crowe & Murray, 2015; Murray, Crowe, & Akers, in press; Murray, Crowe, & Brinkley, 2015; Overstreet & Quinn, 2013). Stigma is the co-occurrence of labeling, stereotyping, and separation that can result in status loss and discrimination (Link & Phelan, 2001). At the root of stigma is social devaluation linked to attributes that are considered discrediting or a mark of failure or shame in the eyes of others (Goffman, 1963). In the IPV literature, researchers have addressed several concepts that are encapsulated within the experience stigma such as victim-blaming, myths, and stereotypes about IPV (e.g., Bryant & Spencer, 2003; Wuest & Merritt-Gray, 2001) and have found that these experiences have implications for whether or not a perpetrator receives legal sanctions, whether or not the victim reports it, and whether or not a third party responds (Bryant & Spencer, 2003; Waltermaurer, 2012). However, these concepts only represent a portion of the stigma (e.g.,

labeling and stereotyping) that people who experience IPV encounter. In the current article, we propose the Integrated IPV Stigmatization Model to highlight how experiences of IPV fit within the definition of stigma. Specifically, we address how those who experience IPV are labeled, stereotyped, and isolated, which may ultimately result in status loss and discrimination. We also describe how IPV-related stigma is experienced on an individual, interpersonal, and structural level. The current study seeks to address these gaps in the literature as they relate to IPV stigma. To provide the context for the development of the model, we begin a review of existing literature on IPV-related stigma and then outline the development of the Integrated IPV Stigmatization Model.

Previous Research on Stigma and IPV

Researchers have begun to consider how experiences of stigma might manifest in the lives of those who experience IPV. For example, Overstreet and Quinn's (2013) IPV Stigmatization Model highlights three components of survivors' experiences of stigma that can prevent their help-seeking behaviors. These include (a) *cultural stigma,* or the negative societal beliefs about those who experience abuse; (b) *internalized stigma,* whereby the person begins to believe negative attitudes as true; and (c) *anticipated stigma,* wherein the person who has experienced abuse expects negative reactions from others once abuse is disclosed. The model highlights the way that these components of stigmas interact and affect one another on individual and interpersonal levels and focuses on perceptions of these stigma experiences rather than the sources. According to the model, the sociocultural context in which IPV occurs can increase cultural stigma and heighten both internalized and anticipated stigma for survivors on IPV. The relationship between internalized and anticipated stigma is said to be bidirectional, so that having more internalized stigma can result in the person anticipating stigma from others. In addition, the more a person anticipates stigma from others, the more internalized stigma can increase. The IPV Stigmatization Model focuses on perceptions of stigma experiences. These internal experiences, although important in our understanding of stigma that survivors of IPV face, are just one facet of the stigma concept and other sources of stigma, such as stigma external to the survivor.

Recently, other researchers have sought to understand the specific components of stigma experienced by survivors of IPV, as well as the sources from which such stigma originates (Crowe & Murray, 2015; Murray, Crowe, & Brinkley, 2015). Building primarily on conceptualizations of stigma presented by Byrne (2000) and Link and Phelan (2001), the authors focused on the following five components of stigma, defined in prior literature but modified to describe how each affects survivors of IPV:

1. *Blame*: Survivors may be blamed or viewed as somehow responsible for the abuse they experienced.
2. *Discrimination*: Survivors may be treated differently from others or encountered judgment and stereotypes as a result of their abuse.
3. *Loss of status*: Survivors may lose standing and/or power within social networks and systems as a result of having experienced abuse.
4. *Isolation*: Survivors may be isolated and separated from others due to having been abused.

5. *Shame*: Survivors may experience negative, painful emotions—such as guilt, embarrassment, and secrecy—as a result of their abuse experiences.

In addition to these preestablished dimensions of stigma, Crowe and Murray (2015) also identified two additional components of stigma that survivors in their study encountered from professionals. First, their experiences were *dismissed or denied*, when the survivor reached out for assistance and the professional either did not believe him or her, or the survivor was told that his or her experience was not important. Even worse, in some cases, the professional encouraged the survivor to accept the abuse or the professional sided with the abuser. The second, *blatant unprofessionalism*, included responses that were unethical and/or violated survivors' rights to competent, professional, and respectful services.

Previous research suggests that the nature of the stigma survivors face can vary based on the source of the stigma. For example, Crowe & Murray (2015) found that the most common components of stigma that survivors faced varied based on the different categories of professionals. For example, the following components of stigma were found to be most common among the following professional groups: (a) law enforcement: dismissed or denied, (b) the court system: blame, (c) medical professionals: blame and discrimination, (d) domestic violence agencies: dismissed or denied, (e) parenting-related resources: blame, (f) religious organizations: blame, (g) workplaces and educational settings: discrimination, and (h) mental health professionals: dismissed or denied. Thus, there appear to be patterns of the components of stigma that are most common from different sources, although more research is needed to explore these patterns beyond just stigma from professionals.

Previous research also suggests that the nature of the abuse experienced may contribute to different patterns of stigma experiences among survivors of abusive relationships. Using a hierarchical cluster analysis to examine whether certain components of stigma appear more likely to co-occur (Murray, Crowe, & Brinkley, 2015), results revealed four identifiable patterns of stigma experiences among a sample of 343 survivors of IPV. One group of participants (about one quarter of the sample) demonstrated generally low experiences of stigma overall. Two groups experienced moderate levels of stigma. One of these groups (14% of participants) noted higher levels of being blamed and treated as a "black sheep of the family," and the others' (19% of the sample) stigma-related experiences included themes of secrecy, separation, shame, social exclusion, and stereotyping. The fourth group, representing approximately 43% of the participants, experienced generally high levels of stigma overall. In examining differences between these groups based on the types of abuse they had experienced, participants in the group that reported the highest levels of stigma also reported the highest rates of verbal abuse. Therefore, experiences of verbal abuse within an intimate relationship may be linked to higher experiences of abuse (Murray, Crowe, & Brinkley, 2015). These findings support the need to examine an additional source of stigma—that of the perpetrator of abuse. That is, the nature of the abuse by the perpetrator may be related directly to whether and how survivors experience and internalize stigma, particularly through verbal and emotional abuse.

In sum, a growing body of research demonstrates that stigma is a significant challenge for many survivors of IPV. However, stigma has been defined differently across studies, and there have been two main focuses in past research: the components of stigma and the sources of it. To

strengthen future research, the current study aimed to delineate an integrated conceptual framework that includes both the sources and components of stigma faced by survivors of IPV. We aimed to identify the most common sources and components of stigma and that survivors face, as well as whether patterns emerged in the components of stigma that were most commonly experienced from these sources. To address these goals, we analyzed qualitative data derived from an electronic survey with 279 survivors of IPV, all of whom had been out of any abusive relationships for at least 2 years. Before describing the methods of the current study, we present the Integrated IPV Stigmatization Model, which was developed through the process of planning and conducting the study and provided the framework for our data analyses.

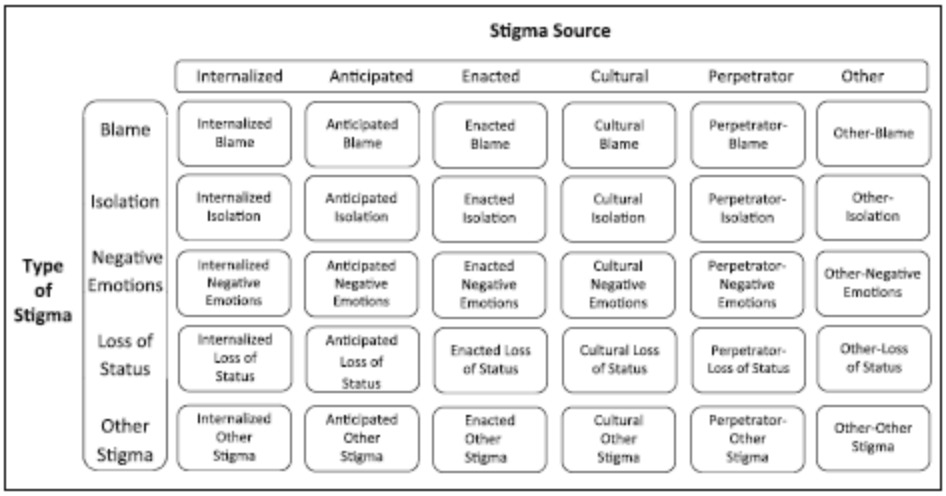

Figure 1. The Integrated IPV Stigmatization Model.
Note. IPV = intimate partner violence.

The Integrated IPV Stigmatization Model

The Integrated IPV Stigmatization Model (see Figure 1) is an extension of the IPV Stigmatization Model described by Overstreet and Quinn (2013). As stated previously, the original model proposed by Overstreet and Quinn included three sources from which survivors face stigma: internalized, anticipated, and cultural stigma. Two additional stigma sources are included in the Integrated Model: enacted and perpetrator stigma. Enacted stigma, or people's perceptions of discrimination and prejudice they experience from others, reflects the extent to which people feel they have been the targets of others' prejudice. The addition of perpetrator stigma was a result of previous research demonstrating the impact of emotional and verbal abuse on stigma (Murray, Crowe, & Brinkley, 2015), as well as our impressions from our initial readings of the study data that demonstrated the frequency with which perpetrators were mentioned as a source of stigma faced by participants.

Definitions of each of the stigma sources in the Integrated IPV Stigmatization Model are as follows: (a) *Anticipated Stigma*: Expectations that others will react in stigmatizing ways if they find out about stigmatizing identity, refers to people's belief that others will discriminate against or socially reject them; (b) *Internalized Stigma*: The extent to which people come to believe and endorse negative and stigmatizing views about themselves (i.e., based on views that are

perpetuated in larger community); (c) *Enacted Stigma*: Perceptions of discrimination and prejudice experienced from others, as well as the extent to which people feel they have been the targets of others' prejudice (e.g., negative comments, public humiliation, being denied housing, physical threats); (d) *Cultural Stigma*: Ideologies that delegitimize experiences of IPV (e.g., the belief that IPV victims provoke their own victimization), as well as the ways that negative beliefs and stereotypes about IPV at the societal level influence the experience of IPV stigmatization at individual and interpersonal levels; (e) *Perpetrator Stigma*: Stigmatizing messages directly from one's perpetrator, which can include emotionally, verbally, and/or psychologically abusive actions that perpetuate the stigma surrounding IPV; and (f) an *Other* category is also included to reflect that stigma may be experienced from other sources than those listed.

Four main components of stigma are included in the Integrated IPV Stigmatization Model: blame, isolation, negative emotions, and loss of status. These are consistent with the components of stigma described in previous research (e.g., Byrne, 2000; Crowe & Murray, 2015; Link & Phelan, 2001). Our initial list of components of stigma included all seven components of stigma that were identified by the authors (i.e., blame, discrimination, loss of status, isolation, shame, dismissed/denied, and blatant unprofessionalism). However, as these components of stigma were identified based on the stigma that survivors experience from professionals, we undertook several rounds of revisions to create a more inclusive set of stigma components that could be experienced across different sources. In addition, in our initial pilot tests of the coding system (which are described in the "Method" section), we identified areas of potential overlap for some of the stigma components, and the components were refined into the following four categories, plus an "other" category: (a) *Blame*: Holding survivors responsible for their own abuse; (b) *Isolation*: Survivors feeling and/or being treated as separated and apart from others as a result of the abuse; (c) *Negative Emotions*: Shame and other painful emotions felt about oneself, caused by consciousness of guilt, shortcomings, or impropriety. These can result in secrecy (i.e., hiding or concealing the abuse); (d) *Loss of Status*: Being viewed as "less than" or not as valued or as powerful, or not taken as seriously as others who have not experienced abuse; and (e) *Other* components of stigma that are not captured clearly in the above categories.

Taken together, the Integrated IPV Stigmatization Model combines the sources with components of stigma, resulting in 30 unique categories of stigma faced by survivors of IPV. Each category is described in greater detail in the "Results" section, where examples of participants' statements are presented as illustrations. As a newly developed model, the aims of the current study were to examine the extent to which the categories reflected survivors' experiences, as well as to identify the sources and components of stigma that survivors face most commonly. To address these goals, this study used content analysis procedures to identify themes in qualitative data from a sample of survivors of IPV who were asked to describe their experiences of stigma. The next section details the methodology used in the current study.

Method

The main research question guiding this study was as follows:

Research Question 1: Does the Integrated IPV Stigmatization Model provide a useful framework for conceptualizing the stigma-related experiences of survivors of IPV?

Assuming that the Integrated IPV Stigmatization Model provided a useful framework, the following additional research questions were examined:

Research Question 2: What are the most common sources of stigma experienced by survivors of IPV?

Research Question 3: What are the most common components of stigma experienced by survivors of IPV?

Research Question 4: What patterns emerge in the most common *components* of stigma experienced from each *source* of stigma experienced by survivors of IPV?

Survey Instrumentation

This study used data collected through an electronic survey, designed specifically for this study to gain an understanding of experiences of stigma among survivors of past abusive relationships. The electronic survey included a demographic questionnaire, quantitative rating questions, and open-ended questions. The survey's first section asked about participants' background characteristics, as well as their experiences with IPV in past relationships, with a focus on their most recent abusive relationship.

The second section was the source of the primary data for the current study. Here, participants were asked to rate the extent to which different components of stigma applied to their experiences of abuse. They were asked to rate each of the following 12 components of stigma on a scale from 1 to 5 (1 = *does not apply at all*, 2 = *applies a little*, 3 = *somewhat applies*, 4 = *mostly applies*, 5 = *completely applies*): (a) blame, (b) "black sheep of the family" role, (c) discrimination, (d) isolation, (e) being labeled, (f) loss of power, (g) loss of status, (h) secrecy, (i) separation, (j) shame, (k) social exclusion, and (l) stereotypes. Then, participants were provided with an unlimited-space text entry box, in which they were asked to describe their experiences related to each term for any of the items that they rated as 3 or above (i.e., "somewhat applies," "mostly applies," or "completely applies"). The following question was provided as an example on the survey: "For example, if you rated 'blame' as 3 or above, in what ways did you experience blame in relation to the abuse you experienced?" All open-ended responses to this section were used for the qualitative data analyses for this study.

Other sections of the survey that were not included in the data analyses for the current study address (a) the extent to which participants experienced stigma from various sources of potential social support and supportive resources (e.g., mental health professionals, attorneys, friends, and family members) and (b) participants' experiences with overcoming past abuse and the stigma that surrounds it. Interested readers are referred to the following other resources for additional information about other research questions that have been examined based on this ongoing

survey of the stigma surrounding IPV (Crowe & Murray, 2015; Murray, Crowe, & Brinkley, 2015).

Participant Recruitment

The survey was hosted on Qualtrics, a secure electronic survey-hosting website platform. All participant responses were collected anonymously. To be eligible to participate in this study, participants had to meet the following 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 2 years; and (d) be able to complete the survey in the English language. Participants were required to answer eligibility questions before they were able to enter the full survey.

Although efforts were made to recruit a diverse and large sample, the sample is considered a convenience sample. We used snowball sampling procedures and invited people who received the invitation to participate to forward it to others they knew who may be eligible and interested in participating. First, we emailed an invitation to participate to personal and professional contacts, as well as sent the recruitment email over relevant listservs. Second, we posted a notice about the survey on Internet-based message boards. Third, we posted the recruitment notice on Facebook pages that were relevant to the target population. These notices were posted on pages that were relevant to survivors of IPV (e.g., survivor support groups, local domestic violence agencies, and state-level domestic violence coalitions), and they were only posted on pages that allowed members of the general public to post on their sites (i.e., it was not required to be a member of a group to post to the sites). All recruitment invitations and notices included a website link where participants could go to complete the survey.

All participants who completed the survey were eligible to enter a drawing for one of two US$50 store gift cards. Participants who were interested in entering the drawing were instructed at the end of the survey to send an email to the researcher's email address. Thus, participants' entries for the drawing were not linked to their responses to the survey. All participants who completed at least the eligibility questionnaire received a list of resources for more information about IPV as a safety precaution.

Participants

A total of 279 participants had completed the survey at the time the data analyses began on March 12, 2014, and responses from all of these participants were included in the data analyses. Participants ranged in age from 21 to 69 years (M = 39.39, SD = 10.47). Most participants were female, with 271 females (97.1%), 7 males (0.03%), and 1 participant not reporting his or her gender. The majority of participants were Caucasian/White (n = 227, 80.3%), followed by African American (n = 27, 9.7%), Hispanic/Latino/Latina (n = 26, 9.3%), Other (n = 13, 4.7%), Native American (n = 9, 3.2%), and Asian (n = 4, 1.4%; *Note.* Participants could select all backgrounds that applied to them, so percentages add up to greater than 100%). Participants had diverse educational backgrounds, with the following reported highest levels of completed education: high school diploma/general education development (GED; n = 76, 27.2%), associate

degree (*n* = 43, 15.4%), bachelor's degree (*n* = 79, 28.3%), graduate degree (*n* = 71, 25.4%), and other (*n* = 10, 3.6%). Their current household income levels were as follows: less than $30,000 (*n* = 120, 43.0%), $30,000 to $59,000 (*n* = 86, 30.8%), $60,000 to $100,000 (*n* = 49, 17.6%), and more than $100,000 (*n* = 24, 8.6%).

Participants reported their current relationship status at the time of taking the survey as follows: married (*n* = 74, 26.5%), divorced (*n* = 65, 23.3%), in a committed relationship and living together (*n* = 43, 15.4%), single (*n* = 39, 14.0%), in a committed relationship and not living together (*n* = 22, 7.9%), dating but not in a committed relationship (*n* = 14, 5.0%), separated (*n* = 14, 5.0%), not reported/other (*n* = 5, 1.8%), and in a legally recognized civil union/domestic partnership but not married (*n* = 3, 1.1%). Most participants were parents, with 206 participants (73.8%) reporting that they had children. Most participants were from the United States (*n* = 237, 84.9%), with a national sample including participants from 44 states in the United States, plus Washington, D.C. Thirty-eight participants (13.6%) lived outside the United States, representing eight different countries, including the United Kingdom, France, Canada, Australia, Turkey, Venezuela, New Zealand, and the Netherlands.

Participants were asked to describe in greater detail their most recent relationship that included any form of IPV. The vast majority of participants (*n* = 238, 85.3%) reported about relationships with partners who were a different gender from them, and only 19 participants (6.8%) reported same-gender relationships (an additional 22 participants did not report their partners' gender). The length of these relationships ranged from less than 1 year to 35 years (*M* = 7.6 years, *SD* = 6.5). Participants described the most significant levels of commitment they had with these partners as follows: dating but not in a committed relationship (*n* = 5, 1.8%), in a committed relationship and not living together (*n* = 42, 15.1%), in a committed relationship and living together (*n* = 76, 27.2%), married (*n* = 127, 45.5%), in a legally recognized civil union (*n* = 1, 0.4%), and other/not reported (*n* = 28, 10.0%). Almost half (*n* = 134, 48.0%) of the participants reported that they had any children with these partners.

The types of abuse that participants reported experiencing in these relationships included the following: physical (*n* = 197, 70.6%), emotional (*n* = 248, 88.9%), verbal (*n* = 231, 82.8%), sexual (*n* = 152, 54.5%), and other (*n* = 55, 19.7%). Examples of the other types of abuse that participants specified included financial and economic abuse, forced abortions, abduction, withholding immigration status, making threats, spiritual abuse, stalking, and destroying property.

Just over one third (*n* = 108, 38.7%) of participants reported that their partners received some form of legal punishment or sanctions as a result of their abusive behaviors. Most participants (*n* = 179, 64.2%) reported that they do not have any current contact with these partners. The amount of time since these relationships ended ranged from 2 years to 40 years (*M* = 8.3 years, *SD* = 7.2).

Data Analyses

Research Question 1 was answered using content analysis procedures (Stemler, 2001) to analyze participants' open-ended responses in Section 2 of the survey. Because of the length of many

participants' responses to this question, the first step to organizing the data was to create a list of statements that could be coded meaningfully. All original responses were entered into a single word processing document in their original form. Then, the lead researcher divided these statements into single-sentence statements (i.e., if the responses were in the form of a paragraph or compound sentences, they were divided so that each sentence within that paragraph became a single statement). Participants' own wording and statements were retained throughout the data coding process, although some minor edits were made to the statements so that each statement could be understood and interpreted on its own (e.g., replacing "it" with the term that word referred to in another section of the paragraph). Examples of participants' quotes that were included in the data are provided in the "Results" section to illustrate the themes identified in the analyses. The final list of participant statements that served as the data for this study included 593 statements.

The coding system used for this study combined an a priori and emergent coding strategy (Stemler, 2001), in that the researchers began with the full set of components of stigma included on the survey and the full set of sources of stigma outlined by Overstreet & Quinn (2013). From these prior conceptualizations, the researchers developed an initial coding system that included themes for the sources and components of stigma. However, multiple iterations of this coding system were developed before the full data coding process began. First, the researchers all examined the initial coding system to identify potential areas of overlap or inconsistency, and initial revisions were made for clarification. Second, the researchers compared the coding system with the list of statements and discussed potential gaps or additional overlapping codes, and additional revisions to the coding system were made at this point. In particular, this round of revisions involved adding the "Perpetrator" category of stigma source, as well as consolidating the original list of 12 components of stigma to the four final categories (i.e., blame, isolation, negative emotions, loss of status, plus the other category), which were designed and defined to be encompassing of the other components of stigma addressed on the survey. Third, the researchers conducted a pilot study, in which all three researchers used the draft coding system to code the sources and components of stigma for a randomly selected sample of 30 participant statements. At this point, additional minor clarifications were made to the final definitions of the coding categories to create the final coding system.

All three researchers coded the full data set. This approach of using three coders provided a built-in validity check for the coding system, and it also served as a basis for deciding upon a final consensus code when there were disagreements in the codes assigned by the three coders. The consensus codes for each statement were determined in the following ways: (a) A statement on which all three coders agreed on the code had the agreed-upon code as its consensus code; (b) a statement on which two of three coders agreed had the code on which both agreed as the consensus code; and (c) when all three coders disagreed on a code, this statement was noted as having No Code and not considered in further analyses.

Research Questions 2 and 3 were examined by calculating the frequencies and percentages of statements coded into each category (i.e., for Research Question 2, the source categories, and for Research Question 3, the component categories). Research Question 4 was examined by examining a crosstab table that examined the components of stigma by each source.

Results

Research Question 1: Does the Integrated IPV Stigmatization Model provide a useful framework for conceptualizing the stigma-related experiences of survivors of IPV?

A total of 593 statements were coded, with each statement receiving two codes each (i.e., the source code and the component code) by three coders. Thus, the total number of statements coded was 3,558. An examination of the interrater reliability of these codings revealed an overall percentage of agreement of 78.7% and a Fleiss's kappa statistic of 0.17, which indicates slight agreement (Landis & Koch, 1977).

To determine whether the Integrated IPV Stigmatization Model provides a useful framework for conceptualizing the stigma-related experiences of survivors of IPV (i.e., Research Question 1), we set the standard that at least 80% of all statements (i.e., at least 474 out of 593 statements) would need to have consensus codes that fell into the main categories for both the source and component codes (i.e., not fall into the "Other" or "No consensus" codes). For the source codes, only 79 (13.3%) of the codes fell into the "Other" or "No consensus" codes. For the component codes, only 87 (14.7%) of the codes fell into the "Other" or "No consensus" codes. Therefore, it was determined that the IPV Stigmatization Model provided a useful framework for describing the stigma-related experiences of survivors of IPV, and we proceeded to analyze the remaining three research questions.

Table 1. Frequencies and Percentages of Statements in Each Source Category.

Source of Stigma	Frequency	%
Anticipated	25	4.2
Internalized	230	38.8
Enacted	117	19.7
Cultural	15	2.5
Perpetrator	127	21.4
Other	18	3.0
No consensus	61	10.3
Total	593	100.0

Research Question 2: What are the most common sources of stigma experienced by survivors of IPV?

Table 1 presents the frequencies and percentages of the statements coded into each of the source categories.

As indicated in Table 1, the most common source of stigma among participants was internalized stigma, followed by stigma from the perpetrator, enacted, anticipated, and cultural. Other sources were indicated in 18 statements, and 61 statements were grouped into the "No Consensus" category. Examples of statements in each category are presented in the discussion of Research Question 3

Research Question 3: What are the most common components of stigma experienced by survivors of IPV?

Table 2 presents the frequencies and percentages of the statements coded into each of the component categories.

As indicated in Table 2, the most common component of stigma reported by participants in this study was isolation, followed by loss of status, blame, and negative emotions. Other components were indicated in 37 statements, and 50 statements were grouped into the "No Consensus" category. Again, examples of statements in each category are presented in the discussion of Research Question 4.

Table 2. Frequencies and Percentages of Statements in Each Component Category.

Component of Stigma	Frequency	%
Blame	130	21.9
Isolation	139	23.4
Negative emotions	100	16.9
Loss of status	137	23.1
Other	37	6.2
No consensus	50	8.4
Total	593	100.0

Research Question 4: What patterns emerge in the most common *components* of stigma experienced from each *source* of stigma experienced by survivors of IPV?

Table 3 presents the cross-tabs for the components of stigma experienced from each source of stigma. This table omits all statements coded as "Other" and/or "No Consensus." The most frequent component of stigma within each source is indicated in bold text.

Table 3. Patterns of Components of Stigma Within Each Source Category.

	Frequency	%
Anticipated (n = 25)		
Blame	2	8.0
Isolation	2	8.0
Negative emotions	4	16.0
Loss of status	**11**	**44.0**
Internalized (n = 230)		
Blame	40	17.4
Isolation	40	17.4
Negative emotions	**88**	**38.3**
Loss of status	29	12.6
Enacted (n = 117)		
Blame	**46**	**39.3**
Isolation	25	21.4
Negative emotions	1	0.9
Loss of status	40	34.2
Cultural (n = 15)		
Blame	**8**	**53.3**
Isolation	0	0.0
Negative emotions	2	13.3
Loss of status	3	20.0
Perpetrator (n = 127)		
Blame	29	22.8
Isolation	39	30.7
Negative emotions	4	3.1
Loss of status	**41**	**32.3**

Note. Statements coded as "Other" and/or "No Consensus" are not included in this table, so percentages do not sum to 100% within each category.

As Table 3 demonstrates, the most common components of stigma experienced varied based on the source of stigma. Loss of status was most common from the perpetrator and anticipated stigma. Negative emotions were the most common component of stigma that was internalized. Finally, blame was the most common component of stigma from enacted and cultural sources. To illustrate the components of statements included in each of the Source × Component categories, Table 4 presents two examples (when available) of participants' statements that fell into each category.

Discussion

The goal of the current study was to examine the sources and components of stigma related to survivors' experiences of IPV. Specifically, we examined the following: (a) whether the Integrated IPV Stigmatization Model, which combines five sources of stigma (i.e., internalized, anticipated, enacted, cultural, and perpetrator) and four components of stigma (i.e., blame, isolation, negative emotions, and loss of status), provided a useful framework for understanding experiences of stigma faced by survivors of IPV; (b) the most common components of stigma experienced by survivors; (c) the most common sources of stigma experienced by survivors; and

(d) patterns in the most common components of stigma from each source. These novel conceptualizations of stigma related to IPV move beyond understanding stigma solely as a consequence of victim-blame to include conceptualizations of stigma from a multilevel perspective (i.e., intrapersonal, interpersonal, and societal).

We found that less than 15% of the total coded statements fell into the "Other" or "No Consensus" category for both the sources and manifestations of each component of stigma. These findings suggest that a majority of the coded statements were captured by the categories included in the Integrated IPV Stigmatization Model. This holistic model of IPV stigmatization revealed that among IPV survivors, the most common sources of stigma were internalized stigma, followed by stigma from the perpetrator, enacted, anticipated, and cultural. In addition, our findings suggest that the most common component of stigma was isolation, followed by loss of status, blame, and negative emotions. Our findings demonstrated that the most commonly experienced components of stigma differed by source. Specifically, loss of status was associated with stigma from the perpetrator and was a common concern related to anticipating stigma from others when IPV is disclosed. We also found that survivors expressed negative emotions, such as shame and guilt, when reflecting on how experiences of IPV were internalized, that is, connected to their identity or sense of self. Our findings also suggested that survivors felt a sense of blame when stigma stemmed from differential treatment/ discrimination from others or in societal representations of IPV. Taken together, our findings demonstrate that survivors of IPV deal with several sources and components of stigma in their daily lives, in addition to the experiences of psychological, physical, and sexual IPV.

Table 4. Examples of Participants' Statements in Each Source × Component Category.

Category	Sample Statements
Anticipated blame	I worry that people will think I'm a slut, that I'm passive, that I "asked for it."
	I hid a lot of things from my less accepting friends because I believed that anything I told those friends would be further ammunition for blame.
Anticipated isolation	I am frightened of being singled out if told many people.
	I didn't have any friends to trust and didn't know who I could tell what without it being used against me.
Anticipated negative emotions	Someone finding out would only mean more shame and punishment.
	I was ashamed I felt like people would think i was stupid and weak if they knew
Anticipated loss of status	I was afraid to tell people what was going on because I did not want people labeling me as weak or a bad girlfriend.
	I was afraid of how it would affect my job and the way my competency at work was viewed.
Internalized blame	I accepted the blame for everything that went wrong.
	I have often felt responsible for letting it get as far as it did by not reporting him.
Internalized isolation	I tend to isolate myself at times from the world. It's more peaceful and easier.
	I felt isolated because I did not want to tell people.
Internalized negative emotions	I have lots of shame because of who I allowed in my life.
	I was completely ashamed to admit what had happened to me.
Internalized loss of status	I felt powerless for a long time.
	I keep my feelings to myself so I can come off as not damaged goods.
Enacted blame	The courts blame me for abuse done to me and my kids.
	People blamed me for the violence.
Enacted isolation	The friends we had had together dropped me when I got divorced.
	No one will talk to me anymore. I assume he's spread rumors.

(continued)

Table 4. (continued)

Category	Sample Statements
Enacted negative emotions	When I came out about the relationship initially, it was met with disdain and not really acknowledged.
	(*Note*. Only one statement was coded into this category)
Enacted loss of status	I was always labeled as an outcast.
	I was labeled as a "loser" or "pathetic" because I would not fight back with my partner.
Cultural blame	I feel that society tells women in abusive relationships that it is their fault for not leaving.
	People think you can just walk away.
Cultural isolation	*Note*. No statements were coded into this category.
Cultural negative emotions	Many feel that women who stay in an abusive relationship enjoy it or have no self-esteem.
	Many women I know are stuck in the cycle of abuse because the community of faith which is mostly very abusive feeds the stereotypes and shame.
Cultural loss of status	I feel like I have a scarlet letter on my chest.
	In a fundamentalist faith community you will lose your status as good wife and mother.
Perpetrator blame	I was blamed by my husband for his abusive behavior and his affairs.
	He lied about what happened and made it my fault.
Perpetrator isolation	My abuser would not allow me to have friends or close family contact.
	Isolation from family and friends was critical in the power and control that the partner used.
Perpetrator negative emotions	My abuser made me ashamed of who I was.
	He belittled me until I felt ashamed of who I was and what our marriage was.
Perpetrator loss of status	He convinced me that I was weak.
	I was his slave.

Limitations

The researchers made a strategic effort to recruit a diverse and large sample of IPV survivors; however, our sample was predominately White, heterosexual, and mostly educated women from diverse income backgrounds. Although our sample characteristics limit the generalizability of the Integrated IPV Stigmatization Model, it does provide an area that is ripe for research in understanding how race, sexual orientation, gender, class, and nationality may modify experiences of IPV-related stigma. For instance, do male survivors of IPV report different sources of stigma as a common experience or different components of stigma as common, and are there differences in Source × Component interactions when compared with the findings of this study? Given that stigma exists within a social and cultural context, it is important to address the identities that one occupies within this context. Another important limitation was found in the relatively low indicator of interrater reliability found with the Fleiss's kappa statistic. Despite the indication of only slight agreement with this statistics, the overall percentage of agreement among the three coders was close to 80%, and the coding process involved three coders and provided a built-in validity check and process for determining consensus codes. Nonetheless, the observed level of interrater reliability may have contributed to some statements being included in the No Code or Other categories. Even in light of these limitations, the findings have several implications for research and practice, which will be discussed below.

Implications for Research

The current study examined the most common sources and components of stigma for survivors of IPV. In this study, sources of stigma were examined on the intrapersonal (i.e., internalized and anticipated), interpersonal (i.e., perpetrator and enacted), and societal (i.e., cultural) levels. For intrapersonal sources of stigma, survivors reported internalized stigma as the most common

source of stigma. Internalization captures negative beliefs about the self (e.g., feeling like a personal failure) because of one's experiences with IPV. When we examined the most common components of stigma when survivors reflected on how experiences of IPV affected their sense of self, they most commonly expressed feelings of shame and guilt. There is recent evidence that both internalized stigma and associated feelings of shame and guilt are related to greater depressive symptoms and indirect support seeking for people who have experienced IPV (Overstreet & Quinn, 2013; Williams & Mickelson, 2008). Future research is needed to explore whether emotions—such as shame, guilt, and embarrassment—account for the relationship between internalized stigma and psychological distress (e.g., anxiety, depressive symptoms) among people who have experienced IPV.

A less commonly reported intrapersonal source of stigma was anticipated stigma. Anticipated stigma occurs when people expect to be negatively judged or devalued if they disclose experiences of IPV to others (Overstreet & Quinn, 2013). Our finding that this source of stigma is associated with concerns about loss of status provides evidence of construct validity for anticipated stigma and distinguishes this source of stigma from internalized stigma. Thus, survivors' internalization of stigma is associated with negative emotions, such as shame and guilt, whereas anticipation of stigma is associated with survivors' concerns about loss of status and being seen as inferior or less than those who have not experienced IPV. Anticipated stigma is an important source of stigma because it may serve as a barrier to help-seeking (Overstreet & Quinn, 2013). Indeed, there is evidence that anticipated stigma is associated with the underutilization of health care services (Earnshaw & Quinn, 2012), and it is possible that anticipating social devaluation from others hinders help-seeking from informal support networks as well, such as family and friends. Although participants identified experiences of anticipated stigma, it was not commonly reported. It is possible that anticipated stigma was not a salient form of stigma because our sample consisted of people who were out of an abusive relationship for at least 2 years. Future work could consider whether there are differences in levels of anticipated stigma for survivors of IPV and for those who are currently experiencing IPV.

It was also important to include interpersonal sources of stigma to understand how stigma manifests in social interactions. Stigma from the perpetrator and enacted stigma were two commonly reported sources of stigma. The findings related to stigmatizing experiences directly from the perpetrator warrant further research attention. In particular, future research should examine the ways that stigma is associated with the perpetrators' behaviors, particularly related to how stigmatizing actions can underscore the emotional abuse perpetrated by the offender. Enacted stigma occurs when people are discriminated against or treated differently because of experiences of IPV. Survivors reported that when these experiences occurred, they felt a sense of blame and responsibility for the IPV they have experienced. Interestingly, this feeling of blame is also a common feature of cultural representations of IPV that are stereotypically aligned with characterizations of victim-blame. Identifying that enacted stigma and cultural stigma are two sources of stigma associated with victim-blame suggests that it is necessary to continue to dismantle the belief that people provoke their victimization or are in some way to blame for their victimization. Future research is needed to continue to identify individual, community-based, and societal-level interventions that can prevent and end the stigma that surrounds IPV.

Clinical Implications

Clients presenting for psychotherapy who have experienced IPV may have encountered stigma from many sources, and this stigma could be compounding the challenges that survivors face following their abuse. Clinicians should be mindful of the stigma surrounding IPV when working with clients affected by IPV, and they can work proactively to address this stigma in the following four ways.

First, clinicians can ensure that their own practices and work settings do not directly or indirectly add to the stigma that survivors face. For example, clinicians can create a safe space for clients to raise concerns related to IPV, such as by including questions about past abuse on their intake assessment paperwork and by displaying posters about IPV in their offices. Such actions can help clients feel that they have permission to discuss IPV-related experiences in their psychotherapy.

Second, clinicians can address IPV-related stigma throughout the psychotherapy process. Clinicians can work with clients to examine the components and sources of stigma that they may have encountered, as well as identify ways that this stigma may be contributing to their current presenting concerns for treatment.

Third, clinicians can be mindful that the stigma that survivors face may affect their ability to make progress toward treatment goals. For example, survivors may have treatment goals to increase their available social support. However, they may encounter stigmatizing responses when reaching out for help from both formal (e.g., professionals) and informal (e.g., friends and family members) sources of support. Likewise, survivors may experience discrimination when seeking employment related to their goals for their careers. Therefore, clinicians can help survivors develop strategies to address these stigmatizing responses, as well as identify alternative approaches for making progress toward their treatment goals.

Finally, clinicians can engage in social justice advocacy work to promote social changes that will reduce the stigma surrounding IPV (Murray & Crowe, under review). For example, they can take action if they see stigmatizing portrayals of IPV in local media outlets, such as by writing a Letter to the Editor if a newspaper article is written in a victim-blaming manner. In addition, clinicians can work within their service delivery systems (e.g., managed care organizations) to advocate for changes to policies that could add to the stigma that survivors of IPV face, such as if third-party payers for psychotherapy require mental health disorder diagnoses to be able to provide treatment, when symptoms may reflect understandable reactions to the trauma faced related to the IPV.

Conclusion

In conclusion, the current study provides an integrated conceptual model for understanding the sources and components of stigma that manifest in relation to experiences of IPV. To date, much of the work in understanding stigma related to IPV has focused on victim-blame, but the Integrated IPV Stigmatization Model highlights that blame is only one component of stigma that can come from internal and external sources. Moreover, the model identifies negative emotions, loss of status, and feelings of isolation as other important aspects of stigma to address as well.

Importantly, this model also includes sources of stigma on an intrapersonal, interpersonal, and cultural level, which serve as various starting points to address and mitigate the negative effect of stigma in the lives of those who currently experience IPV and survivors.

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